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President and CEO

May 25, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, DC 20201

Re: Center for Medicare and Medicaid Innovation; Request for Information on Direct Provider Contracting Models

Submitted electronically to DPC@cms.hhs.gov

Dear Administrator Verma,

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching full-service community hospitals in urban and rural parts of the United States, as well as inpatient rehabilitation, psychiatric, long-term acute care, and cancer hospitals. The FAH appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) on the referenced Request for Information on Direct Provider Contracting Models (DPC RFI).

Direct Provider Contracting Models

We appreciate that CMS is committed to testing innovations in health care delivery and attempting to improve quality and value for the patient through a variety of models. As CMS notes in the DPC RFI, the Agency already offers providers numerous avenues to explore innovation, and FAH appreciates the opportunity to partner with the Agency on many of them. These include, among others, the Medicare Shared Savings Program (MSSP), the Comprehensive Primary Care Plus Model, the Next Generation Accountable Care Organization (ACO) Model, and the State Innovation Model Initiative. CMS has worked hard to develop and grow these models, with each offering providers a distinct way to measure improvement in patient care, take on risk, and grow capacity to expand into additional models.

The DPC RFI outlines a new type of model where CMS suggests it could contract directly with participating physician practices to establish those practices as the main source of care for primary care or other services for beneficiaries that voluntarily enroll. CMS considers the use of a fixed per beneficiary per month payment to cover the cost of these services with the expectation that the contracted physician practice would provide those services in a manner agreeable to both CMS and the physician practice. We caution CMS with regard to implementing these types of arrangements, especially the potential for significant adverse impact on existing accountable care organizations (ACO) and other Center for Medicare and Medicaid Innovation (CMMI) models.

Impact on Existing CMS Innovation Models

Given the time and resources that CMS, providers, and patients have devoted to improving and implementing CMS's existing models, it is imperative that the Agency not only continue to devote energy and resources to these models but to also examine how they would be affected by the launch of a new model, in particular whether this new model would disrupt their operations and diminish their performance and potential.

It is clear that CMS has been successful in developing, implementing, improving, and expanding a number of important accountable care and primary care focused models. Participation rates have increased every year, CMS has committed substantial time and energy and other important resources to improving the models to boost participation rates, and participating providers are learning from early experience to improve their performance.

For example, MSSP participation has grown each year and reached over 500 entities in 2018. This growth has occurred throughout the provider community with physician-led ACOs growing along with all other types of ACOs. The early investment in MSSP has allowed CMS to introduce ACOs with greater levels of financial risk and larger responsibility for participants in population health. With 51 participants, the Next Generation ACO program is testing how providers can deliver better care and outcomes through population-based payment and higher levels of risk.

ACO participants are engaged as partners with CMS in other models as well. Providers are devoting time and resources to exploring participation in the new Bundled Payments for Care Improvement Advanced (BPCI Advanced) and are continuing participation in the Comprehensive Care for Joint Replacement (CJR) Model and the Comprehensive Primary Care (CPC) Plus Model. The provider community is committed to the work, but the currently deployed models require time to mature and for providers to learn and improve.

Thus, we encourage CMS to first understand the impact the DPC model and other new models could have on the Agency's existing innovation models. As such, CMS should consider:

- How would model overlap, hierarchy, and attribution issues be managed? These are areas that have required considerable collaboration between CMS and providers, and the introduction of a new model such as the DPC model could compound them significantly.
- How would the DPC model and similar type models impact participation in existing models? How could patient attribution to new models undermine the success of existing models? For example, it is clear from recent public statements that CMS is interested in

pushing the pace of ACOs taking greater levels of financial risk. How will CMS assure providers interested in greater risk that new models will not undermine their investment, by for example, cherry-picking patients?

- How does CMS plan to allocate finite resources to manage existing and new models? CMS's administrative resources are not limitless, and the obligations associated with deploying a new model could result in additional issues with data timeliness, responsiveness, and priority updates for current models.

This caution is not unlike concerns that the FAH has posed to CMS regarding expansion of models in Medicare Advantage (MA). As we have previously noted, "There is also the potential for increased provider confusion, which would come at a time when providers are already struggling to keep up with significant delivery system reforms in Medicare fee-for-service, including accountable care organizations (ACOs) and bundled payments, as well as contracting with a myriad of MA plans."

As such, we believe CMS is better served in the short-term by devoting its energy and resources to existing models, incorporating a number of the proposals in the DPC RFI into its existing models, as further discussed below, and determining how it can build off of the existing models to further reform care delivery.

Adopt Improvements to Existing Models

CMS has been diligent in seeking stakeholder feedback and making improvements to its current models. As part of the DPC RFI, CMS poses a number of questions to assist in formulating model design. It is clear that many of the policy questions where CMS seeks guidance are applicable to current ACO models and CMS should consider improvements to these models based on the feedback it receives to the DPC RFI.

Beneficiary Choice and Assignment

There are number of opportunities for CMS to enhance its models through greater flexibility in beneficiary choice and assignment. Regardless of the model, CMS should allow ACOs the choice of either retrospective or prospective patient assignment. Additionally, beneficiaries should be provided the opportunity to affirmatively align with an ACO of their choice, and we encourage CMS to make that process as beneficiary-friendly as possible. Participating ACOs have also found benefit in certain beneficiary incentives, and we encourage CMS to think about those offerings broadly so that providers can consider a full range of appropriate incentives that encourage and lead to improved beneficiary health.

Varied Risk Options Across Current and Future ACO Models

CMS should continue to develop and reform the risk offerings of its current ACO programs. The benefit of the stepwise design CMS has adopted for its ACO offerings is that providers at varying levels of advancement and sophistication in care delivery reform can enter the ACO space where appropriate and, through time and learning, advance into ACO arrangements with greater levels of risk and reward. CMS has the opportunity to build off of the success it has achieved thus far to partner with providers willing and able to adopt models with greater levels of risk. Be it adopting downside

risk for the first time, partial capitation or even full capitation, CMS has willing providers at all stages of preparedness to take on the challenge of greater risk.

For example, CMS could test a voluntary Global Payment ACO model, which would add a prospective, capitated payment model to the Medicare ACO portfolio. To support affordable and accessible health care, it is critical that all components of the health care delivery system efficiently provide care to patients. Prospective, global payments could advance this concept and facilitate a payment model where all providers are accountable for providing better care for a patient's total health care needs. This model also would introduce choice for patients who may want to access all of their health care needs under one accountable entity. For providers, this option would introduce flexibility, accountability, and the freedom to manage a population's health while driving efficiencies, and most importantly, better patient outcomes. Such a model would build on the evolution of ACO programs by allowing providers to take on higher levels of risk in order to better coordinate patient care and improve health outcomes across all care settings.

In addition to exploring additional opportunities for varying levels of risk, CMS should also consider making improvements to its risk adjustment methodology. As the FAH has pointed out in the past, the use of the Hierarchical Condition Category (HCC) scores for the MSSP underestimate the severity of high cost populations and hence underpay them. Additionally, CMS's methodology treats the impact of health status changes to continuously assigned beneficiaries disparately, generally providing for a decrease in risk score for improved health but rarely providing for an increased score for beneficiaries that experience deteriorating health status. CMS should consider a methodology that more fairly accounts for beneficiaries who become ill or develop a new condition while assigned to an ACO.

Expand Pool of Eligible Providers

If CMS's innovation agenda is to be successful in the long-term, it is important that additional providers see value and opportunity in the offered models. To that end, CMS should focus on additional ways it can attract physician specialists as participants in the ACO models. To date, the composition of ACOs has been primarily focused around primary care, often leaving physician specialists to wonder where they fit into the framework. CMS should both adjust program rules to encourage broader physician specialist participation and also highlight the benefits of participation, including the opportunity to work in multiple models, the opportunity for involvement in developing clinical guidelines and pathways, and a referral base that values high-quality coordinated care. Given this, CMS has an opportunity to expand its provider participation base through its existing models rather than through additional model expansion.

Timely and Frequent Data Transmissions

Providers must be given the tools needed to manage patient care and achieve program goals. Specifically, it is critical that providers receive relevant and timely data and be permitted enough time to analyze the data and take appropriate action with participant partners on a timely basis. The data must be provided prior to the start of any new model and at regular intervals (e.g., monthly) throughout the model.

To successfully manage risk, providers must have sufficient time and data to analyze and understand the composition, characteristics, and needs of their patient population, as well as the quality of local providers. Comprehensive management and analysis of data is the foundation for providers to redesign and coordinate care, select and form networks with the right partners, and establish the necessary organizational and technological infrastructure.

Given our member hospital experience in receiving data from CMS under current models, we have concerns about the timeliness of the data received and its quality. For example, the CJR Final Rule was announced in November of 2015, however, participant hospitals did not receive their performance year claims experience until September 2016. In many cases, our members did not find the data helpful, as it was produced in a “raw” format that was difficult for our hospitals, and especially smaller hospitals, to analyze. Those hospitals that could analyze the data found the data to be incomplete in many cases and not consistent with the hospital’s own data. The FAH urges CMS to work more closely with providers to better define the data parameters and the format(s) of data that would be most helpful to providers and its collaborators. This would allow them to more effectively examine their own cost and quality data and act on these data to improve the care provided to beneficiaries in a cost-effective manner.

Appropriate Program Waivers

The current health care program integrity regime has not kept pace with the value CMS places on the redesign of the health care payment and delivery systems and is designed to keep hospitals and physicians and other providers in silos, rather than working in alignment as a team, which is necessary for success in a new delivery system. To truly effectuate change, the hospital community must be afforded the flexibility to align physicians’ (as well as other providers’) otherwise divergent financial interests, while promoting incentives to reduce costs and improve quality. While CMS’s models offer the chance to change this paradigm, the Stark physician self-referral law (Stark law), anti-kickback statute (AKS), and certain civil monetary penalties (CMPs) stand as an impediment. A legal safe zone is needed that cuts across these laws. We urge CMS to put aside its current piecemeal approach and work with the Office of Inspector General to develop a single, overarching waiver for CMS-led innovation models applicable to the Stark law, AKS, and relevant CMPs. This would encourage financial relationships that incentivize collaboration in delivering health care, while rewarding efficiencies and improving care.

Improve Quality Metrics

Measuring quality is an integral part of all CMMI models and is a key component of a potential expansion of a successful model. It therefore is imperative that CMS carefully evaluate the quality measures proposed and used in each model to ensure that the measures selected fit the purpose of the demonstration. In addition, the measures must appropriately capture accurate and relevant timely data directly related to the care provided to the patient. Any quality measurement program should recognize pre-established goals as well as quality improvement from one measurement period to the next.

The FAH recommends that the data collection methods used in any CMMI model minimize data collection burden and incorporate data collection methods that can be pulled directly from patient

records. In addition, the quality measurement results must be shared with clinicians and providers in a timely manner to inform and facilitate improvement in patient care.

The use of tools such as frequently asked questions (FAQs) are very helpful for informing patient care and improving quality and are essential for launching an effective new program of quality measurement. These types of tools enable clinicians and administrators to ask detailed questions as they arise rather than trying to interpret general rulemaking guidance. The FAH strongly encourages CMS to incorporate such tools in the development of any new CMMI projects. However, FAQs must be updated frequently and provided in a forum where providers have easy access at all hours of the day.

CMS has placed emphasis on the need to reduce administrative burden stemming from quality measures for Medicare providers. The FAH believes the Agency should apply the Meaningful Measures initiative in these models, as it does in other quality programs to stem the proliferation of measures in both the government and commercial payer space. The current quality measures are numerous; often are not relevant to the program's purpose; and incorporate multiple different definitions, inclusions, exclusions, and reporting periods for each measure, adding significant administrative costs to the reporting process and hindering the ability of individual providers to succeed under a complex array of differing quality measures.

Thank you for the opportunity to comment. Should you have any questions, please feel free to contact me at (202) 624-1500.

Sincerely,

