

The Alliance for MACRA Reform

May 25, 2018

Adam Boehler
Deputy Administrator and Director
Center for Medicare and Medicaid Innovation
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Submitted electronically to: DPC@cms.hhs.gov

Re: Request for Information on Direct Provider Contracting Models

Dear Deputy Administrator Boehler:

On behalf of the Alliance for MACRA Reform (the Alliance), I am pleased to submit these comments regarding the Request for Information (RFI) on Direct Provider Contracting Models. The Alliance is a group of multi-sector stakeholders, that has coalesced around two main purposes: (1) to develop and advocate for MACRA reforms and implementation strategies that focus on improving the current law and its execution; and (2) to find ways to reduce provider and CMS burden by aligning the incentives of Congress, stakeholders, and related programs implemented by the federal government to improve patient care. The Alliance applauds the Centers for Medicare & Medicaid Services (CMS) for putting forward its “Request for Information on Direct Provider Contracting Models.” We believe that a few areas of the narrative are notable and deserve recognition before providing answers to the questions presented.

GENERAL COMMENTS

We concur with the RFI statement that there are “physicians, non-physician practitioners, and physician group practices looking for additional options to participate in an alternative payment model and with a desire to transform their practice and engage with patients in a way in which current initiatives have not previously offered.”¹ Within some areas of medicine – especially in areas of specialty and subspecialty – the nature of a provider’s practice limits his or her ability to qualify for participation under the current thresholds, as outlined under the MACRA statute. For others, the prospect of being able to lead an APM may be years away, simply because of inadequate opportunities for patient engagement that can complicate successful APM adoption. Issues such as these are constraints to participation, but not indicative of a lack of desire to support and promote greater value in the Medicare program. Rather, we believe significant appetite for APM participation exists across medicine, a fact which creates an opportunity for the program.

¹ CMS, *Request for Information on Direct Provider Contracting Models*

We agree that voluntary participation models allow for philosophies and components that better reflect a value proposition across the Medicare program: a system of reimbursement that aligns the incentives of physicians, beneficiaries, and the program, in ways that foster collaboration as a means of achieving success, can promote improved value. The ability of physicians and patients to work closer together, in ways outside of normal program requirements that ensure program expenditures are protected, or even reduced, is one means of promoting incentive alignment.

We also recognize that third-parties can play an integral role in helping to facilitate the types of behaviors that are of critical importance to realizing an enhanced value proposition. Modern analytics, digital platforms, and data technologies offer CMS, stakeholders, and beneficiaries opportunities for new and advanced models of care. For example, clinical data registries can convert real-world evidence into data invaluable for the program and other agencies of the federal government when supported by universally understood requirements for reliability, validity, and appropriateness.

The Alliance has been working to develop policies that align closely with the philosophies contained in this RFI. Where possible, we have added considerations related to those policies, and to stay true to the purpose of the RFI, we have added additional thinking on ways to advance the goals as outlined in the RFI without speaking directly to a particular question.

QUESTIONS RELATED TO PROVIDER/STATE PARTICIPATION

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?

Organizational mechanisms that allow providers to group together, regardless of tax identification numbers (TIN) or ownership interest, will be a key consideration. Models of care that create opportunities for new value propositions based upon clinical alignment or employment considerations can solve some problems related to successful adoption like incentive alignment. However, considerations of employment or ownership also limit the scope and potential of new model development and physician (and other provider) engagement in such models. Convening mechanisms that do not require ownership interests allow providers to work together around episodes and engage in other practices that are unique and helps to inform CMS of new and next-generational models. Conveners, as utilized under BPCI, are one such example of opportunities for physicians to work together without such constraints. However, we believe that other legal and programmatic mechanisms, such as the recognition of and allowance for limited liability corporations (LLCs), can facilitate physician and provider collaboration in ways not currently possible. We suggest that consideration be given to allowing for a multitude of ways for physicians to work together to support the spirit and philosophy of the RFI.

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)?

The Alliance believes that consideration should be given to participants, third parties working with participants, and data or digital platforms to support data aggregation, analytic work, and other program requirements in ways that lower burden on physicians, care teams, and the program. Additional consideration should be given to flexible regulatory approaches that allow for the inclusion of unique model adoption and practice as a means of delivering greater value to individual, versus population-level, patients. Such unique approaches would allow for consideration of adding new and unique components to existing model types such as BPCI as a means of promoting next-generation model development.

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?

We believe that strong consideration should be given to allowing flexible approaches to current programmatic requirements to realize the full potential of direct physician contracting as a means of establishing and succeeding under new and innovative models of care. For instance, the ability to deliver quality services via technology can provide access benefits to the patient while reducing overall costs of providing and reimbursing for care. In addition, consideration given to supporting alternative value arrangements where physicians, non-physician practitioners, and physician group practices can collaborate with other stakeholders such as product manufacturers, vendors, and commercial payers. Such collaboration can foster greater value and deliver unique value propositions where individual engagement has not or cannot succeed. Current statutory and regulatory barriers, such as the Anti-Kickback Statute (AKS), can prevent successful collaboration by prohibiting meaningful value activities such as meaningful data sharing intended to improve care delivery and adherence. We recommend regulations that prevent these activities be reviewed, and exceptions promoted, when the quality of patient care and spending under the program can be protected.

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?

We recommend that CMS view this issue not as one of necessity, but opportunity. Allowing for arrangements that lower patient out-of-pocket costs would facilitate beneficiary engagement and more closely align their interests with other model participants. Promotion of patient-centered care will require flexible regulatory approaches to current barriers that prohibit models from creating cost-saving opportunities for beneficiaries. The program is also encouraged to approach this, and other issues outlined in our response, with due consideration given to the ways that all physicians can meaningfully contribute. We therefore encourage CMS not to limit the opportunities outlined in this RFI to primary care physicians, but rather allow for participation by all specialties.

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?

The MACRA Alliance agrees data acquisition is a core component of the drive toward greater value, and data is a building block of measure, episode of care, and model development. Accurate, reliable, and clinically relevant data aids evaluation of treatment options and supports medical decision-making by both patients and providers. It can allow greater insight into particular treatments, increase opportunities to guide product development, reduce side-effects or improved outcomes from illness or disease, and provide vendors an opportunity to better support stakeholder collaboration and engagement with the program. Ultimately, data is necessary for promoting patient-centered care, fully informed medical decision-making, and help define the future of personalized medicine.

As CMS notes, opportunities for payers to use such data can result in greater understandings of population management, quality outcomes, and resource-use management – all important considerations for a value-based health care system. Such information can be used to better identify strategies to lower out-of-pocket costs, and to better align their incentives with the philosophies of value payments and new care models.

Utilizing third-party collection methods, such as clinical data registries, is one example of a mechanism with great potential for the Medicare program. Empowering clinical data registries to collect and collate data before sending it to the agency can improve the insights gleaned from such data, improving its value to the program. Access to CMS data can even improve such functions, allowing for modern analytics and big data insights that increase the value and use of such data. Third parties, registries, and digital platforms can also serve as valuable partners to the program by augmenting current CMS data system capabilities. The Alliance continues to identify ways to

facilitate such use as a means of supporting the agency in its efforts and look forward to being a resource and partner to CMS going forward.

ADDITIONAL ISSUES

As the Administration considers issues related to model identification, development, and adoption, we encourage the program to consider additional ways to facilitate physician adoption. The Alliance has been working on policies to support this goal including:

- **Create APM adoption opportunities for “hard to adopt” physicians.** Some areas of medicine, as touched on above, have obstacles to APM and risk adoption by virtue of their specialty. Areas of subspecialty, such as those found in ophthalmology and orthopaedic surgery, are prime examples of “hard to adopt” providers. While there is great interest in participating in APMs they are unable to do so. Efforts aimed at properly identifying these physicians, and working to create meaningful adoption methods that allow them to support and thrive within such models can help increase the value of care within the entire Medicare program
- **Better Align Physician Reporting with APM identification, testing, and adoption.** We believe that physician reporting can be a powerful tool, if utilized correctly, to help provide CMS the data it needs to identify models for testing and gather the data necessary to validate (or invalidate) models for the MACRA APM Pathway. The Alliance believes such alignment can in many ways expand the ability of the Medicare program to act as an incubator for new ideas that can transform care throughout our health system. As noted above, such reporting – if supported by convening mechanisms that allow for providers to work together across specialty – can also facilitate new measure and episode development as a means of furthering new model development.

CONCLUSION

As an organization, we look forward to supporting CMS through this and other areas of interest that seek to promote new value models and other reimbursement initiatives that can succeed in delivering great quality care and cost effectiveness for all stakeholders, including public payers.

Thank you for your consideration of our comments and recommendations. If you have any questions, please feel free to contact me at: 202-774-1419 or Robert.Horne@leavittpartners.com.

Sincerely,

Robert Horne
Advisor to the MACRA Alliance
The MACRA Alliance