



May 23, 2018

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Verma:

On behalf of the AMGA, we appreciate the opportunity to comment on the Center for Medicare and Medicaid Innovation's (CMMI's) nine-page "Request for Information on Direct Provider Contracting Models." Founded in 1950, AMGA represents more than 450 multi-specialty medical groups and integrated delivery systems representing about 177,000 physicians who care for one-in-three Americans. Our member medical groups work diligently to provide innovative, high quality patient-centered medical care in a spending efficient manner. Many of our medical groups already participate in the Accountable Care Organization (ACO) or the Medicare Shared Savings Program (MSSP) and in the Next Generation ACO and in the Comprehensive Primary Care + demonstrations. AMGA therefore has a strong interest in improving population health, care quality, and reducing Medicare spending growth.

The Direct Primary Contracting (DPC) Request for Information (RFI) poses 22 questions for comment in six categories: Provider/State Participation (#1-#5); Beneficiary Participation (#6-#8); Payment (#9-#12); General Model Design (#13-#15); Program Integrity and Beneficiary Protections (#16-#20); and, Questions Related to Existing ACO Initiatives (#21-#22). Our comments are largely limited to the last category.

Questions Related to Existing ACO Initiatives

The RFI asks, "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." The RFI also asks, "would the DPC model help address certain physician practice-specific needs or [emphasis added] would physician practices prefer refinements to existing ACO initiatives to better accommodate physician-led ACOs?"

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On balance AMGA believes “strengthening” and/or “refining” the existing MSSP offers far more advantages than fielding an ACO-related demonstration. We offer the following reasons.

First, CMS admits a DPC demo ostensibly would be redundant. The RFI states CMS has already implemented “a number of initiatives related to primary care.” CMS specifically identifies the MSSP and the Comprehensive Primary Care + demonstration (that includes MSSP provider participants) as these primary-care related initiatives. As stated, a DPC demo’s goals would also be the same as, or similar to, the MSSP. That is, enhance or improve beneficiary access, reduce administrative burden, and create a better provider revenue stream. Innovations CMS identifies the agency could test in a DPC demo, that is paying a fixed per beneficiary per month payment and making modifications to claims submission processes, could also just as easily be tested via the MSSP and via ACO demonstrations. Yes, a standalone DPC demonstration could address innovation gaps not currently being implemented or tested in other Medicare demonstrations. However, the better approach would be to leverage both CMS’ and the provider community’s already considerable investments in the MSSP and in ACO demonstrations by implementing or testing delivery design ideas identified in this RFI “to” as CMS notes, “strengthen existing initiatives.”

Proposing a DPC demonstration will likely have a negative effect, intended or not, on the MSSP. A DPC demo poses lost opportunity costs to the ACO program. Fielding a similar primary care demonstration will likely, if not undoubtedly, reduce the number of assignable MSSP beneficiaries as well as the number of beneficiaries who voluntarily attest to participate in an ACO. It also runs the risk of dampening provider interest in the MSSP.

This is particularly problematic since we now know the MSSP was designed with a problematic required minimum number of assigned beneficiaries. As Lynn Barr and her colleagues recently concluded in a May 11 [Health Affairs](#) Blog post, “The roughly 400 ACOs with fewer than 20,000 lives [the mean number beneficiaries in an ACO is less than 18,000] routinely experienced savings and losses of 10 percent to 20 percent simply due to statistical variation in health care spending.” “The effect of statistical variation,” the authors stated further, “can create spurious results that wrongly penalize or reward [MSSP] participants.”¹ Going forward, CMS cannot now reasonably expect provider organizations, particularly physician group practices, to take on financial risk in MSSP when year-over-year results are statistically random. (As an aside, at AMGA, we believe, that while an adequate minimum number of assigned beneficiaries is relevant in determining predictably earning shared savings, financial benchmarks, or spending per beneficiary per year, is more important. We are currently scrubbing CMS’s MSSP data files to make this known.) We note this detail because this problem likely will be compounded by the fact a DPC demo would leave the MSSP, at least in the near term, with less opportunity to attain reductions in spending growth and do so in a statistically reliable way.

Regardless of whether or not CMS fields a DPC demo, the ACO stakeholder community recognizes the MSSP needs to be reformed. The ACO provider community is well aware Secretary Azar recently termed MSSP performance as “lackluster” and “underwhelming.” Per question 22, we are confident in stating that the current 561 ACO provider groups, many of whom are AMGA members, have made substantial financial investments in clinical practice reforms to provide improved quality at reduced Part A and B spending growth for 10.5 million beneficiaries, certainly “would . . . prefer refinements to existing ACO initiatives to better accommodate physician-led ACOs.”

While certainly not the focus of this RFI, there are several recognized improvements that need to be made to improve MSSP provider participation and performance success. Refinements or improvements in these categories are necessary: provider assignment and participation; establishing, updating and resetting financial benchmarks; risk adjustment for the continuously assigned; quality

performance measurement; beneficiary incentives; payment waivers; and, accounting for financial overlap when an ACO beneficiary is also a recipient of care via another CMS pay for performance model, for example, the forthcoming Bundled Payment for Care Improvement (BPCI) Advanced demonstration and the current Comprehensive Care for Joint Replacement (CJR) demonstration.

More generally, for the MSSP to ultimately succeed it needs to be on a level playing field with the Medicare Advantage (MA) program such that the two programs can compete. MedPAC made this argument in chapters one through three its June 2014 report to the Congress.² For these reasons AMGA is currently leading a group of MSSP stakeholders, including the AMA, AAFP, ACP, AHA, AHIP, APG, FAH, MGMA, NAACOS, Premier and the Transformation Task Force, in an effort to reach consensus on several regulatory recommendations to improve the MSSP. Our goal is to forward these recommendations to CMS sometime this summer.

Before making additional comments, AMGA has repeatedly encouraged CMS to evaluate formally the MSSP, Medicare's flagship pay for performance program. It is beyond doubt had CMS awarded an annual evaluation of the MSSP, that at minimum created a comparative control group, it is reasonable to assume the program would be today designed more intelligently, would have enjoyed greater provider participation, attained greater quality improvement, and contributed significantly more to lowering Medicare spending growth now six years after the program's launch.

General Comments

Beyond the possible if not likely adverse effects a DPC demo would have on the MSSP, a DPC demo raises several additional questions or other problems. We note these 10.

1. CMMI already is fielding more than two dozen demonstrations. AMGA has heard from numerous physician group practice members that they already suffer from demonstration fatigue. Launching another demo, particularly another one that is primary care focused, compounds the problem.
2. The RFI asks "which currently covered Medicare services, supplies, tests or procedures should be included in the monthly PBPM payment." Fielding a demo that does not include all Part B services will fracture care or undermines care comprehensiveness, continuity and coordination – already a substantial problem under Medicare. Should all Part B services be included the beneficiary would still need or receive Part A and D coverage. Among other problems how this is accomplished will likely come at the expense of confusing the participating DPC demo beneficiary.
3. Does not engaging small independent practices in a DPC demo run counter to, or eliminate the rationale for, the agency's policy of excluding a substantial percent of providers, approximately 60%, from participating in MIPS?
4. Since the RFI notes CMS is considering "including small independent practices," per our noting above year-over-year MSSP performance is statistically random, how can performance by small practices with comparatively lower numbers of assigned beneficiaries be accurately measured.
5. Concerning practice size, has CMS considered the fact providers participating in commercial DPC arrangements do so at least in part to reduce their panel size substantially. Has CMS considered the long-term consequences of this on Medicare beneficiary access?
6. Under CMS' ACA Section 3021 demonstration authority, does not a DPC demo have to include financial risk? If not, how would this demo align with the Congress's intent to move providers into risk bearing contracts, or how does it help CMS move providers into the MACRA APM pathway?

7. The RFI notes CMS is considering DPC provider participation “through a convening organization such as an ACO, physician network, or other arrangement.” How likely are MSSP or Next Generation demonstration providers, already substantially preoccupied with working to achieve success, to convene DPC participants?
8. Alternatively, the RFI states DPC providers could alternatively participate via a “physician network or other arrangement.” We would question CMS taking a MIPS “virtual group” approach since the agency has estimated only slightly more than a dozen virtual groups will form this year primarily because CMS has failed to take steps to prime the pump in creating virtual groups.
9. Since the RFI asks whether “practices be at risk financially for all or a portion of the total cost of care,” if CMS does decides to put DPC demo providers at financial risk would the demo be defined as an Advanced APM? If so, if DPC demo providers are small independent practices how can they be expected to meet capital reserve requirements however lenient? In addition, how could they ever qualify under either Advanced APM threshold to earn the 5% APM bonus?
10. The RFI states CMS is considering fielding the demo via direct contracting with Medicare Advantage plans. Here again this appears redundant since MA plans in all 50 states will soon be able to participate in the Value Based Insurance Design (VBID) demo. Since participation in the VBID demo to date has been extremely limited, we see no evidence MAOs, or the 90 plus percent that are offered by commercial plans, would welcome participation in a DPC demo. CMS is also challenged in fielding a DPC demo via MAOs due to the agency's non-interference clause. In addition, MA plans are currently preparing to offer expanded supplemental benefits, will be no longer be required to abide by a benefit uniformity standard nor be required to meet a meaningful differences evaluation in offering varying plan designs, further evidence they may be disinterested.

Leaving aside our strongly held view the agency, the Medicare program, providers, beneficiaries, and the taxpayer would be substantially more advantage should CMS refocus or recommit its energies to improving the MSSP, based on our reading of the RFI, we are forced to conclude a DPC demo cannot work or be made to work effectively. In our experience the administrative and clinical competencies CMS requires in order to participate in a CMMI demonstration likely far exceed those currently participating in commercial direct provider contracts or other small and/or independent providers who have to date held an interest in the model.

We thank CMS for consideration of our comments. Should you have questions please do not hesitate to contact AMGA's David Introcaso, Ph.D., Senior Director of Public Policy at (703) 842.0774 or at dintrocaso@amga.org.

Sincerely,



Jerry Penso, M.D., M.B.A.
President and Chief Executive Officer
AMGA

Notes

1. Lynn Barr, et al., “Payment Reform In Transition – Scaling ACOs for Success,” Health Affairs Blog (May 11, 2018), at: <https://www.healthaffairs.org/doi/10.1377/hblog20180507.812014/full/>.
2. MedPAC, Report to the Congress (June 2017), at: http://www.medpac.gov/docs/default-source/reports/jun14_entirereport.pdf?sfvrsn=0. See also, David Introcaso, “Medicare's Programs Should Compete” Health Affairs Blog (June 15, 2017), at: <https://www.healthaffairs.org/doi/10.1377/hblog20170615.060627/full/>.