

Via Electronic Mail
Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Re: CMS Request for Information: Direct Provider Contract Model

May 25, 2018

Dear Administrator Verma:

The Physicians Foundation respectfully submits this response to the Centers for Medicare & Medicaid Services (CMS) informal request for information (RFI) regarding a Direct Provider Contract (DPC) model. The Physicians Foundation is a 501(c)(3) not-for-profit organization created from a settlement on behalf of all physicians in the United States. Today, its governing Board of Directors represents 17 state medical societies and three county medical societies from across the country.

As an organization representing physicians and the patients they serve, we are grateful for the opportunity to help shape how CMS and the Center for Medicare and Medicaid Innovation (CMMI) think about reforms that directly address the realities of beneficiaries lives from the perspective of physicians that care for them. Having submitted a RFI for CMMI's New Direction, we were pleased to see our comments related to physician access, burden and quality care mirrored in the RFI for a DPC model.

It is becoming clear that to improve health and reduce long-term healthcare expenditures, a broader notion of health is needed; rather than just treating and managing illness¹, we believe any contracting approach that incentivizes health is better positioned to achieve the types of goals stated in the DPC model, those of enhanced access, burden reduction, improved quality and reduced cost. Such goals align with the Physicians Foundation's mission to empower physicians to lead in the delivery of high-quality, cost-efficient healthcare. We appreciate that the model is still early in development and if the model were to explicitly reinforce a commitment to whole-person care, we feel its value would become even more apparent.

Our healthcare system has historically failed to account for the social determinants of health, and our continued failure to do so contributes to poor patient outcomes and physician burnout.² We believe that a DPC model could address adverse social determinants of health through payment incentives, quality measures and other model design features. We also believe that protections are needed within a DPC model to ensure that the most vulnerable beneficiaries have equal access to the model and are not relegated to inferior care due to an inability to contract effectively or inability to pay. The unanticipated consequences of new payment models has been described elsewhere in detail and creates risk around

¹ Cooper, Richard. Poverty and the Myths of Health Care Reform. Johns Hopkins University Press, 2016.

² Ibid.

increased cost, utilization and inequity.^{3,4} To that end, our comments emphasize 1) the need to account for poverty by addressing the social determinants of health and prioritizing the needs of vulnerable populations, 2) opportunities and challenges for the DPC model (or models) goal of reducing administrative burden on physicians so they can focus on delivering high quality care and 3) a focus on ways to integrate and simplify current models of care. We have therefore limited our response to the RFP to selected questions 1, 2, 7, 9, 11 and 14.

Response to Question 1

One of the key questions in healthcare right now is whether small physician practices can survive in the current reform and policy environment which favors consolidation of physicians and physician practices.⁵ Small practices have less shared resources, are more likely to be subject to the penalties of the Merit-based Incentive Payment System, under the Medicare Access and Chip Reauthorization Act (MACRA), and much of the additional funding associated with Alternative Payment Models (APMs) make their way to local physicians and other providers only indirectly through the filter of large convening entities (e.g., accountable care organizations, medical homes, state innovation model) and their contracting arrangements.

These conditions make it difficult for small and independent physician practices to feel ownership and accountability for the new payment models within these indirect contractual relationships. Ironically, to the extent these independent practices are embedded in the communities they serve, they are the embodiment of person-centered care the models seek to promote, and yet these practices increasingly struggle to survive. Most importantly, in many rural settings the independent practice may be the only source of medical care in the area.

Through CMMI, a DPC model could test contracting mechanisms and incentives that empower local decision-making and financing at the level of a small/independent physician practice thereby providing the opportunity to learn how an independent practice model would differ (in outcomes, access and cost) compared to convening models. This has not yet been systematically tested through CMMI and could provide important learning. Some small practices are experimenting with ways to pool and manage resources across groups (e.g., pods or shared service networks) while at the same time maintaining their independence and intimacy with patients and communities.⁶ These approaches could be incentivized and supported through CMMI. However, we recognize there are a number of challenges that would need to be addressed as the model is being developed:

- Because the number of independent practices engaged in an existing “convening” model is already large (e.g., CPC+ has or will engage approximately 5,000 practices) it is likely a model targeting practices not engaged in such a model will make a proper and meaningful evaluation

³ Kaplan, Gary. “Time to Sink the Two Canoe Payment Models Argument.” NEJM Catalyst, 27 Mar. 2018

⁴ Mechanic, Robert. “When New Medicare Payment Systems Collide | NEJM.” New England Journal of Medicine, Oxford University Press, 2016, www.nejm.org/doi/10.1056/NEJMp1601464.

⁵ Khullar, Dhruv. “Service Sharing as a Path to Viability for Small Physician Practices.” JAMA Internal Medicine, American Medical Association, 3 Apr. 2018, jamanetwork.com/journals/jama/article-abstract/2673278?redirect=true.

⁶ Ibid.

difficult. It will also challenge the actuarial analysis of net impact to the trust fund needed to address scalability of a model. It is possible some of the primary care practices could be carved out or “nested” within an existing model.

- For a DPC-type model, there is some important learning to be leveraged from the Advanced Payment ACO model that recently concluded.⁷ That model targeted 36 small physician-based Medicare Shared Savings ACOs with upfront payments to invest in basic resources (e.g., billing and accounting systems, FTEs, data management and IT infrastructure) that would be recouped against shared savings. Overall, the model did not improve care or produce the anticipated savings, but it demonstrated the type of basic support and resources independent physician practices need to survive in a value-based purchasing environment. Many of the physician practices targeted in the DPC model will be in a similar situation and these challenges apply more broadly to most CMMI models.⁸
- To date, many of the convening-type models have produced negative, equivocal or neutral results.⁹ It is especially interesting to note that none of the models have directly addressed poverty and the unmet needs of patients (pre-AHC and CPC+). The inability of physicians and other providers to address these needs in their patients is associated not only with higher costs (e.g., increased utilization) but it is also considered a driver of physician burnout.¹⁰ A DPC model could attract physician practices and those not currently engaged in a model by establishing incentives and specific measures intended to help address physician burnout. This does not exist, to our knowledge, in any reform model presently and it would therefore provide an exciting learning opportunity.

Lastly, on the point of reduced administrative burden, the number of contracts a physician practice will be involved in should be considered. As the number of contracts a physician is engaged in increases, so will the degree of effort and complexity to manage them. The proposed DPC model should seek to align the incentives and harmonize the reporting demands and payment incentives between the various types of contracts.

Response to Question 2

Given the DPC model includes a focus on physician practices not currently engaged in an APM, it should carefully consider what participants in these types of practices need to be successful. To the extent a DPC model is focused on health and cost, there is an opportunity to integrate a number of tools, capabilities, resources and financial incentives emerging across the market to address the major driver of poor health and cost in the system - unmet social needs. These include the following:

⁷ L&M Policy Research “Evaluation of CMMI Accountable Care Organizations Initiatives.” 25 November 2016, <https://innovation.cms.gov/Files/reports/advpayaco-fnevalrpt.pdf>

⁸ Perla, R., et al. “Government As Innovation.” *Health Affairs*, 28 Feb. 2018, www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.1109.

⁹ Kennell & Associates. “Systematic Review of CMMI Primary Care Initiatives.” Feb. 2018

¹⁰ Patel, Minal R., et al. “Social Determinants of Health.” *Advances in Pediatrics.*, U.S. National Library of Medicine, 1 Aug. 2016, www.ncbi.nlm.nih.gov/pmc/articles/PMC4945373/.

- The resources required to care for patients differs depending on the patient’s life circumstances, symptoms, needs, and abilities to interact with the health care system, and whether a health system’s processes and programs support these patient differentials.¹¹ To account for these differences, CMS could risk-adjust the payment formula of the per beneficiary per month rate (PBPM) for the estimated additional costs of providing care for vulnerable populations and those that face adverse social determinants of health.
- Require and incentivize 2015 EHR certification to capture social, psychological and behavioral data using LOINC terms (As required for CPC+ track 2 starting 2019).^{12,13} Collecting data on social determinants of health is linked to improved patient outcomes.
- Require practices to build screening patients for unmet social needs into their clinical workflows (using tools established for AHC/CPC+) and establishing financial incentives around screening and navigation. Beyond the examples of AHC and CPC+, states across the country have built into Accountable Care Organization and Managed Care contracts screening for the social determinants of health and the learning from these initiatives could be crucial to understanding how to build such provisions into a DPC model.¹⁴
- To the extent DPC practices can leverage community resources being developed through other models such as AHC and CPC+ this should be built into structural requirement of the model.
- Measurement is critical to drive improvement and learning, but the number of measures used by CMS is long and many are not necessarily patient or community-centered. For example, the 2018/2019 CMS Quality Benchmarks for the Medicare Shared Savings Program does not include a single measure on social needs, despite the link between those co-variates and utilization.¹⁵ Through this model, there is truly a significant opportunity to reduce the number of measures to help model participants focus on a core set of measures versus trying to be comprehensive, often through myriad process measures. At the same time as reducing measurement burden, select measures should be included to address the social determinants of health and physician

¹¹ Committee on Accounting for Socioeconomic Status in Medicare Payment Programs, Accounting. “Introduction.” *Advances in Pediatrics*, U.S. National Library of Medicine, 12 Jan. 2016, www.ncbi.nlm.nih.gov/books/NBK338757/

¹² Andermann A. Taking action on the social determinants of health in clinical practice: a framework for health professionals. *CMAJ : Canadian Medical Association Journal*. 2016;188(17-18):E474-E483. doi:10.1503/cmaj.160177.

¹³ Pelletier, Stephen. “Merging Social Determinants Data into EHRs to Improve Patient Outcomes.” *AAMCNews*, 15 Sept. 2016, news.aamc.org/patient-care/article/merging-social-determinants-data-ehrs/.

¹⁴ Healthcare Strategies, Center. “Addressing Social Determinants of Health through Medicaid Accountable Care Organizations: Early State Efforts.” Center for Health Care Strategies, 14 Feb. 2018, www.chcs.org/resource/addressing-social-determinants-health-medicare-accountable-care-organizations-early-state-efforts/.

¹⁵ Medicare Shared Savings Program: Quality Measure Benchmarks for the 2018 and 2019 Reporting Years. December 2017, Version 1. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/2018-and-2019-quality-benchmarks-guidance.pdf>

burnout, as noted above. Both of these issues are priorities for the Physicians Foundation and our members.

Response to Question 7

- To support practices and beneficiaries in the enrollment process, CMS should consider funding Medicare eligibility and enrollment specialists, that are either based in the practice or in the community. Such specialists will have the subject matter expertise to not only protect the beneficiary to ensure they fully understand the care they are choosing, but will also have the content knowledge to understand other Medicare models.

Response to Question 9

- Require and reimburse physician practices via the PBPM rate for teaming and/or staffing structures that reduce physician burden and promote quality care (e.g., team-based models, group care models, integrated Behavioral Health, Community Health Workers, Peer Coaches, Patient Navigators, administrative supports, case management and Medical Assistants).^{16,17}
- A DPC model provides an opportunity to test emerging risk-adjusted payment models that account for community-level need (food, housing, transportation) and to use this data to establish cost benchmarks for shared savings for physician practices that are closest to the communities they serve. Physicians know that payment and contracting models that account for medical problems, but not social risk, will underpay for treating vulnerable populations, potentially exacerbating inequity in the health system. A new model developed by researchers at the University of Massachusetts Medical School adds readily available SDoH variables to medical diagnoses, age and sex that go beyond socioeconomic status level variables and could be integrated into a DPC contracting model.¹⁸

Response to Question 11 (also informs Question 3)

The issue of risk and capacity are related and could be considered jointly in the context of incentives built into a DPC model that also encourage physician practices to participate in new models.

- CMS should not assume (or require) that such practices will be able to make a large capital investment in a model, particularly one targeting independent physician practices that have not participated in an APM to date. The capacity and infrastructure of small physician practices will vary greatly (e.g., accounting, beneficiary engagement, EMR capability, managing risk, patient

¹⁶ Reckrey JM, Soriano TA, Hernandez CR, et al. The Team Approach to Home-Based Primary Care: Restructuring Care to Meet Patient, Program, and System Needs. *Journal of the American Geriatrics Society*. 2015;63(2):358-364. doi:10.1111/jgs.13196.

¹⁷ Erickson SM, Rockwern B, Koltov M, McLean RM, for the Medical Practice and Quality Committee of the American College of Physicians. Putting Patients First by Reducing Administrative Tasks in Health Care: A Position Paper of the American College of Physicians. *Ann Intern Med*. 2017;166:659–661. doi: 10.7326/M16-2697

¹⁸ Ash, Arlene S. "Social Determinants of Health in Managed Care Payment Formulas." *JAMA Internal Medicine*, American Medical Association, 1 Oct. 2017, jamanetwork.com/journals/jamainternalmedicine/article-abstract/2647322?redirect=true.

population). This capability will influence a practice's tolerance for downside risk. Through this model, CMMI should not require downside risk for all practices in order to encourage maximum participation, but it could incentivize practices with greater capacity to take on downside risk by offering an upfront capital investment (similar to the Advanced Payment ACO model) but with a discounted repayment rate offset against shared savings on a sliding scale. Those taking downside risk would also be eligible for greater shared savings.

Response to Question 14

- Incentivize providers for improvements on key quality indicators related to the social determinants by building a select set of measures of unmet needs into the data and reporting requirements of the model. There are currently a number of health systems and physician practices that collect this data and are demonstrating reductions in cost through addressing their patient's social needs. For example, a recent study demonstrated that SNAP enrollment produced annual health care savings of \$1,400 compared to low-income individuals not on SNAP after controlling for factors known to be common across SNAP participants.¹⁹ Though much of the focus around social needs is typically around high-cost/high-need individuals, a recent study across three academic primary care practices (N = 5,125) found that 38.2% of patients that screened positive for an unmet need had commercial insurance vs. 15.5% that had Medicaid.²⁰

Summary

We encourage CMMI to include the social determinants of health as a guiding design principle for the DPC model, and revisions to current models, to account for these crucial drivers of health and cost. By doing so, CMMI would send a powerful signal to the market, and would ensure future payment and care delivery models are designed to focus on health, rather than only treating and managing illness.

We appreciate the opportunity to share these perspectives with CMS and encourage the agency to strongly consider the social and built environments in which patients live and physicians practice that so significantly drive health. We ask that our physician communities are supported with the systems and structures that allow us to provide comprehensive care to patients, and to dedicate ourselves even more fully to our patient-facing work, rather than to administrative and regulatory requirements. We are grateful for CMMI's leadership role in advancing high-quality care, and we stand ready to work together with CMMI - we are eagerly prepared to clarify or dive further into any of the comments above, should the opportunity arise.

Respectfully submitted,
Gary Price, MD, President
Walker Ray, MD, Immediate Past President
Timothy B. Norbeck, Chief Executive Officer

¹⁹ Berkowitz SA, Seligman HK, Rigdon J, Meigs JB, Basu S. Supplemental Nutrition Assistance Program (SNAP) Participation and Health Care Expenditures Among Low-Income Adults. *JAMA Intern Med.* 2017;177(11):1642–1649. doi:10.1001/jamainternmed.2017.4841

²⁰ Berkowitz SA, Hulberg AC, Standish S, Reznor G, Atlas SJ. Addressing Unmet Basic Resource Needs as Part of Chronic Cardiometabolic Disease Management. *JAMA Intern Med.* 2017;177(2):244–252. doi:10.1001/jamainternmed.2016.7691