May 30, 2019

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Submitted electronically to DPC@cms.hhs.gov

Re: Direct Contracting Geographic PBP Request for Information

Dear Administrator Verma:

On behalf of the Premier healthcare alliance serving approximately 4,000 leading hospitals and health systems, hundreds of thousands of clinicians and 165,000 other provider organizations, we appreciate the opportunity to provide feedback on the Direct Contracting (DC) Geographic Population-based Payment model as well as the DC Professional and Global and Primary Care First (PCF) models. Premier healthcare alliance, a 2006 Malcolm Baldrige National Quality Award recipient, maintains the nation's most comprehensive repository of hospital clinical, financial and operational information and operates one of the leading healthcare purchasing networks. Our comments primarily reflect the concerns of our hospitals and health systems, their employed physicians and independent physicians aligned with them. Premier runs the largest population health collaboratives in the country. Premier's Population Health Management Collaborative has worked with well over 200 accountable care organizations (ACOs) and is currently comprised of more than 70 ACOs, including six Next Generation ACOs (NGACOs).

Premier applauds the Centers for Medicare & Medicaid Services (CMS) for expanding the offerings of alternative payment models (APMs) that meet the definition of an Advanced APM under the Quality Payment Program. We believe providers are best situated to drive care innovation, bringing their hands-on knowledge of the patient population and community needs. Accordingly, our comments provide recommendations on how to best structure the model to ensure the success of providers participating in the models.

GENERAL COMMENTS

Model Timelines. The launch of multiple new models, including other expected to-be-announced APMs, simultaneous to application periods for ongoing models such as the Medicare Shared Savings Program (MSSP) and the Bundled Payments for Care Improvement (BPCI) Advanced model, presents an immediate challenge for providers attempting to develop their ongoing population health strategy. Ideally, providers would like to have the request for application available at the same time as the application periods for MSSP and BPCI-A so they can compare and contrast models. **We recommend that CMS work to align model timelines so that providers can transition seamlessly between models.** Moreover, CMS should confirm the ability to enter the new models in later performance years. Finally, CMS should provide more specific timing for the release of additional information about the new models.

Vision for Delivery System Reform. While Premier is pleased that CMS is offering opportunities for providers to accept additional financial risk, the new models are likely to appeal to entities that are already in other risk-bearing APM models. **It is imperative for CMS to provide a long-term vision and roadmap for the transition to value-based and risk-based models.** In the absence of a clear timeline,

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some providers are reluctant to embark on new models. When providers have a clear plan for moving to new models (e.g., the Maryland All-Payer model), providers work aggressively to succeed in the model and more rapidly advance to the risk-bearing model.

Model Overlap. The rollout of several APMs within a relatively short time frame often results in portions of the patient population qualifying for multiple models. The increasing number of APMs tested simultaneously by CMS elevates the need to ensure that models are complementary. **Because model overlap impacts the financial performance of providers who participate in multiple models, CMS should give precedence to the total cost of care models that may experience material financial harm in absence of protections**. Specifically, CMS should:

- Provide attribution and financial reconciliation preference to longitudinal, total cost of care models, which are at the greatest financial risk and are often prospectively assigned their patient population by CMS.
- Allow total cost of care entities to choose if beneficiaries can be aligned to other models (that is, total cost of care entities should be able to choose if their beneficiaries can also be included in PCF or bundled payment).
- Reward APM entities participating in multiple risk-based models. CMS should explore options to reward providers who partner with the Center for Medicare & Medicaid Innovation (CMMI) on multiple APMs (e.g. increased opportunity for shared savings in some models, additional flexibilities).
- Study the impact of model overlap independently and as part of the evaluation of all CMMI models.

Stakeholder Input. We urge CMS to seek public comment on all new payment models prior to releasing an application. Specifically, CMS should have a formal public comment on the PCF and DC Professional and Global models after the request for applications is released. Similarly, CMS should allow additional rounds of public comment on the DC- Geographic model. Finally, we suggest that CMS establish technical expert panels to provide input on operational issues of model implementation.

Primary Care First Model

Premier requests that CMS provide additional information on how CMS anticipates that PCF will qualify as an Advanced APM. It is unclear if the model qualifies through the medical home model, and thus limited to provider groups of less than 50, or if the model meets the broader nominal financial risk criteria. Additionally, CMS should clarify how PCF can overlap with other models if beneficiaries can be attributed to this model and other downside risk APMs.

Direct Contracting Professional and Global Models

Premier requests clarification on the opportunity for current MSSP or NGACO participants to participate in the Professional and Global Direct Contracting Models. The DC Professional and Global models include a PY0 in 2020 to provide an opportunity for beneficiary alignment. **CMS should allow current ACOs to transition between models by allowing enrollment in the Professional or Global models in performance year 1 of the program (2021) or allowing concurrent participation in PY0 and another existing APM**.

Premier also requests clarification on how rural health will be addressed in the new models, including how rural health center and federally qualified health center payment is incorporated in the models. Many of the existing APM models present challenges for rural communities. We encourage CMS to articulate its approaches for including rural providers in these models.

DC GEOGRAPHIC PBP MODEL

Model Design

Direct Contracting Entities (DCEs) and other provider-led APMs with two-sided risk require the ability to tailor services to address non-clinical needs that impact health outcomes. **CMS should allow DCEs to tailor benefits to incent care for certain conditions and populations and to help address social determinants of health (SDoH).** Currently, CMS provides these types of flexibilities to Medicare Advantage (MA) plans participating in CMMI's Value-based Insurance Design (VBID) program, which permits non-uniform benefit design based on condition and/or socioeconomic status. Subsequently, CMS extended benefit design flexibilities to all MA plans in the PY 2020 Final Call Letter to permit the provision of supplemental benefits to chronically ill beneficiaries in the form of non-medical services that may be used to address SDoH. These flexibilities should be allowed for DCEs and other APMs bearing more than nominal risk.

CMS should incorporate measures into the payment structure that encourage DCEs to address the SDoH, including through screening and referral. Given the importance of making connections with community-based organizations, social service, and public health agencies to help address SDoH, it is essential that selected DCEs have a historical presence and track record of community partnerships in their target region.

Target Region Selection

Premier supports target region selection criteria that will inform the suitability of the model across multiple types (i.e. cost, location) of regions. As such, **CMS should test the Geographic PBP model in both high- and low-cost regions.** Dependent upon the structure of discounts determined by CMS, incentives are likely to differ in high- and low-cost regions, and both should be explicitly tested to understand these factors. DCEs in low-cost regions are likely to explore areas of potential savings that will not be assessible to DCEs in high-cost regions until multiple years into the model. Premier is concerned that an overt focus on high-cost regions may attract non-provider entities (e.g., insurers without prior market presence, private equity, etc.) that could have an interest in capitalizing on initial potential savings in the model but have more limited ties to the long-term health of the region. **Premier encourages CMS to select DCEs that have invested in the region and an expressed commitment to advancing the health of the community, even after the initial model period has ended.** Provider groups have spent significant time and effort developing relationships with their community care partners and financially investing in their regions.

Premier recommends testing Geographic PBP in areas with low penetration of APMs. Premier strongly recommends excluding beneficiaries attributed to total cost of care models from inclusion in the beneficiary list for a Geographic DCE, unless the current total cost of care APM is the entity applying to become a DCE. If the selected target regions include existing Medicare total cost of care APM participants, including NGACO, ESRD Seamless Care Organizations, and MSSP, CMS should exclude beneficiaries from alignment to the Geographic PBP and maintain attribution to existing models. However, if CMS desires to consolidate all Medicare FFS activity under a DCE in a region, we urge CMS to require the DCE to assume an existing model Participation Agreement through a delegation from CMMI. **We oppose any effort to alter or terminate any existing APM Participation Agreements within a selected DCE region.** Existing APM participants have made significant strides in redesigning care processes, improving quality and reducing costs. These efforts should not be hindered or halted by new models.

CMS anticipates offering two options for payment within the Geographic PBP, total cost capitation (TCC) or fee-for-service (FFS) payment with retrospective reconciliation. Under the TCC option, the DCE will be able to contract with providers and potentially offer additional benefits when patients stay in the "preferred network." **If CMS permits preferred networks in the model, requirements should be included to ensure there are not unreasonable restrictions on access to care and benefits**

DCE Eligibility

Generally, Premier supports the criteria for DCEs outlined in the RFI; however, we want to ensure that provider-led entities are able to compete with insurer or investor-backed entities that may have more up-front capital or experience with implementing managed care functions. There is currently active competition in the market between different types of organizations seeking to align providers to take risk. This is indicative of the new competitive model in a healthy healthcare market. Within that context, Premier believes that providers, who are closest to the care delivery process, with the right incentives are the key to driving change in healthcare. Accordingly, **the Geographic PBP model should encourage participation by provider-led entities**. Providers drive care delivery innovations and have regular face-to-face interactions with beneficiaries and the broader community. Thus, providers are best positioned to ensure that APMs deliver patient-centered care. Premier offers the following considerations for the criteria proposed by CMS to ensure provider-led entities can be successful candidates for the DC-geographic model.

Historical Presence. Premier supports the inclusion of historical presence in the selection criteria and believes that it should carry significant weight in the selection process. **Historical presence will constitute an essential element for success in the model. CMS should place a premium on selecting DCEs with prior experience in providing care in the local market.** Additionally, Premier recommends that CMS add a component evaluating pre-existing relationships with community organizations that can support addressing SDoH.

Risk management experience. While CMS should evaluate whether applicants are able to manage risk in the selection process, **CMS should refrain from requirements that artificially constrain participation in the model**. For example, CMS should ensure that the repayment mechanism in the Geographic PBP does not significantly differ from the mechanism in the MSSP program, when proportionally adjusted for population size. Further, **CMS should count participation in upside-only models as relevant experience in managing risk.** APM participants that have not transitioned to downside risk have experience managing costs to an established benchmark. Additionally, the limitations in the current models prohibit organizations from bearing two-sided risk, the flexibilities in any of the Direct Contracting models, including the Geographic PBP, could be sufficient to encourage transitioning to downside risk.

Claims payment. We appreciate that the model allows DCEs an option to pay claims or maintain FFS payment. Premier believes that **CMS should not have a preference for DCEs that propose to pay their own claims, as it may unduly limit the pool of potential applicants for the model**. For DCEs with an expressed interest in developing claims processing capability, Premier recommends that CMS provide technical support to the DCE to develop this capacity.

Proposed discount. **Premier recommends that CMS avoiding selecting participants primarily on the amount of the proposed discount**. As stated in our comments on model design, regional variation in spending may offer the opportunity for larger discounts. Further, CMS should ensure that proposed discounts are empirically supported and do not exceed reasonable and/or sustainable payment needed to provide care to the population.

Size of region. CMS has expressed that the minimum aligned beneficiary will be 75,000 beneficiaries. However, an upper limit should also be established to ensure that the experience of DCEs are analogous, and that the results of a DCE are not solely attributable to a large risk pool. Accordingly, CMS should refrain from a preference for large risk pools in their target region selection and DCE awards.

Beneficiary Alignment

Attribution. Premier disagrees with the assertion that risk would be evenly distributed among DCEs through random assignment solely through a large attributed population. **CMS should continue to account for demographic and health factors in the Geographic PBP through risk adjustment models comparable to Medicare Advantage**, which is well-established and actuarially supported. Premier proposes the following beneficiary alignment hierarchy to elevate the role of beneficiary choice and continuity of care:

1. Prospective alignment through the DCE's participants
2. Voluntary beneficiary alignment based on selection of primary care provider
3. Voluntary beneficiary alignment by direct selection of DCE entity
4. Stratified random assignment for beneficiaries who do not align and are not part of another total cost of care APM model

Premier believes that a stratified random assignment will ensure similar risk pools in target regions with multiple DCEs. Random assignment should also potentially consider the location of contracted providers. For example, if a DCE is permitted to establish a "preferred network" under the TCC payment option, allowing for additional benefits/reduced cost sharing for visiting a preferred provider, beneficiaries assigned to the DCE should have reasonable geographic access to those providers. If voluntary beneficiary alignment by selection of the DCE entity is permitted, CMS should consider employing marketing rules, similar to those used in MA, to ensure that beneficiaries are aware of their choices.

Number of DC Entities in a Region. **Premier encourages CMS to make awards to more than one DCE in a target region to support competition**. However, in select regions, it may not be essential to have multiple DCEs if there is already high APM penetration (with patients under current total cost of care models excluded from DCEs) that would constitute competition for the DCE.

Beneficiary Notification. Informing beneficiaries of their care options provides an opportunity for beneficiaries to proactively engage and state their preferences. However, experience in other APM programs have underlined the importance of consistency, coordination, and simplicity in beneficiary communications. For example, CMS has modified that content, frequency and delivery mechanisms multiple times since the MSSP's inception. These changes and requirements, while well-meaning, have often created confusion for beneficiaries and increased provider burden. Geographic DCEs will have a much larger patient population than other APMs and will include networks of many providers. Given this larger scope, **CMS should require DCEs to send beneficiary notifications, rather than at the individual provider level.** CMS should work with DCE entities to develop clear and concise communications. Further, if other APMs operate in the region, CMS should align the timing and format of communications across all programs to enhance beneficiaries' experience and prevent negative impacts on patient care.

Program Integrity and Beneficiary Protections

Behavioral Health Information. Coordination with behavioral health is necessary to ensure that beneficiaries are receiving the appropriate care. **Premier recommends reform of the 42 CFR Part 2 regulations to make substance use data more readily available to providers who are already**

subject to HIPAA patient privacy protection regulations. Access to a patient's entire medical record, including addiction records, ensures that certain providers and organizations, when medically necessary, have all the information necessary for safe, effective, high quality treatment and care coordination that addresses all of a patient's health needs.

Waivers. Provider success in APMs is often contingent upon waivers of regulatory requirements that are applicable to FFS but have limited relevance in value-based payment. **Clarity around the waivers that will be available to DCEs and providers that contract with a DCE are essential during the application period. Premier also encourages CMS to extend the waivers offered in the highest-risk models to all providers that accept two-sided risk.** A common framework across models would facilitate ease of moving from lower-risk into higher-risk models, while preserving consumer protections and fraud safeguards.

Flexibility in the Model. In full financial risk arrangements, participants require wider capabilities to manage cost and utilization. In MA and in the private market, payers are able to use a wider set of cost containment tools, including utilization management (UM). **Premier recommends that CMS permit tools in the model that would support risk management value-based purchasing principles**, similar to the flexibilities currently available to MA plans. However, the flexibilities in MA are accompanied with additional requirements (e.g. accreditation) which would be costly for provider led entities. CMS should create a balance between additional flexibilities and additional requirements by allowing DCE entities to propose the flexibilities to incorporate in its model and the approaches for ensuring beneficiary safeguards.

Beneficiary Protections. **Premier supports the ability for DCEs to offer beneficiary incentives to encourage adherence to prescribed best practices**. In all value-based arrangements, it is important that CMS ensure beneficiaries receive high quality care and that stinting on necessary care does not occur. Concern about stinting may be elevated in the Geographic PBP model, especially if new entities with limited experience in the provision and management of care are included in the model. **CMS should mandate a minimum set of quality and stinting prevention measures to protect access to care.** Appropriate weighting of outcomes-focused care measures should be included as a component of the benchmark to ensure the protection of care quality. Additionally, CMS could also encourage alignment with commercial payers by adopting certain high-value performance metrics (e.g. network adequacy standards) that are used in MA.

Payment

Benchmarks. CMS proposes a discount approach for the Geographic PBP model. We believe, however, **that CMS should consider MA regional expenditures and historical FFS expenditures when considering a DCE's proposed benchmark**. We are encouraged that MA regional expenditures are incorporated into the benchmarking approach within the Professional and Global models. Premier has long advocated that CMS should incorporate MA regional expenditures into the benchmark determination for all total cost of care models as a method to incorporate regional expenditures into the benchmark.

CMS should balance the certainty of model design and benchmark with the flexibility for DCEs to modify proposed discounts on occasion rather than locking in one discount for the entirety of the performance period. Applicants that propose a discount to the benchmark for a geographically aligned population prior to the start of the model will inevitably learn new things about that newly aligned population and continually refine their approach to best care for those beneficiaries. Further, CMS should ensure that proposed discounts are empirically supported and do not exceed reasonable and/or sustainable payment.

Inclusion of Part D. We understand CMS' desire to incorporate drug costs into payment models, however, in the absence of the ability to introduce a formulary to help control drug costs any APM will struggle to incorporate Part D costs into the model. CMS should allow DCE entities the option to include Part D**; however, inclusion of Part D should not be required or given preference in the evaluation criteria**.

Expenses outside of the target region. Participants in other APMs are held responsible for expenditures that occur outside of their contracted providers regardless of geography. Similarly, **services and costs for beneficiaries occurring outside of the target region should be attributed to the DCEs' spending**. CMS should factor in the natural boundaries of the target region and healthcare seeking patterns of the Medicare FFS population in the construction and selection of target regions. DCEs could also be allowed to offer incentives to stay within the DCEs' contracted provider network.

CONCLUSION

The Premier healthcare alliance supports CMS' efforts to transform healthcare care delivery and appreciates the opportunity to share ongoing feedback on the Direct Contracting Geographic Population-based payment model. If you have any questions regarding these comments or need more information, please contact Aisha Pittman, senior director of payment and quality policy, at aisha_pittman@premierinc.com or 202.879.8013.

Sincerely,

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