May 30, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Submitted via email at DPC@cms.hhs.gov

Re: Geographic PBP RFI

Dear Administrator Verma:

The Medical Group Management Association (MGMA) appreciates this opportunity to provide feedback regarding the Direct Contracting (DC) Geographic Population-based Payment (PBP) model. We support the Centers for Medicare & Medicaid Services' (CMS) goal of increasing participation in Advanced Alternative Payment Models (APMs) by creating additional opportunities that encourage provider flexibility and choice and reduce burdensome regulations and one-size-fits-all requirements. MGMA commends CMS for seeking stakeholder input at the outset of DC Geographic PBP model development, and we look forward to an ongoing, constructive dialogue as model details are refined.

MGMA is the premier association for professionals who lead medical practices. Since 1926, through data, people, insights, and advocacy, MGMA empowers medical group practices to innovate and create meaningful change in healthcare. With a membership of more than 45,000 medical practice administrators, executives, and leaders, MGMA represents more than 12,500 practices of all sizes, types, structures, and specialties that deliver almost half of the healthcare in the United States.

Before commenting specifically on the draft Geographic PBP option, the Association wishes to emphasize our support for CMS' recent announcement creating more voluntary Advanced APMs through the Primary Care First (PCF) and DC models. MGMA continues to support the clear objective of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to incentivize physician group practices to embrace alternatives to fee-for-service and incur greater performance risk for clinical outcomes and the cost of care. Unfortunately, physician group practices have limited opportunities to move into an Advanced APM. CMS estimates that less than 220,000 clinicians will become qualifying participants in Advanced APMs this year, compared to the 798,000 clinicians expected to participate in the Merit-based Incentive Payment

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System (MIPS).[1] Many practices are interested in joining an APM, but are unable to do so because there are not viable options for practices of their size, specialty, or location. In a 2018 survey of MGMA members, 55% of over 400 respondents reported that Medicare does not offer an Advanced APM option that is clinically relevant to their practice.[2]

We are encouraged by the potential of new models to support physician group practices that currently have few APM opportunities. MGMA urges CMS to consider the following principles for encouraging physician practice participation and allowing for their success in a DC model:

- Patients over paperwork – Burden reduction must be a priority for CMS when implementing the new primary care APMs, including the DC model's Geographic PBP option. Collecting and reporting quality metrics remain technically challenging, data intensive, and administratively burdensome. Bureaucratic barriers to care, including prior authorization and appropriate use criteria, are at odds with care delivery and financial models in which participants are accountable for care outcomes.

- Alignment of patient incentives – DC model participants across all options should be provided the authority to revise beneficiary cost-sharing and other out-of-pocket expenses to encourage Medicare beneficiaries to actively engage in their care and seek high-value care providers.

- Access to data – Data sharing will be of the utmost importance for participants in any DC model. CMS should devote significant resources to providing timely and actionable analyses of patient care trends, including gaps in care and cost drivers, to DC participants. To the extent possible, these reports should be customized according to the specific DC arrangement and regularly updated, preferably in real time.

- Care coordination – Modernization of fraud and abuse rules is needed to better support care coordination in innovative payment arrangements. Working in concert with the relevant federal agencies, CMS should develop a standard waiver of certain otherwise applicable Medicare fee-for-service rules to allow participants of all Advanced APMs to effectively coordinate and assume accountability for beneficiary care.

In addition, MGMA urges CMS to consider our specific feedback that follows. Because there remain many unanswered questions about the DC models, particularly the Geographic PBP option, we urge the agency to develop the model as transparently as possible so that potential participants can make fully informed decisions about participation. CMS should release detailed model information and seek comments about the model refinements prior to accepting model applications.

[1] 83 Fed. Reg. 59452, 59721 (Nov. 23, 2018).
[2] "MGMA 2018 Regulatory Burden Survey" (Oct. 2018).

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Questions Related to General Model Design

CMS: How might DCEs in the Geographic PBP model option address beneficiary needs related to social determinants of health (such as food, housing, and transportation) with particular attention to whether the geographic scale contemplated under the payment model option creates new opportunities for success in terms of community-based initiatives? What barriers might prevent DCEs from addressing these social determinants of health? Are there additional incentives that CMS could offer to DCEs to motivate these entities to address social determinants of health?

Integrating health and social services that extend care beyond the traditional clinical office visit can help improve overall beneficiary health and reduce costs. Participants in the Geographic PBP model should be given appropriate flexibility to select non-medical services such as transportation for patients with limited transit options or food delivery for patients without adequate access to healthy options. CMS has already expanded the types of health-related benefits Medicare Advantage plans can include in their policies. MGMA urges CMS to grant participants in the DC model the flexibility to target patient populations who would benefit from certain non-medical benefits if there is an expectation that the benefits will help patients maintain their health or overall function.

Questions Related to Selection of Target Regions

CMS: What criteria should be considered for selecting the target regions where the Geographic PBP model option would be implemented? For example, are there attributes of target regions, such as low penetration of advanced alternative payment models or higher healthcare costs than the national average, which CMS should consider in selecting target regions for the Geographic PBP model option? What impact would this have on competition in target regions where the Geographic PBP model option is ultimately implemented?

MGMA recommends that CMS prioritize markets with low penetration of Advanced APMs to avoid interference with the evaluation of existing models. CMS will also need to consider the effects that DC target regions may have on competition to avoid inadvertently encouraging consolidation. While the DC model offers an opportunity for larger health systems to participate in value-based care, it could also provide an avenue for further consolidation as larger systems pursue vertical integration efforts by buying up independent physician practices. This trend could be exacerbated in the Geographic PBP option where a DCE is held accountable for the total cost of care for aligned beneficiaries in a targeted region. Practices may feel pressured to join a DCE or find that their patient populations have been assigned to a practice within the DCE. At a minimum, CMS must avoid compromising the financial viability of physician group practices and should encourage DCEs to provide information on how they would work with area physician practices.

Questions about DCE Eligibility

CMS: Should we consider allowing States to participate as a Geographic PBP DCE or in partnership with a Geographic PBP DCE? What would be the pros and cons associated with allowing State participation? Which authorities would States need in order to implement

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similar risk arrangements in their Medicaid programs? What supports or technical assistance would States need from CMS to establish risk arrangements in Medicaid?

MGMA supports multi-payer APMs and urges CMS to allow states to participate in this model. A common theme we have heard from our own membership as well as various panels on successful APM ventures is the importance of engaging multiple payers in a single model. There are proven benefits for all parties from an economies of scale standpoint. Additionally, aligning monetary incentives across payers would provide a greater incentive for participants to invest money and resources to ensure success in the model. Payers and participants would both benefit from shared data, shared cost of developing new technologies and procedures, and the insights that a model with a large patient population is able to provide about public health outcomes and the development of new APMs of similar design or focus. Permitting state participation offers further opportunity for DC participants to engage with multiple payers.

Questions Related to Program Integrity and Beneficiary Protections

CMS: What monitoring methods can CMS employ to ensure beneficiary access to care is not compromised and that beneficiaries are receiving the appropriate level of care? What data or methods would be needed to support these efforts?

MGMA believes that patient safety, outcomes, and experience must be at the forefront of care delivery reform. A fundamental goal of existing CMMI models and value-based care in general is not just cost reduction, but also improvement of clinical outcomes. Reporting a reasonable number of quality measures focused on patient outcomes could help ensure beneficiaries are receiving high quality care. This dual focus protects against stinting care or substituting cheaper or lower quality services for the care that is needed. By rewarding quality achievement and appropriately risk adjusting for patients' medical and socioeconomic risk factors, the DC model would incentivize improved patient outcomes while preserving the necessary flexibility that enables physicians to put their medical expertise to work when developing high-value care strategies for each unique patient. While we recognize some monitoring activity may be necessary, we recommend CMS pursue opportunities to streamline program integrity efforts across all programs and keep paperwork to a minimum.

CMS: What regulatory flexibilities or operational activities would be needed to promote DCE success and how might such flexibilities affect program integrity of the Medicare program?

MGMA has long advocated for regulatory flexibilities in the context of value-based care arrangements. We encourage CMS to develop a standard waiver of certain otherwise applicable Medicare fee-for-service rules to allow all Advanced APM participants, including those in the DC model Geographic PBP option, to effectively coordinate and assume accountability for beneficiary care. This waiver should continue flexibilities from previous and existing CMS Innovation Center models, such as the SNF 3-day, telehealth, and home visit waivers.

In general, MGMA also urges CMS to move away from the current piecemeal approach to fraud and abuse and payment waivers and instead develop a single, overarching waiver that automatically exempts all qualified APM participants from redundant Medicare billing and fraud

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and abuse requirements. CMS should then extend this template waiver to current and future Innovation Center models to further streamline and simplify the waiver process and mitigate confusion across the provider community. Particularly as these models may overlap and all center on a common premise of incentivizing care communication and taking financial accountability for a patient or episode of care, participating group practices would benefit from the same waiver. As more APMs are developed and overlap with one another, it will be in CMS' own interest to keep program integrity paperwork to a minimum and streamline requirements across programs.

CMS: Providing incentives to beneficiaries to positively influence their behavior and healthcare decision-making could implicate the fraud and abuse laws and potentially raise quality of care, program cost, or competition concerns, particularly if the incentives would cause beneficiaries to be aligned to one DCE over another entity participating in DC or another CMS initiative. What safeguards should CMS put in place to ensure that any beneficiary incentives provided do not negatively impact quality of care, program costs, or competition?

The current legal framework inhibits physician group practices from using appropriate patient incentives to help achieve better clinical outcomes for Medicare beneficiaries. Arrangements whereby a physician group practice furnishes an item or service to a patient as an in-kind engagement incentive can invoke the Anti-kickback Statute (AKS) or beneficiary inducements Civil Monetary Penalty (CMP) rule, even when provision of the item or service is intended only to achieve improved patient outcomes. For example, beneficiary inducement prohibitions could apply to:

- Financial assistance programs that offer car seats to low-income mothers once discharged from the hospital;
- Healthcare coaches that remotely monitor high-risk patients to encourage intervention before a hospital admission;
- Bereavement or education programs offered by an oncology clinic to the families of terminal patients not eligible for hospice care;
- Digital tools offered to diabetic patients to track and transmit physiological data to a provider; and
- Motivational incentives for substance abuse patients to adhere to a treatment regimen.

In many instances, the "inducement" offered by a physician or provider can result in benefits to the patient, the program, or both. MGMA supports providing patients with incentives that are linked to health and wellness or have a reasonable connection to medical care. MGMA encourages CMS to work with the HHS Office of the Inspector General to identify appropriate beneficiary inducement and other payment waivers that would better allow DP model-participating providers to coordinate with other physicians and appropriately engage patients in their care. By creating a broad, flexible waiver, CMS could grant practices participating in value-based arrangements the flexibility to provide appropriate incentives to beneficiaries to facilitate their involvement in their care.

Additionally, CMS should work with Congress to create copay waivers for APM participants, including those in the Geographic PBP option, to prioritize high-value services to drive better

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health outcomes and lower costs. Regular appointments with and monitoring efforts by clinicians can help ensure chronic conditions are kept from unduly progressing and prevent new conditions or exacerbations of existing conditions. However, MGMA has heard from our members that when it comes to chronic care management services for instance, beneficiaries are hesitant to take advantage of this high-value service due to the copay. Because routinely waiving patient co-payments can potentially implicate both the CMP beneficiary inducement provisions and the AKS, physician practices wishing to deliver and be reimbursed for these services are hamstrung by outdated rules.

MGMA recognizes that beneficiary incentive programs can either improve or undermine care delivery, but with proper safeguards, these initiatives can have a positive effect that results in a more patient-centric care delivery model that is both safe and cost-effective. Certain restrictions or patient protections could be implemented to allow physician group practices to use proper beneficiary incentives while preventing those incentives that negatively impact professional independence.

Conclusion

MGMA members facilitate day-to-day operations of new payment models and bring valuable perspectives to the development of APMs. Thank you for this opportunity to offer comments on the development of the DC model's Geographic PBP option. We strongly encourage CMS to publish detailed information about a DC demonstration and seek additional comments before calling for model applications.

We are happy to serve as an ongoing resource in future discussions about the DC model. Please contact Mollie Gelburd at 202.293.3450 or mgelburd@mgma.org with any questions.

Sincerely,

/s/

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