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Director
Center for Medicare and Medicaid Innovation
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: Request for Information on Direct Contracting (DC) Model - Geographic Population-Based Payment (PBP) Option

Dear Secretary Azar,

On behalf of the American College of Physicians (ACP), I am pleased to share our comments on the Centers for Medicare and Medicaid Innovation's (CMMI's) Request for Information on the Direct Contracting (DC) Model – Geographic Population-Based Payment (PBP) Option. The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 154,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

ACP commends the administration for its work to develop new innovative payment models in the primary care space and appreciates this opportunity to offer feedback. We underscore the importance of ongoing transparency and stakeholder feedback to the successful development of any new alternative payment model (APM) and look forward to providing more detailed feedback throughout the development process.

Risk-adusted capitated payment models potentially can help facilitate predictable spending and encourage high value care with improved health outcomes and lower utilization of unnecessary services and spending. However, ACP notes that capitation and other high-risk models are not feasible for all practices and encourages CMS to continue to develop a diverse range of APMs that feature varying risk levels and accommodate a diverse range of practices of varying

specialties, sizes, and geographic makeups, particularly practices that are independent and/or located in rural areas. Moreover, we urge CMS to carefully consider the impact that introducing a model like this would have on participation in existing Medicare models, particularly in geographic areas with a high density of participation in CMS population-based APMs such as Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs). CMS should make a concerted effort to launch this model in geographic areas that have fewer penetration of existing population-based APMs. CMS should also be cognizant of the impact a model like this could have on local market dynamics, including consolidation. A paper coauthored by the Rand Corporation and the American Medical Association[1] noted that practices often merge to be able to afford the high capital investments required to start and succeed in certain APMs, which is why available up front funding is so important, as elaborated on later.

Models that hold participating clinicians and entities accountable for quality, utilization, and cost by offering prospective, fixed payments to cover total cost of care offer an important opportunity to remove administrative barriers that add unnecessary system cost and more importantly detract from direct patient care. Keeping with CMS' *Patients Over Paperwork Initiative* and ACP's own *Patients Before Paperwork* Initiative, we implore CMS to explore every opportunity to remove unnecessary burdens for participants in this model, including claims-based billing, prior authorization, and payment requirements for certain services. CMS should also act on its *Meaningful Measures Initiative* by utilizing a small set of evidence-based, outcomes focused measures that capture important, valid, and clinically-relevant performance and cost information. Patient safety and program integrity can and should be upheld without requiring clinicians to report on so many measures that they actually spend more time reporting data than delivering care to patients, as is currently the case.

It is vitally important that any APM, but particularly a capitated payment model, provide ample funding to support primary care, cognitive, and care management services provided by internal medicine specialists, which the Medicare Payment Advisory Commission and others have consistently noted are routinely undervalued in our current fee for service (FFS) reimbursement system.[2] Internists have unique training and skills in providing primary, preventive and comprehensive care to adults, particularly in the diagnosis, treatment, and management of patients with complex conditions. Access to primary care has been associated with higher quality of care,[3,4] lower system costs,[5,6,7,8] higher patient satisfaction,[9] and lower mortality rates,[10,11] which are the very outcomes a capitated model aims to accomplish. In a model based

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[1] Effects of Health Care Payment Models on Physician Practice in the United States. Rand Corporation. AMA. 2015. https://www.rand.org/content/dam/rand/pubs/research_reports/RR800/RR869/RAND_RR869.pdf
[2] http://www.medpac.gov/docs/default-source/reports/jun18_ch3_medpacreport_sec.pdf?sfvrsn=0
[3] Influence of primary care on breast cancer outcomes among Medicare beneficiaries. Ann Fam Med. 2012.
[4] Contribution of primary care to health systems and health. Milbank Quarterly. 2005.
[5] National study of barriers to timely primary care and emergency department utilization among Medicaid beneficiaries. Ann Emerg Med. 2012
[6] Health care utilization and the proportion of primary care physicians. Am J Med. 2008.
[7] Can PC visits reduce hospital utilization among Medicare beneficiaries at the end of life? J Gen Intern Med.
[8] Medicare spending, the physician workforce, and beneficiaries' quality of care. Health Aff. 2004.
[9] Linking primary care performance to outcomes of care. J Fam Pract. 1998.
[10] Primary care attributes and mortality: A national person-level study. Ann Fam Med. 2012.
[11] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2724393

on delivering efficiencies through reduced unnecessary services and downstream complications, effective comprehensive, longitudinal, preventive care and care management from internal medicine specialists will be a priority and must be valued as such in the underlying payment structure.

ACP strongly supports patient freedom of choice. However, for a capitated model to work, it is important that patients are encouraged and see tangible benefit in remaining and seeking care within their DC-participating care team except when required care is unavailable from the team; in the latter cases, it is important that care be coordinated with the DC-participating team. Consequently, positive financial, in-kind, and other patient incentives will be instrumental to the success of this model, as elaborated on more fully below.

Finally, one of the most consistent themes we hear from our members is the importance of data and performance feedback, particularly with high-risk models. To accept the risk of capitated payments, direct contracting entities (DCEs) and their downstream clinicians need access to robust data prior to making participation decisions, as well as at regular intervals throughout participating in the program to ensure they are on track with quality outcomes and utilization targets. At minimum, CMS should provide quarterly feedback reports with the goal to progressively work toward providing real-time claims data.

In addition to these important considerations, we respond to several of the specific questions included in the RFI in more detail below.

1. How might DCEs in the Geographic PBP model option address beneficiary needs related to social determinants of health with particular attention to whether the geographic scale creates new opportunities for success in terms of community-based initiatives? What barriers might prevent DCEs from addressing these? Are there additional incentives that CMS could offer to DCEs to motivate these entities to address social determinants of health?

We appreciate CMS' attention to the important ramifications DC models can have on access to care for vulnerable patient populations and the opportunities they present to address social determinants of health and facilitate access to community supports. In designing any model, but particularly a regional model, it is critical CMS consider the model's impact on patient populations that are adversely affected by social determinants of health. Proper risk adjustment that accounts for social determinants of health and other risk factors including age, comorbidities, condition severity, and other factors affecting their health will be important to ensuring already vulnerable patient populations are not put at further risk. The structure of beneficiary cost sharing is an important consideration. It must be designed in such a way that it does not create barriers to care, particularly for lower income or other patients who do not have the same capacity to pay out-of-pocket medical expenses. Before moving forward, CMS must thoroughly study potential impacts on workforce, cost, and patient access to care, particularly in local communities and for vulnerable patient populations.

It is equally important for CMS to consider the impact on social determinants of health across regions, particularly comparing regions in which the model is available verses those where it is not. Capitation and other high risk models typically work best with large beneficiary populations

over which to spread risk, and as a result, can be more challenging to implement in rural areas. While ACP supports capitation models as an important piece of the transition to risk, we also remind CMS that this advanced level of risk may not be feasible or appropriate for all practice types, particularly those that are independent and/or in rural areas. As the agency continues to explore APMs, it is important it design a diverse range of APMs with varying structures and levels of risk to accommodate a variety of practice types, including small, rural, and independent practices, to ensure these practices are not left behind in the transition to value.

APMs could be a valuable tool to learn more about and address social determinants of health by capturing and evaluating detailed demographic information to identify and better understand potential risk factors. CMS should leverage this model and the sophistication of its likely participant pool by collecting detailed population demographic information that could contribute to research on social demographic factors that have an adverse impact on health outcomes. Furthermore, CMS should collect detailed information about the types of innovations the various DCEs deploy and closely monitor patient satisfaction scores, outcomes, and utilization of services to evaluate which innovations produce the most promising results to explore further and potentially incorporate into future demonstrations. We refer CMS to ACP's position paper for detailed policy recommendations to address social determinants to improve patient care and promote health equity.

2. Given the geographic basis for the design of the Geographic PBP model option, the evaluation will need to construct a comparison group from areas outside of the payment model option's target regions. While we anticipate there would be ample geographic areas not included as target regions in the Geographic PBP model option, we are seeking input on considerations that CMS should weigh to best identify a comparison group for this payment model option. Additionally, the selection of a target region itself (size, location) could impact the extent to which evaluation results would be representative of the broader Medicare population. Given the unique design of the payment model option relative to prior CMS Innovation Center models, what special evaluation considerations might CMS consider?

While we appreciate that accurate evaluation of the financial and quality outcomes of a payment demonstration are critical to protecting the Medicare trust funds and justifying potential future expansion of a model, there are a number of evidence-based methods to accurately evaluate models without limiting participation in the model through evaluation approaches such as control groups, which essentially cut participation in half. For that reason, the use of control groups for program evaluation purposes has been opposed by ACP.[12] As the RFI notes, there is a high likelihood a full capitation model will be concentrated primarily in high density areas. CMS should be consciously aware of this and account for it by comparing spending in other geographic areas with similar population density and demographics. CMS can improve the accuracy of comparisons across DCEs and to non-DC entities by risk adjusting at the DCE level to account for differences in geographic regions and service populations.

3. 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

[12] https://www.acponline.org/acp_policy/letters/letter_to_cmmi_re_rfi_on_dpc_models_2018.pdf

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?

CMS should avoid being overly restrictive in selecting target regions. The number of participants that will be able to accept risk for total cost of care will inherently be limited, we feel that if CMS places too many restrictions it will only hinder participation in the program unnecessarily. Because risk is significantly shifted to the participating DCEs, there is little to no risk in terms of the Medicare trust funds so there are no major benefits to CMS placing limitations on the types of DCEs or regions that can participate. In the interest of expanding participation in Advanced APMs rather than risking potential siphoning of patients from existing models and program evaluation complications, CMS should consider regions that have a more limited degree of participation in existing Advanced APMs. To maximize improvements in patient outcomes and cost savings, CMS should also look at existing claims data to identify areas that could stand to improve the most in one or both of these areas.

4. What are the benefits and/or risks to access, quality, or cost associated with the implementation of the Geographic PBP model option in a target region that includes a rural area? What safeguards might CMS consider to preserve access and quality for beneficiaries in rural areas in a Geographic PBP target region? How would rural market forces (for example, out-migration, hospital closures, and mergers/acquisitions) affect the DCE's ability to lower cost and improve quality under the payment model option?

As noted earlier, full capitation models are inherently challenging for rural populations due to smaller patient populations over which to spread risk and a more limited ability to absorb personnel, care management, and technology costs due to smaller economies of scale. However, CMS can mitigate this by ensuring it does not set selection criteria that is unnecessary stringent, including a manageable, potentially separate, lower, discount rate for DCEs in rural regions. CMS could also mirror some of the safeguards it finalized for the professional and global options of the DC model, including risk corridors and stop gaps. Advance funding opportunities to build the necessary infrastructure including technology and support staff would be helpful to all participants, but particularly help to address one of the major setbacks that have a disproportionate impact on smaller, independent, and rural practices. Finally, as noted below, CMS should consider lowering the minimum 75,000 beneficiary lives threshold, which creates a clear barrier to participation for smaller practices and systems.

5. What are the benefits and/or disadvantages of the DCE selection criteria under consideration for the Geographic PBP model option? What other selection criteria and core competencies should CMS consider requiring applicants to address? Please describe the benefits of including such additional selection criteria. What criteria are of the greatest importance and therefore should receive the greatest weight in our selection decisions?

ACP agrees that with any high-risk model, it is important and expected that participants have a proven level of sophistication and experience with high-risk payment arrangements. If participating entities are contracting with downstream clinicians and practices, they should

have a proven ability to carry out the terms of responsibilities, including repaying any incurred losses, making good on payments to contracted clinicians, and providing strategic and operational direction and technical assistance to their clinician network. We also agree with CMS that it would be appropriate for the entity to have a historical presence in the target region to demonstrate their knowledge of and ability to manage care for that given population. To ensure appropriate levels of patient access and choice are maintained, it is important the DCE has a robust network of in-network clinicians in a variety of specialties and settings, particularly primary care physicians, which are vital to patient-centered health reform efforts but have been in decline in recent decades. The American Association of Medical Colleges predicts that the United States will face a projected shortage of between 14,800 and 49,300 primary care physicians by 2030.[13] Moreover, this shortage of primary care clinicians can be particularly pronounced in certain geographic areas. ACP has reservations about setting a strict minimum of 75,000 patients and the impact this will have on the ability of rural and/or independent medical practices and systems to participate. While we appreciate that having a larger patient population can be helpful in spreading risk, smaller and independent practices can be effective at managing expense for a small defined patient population and should have the option to participate if they feel they can absorb the risk and are willing to be held accountable. Medical Loss Ratio and Medicare Risk Adjustment may be a more effective way to screen an applicant's ability to take on risk rather than beneficiary population size alone.

6. What types of entities might participate in the Geographic PBP model option that have not participated in CMS Innovation Center models or other Advanced Alternative Payment Models offered by CMS, such as the Medicare Shared Savings Program, to date? What conflicts of interest issues might arise and how should CMS and/or the DCE address them?

As CMS has noted, this type of model could be attractive to a number of convening entities that perhaps have not engaged with Medicare FFS, but already fill a similar role in the Medicaid, Medicare Advantage, and private payer sectors, including (but not limited to) Medicaid Managed Care Organizations and Medicare Advantage Organizations. While participation should not be limited to these types of organizations, ACP agrees that allowing these types of organizations to participate in a capitated payment model through Medicare could be an important way to align performance measurement and physician reimbursement across payers, which is a critical piece to reducing administrative complexity and burden on clinician practices.

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

States seem like a reasonable conduit that could organize capitation models at this level, particularly given the geographic focus. We encourage CMS to not restrict states from applying to serve as DCEs and note the promising results that some states have achieved with population-based payment models at the state level, including Maryland's All Payer Model and

[13] https://news.aamc.org/press-releases/article/workforce_report_shortage_04112018/

Vermont's All Payer ACO Model. Many states have familiarity with capitation based payment through their Medicaid programs, so it would be reasonable to allow a state to enter into a similar organization with Medicare to promote alignment between the programs. However, particularly if CMS is to engage directly with states, the agency should be especially vigilant about monitoring the impact of this program on market dynamics, including consolidation of smaller and independent practices.

8. We seek information on what alternative alignment methodologies CMS might consider and the relative pros and cons of alternative approaches for beneficiaries and for DCEs operating in the same target region. Are there hybrid approaches to consider?

Regardless of assignment methodology, it is important to the success of any capitated model that the assigned patient population for which a DCE or individual clinician is responsible is clearly defined and known in advance. Informing the patient of his/her alignment in the model and any enhanced services, cost sharing opportunities, or other benefits of being aligned is critical. In the interest of preserving patient access, choice, and continuity of care, it is vital to maintain patient access to their preferred Medicare clinician. Therefore, voluntary alignment should take preference, as it does for the professional and global PBP options. This would also help to provide consistency across the DC model options. Similar to those options, voluntary alignment could be supplemented by claims-based alignment. ACP strongly supports the development and use of patient relationship codes to facilitate voluntary patient assignment.

9. Are there transparency/notification requirements that CMS should consider to protect beneficiary freedom of choice of any Medicare provider or supplier for beneficiaries aligned to a DCE participating in the Geographic PBP model option?

Patients must be made aware of their rights to privacy and freedom of choice upon alignment to the model. Accordingly, ACP supports a basic level of notification required pertaining to the patient's alignment in the model including any available patient incentives or enhanced service supports, and their ability to opt-out of information sharing. However, we also note that in the interest of reducing burden, CMS should not place overly restrictive requirements in this regard so as not to unnecessarily burden both the practice and patient while ensuring this information is always immediately available upon request.

10. How might DCEs inform beneficiaries of the payment model option and engage them? What barriers would DCEs face in engaging with beneficiaries in their target region?

In addition to educating patients about their rights to patient choice and data privacy, in the interest of improving patient care and ensuring the success of the model, patients must be engaged in their own care and educated about the key advantages of aligning with a DCE and downstream entities, including any available beneficiary incentives such as supplemental services, reduced cost sharing, and other benefits. This could be communicated in-person at appointments, over email, and through written materials available in the office suite.

11. 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?

With any APM, but particularly with full capitation models, CMS must carefully monitor patient safety, access to care, and appropriate level of care through quality metrics including but not limited to network adequacy, outcomes metrics, and patient experience ratings. However, in line with its Meaningful Measures Initiative, CMS should ensure that metrics used are clinically relevant, targeted and effective without placing undue burden on clinicians and actually detracting from direct patient care. ACP's Performance Measurement Committee issued a report that was published in the New England Journal of Medicine with detailed recommendations on how CMS can improve quality measurement to maximize effectiveness. CMS should collect data related to and specifically monitor for disparities in access, safety, or outcomes related for at risk patient populations including those that are dually eligible for Medicare and Medicaid, and other social determinants of health.

12. 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?

Because full capitation models shift risk to the DCE, these entities should be able to set their own terms with the clinicians and practices with whom they contract, and should not be subject to the same administrative and regulatory hurdles as other practices who operate on a FFS basis, such as prior authorization requirements, billing requirements for telehealth, at-home, and other services. Given the DCE would be responsible for additional spending, they are inherently incentivized not to perform unnecessary services. Leaving these restrictions in place for high-value services only places unnecessary restrictions on the entity's ability to fully innovate and deliver patient-centered care. However, as with any capitated model, CMS must continue to closely monitor that systems are not selectively choosing healthier patients or foregoing certain services. This can be accomplished through reporting a combination of high-impact outcomes metrics and patient-reported satisfaction measures, as well as monitoring for notable changes in patient attribution, average risk scoring, and service billing.

ACP and other stakeholders have repeatedly called for CMS to establish a consistent set of Medicare payment and fraud and abuse waivers across all Advanced APMs[14] to provide clarity and consistency for Advanced APM participants, as well as protections for practices forming an Advanced APM entity. Currently, participants are only protected if they have already formed an APM entity, leaving those that are in the process of contract negotiations vulnerable. Extending protections beyond current participants to those actively in the process of forming an APM entity or new model would help to promote the participation in existing Advanced APMs, as well as the development of new models altogether.

13. 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

[14] https://www.acponline.org/acp_policy/letters/acp_comments_on_cmmi_new_direction_rfi_2017.pdf

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?

While an APM should never limit patient patients from seeing certain clinicians, establishing a strong core relationship between the patient, family and his/her care team with the patient at the center of his/her own care are vital underpinnings to a system that delivers on efficient utilization of resources and lower costs, and more importantly, improved patient outcomes and patient-centered care. We refer to you to ACP's principles for patient and family partnership in care for tactics to build a strong physician-patient relationship. Therefore, ACP supports the use of enhanced patient supports, services, and cost sharing strategies to positively encourage patients to take advantage of high value services and seek care within their dedicated clinician care team, e.g. the DCE-aligned team of clinicians, with the important prerequisite that all patients are given fair access to these services regardless of socioeconomic status or other social determinants of health. With any Medicare payment demonstration, it is critical that quality of care and continued access to services for all patients be closely monitored through patient- and practice-reported metrics, noticeable changes in attribution, service use, and risk-adjustment data, and robust evaluations to assess overall impacts on access, quality of care, cost and competition, particularly for vulnerable patient populations.

14. CMS would calculate the historical total cost of care for a geographically aligned population in order to set the spending target for the DCE, also known as the benchmark. We are interested in feedback regarding adjustments we should consider in calculating the benchmark for the performance year, such as the use of the U.S. Per Capita Cost national trend, other trend factors or specific geographic adjustments.

A finely tuned benchmarking methodology is critical to the success of any APM, but especially for high-risk capitation based models. Consistent with past ACP recommendations to the Medicare Shared Savings Program,[15] in order to accurately evaluate a participating entity's ability to bend the utilization and cost curve compared to its regional service population, it is important that a DCE's own cost savings success is not counted against them when setting future performance benchmarks. This will be especially important to this model, as DCEs will likely encompass a large proportion of their patient population, particularly in rural areas, where participating entities may comprise an even larger proportion of their regional market. To mitigate concerns about potential diminishing returns, e.g. an increasingly limited amount of fat to trim, CMS could consider incorporating an element of national benchmarking, as well as reducing the "discount" if a particular DCE is already proven to be a low-cost clinician.

15. We envision applicants will propose a discount to the benchmark for the geographically aligned population. We seek comment on the range of discounts we might expect applicants to propose and why (e.g., by analogy or reference to other experiences). How might we think about requiring applicants to structure these proposed discounts over the life of the model?

[15] https://www.acponline.org/acp_policy/letters/acp_response_to_proposed_2019_mssp_rule_2018.pdf

If CMS allows participants to propose their own discounts, the agency should offer incentives for participants to choose higher discounts, such as an increased opportunity for performance-based incentive payments. To ensure participation in the model, particularly by a variety of entities including those in rural regions, CMS should not set the minimum discount so high that it would disincentive participation. This is especially important in the beginning of the model's lifecycle when interested parties will not have the same level of data, experience, or confidence to justify a higher discount. By keeping the minimum discount low, particularly in the early years of the model, while at the same time offering increased incentives to select higher discounts, CMS will maximize participation in the model while establishing a glidepath to higher levels of risk, all with minimal financial risk on behalf of the Medicare trust funds. In the end, it would be better to have dozens more participants and achieve a savings of 1-2% than not having all those entities not participate in the first place. But by offering higher reward in exchange for taking on greater risk in the form of a higher discount, CMS will still provide an incentive for those entities that are willing to accept greater levels of risk to do so. As noted above, CMS should consider lower discounts for DCEs already proven to be low cost relative to regional and national spending trends to encourage their ongoing participation in the model.

16. We are interested in feedback on the payment methods available to DCEs in the Geographic PBP model option. In particular, we would like feedback on the "notional" account policy, described above, under which DCEs could select to have CMS continue to make FFS claims payments to all healthcare providers in the region. These FFS claims payments would be reconciled against the DCE's benchmark as part of final settlement.

ACP supports choice and flexibility to APMs, which is particularly critical for high-risk, high-reward models. While we support evolving away from a FFS reimbursement system, we also recognize that moving to a capitated payment system is already a major transition, and offering an option to maintain an element of FFS payment, particularly in the early years of the model, could allow clinicians much needed time to familiarize themselves and gain confidence with the model before fully transitioning away from FFS payments. However, DCEs and downstream physicians that do agree to with a capitated model and gradually transition away from FFS should be recognized and rewarded through drastically streamlined billing requirements.

17. Should DCEs' benchmarks include accountability for Part D drug costs? What opportunities and challenges might this provide to entities participating in the Geographic PBP model option? Are there other approaches to control prescription drug costs that we should consider short of incorporating Part D costs into DCEs' benchmarks?

ACP appreciates CMS' attention to the important issue of the rising cost of Part D drug costs. There are many potential negative patient consequences that could result from incorporating Part D drug costs in the model. Physicians have little ability to control the cost of drugs, so incorporating Part D drug costs into the model could pose serious concerns related to patients' ability to access lifesaving drugs. With a model already featuring high levels of risk, introducing any additional elements, particularly areas where physicians may have less control over spending, could be the difference between a DCE deciding to participate or not in the model. At the same time, ACP appreciates that incorporating Part D drugs costs in the model could be an effective way to curb spending and steer patients towards generics and other price-effective

alternatives while maintaining access. Given all of these considerations, ACP would suggest that if CMS does have an interest in including Part D drug costs in capitated payments, it does so on an optional basis, particularly in the early years of this model. If made optional, DCEs may also be more inclined to test incorporating Part D drug costs. Further, CMS could compare DCEs that elect this option to those that do not to monitor impacts on patient access to drugs, ability to reduce savings, health outcomes, and other factors which could provide valuable insights related to the relationship of Part D drug spending to overall spending, effective strategies to mitigate spending, and the role of prescription drug costs in this and other future APMs. We appreciate CMS exploring new ways to curb spending on drugs to protect the Medicare trust funds and individual patients cost sharing, and look forward to continuing to support the Agency in these efforts. We direct you to our policy paper on stemming the escalating cost of prescription drugs for a set of more detailed policy recommendations on this topic.

18. If DCEs were to enter into their own downstream payment arrangement with healthcare providers, how should cost sharing amounts be determined and collected from beneficiaries?

Beneficiary cost sharing has important implications on patient behavior and uptake of certain services. It should be carefully considered when designing any model, particularly its ability to positively or negatively impact access health inequities caused by social determinants or other factors. DCEs must not shift risk or expense to the patient as a result of their electing to participate in the model. To prevent against this, beneficiary cost sharing should not be allowed to exceed current Medicare rates. However, because DCEs are held accountable for costs, they should have the freedom to lower or eliminate cost sharing to incent certain high value services and use Medicare funds to fund other services proven to have a positive impact on patient health and well-being, including those not directly related to billable health services, such as transportation costs or nutritional support services. CMS and DCEs should also use this model as an opportunity to explore ways to structure patient cost sharing in a way that helps to mitigate the access inequities, poorer health outcomes, and other issues that are attributed with social determinants of health. Beyond aiming to improve the equity of health in our local communities, which should be an inherent goal of any new innovation, targeting underserved patient populations with better care management, community supports, and earlier interventions is an important way to improve patient outcomes and reduce downstream complications and costs for the individual DCE and the model as a whole.

19. How should CMS address utilization of services and costs for beneficiaries aligned to a DCE that occur outside of the DCE's target region?

For this model to work, DC aligned clinicians must have an ability to work with patients, engage them in their own care, have important conversations about the pros and cons of various treatment options, monitor ongoing disease management, and steer patients towards appropriate, cost-effective treatments. Patients need some incentive to seek care within their aligned network of clinicians. While patients should not be limited in where or what care they receive, we underscore the importance of informing patients about the model and what it means for them, including any financial, supplemental services, and other benefits that might encourage them to seek care from their DC-aligned care team. It is also important CMS account

for outcomes, services and costs that do occur outside of a DC-aligned practice that DC clinicians have no influence over. Such claims should continue to be paid on a FFS basis.

III. Conclusion

ACP appreciates the opportunity to provide feedback on CMS' Request for Information on the DC Model – Geographic PBP Option. We hope the Innovation Center carefully considers our recommendations in this letter. Specifically, we ask that in designing this model, CMS:

- Provide ample reimbursement for internists providing comprehensive primary care services that are critical to managing the health needs of a defined patient population;
- Develop a diverse portfolio of APMs with varying levels of risk and design that will accommodate a range of practice types, including independent, small, and rural;
- Not constrain potential participation in the model with arbitrary thresholds, control groups, or other overly restrictive qualifying criteria;
- Consider the impact on existing Medicare models and vulnerable patient populations within and across geographic regions;
- Leverage the high level of risk to reduce administrative burden to the maximum extent;
- Offer patients positive incentives to remain within DCE-aligned practices for their care, including reduced cost sharing, supplemental services, and benefit enhancements;
- Not hold participants accountable for services and costs that occur at other practices or are otherwise beyond their control;
- Evaluate clinicians on a small set of impactful, clinically accurate, and statistically valid quality cost and utilization measures; and
- Gives interested DCEs and clinicians access to the data they need to make participation decisions and monitor they are on track with outcomes, utilization, and cost targets.

We understand this is the beginning of an ongoing conversation and look forward to continuing to partner with you to provide feedback throughout the development of this and other APMs. Thank you for considering our comments. Please contact Suzanne Joy by phone at 202-261-4553 or e-mail at sjoy@acponline.org if you have questions or need additional information.

Sincerely,

Ryan D. Mire, MD, FACP
Chair, Medical Practice and Quality Committee
American College of Physicians