May 23, 2019

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Center for Medicare and Medicaid Innovation
7500 Security Boulevard
Baltimore, MD 21244

RE: Response to Request For Information: Direct Contracting—Geographic Population-Based Payment Model Option

Dear Direct Contracting Program Team,

COPE Health Solutions applauds the direction of the Geographic Contracting Proposal to offer entities an opportunity to assume the total cost of care (TCOC) risk for Medicare fee-for-service (FFS) beneficiaries in a defined target region. There is a need for the timely development and implementation of more innovative alternative payment models (APMs).

Health care continues to require partnerships and collaborations to successfully adopt risk arrangements focused on the patient via whole person care. Currently, health systems and physician providers committed to value-based payment are participating in APMs that require them to substantially change their delivery of care, make investments in the necessary infrastructure for APM participation, and willingly take on "more than nominal" financial risk, often for costs over which they have no control. This is undertaken not simply by fiat, but by a well-grounded belief that being "at risk" properly aligns incentives for optimal patient care.

When we examine factors that will contribute to success in any of the CMS proposals, we have seen in both the MSSP and commercial ACO contracts that success requires a foundation for managing population health using, among other things, patient-centered medical homes and care management programs. They also tend to have a high degree of clinical integration and sophistication with health information technology and informatics, which are needed to identify high-risk patients and create workflows that enable providers to meet patient needs efficiently. Having previous experience managing risk, for instance, through prior ownership of a provider-sponsored health plan, also helps. In commercial contracts, we have noticed that successful APMs often have a robust payer-provider partnership that is built on transparency, shared value propositions, aligned incentives, and shared risk. Therefore, while we applaud the proposal as directionally correct, we perceive potential weaknesses that may significantly limit participation by the entities CMS is seeking to encourage in a movement to value-based payment.

There is a need to remove some of the regulatory barriers and complexity associated with the program. Further, for those providers that do successfully contract, we are concerned about the degree of financial and operational risk necessary, absent adequate safeguards and risk corridors. Here are several considerations we submit to CMS:

CMS should start with an operational goal that resolves the current problems in Medicare FFS. These include:

- The misalignment of financial incentives between professional and health systems providers in FFS
- The lack of affiliation of members to physicians and health systems

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- The small number of entities capable of bearing the financial and operational risk
- The infrastructure investments in building the "chassis" for VBP and population health, both at the health plan and provider level
- The lack of "spread" and continuity of value-based risk payment across a medical group, IPA, ACO or health system's payers

The role of the health plan should be to support the provider organization. We are assuming, for the purposes of this letter, that CMS intends to encourage taking of risk by entities other than the traditional health plans. However, a clear delineation of the role of health plans is essential. We propose to limit the participation of a plan to act as infrastructure partners or provide administrative services only.

Contracting should not disadvantage Medicare ACOs and other provider configurations. Among our questions are, whether and to what extent, a professional services applicant would envision participating in the Professional Contracting model, as well as partnering with an institutional provider in contracting for a geographic service area? May an existing MSSP or ACO provide the infrastructure?

Although the proposal states that a Medicare Advantage plan may apply, we are assuming that because of the attribution issue in FFS Medicare that a Medicare Advantage plan would have to follow those rules. To do otherwise would uniquely disadvantage current Medicare ACO participants from proposing to contract.

In undertaking risk for a target population in a geographic area of at least 75,000 Medicare beneficiaries, a contracting entity would have to have pre-existing demonstrated capabilities in undertaking risk-based contracting. This necessarily limits participation to those entities that have already built impressive administrative and operational capabilities, as well as having significant and deep financial reserves. This sadly potentially limits participation to entities in areas that have had significant Medicare Advantage penetration. These are not the geographic areas that need the boost to achieve greater penetration of value-based contracting. CMS needs to consider how to engage regions that resist the shift to value-based arrangements and modify the Direct Contracting Geographic Model to encourage the creation of infrastructure and expansion financial alignment that would speed the development in these volume-driven areas, where the potential for impact would potentially be the greatest.

CMS must address the attribution and affiliation issue to limit patient leakage. For hospitals, health systems, and large organized physician groups, attracting patients to receive care in their network and keeping them in-network has always been important. However, the concept of keeping patients in-network in this geographic contracting model is even more essential because the entity is responsible for paying FFS to the outside network providers, versus presumably a contracted rate. Not having patients leak outside the network is critical because otherwise, they are going to lose control of how spending is done and how care is provided for those patients. If patients cannot be kept in network, it will make it exceptionally difficult to achieve the goals of contracting. In addition to the financial implications of keeping patients in the contracted network, providing Medicare patients with care from network providers can also boost the care coordination goals of the undertaking. While we recognize limitations on penalizing someone who goes out of network, is it possible to permit financial incentive payments for members that focus their utilization with the network providers and actively participate in evidence-based lifestyle programs that are known to improve the health of the population, other incentives, and benefit design changes to encourage in-network utilization?

There must be more certainty around re-contracting and limitations on rebasing. One concern is the limitation to annual contracting. Not to overstate the issue of the cost of building infrastructure, but these are tremendous and require the sustained commitment of resources both financial and professional, and with no guarantee of renewed contracts, financial projections are unreliable. Further, the rebasing of reimbursement benchmarks from each contract period, while understandable on the part of CMS, quickly becomes illogical for the participating entity. While benchmarks for spending are being reduced each year, the cost of the infrastructure needed to lower spending (e.g., care coordinators,

information technology systems) remains either fixed or more likely, increases as the population ages, and their acuity increases. How does the contracting entity work around this? This is a big issue when one considers that one of the major hurdles to the bidding process to join the program is the cost of entry, and that includes the intense infrastructure. Entities that are not able to recover those capital investments in the first year in the program and/or reduce them will have difficulty taking on further downside risk in their second contract. This is an area where CMS could help by taking into account the infrastructure investment, in the spirit of the objective of the Meaningful Use Program, and not rebasing onerously in the second year of the contract.

Risk scoring methodology must fairly account for expenses in the last year of life. The data risk score collection is very different between models. It is essential to address the risk adjustment and re-scoring methodology to ensure that it more accurately reflects the cost of this elderly population. In our experience, in this population, approximately 10% of these elderly individuals will pass away in the contracting year. This final year of life consists of extraordinary efforts and extraordinary costs. Many of these members have risk scores of 0.8, and the current risk scoring methodology excludes these members' final year; this results in not funding properly the true cost of care for to the risk population over time.

Another issue that may continue in the geographic and other contracting proposals is the risk adjustment used to calculate spending targets. Currently, CMS does not allow an increase in the acuity of a population to increase an ACO's payment, but it does allow it to reduce payment. It is unbalanced and unfair. It should either allow a positive adjustment or remove the negative adjustment.

CMS must reconcile financial oversight issues with state regulatory agencies or exempt participating entities from these rules. States are increasingly concerned and involved in policing the increased financial risk exposure for provider entities. For example, California recently proposed to oversee and approve any provider contract undertaking any financial risk, regardless of level. CMS must reconcile these conflicts.

Geographic contracting poses a high risk of further consolidation among providers or health plan penetration, inviting anti-competitive regulatory scrutiny. Success in this contract proposal requires size and geographic penetration. Four target regions may not represent the areas where such a geographic contracting model could successfully come together. This envisions large providers or a large health plan coming together to provide increased programs within the service area. This raises the risks of anti-competitive behaviors that disfavor smaller competitors and other health plans. Since it is generally believed that increased competition results in lower prices, concerns over over-concentration will invite a regulatory response.

Counter competitive action by health plans must be contemplated and restricted. If a contract for a geographic area is awarded to a provider or a group of providers or provider health plan, it invites potential retaliation by other health plans in the service area, who do not wish to encourage a potential system competitor.

Overall, as mentioned above, we applaud the proposal as directionally correct, and on behalf of COPE Health Solutions, we thank you for the opportunity to submit our input and hope you will consider it as you refine your geographic contracting model.

Regards,

Allen Miller
Principal & CEO