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May 24, 2018

Via Email
Seema Verma
Administrator - Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS Request for Information: Direct Provider Contracting

Dear Administrator Verma:

The American College of Cardiology (ACC) appreciates the opportunity to provide input on the CMS Request for Information: Direct Provider Contracting.

The ACC is the professional home for the entire cardiovascular care team. The mission of the College and its more than 52,000 members is to transform cardiovascular care and to improve heart health. The ACC leads in the formation of health policy, standards and guidelines. The College operates national registries to measure and improve care, offers cardiovascular accreditation to hospitals and institutions, provides professional medical education, disseminates cardiovascular research and bestows credentials upon cardiovascular specialists who meet stringent qualifications.

General Comments:

The College believes that alternative payment models have significant potential to enhance patient care and shares the CMS goals of improving quality of care while lowering the costs for Medicare and Medicaid. ACC appreciates prior CMS initiatives to create pathways to reward specialists for delivering quality care through value-based payment models. As stated in ACC's response to the CMMI New Direction RFI, the College continues to strongly support the concept of physician specialty models. These types of models are an opportunity to address the needs of patients with complex medical conditions through value-based payment arrangements that increase quality of care while reducing cost. **With the release of the Bundled Payments for Care Improvement Advanced model, ACC encourages CMS to continue the development of physician specialty models that qualify as Advanced APMs under the MACRA statute.**

ACC released its APM Framework in February to assist members in preparation for APM participation with a focus on organizational readiness, clinical practice transformation, data/analytics and assuming financial risk. The Framework can be found at www.acc.org/APM.

CMS should ensure that a potential direct provider contracting model includes an appropriate role for specialists. ACC recommends that CMS review the November 2017 *JAMA Cardiology* article entitled "Payment Reform to Enhance Collaboration of Primary Care and Cardiology: A Review."[1] This article resulted from an in-person meeting held in January 2016 where ACC members participated along with representatives from primary care organizations, payers, CMMI, health system leaders, and others. Table 1 of the article outlines five models of care under a collaborative management framework between cardiology and primary care. ACC urges CMS to consider the important work that has already been done in this space when developing a direct provider contracting model. The College would appreciate the opportunity to discuss this work further with CMS.

In this letter, ACC is offering detailed comments related to provider participation, payment and financial risk, and existing ACO initiatives.

Provider Participation:

ACC strongly supports an appropriate role for specialist clinicians in a direct provider contracting model. **CMS should ensure predictability in the services covered under the model and their associated costs to incent provider participation.** Ideally, services associated with common conditions should be included. For cardiovascular disease, this could include heart failure, atrial fibrillation, and coronary artery disease. Additionally, basic cardiovascular stress testing, electrocardiography, echocardiography, and tobacco cessation, could be included in the model. Services for complex cardiovascular conditions with unpredictable costs should only be included if predictable reimbursement is guaranteed. **Carve outs for complex clinical services, and those beyond a provider's control (such as emergency care) are necessary, especially if downside financial risk is assumed.**

The model design should account for differences in practice setting. CMS should be cognizant of the challenges facing small and independent practices. **Any direct provider contracting arrangement should seek to reduce administrative burden, particularly in CEHRT usage, quality reporting, and billing processes for these settings.**

It is important that participating providers have tools to ensure that they are not held financially responsible for events outside of their control. Incentives for patients to remain within a participating provider's system or network, such as copay waivers, should be included. The model design should also encourage the use of patient-centered care management tools, such as telehealth.

Participating practices should be given flexibility to partner with larger entities, such as convening organizations with legal authority to receive and make payments, to ensure an

[1] Farmer, SA et al. "Payment Reform to Enhance Collaboration of Primary Care and Cardiology: A Review." *JAMA Cardiology*. 2018;3(1):77-83.

adequately large patient population. Lack of an adequate patient population could lead to high cost outliers driving financial losses, especially in a small or independent practice. A minimum patient population, similar to the Medicare Shared Savings Program, is desirable to avoid outliers driving financial losses. CMS should also consider a set beneficiary enrollment period and limitations on changing practices or disenrollment from a participating practice.

Payment and Financial Risk:

ACC cautions CMS against a payment methodology that incorporates financial risk for the total cost of care for beneficiaries enrolled with a participating provider. Responsibility for cost in the per beneficiary per month payment should be limited to predictable services. Furthermore, the payment methodology should incorporate robust stop loss safeguards. The level of stop loss protection should be calibrated to the size of the practice, with smaller practices having a higher level of protection.

Assumption of financial risk should account for the size of the patient population and the potential for outliers to drive financial losses. **Varying levels of financial risk should be offered to participating providers.** These varying levels should reflect differences in practice setting and experience with value-based payment arrangements. A glide path to increasing levels of financial risk should be available to providers. This will allow participating providers to initiate potentially costly practice transformation efforts without incurring large financial losses early in the model's performance period.

Appropriate and robust risk adjustment is integral to avoid "cherry picking" beneficiaries based on health status. **Any risk adjustment methodology should account for social risk and the social determinants of health in addition to medical risk.** ACC recommends CMS consider the Hierarchical Condition Categories models as currently used in Medicare Advantage. These models incorporate social risk through accounting for dual eligible status as well as medical risk, as a starting point. This methodology is preferable to the way the HCCs are currently used in other cost measures, such as the Medicare Spending per Beneficiary measure, which does not account for dual status.

Existing ACO Initiatives:

ACC recommends modifications to current ACO programs to achieve the advantages of a direct provider contracting arrangement rather than layering on a new initiative for providers participating in ACOs. ACOs could participate as convener organizations in a direct provider contracting model.

As Medicare Shared Savings Program participants move into downside risk tracks CMS should ensure providers have the tools necessary for successful participation. Specifically, these tools include copay waivers and other incentives to use ACO-affiliated providers. CMS should also ensure there are appropriate and robust stop loss protections for ACOs assuming downside risk.

Finally, CMS should make modifications to existing ACO programs that encourage collaboration between cardiologists, the cardiovascular care team, and primary care, including those outlined in the previously discussed *JAMA Cardiology* article.

Conclusion:

ACC is committed to working with CMS and providers to enable success in the value-based payment environment. The College looks forward to ongoing discussion and collaboration with CMS in creating opportunities for cardiologists and the cardiovascular team to participate in a potential direct provider contracting model and other alternative payment model initiatives.

If you have any questions or would like additional information regarding any recommendations in this letter, please contact Bryant Conkling, Associate Director, Payment Reform, at (202) 375-6399 or bconkling@acc.org.

Sincerely,

C. Michael Valentine, MD, FACC
President