AMERICAN SOCIETY OF PLASTIC SURGEONS®
THE PLASTIC SURGERY FOUNDATION™

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May 25, 2018

The Honorable Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd,
Baltimore, MD 21244-1850

Via Electronic Submission: DPC@CMS.hhs.gov

Re: Request for Information (RFI) Direct Provider Contracting Models

Dear Administrator Verma:

The American Society of Plastic Surgeons (ASPS) appreciates the opportunity to provide comments in response to the Center for Medicare and Medicaid Innovation (Innovation Center) Request for Information on Direct Provider Contracting (DPC) Model, released on April 23, 2018.

ASPS is the largest association of plastic surgeons in the world, representing more than 7,000 members and 94 percent of all American Board of Plastic Surgery board-certified plastic surgeons in the United States. Plastic surgeons provide highly skilled surgical services that improve both the functional capacity and quality of life of patients. These services include the treatment of congenital deformities, burn injuries, traumatic injuries, hand conditions, and cancer reconstruction. ASPS promotes the highest quality patient care, professional and ethical standards, and supports education, research, and public service activities of plastic surgeons.

While pleased to see the Innovation Center has listened to the many concerns raised about the need for additional models that provide the appropriate incentives for providers to deliver high quality, efficient care that takes into account the cost and quality of care for the services provided to a designated patient population, we share the following concerns about the concepts the Innovation Center has put forward as part of the DPC RFI.

<u>Design of the Model</u>

Over the last decade, there has been a great deal of interest in improving the care experience, reforming reimbursement and improving the quality of healthcare. We understand that the Innovation Center is statutorily authorized to test innovative health care payment and service delivery models but as a specialty society, are disappointed that the focus of this latest person-centered redesign model focuses almost exclusively at primary care services.

ASPS believes a DPC model should look beyond primary care, empowering beneficiaries with complex medical needs to seek out and receive the best care available. The Agency has indicated it wants to empower beneficiaries to do just that, but we remain concerned that the proposed model concept will direct beneficiaries to what is essentially a medical home where the beneficiary has historically received primary care services, but with a potentially added element of capitation that could affect patient access to care beyond what the primary care practice is able to provide. A lack of empowerment will be felt most acutely for beneficiaries who live in rural areas, with limited access to specialists participating in this or other Medicare programs as well as those with chronic conditions that require the attention of specialty providers.

Additionally, ASPS believes that if the Innovation Center was to proceed with a DPC model, it should include a safety-valve for emergent, long-term care conditions such as traumatic burns or cancer reconstruction. Without that, we are unsure of the viability of this model, which appears to be based on a two-sided risk structure from inception, while simultaneously allowing the patient to make yearly participation decisions.

Program Integrity

While we believe the Agency did not intend to exclude specialty care from the services eligible for fixed pay arrangements, we note that in this RFI, CMS has indicated it will pay a fixed payment to cover the *primary care* services the practice would be expected to furnish. We believe that DPC models could potentially hold value for multiple beneficiary types and conditions, but these must allow for payment, quality measurement, and risk-stratification to be specific to the beneficiaries treated by the participating practices.

For this DPC program to be successful, it must assure that *all* providers receive fair payments and ensure every beneficiary can face predictable and affordable costs when they seek care. As such, we ask the Agency to clarify the payment arrangements if it were to proceed with this type of model.

Safeguards should also include reviews to ensure there are no patterns of fee limitations or increased administrative burdens. Physicians already document the clinical information needed to treat patients and to demonstrate medical necessity. It is this information that CMS should rely on to assess the care delivered under such a model and refrain from creating additional documentation and data collection burdens. In fact, we believe that in order for such models to provide value to beneficiaries and to the Medicare program, the Innovation Center must reduce the burden on practices so that they can increase their focus on actually delivering care to patients and make it a priority to not demand more information from practices, but explore what information the Medicare program can furnish to providers to enhance care. This will

include efficiently getting providers data on care that the beneficiaries receive elsewhere in the system, access to claims data to complement the clinical data that practices already maintain, and technical assistance for practices to analyze and incorporate this information.

As the Agency improves existing payment models like ACOs, we are hopeful the lessons learned there can translate into new program set-up and further enhance the doctor-patient relationship by eliminating administrative burden for clinicians and providing increased flexibility to provide the high-quality care for all patients. However, we believe that CMS' previous models should use the potential implementation of a DPC model to move away from programs that incorporate resource use measurement predicated on total cost of care. A DPC model should instead focus on the efficiency of services directly related to the condition for which the practice is treating the patient and/or the services over which the treating physician can exercise a meaningful level of influence. Given CMS' concern regarding stinting and patient access to care, we strongly recommend against grading practices on total cost of care.

Conclusion

ASPS appreciates the willingness of the Agency to obtain feedback before the launch of this new payment initiative, and looks forward to working with the Agency to help shape this into a meaningful program.

Should you have any questions about our comments, please contact Catherine French, ASPS Health Policy Director, at cfrench@plasticsurgery.org or at (847)981.5401.

Sincerely,

Jeffrey E. Janis, MD, FACS
President, American Society of Plastic Surgeons

cc: Lynn Jeffers, MD – ASPS Board Vice President of Health Policy & Advocacy
Paul Weiss, MD – Chair, ASPS Coding and Payment Policy Subcommittee
Devinder Singh – Chair, ASPS Legislative Advocacy Committee, Regulatory Affairs