May 24, 2019

Adam Boehler
Director, Center for Medicare and Medicaid Innovation
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244
Submitted electronically to: DPC@cms.hhs.gov.

Re: Request for Information on Direct Contracting – Geographic Population-Based Payment Model Option

Dear Director Boehler:

Community Catalyst respectfully submits the following comments regarding the Request for Information on Direct Contracting – Geographic Population-Based Payment Model Option

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1998, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. The Center for Consumer Engagement in Health Innovation focuses on health system transformation and bringing the consumer experience to the forefront of health. The Center works directly with consumer advocates to increase the skills and power they have to establish an effective voice at all levels of the health care system. We collaborate with innovative health plans, hospitals and providers to incorporate the consumer experience into the design of their systems of care. We work with state and federal policymakers to spur change that makes the health system more responsive to consumers, particularly those that are most vulnerable.

We are encouraged to see that the Innovation Center is exploring models that emphasize the importance of primary care and move the health system from one focused on volume to a system focused on value. If designed well, such models could improve health outcomes and patient experience while lowering overall health system costs. However, the needs of beneficiaries must be placed at the forefront of model design and implementation and it will be crucial to ensure new models do not undermine current Medicare and Medicaid beneficiary protections, including protections against cost sharing and access to the full range of covered health services. As CMMI moves forward with designing and implementing new models, we look forward to working closely with you to ensure these models work first and foremost for beneficiaries.

General Comments:

Consumer Engagement

People with Medicare and Medicaid are uniquely positioned to explain how new models might affect them, which makes bringing consumer engagement to the forefront in model design an important tool. Beneficiary and stakeholder participation is critical for several reasons: by exploring the perspectives of beneficiaries, CMS can better fit the model's design to the needs, abilities, and desires of affected populations. Additionally, beneficiaries and their families and caregivers may be better able to identify participation barriers they might face within a model. Consumer engagement also ensures that beneficiaries buy into models and will stick with them throughout their duration. People who feel a system reflects their needs and concerns are more likely to be willing and engaged participants. Likewise, people who feel they are heard are more likely to stay with a particular model, plan, or provider, making possible longer-term analysis of patient outcomes and increasing the chance of positive provider influence over behaviors. This is particularly important for direct contracting models in which providers will be accountable for the cost of patient care and health outcomes and accurate per-member per-month payments are crucial to model success.

In the same way that CMS has been providing robust assistance to providers as they adopt new models of care, it is critically important to engage the patients who will be directly impacted by these models. We hope that the administration will uphold its stated commitment to creating a patient-centered health system by meaningfully engaging consumers in the design, implementation and evaluation of the proposed direct contracting models, as well as by promoting patient engagement at the clinical level in practices participating in these models. We encourage CMMI to consider consumer engagement as a guiding principle through the model development process and to build in specific structures for that engagement.

Rigorous Evaluation and Monitoring Standards

The direct contracting models CMS is proposing represent an unprecedented step in transforming the health care system, and while they have the potential to improve care and lower costs, they also come with many potential pitfalls and risks for beneficiaries. It will be crucial to rigorously evaluate these models, make changes based on lessons learned, and continuously monitor model implementation to ensure beneficiaries are protected and that their health needs are being met. CMS should also carefully monitor the impacts of these models on health disparities. We recognize that one of the goals of such a model would be to reduce administrative burden, but this goal notwithstanding, we ask that CMMI commit to a rigorous and comprehensive evaluation.

<u>Questions Related to General Model Design</u>

1. Addressing Social Determinants:
   We are glad to see CMMI's interest in exploring ways that new models can be used to better address patients' social determinants of health. A growing body of evidence points to the important role a patient's social and economic circumstances play in determining

their health and one of the major benefits of direct contracting models is the flexibility and incentives they offer for better utilizing the health system to address social needs. We offer the following recommendations for ensuring that the proposed direct contracting model addresses patients' social needs.

- DCEs should be required to show that they have an evidence-based social and economic determinants screening tool, as well as a referral system in place to use when the screening tool points to the need for interventions.
- DCEs should be required to partner with community-based organizations and social service providers in their area.
- CMMI should require that DCEs invest a portion of shared savings into community programs that address patients' social and economic needs. These investment decisions should involve a robust community engagement process.

Questions Related to DCE Eligibility

1. DCE Selection Criteria:
   We are supportive of the selection criteria that CMMI proposes in the RFI and also suggest the inclusion of additional criteria including:
   - The applicant's successful track record in and strategy for engaging patients and caregivers in model implementation.
   - The applicant's ability to partner with community-based organizations and social service providers and strategy for addressing patients' health-related social needs.

   Regarding the weight and priority assigned to the various selection criteria, we ask that CMMI place a strong emphasis on criteria that directly impact quality of care and beneficiary protections, including whether the applicant has the capacity for supporting delivery transformation efforts (with particular attention paid to the ability to support care coordination and meet the needs of patients with complex health and social needs). CMMI should also prioritize organizations that have direct clinical engagement with beneficiaries in the area and experience coordinating with community partners.

Questions Related to Beneficiary Alignment

We strongly recommend that CMS rely on an active and voluntary enrollment process and do not support the proposal to randomly align beneficiaries to competing DCEs, which would create beneficiary confusion around their care options. Educating consumers about what these new arrangements involve, their rights and responsibilities, and the benefits and potential risks of joining such an arrangement will be crucial to a successful active-enrollment process. To this end, we recommend:

- Establishing an APM ombudsman program. With an increasing number of new models being tested in Medicare, the system is becoming more and more complex for

beneficiaries to navigate. There must be robust consumer assistance systems in place that will help beneficiaries make educated choices that best fit their individual needs.

- Utilizing the strong infrastructure already in place to address beneficiary questions and concerns, including well-trained State Health Insurance Assistance Programs (SHIPs).
- Active collaboration with community-based organizations (CBOs), including those that represent communities of color and/or non-English speaking beneficiaries, around education and outreach.
- Participating practices provide detailed information about their practice and how care will be coordinated. Information should be provided in ways that are accessible and understandable by beneficiaries, including in different languages as needed, based on the beneficiary population.
- Beneficiaries receive clear information on the appeals and grievance process
- CMS issue additional guidance on the types of educational materials providers will be permitted to give to beneficiaries. CMS also should provide clear guidance on the role it will play in reviewing materials sent to beneficiaries, to ensure the materials are neither misleading nor coercive.

Additionally, freedom of choice of provider is a critical beneficiary protection in Medicare. Beneficiaries should not be prevented from seeking care elsewhere and, accordingly, they should be allowed to enroll or disenroll at any time. It is crucial that beneficiaries in DCEs have the same access to services and providers, without utilization management, as other beneficiaries. The benefits of becoming part of a DCE are based on building meaningful patient-provider relationships and delivering well-coordinated and integrated care. These should be the drivers that incentivize patients to seek care within their target region/preferred provider network.

Questions Related to Program Integrity and Beneficiary Protections

1. Ensure beneficiary access to care:

   Stinting on care is a major concern we have about direct contracting models from a beneficiary perspective. The models must be carefully designed to ensure that clinical decisions are not made based on cost alone and that will require a robust, patient-centered quality measurement strategy, along with a strong appeals and grievances process.

   We ask that CMMI include quality metrics in its requirements with providers, focusing on outcome metrics as opposed to process metrics. The metrics should include numerous patient-reported outcome measures and measures specific to quality of life, patient satisfaction, and functionality.

   A strong appeals and grievances process is also necessary to protect beneficiaries. This process should be clearly laid out for consumers in all educational materials and should be aligned with existing Medicare and Medicaid processes to prevent confusion.

3. Beneficiary Incentives:

Meaningfully engaging beneficiaries as partners in care and delivering patient-centered care that meets the needs of patients and families is the best way to encourage beneficiaries to participate in new models of care. Building a care delivery model that patients and families want to use is more likely to result in strong beneficiary alignment than are financial inducements or rewards.

While we do not believe financial incentives alone are sufficient for meeting goals of improved patient engagement and strengthened patient and provider relationships, we do recognize that removing financial barriers by waiving or reducing copays has the potential to improve beneficiary access to care. We recommend that the use of financial incentives be limited and focused on the goals of removing barriers to care, building strong relationships between providers and beneficiaries, and engaging patients in their care.

Furthermore, Medicare beneficiaries are particularly vulnerable to fraud and millions of dollars have been spent educating beneficiaries about potential scams. Financial rewards may contribute to perceptions of fraud. We are concerned that a beneficiary who is eligible for and receives the reward – at a time well removed from when care was accessed – may be confused and believe it to be a scam. Relatedly, a fraudulent actor could use the reward as an opportunity to scam beneficiaries.

Questions Related to Payment

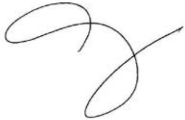
The success of any direct contracting model will be largely dependent on how the Per beneficiary per month payment (PBPM) amount is calculated, as this amount impacts the financial viability of the models, the incentives a provider has to lower costs or improve care, and the likelihood that practices will try to cherry-pick among their patient population. This is also a critically important factor in ensuring beneficiaries have access to all needed health care services and plays a large role in defining the scope of care providers are responsible for providing and coordinating. Risk adjustment, in particular is critical for ensuring that DPC models are successful and that practices aren't incentivized to only enroll healthy individuals. We recommend a risk adjustment strategy that also accounts for a patient's social, economic, and behavioral health needs, as well as functional status, in addition to physical health needs.

Direct contracting models should include payments sufficient to increase focus and resources devoted to primary and preventive care services. We encourage CMMI to set payment rates based not solely on actual primary care services utilized in the past, but to account for services utilized in other settings that could have been avoided had they been dealt with in a primary care setting. We also encourage meaningfully addressing the historical underfunding of primary care.

In closing, while we are enthusiastic about the focus on primary care innovations, we also recognize the potential negative impacts on beneficiaries if these models are not carefully designed and implemented. We ask that you continue to involve stakeholders, including

consumers, in the model development and implementation process. We look forward to working with you as you continue model development and implementation. Please do not hesitate to contact me at ahwang@communitycatalyst.org should you have any questions or if you would like additional information.

Sincerely,



Ann Hwang, MD
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