CENTER FOR CONSUMER ENGAGEMENT
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May 25, 2018

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

Re: Request for Information on Direct Provider Contracting Models

Dear Deputy Administrator Boehler:

Community Catalyst respectfully submits the following comments in response to the request for information (RFI) regarding direct provider contracting models.

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 focus on building meaningful provider-patient relationships. 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. It is also important that any new models are implemented in addition to, rather than in place of, promising models already underway, such as CPC+. We also ask that those models continue to receive the funding and attention necessary for continued implementation and evaluation, even as CMMI begins to test other alternative payment models. 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:

Further Opportunities for Stakeholder Feedback

We understand that CMMI is early in the process of model development and appreciate the opportunity to weigh in at this early stage. That being said, the lack of details provided in this RFI regarding what a DPC model will actually look like make it difficult to assess the merits of the proposal and evaluate potential impacts on beneficiaries. This lack of details necessitates further opportunities for stakeholder review before a model is actually implemented. As CMMI continues to shape what a potential DPC model will look like, we ask that the Center provide further opportunities for public comment. We also ask that CMMI clearly lay out what behaviors they are trying to incentivize with this new model, what results they hope to see, and what they believe this model can accomplish that existing models like CPC+ or ACOs cannot.

Patient Engagement Must be a Critical Component of the Design, Implementation, and Functioning of Any New Models

While we are enthusiastic about the possibilities of innovative primary care models, we recognize that there are a number of risks for physicians and patients depending on how these models are implemented. We know that CMMI is still at the early stages of model development, so it will be crucial to continue engaging with stakeholders as model development continues, particularly consumers. 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 through their duration. People who feel a system reflects their needs and concerns are more likely to be willing and engaged participants and 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 DPC models where 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 any DPC models, as well as by promoting patient engagement at the clinical level in practices participating in DPC models. We include specific recommendations related to consumer engagement in our responses to many of the questions posed in the RFI, but 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.

New Models Should Compliment Other Ongoing Efforts to Improve Primary care

One area of particular concern is how these new models might impact or potentially disrupt other existing payment models, particularly Comprehensive Primary Care Plus (CPC+), that are also aimed at improving care coordination. CPC+ is a promising model with a number of patient-friendly features and we are eager to ensure that the model continues and is fully evaluated. CMMI should develop a DPC model in a way that enhances existing models and does not disrupt provider or patient participation in those models. We also ask the CMMI consider if and how they might be able to pursue the stated objectives of a direct provider contracting (DPC) model – including enhanced beneficiary-provider relationship and active beneficiary choice – by refining and building upon existing payment models, such as accountable care organizations (ACOs) or the CPC+ program. At the very least, CMMI should be sure to draw on lessons learned from ACOs and CPC+ as they develop new models.

Additionally, we hope that this RFI is just one step of many that CMS will consider taking in order to promote accessible, high value primary care. In order to make real and lasting change, these efforts should be accompanied by efforts to grow and strengthen the primary care workforce through programs like the National Health Service corps or increased use of community health workers and reforms to payment rates for primary care services.

Workforce Assessment

Before proceeding with any model implementation, CMS should conduct an assessment of the impacts such a model would have on the primary care workforce. Many areas of the country already experience a primary care shortage. While direct contracting models may be appealing to primary care providers and encourage more professionals to enter primary care in the long term, a decrease in provider panel size potentially associated with DPC models could have negative impacts on Medicaid and Medicare beneficiaries' access to primary care in the short term. It is important for CMS to understand these implications before proceeding with implementation.

Rigorous Evaluation and Monitoring Standards

Introducing direct provider contracting into Medicare or Medicaid would be a new concept 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. 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.

Patient Protections in Case of Provider Losses

This RFI envisions a new model of care that would encourage an increasing number of primary care providers, including smaller, independent practices, to move towards risk based arrangements. While we are supportive of the continued efforts to reward value over volume, we are mindful of the potential risks to consumers when a practice takes on financial risk it might not be prepared to absorb. We ask that as CMMI develops a DPC model, they include requirements for reinsurance and risk-based capital standards to protect consumers in the face of provider losses.

Responses to Specific Questions:

Question 2: Practice Requirements

One major component that is lacking in the current RFI is information about the desired care model DPC arrangements would incentivize. If CMMI moves forward with a DPC model, it should be built around a goal of providing coordinated, integrated, patient-centered primary care and should be accompanied by clearly defined functions and expectations that serve that goal, similar to the requirements in CPC+.[1] There are a number of features and competencies we think practices should demonstrate in order to ensure that DPC models are patient centered, successful in improving health outcomes, and equipped to serve the full spectrum of Medicare and Medicaid beneficiaries, not just the healthiest patients. While this is not an exhaustive list of the necessary competencies, the following features are particularly important from a consumer perspective.

- **Demonstrated Capabilities in Care Coordination, Integrations and Management**
  The core of any DPC model should be the ability to provide patients with coordinated, integrated care that meets their individual health needs and goals. Practices should only be permitted to participate in a DPC model if they can demonstrate their ability to provide such care, including but not limited to:
    - The ability to provide continuous and accessible care including same day services, 24/7 telemedicine access, and e-consults
    - Processes for developing care plans and providing appropriate follow up
    - The necessary EHR technology
    - A seamless referral system for specialists and lab tests
    - An integrated care team
    - Integrated behavioral health services including systems for screening, diagnosis, treatment, and referral.

- **Meaningful Consumer Engagement Mechanisms**
  Meaningful patient and caregiver engagement will be critical to the success of these models, as that success is dependent on a practice being able to meet patients' needs and keep patients engaged over the long term. As we will describe in more detail in response to these questions, there are also a number of risks for patients if DPC models are not designed and executed well. Meaningfully engaging patients and their families at every level and step of the process will help protect against these risks. To this end, practices in DPC models should be required to:
    - Set up Patient and Family Advisory Councils and integrate recommendations into the practice. This is similar to the requirement for practices participating in CPC+.[2]

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[1] The Center for Medicare and Medicaid Innovation. "CPC+ Care Delivery Requirements." Available at: https://innovation.cms.gov/Files/x/cpcplus-practicecaredlvreqs.pdf
[2] ibid

    - Utilize shared decision making tools and actively involve patients and, when appropriate, their caregivers in the development and maintenance of their care plans
    - Utilize user friendly platforms and technologies that allow patients timely access to their health information

- **The Ability to Provide Accessible, Culturally Competent Care that Addresses Health Equity**
  Because of the emphasis on coordinated care and establishing strong provider-patient relationships, DPC models have the potential to improve health equity in their communities. However, there are many risks involved in implementing a DPC model, including cherry-picking, geographic disparities, or care stinting that could increase disparities. Practices should be required to make improving equity a central goal and should have, at a minimum, the following competencies:
    - *An evidence based social determinants screening tool and referral system:* One of the major benefits of a direct contracting model, particularly in primary care, is that providers have more time to devote to learning about their patients' health needs and developing a comprehensive health plan. A growing body of evidence points to the important role a patient's social and economic circumstances play in determining their health. Practices participating in DPC models 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.
    - *Accessibility:* Practices participating in a DPC model should be required to meet standards for accessibility related to language and disabilities. Translation services must be available and facilities and equipment must be accessible for people with disabilities. This is important for ensuring high quality, patient centered care and improved health outcomes, but it is also vital in trying to prevent cherry picking or discriminatory implementation of these models. Practices that aren't equipped to serve patients with more complex needs will not be incentivized to take on those patients.
    - *A diverse workforce that reflects the community served:* Practices should demonstrate that they are equipped to provide culturally competent care to the community served by hiring a diverse workforce reflective of community demographics, including community health workers, promotores, or peer counselors

Question 4: DPC Arrangements in Medicaid

There is already significant flexibility in Medicaid to test new models of care and payment, similar to the arrangements envisioned in this RFI. While this flexibility offers states the chance to adopt innovative solutions that advance patient-centered care and improve health outcomes, it also comes with risks for Medicaid beneficiaries, who are low-income and often have complex health needs. It is important that CMMI take into account the unique needs and challenges of Medicaid beneficiaries when considering how to advance DPC arrangements in the program. We are opposed to any arrangements that would lead to higher out-of-pocket costs for Medicaid beneficiaries, undermine important beneficiary protections, or limit access to coverage through work-requirements, time limits, or lock-out periods.

Question 6: Freedom to Enroll and Disenroll

Freedom of choice of provider is a critical beneficiary protection in Medicare, so we are pleased that CMMI is acknowledging that this right would be retained under DPC models. Beneficiaries should not be prevented from seeking care elsewhere and they should be allowed to enroll or disenroll at any time. It is crucial that beneficiaries in DPC plans have the same access to services and providers as other beneficiaries. The benefits of becoming part of a DPC practice are based on building meaningful patient-provider relationships and delivering well-coordinated and integrated care. These should be the drivers that incentivize patients to stay with their current DPC provider rather than lock-in periods or the erosion of freedom of choice of providers.

Given the potentially high incentives for cherry-picking in a DPC like model, providers should not be allowed to disenroll or to refuse to enroll a beneficiary except in rare circumstances, similar to those allowed under Medicare Advantage, including moving out of the geographic area, losing entitlement to Medicare/Medicaid, incarceration, or death.

Question 7: Beneficiary Outreach and Engagement

- **Outreach and Education:**

  Any direct contracting models that CMMI develops will require robust consumer education and engagement to be successful. We have long advocated for active, voluntary enrollment in other new models of care, such as Medicare ACOs, and are glad to see that CMMI is envisioning an active enrollment process for these new models. 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.[3]

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[3] The Social Security Administration provides its materials in 18 languages. See http://ssa.gov/multilanguage/. The U.S. Justice Department has a safe harbor provision for HHS recipients in meeting written translation

  - Beneficiaries receive clear information on the appeals and grievance process, as well as information about when and how beneficiaries can disenroll from a DPC practice.
  - 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.[4]

- **Financial 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.

  Any use of financial incentives should be limited to and focused on removing barriers to care, building strong relationships between providers and beneficiaries, and engaging patients in their care. Waiving or reducing copays may have potential to improve beneficiary access to care by removing financial barriers but we do not believe monetary reward will achieve the goals of strengthened relationships between patients and their providers and enhanced patient engagement in their health.

  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.

- **Additional Consumer Engagement Mechanisms:**

  An active enrollment process is not sufficient consumer engagement for a DPC model. If these models are to succeed at better coordinating care and strengthening the patient-provider relationships, patients need to have the tools necessary to be full partners in their care. In addition to a patient-centered active enrollment process, there are a number of

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requirements by providing written translations for each language group that represents 5 percent or 1,000 people, whichever is less, of eligible individuals. See http://www.justice.gov/crt/about/cor/lep/hhsrevisedlepguidance.pdf. Additionally, the Department of Labor requires that certain plans covered under ERISA provide summary plan descriptions in languages, where the lesser of 500 people or 10 percent of plan participants speak the same non-English language. See29 CFR 2520.102-2(c)(2).

[4] See Coalition for Better Care, Comments on Next Generation Accountable Care Organization Model Request for Applications, May 18, 2015. Available at http://www.nationalpartnership.org/research-library/campaigns/campaign-for-better-care/coalition-for-better-care-comments-on-next-generation-aco-model.pdf.

steps CMS and individual practices should take to ensure that consumers are meaningfully engaged. These include:

- A requirement that practices use shared decision making tools and actively involve patients and, when appropriate, their care givers in the development and maintenance of their care plans
- The use of patient reported outcome measures when evaluating quality of care, including quality of life and patient activation measures.
- The use of user friendly platforms and technologies that allow patients timely access to their health information
- As mentioned above, requirements that practices set up Patient and Family Advisory Councils.

Question 8: Cost Sharing:

One major concern from the beneficiary perspective is the possibility that a Medicare DPC model could open the door to balance billing, with DPC practices potentially charging fees higher than what Medicare covers. It is crucial that all current consumer financial protections in Medicare and Medicaid remain in place under a DPC model and beneficiaries should not face higher out-of-pocket expenses than currently allowed under the law. We are also concerned about possible cost-sharing associated with any monthly fees that might be part of a DPC model. Additional cost-sharing not tied to a particular service is confusing for beneficiaries and may be a barrier to lower income Medicare beneficiaries entering a DPC practice.

We are supportive of models that may waive co-payments or deductibles as a way to reduce barriers to effective care and as a strategy for furthering the quality related goals of a potential model (for example, waiving cost-sharing for services that are shown to prevent or improve care for chronic illness). We do not support waiving cost-sharing as a way to incentivize patients to join a particular practice. However, it is difficult to envision how waiving cost-sharing would work in Medicare given the large number of beneficiaries with Medigap plans and we have concerns with the potential consequences for the Medigap risk pool and premiums if populations enrolled in DPC decided to forgo Medigap insurance.

We are also concerned that beneficiaries might face confusion over what services are included in the care they receive from the DPC and may be surprised by or unprepared for out-of-pocket costs when they seek care in another setting. It will be vital that beneficiaries who are considering enrolling in and who are enrolled in a DPC model be given clear, user friendly information about what services are covered and what cost sharing they are responsible for.

Question 9: Payment Calculation

The success of any DPC models will be largely dependent on how the 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.

Any DPC model, including the DPC primary care model, should include payments sufficient to increase focus and resources devoted to primary and preventive care services. One payment strategy we encourage CMMI to explore is setting the payment rate as a percentage of total cost of care. This model would be based not solely on actual primary care services utilized in the past, but would account for services utilized in other settings that could have been avoided had they been dealt with in a primary care setting, and address the historical underfunding of primary care. The payment would be based on this ideal primary care investment level and include a defined bundle of primary care and behavioral health services, including both directs services and care coordination. This amount would then be risk adjusted based on population characteristics and the cost of any of these services that are provided outside of the DPC practice would be deducted from the PBPM payment.

Question 14: Quality Measurement

Quality measures will be critical to ensuring that a DPC model doesn't lead to stinting on care. Because that risk is so high in a capitated payment model like the kind CMMI is envisioning, it is especially important that the Center utilize a patient centered quality measurement process. We recommend that CMMI:

- Incorporate performance and quality measures into the determinations of performance-based incentives for total cost of care. We recommend that CMMI utilize a minimum quality "gate" that must be met before providers can pull down a bonus payment.
- Incorporate patient reported outcome measures, including quality of life measures, and patient satisfaction measures.
- Include incentives for improvements in quality measures, not just for absolute levels of performance. This will help ensure that providers are not incentivized to exclude sicker or more complex patients from their practice.
- Engage consumers in the measure development, selection and implementation process to ensure that quality measures are aligned with patients' goals in a DPC model and address any concerns patients might have about the quality of care they will receive

Question 16: Preventing Care Stinting

Stinting on care is another major concern we have about DPC 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.

As we outline above, 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.

Question 17: Preventing Cherry Picking

We are very concerned about how beneficiaries will be encouraged or discouraged from enrolling in a DPC practice, as well as how a DPC model would prevent participating practices from cherry picking the healthiest enrollees. Without solving these problems, DPC models run the risk of becoming discriminatory, exacerbating health equity issues, and locking out of the models the complex patients who would benefit from care coordination the most. In order to avoid this, at the very least, CMMI should:

- Place strict limits on practices' ability to reject or disnenroll beneficiaries.
- Prohibit the use of financial incentives that aren't tied to specific health goals, but are used merely as a promotional tactic to encourage certain beneficiaries to join a DPC practice.
- Prohibit marketing to current patients based on health status.
- As described above, utilize a risk adjustment strategy that accounts for patients' social, economic, and behavioral health needs, as well as functional status, in addition to physical health needs.
- Closely monitor practices' patient mix to look for evidence of cherry picking. CMS should review the recent claims history of beneficiaries who enroll in the DPC program. If it appears that a practice may be discriminating based on health status, CMS should reserve the right to review further claims/encounter data from the practice's Medicare Advantage and FFS beneficiaries to ensure that the organization is not cherry-picking the healthiest beneficiaries to enroll in the DPC model.

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 stakeholders have another chance to weigh in on these models once more details are available. 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
Director, Center for Consumer Engagement in Health Innovation