



Working Together for an Affordable Future

RFI for Geographic Population-based Payment Option  
DPC@cms.hhs.gov

May 30, 2019

Seema Verma, Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, D.C. 20201



Dear Administrator Verma:

NCHC is a nonpartisan, nonprofit organization representing more than 80 participating organizations, including medical societies, businesses, unions, health care providers, faith-based associations, pension and health funds, insurers, and groups representing consumers, patients, women, minorities, and persons with disabilities. The Coalition is committed to advancing - through research and analysis, education, outreach, and informed advocacy - an affordable, high-value health care system for patients and consumers, payers, employers, and taxpayers.

**High-level Comments on Direct Contracting Advanced Alternative Payment Models**

The National Coalition on Health Care is supportive of the Direct Contracting Models (DCMs) as opportunities to provide better care and value to Medicare beneficiaries. We also support greater options for physician groups and their partner organizations to collaborate in total cost-of-care models that qualify as advanced alternative payment models (AAPMs) to incentivize high quality and efficient care delivery.

We have concerns about how accountability will be determined when models overlap in geographies. As different payment models in fee-for-service (FFS) Medicare proliferate, providers and beneficiaries could experience disruption and confusion if entities to which they align or are attributed change or reorganize frequently. Annual open enrollment periods (OEP) aligned with the Medicare Advantage OEP may be needed to promote informed choice and stability. Moreover, overlapping models make it challenging to attribute savings, losses, or other incentives.

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We view the DC model as well suited for physician groups and their partners who want to serve the 11 million dual-eligible beneficiaries through specialized care models designed for high-cost, high-needs beneficiaries. The DC model gives CMMI the ability to tailor contracting terms, such as quality measures, supplemental benefits, and risk adjustment. The DC model allows close scrutiny of the DCE and its partners' qualifications, while providing other beneficiary protections and ongoing monitoring of care.

Medicare beneficiaries with high needs related to chronic conditions, disability, frailty, or social and economic disadvantages already benefit from the care coordination, specialized care teams, and tailored benefits provided by Medicare Advantage Special Needs Plans (MA SNPs). A recent analysis by Avalere indicates dual-eligible beneficiaries experience lower costs and better outcomes in Medicare Advantage.<sup>1</sup> Enrollment data reflects that these beneficiaries are less likely to be enrolled in MA or MA SNPs than beneficiaries who are not dual-eligible.<sup>2</sup>

CMS has worked closely with several states in recent years to align Medicaid and Medicare services for dual-eligible populations. As recently as April 2019, CMS announced three new opportunities, separate and apart from the Direct Contracting model, for states to test innovative models of integrated care for dual-eligible beneficiaries.<sup>3</sup> In short, there are multiple models focused on the alignment of dual-eligible beneficiaries already launched or under consideration. CMS should provide clarity to stakeholders on the dimensions on which these models are aligned, and on which they differ (through a detailed side-by-side, for example).

As CMMI launches the DC models and selects DCEs that want to serve dual-eligible beneficiaries, it will be important to understand if and why qualified entities emerge in certain geographies and not others, and whether those geographies are currently served by MA, MA SNPs, or PACE programs. How will the DC model align with state Medicaid MCOs and partner to achieve state priorities? What features of the different models are more attractive to beneficiaries and to physicians, and why? What can be done to bring stability and continuity to these models?

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<sup>1</sup> Teigland et al, "Medicare Advantage Plans Outperform Fee-for-Service Medicare Plans in Caring for Dual-Eligible Beneficiaries with Chronic Conditions," Avalere, May 20, 2019

[https://go.avalere.com/acton/attachment/12909/f-69e32532-ce17-42c8-87bc-8b95e12e258a/1/-/-/-/BMA\\_Duals\\_ISPOR\\_2019.pdf?nc=0&ao\\_optin=1](https://go.avalere.com/acton/attachment/12909/f-69e32532-ce17-42c8-87bc-8b95e12e258a/1/-/-/-/BMA_Duals_ISPOR_2019.pdf?nc=0&ao_optin=1)

<sup>2</sup> See Wiener, et al, "Integrating Care Through Dual Eligible Special Needs Plans: Opportunities and Challenges", ASPE, 2019 <https://aspe.hhs.gov/basic-report/integrating-care-through-dual-eligible-special-needs-plans-d-snps-opportunities-and-challenges#overview>

<sup>3</sup> CMS Letter to State Medicaid Directors, April 24, 2019

<https://www.medicare.gov/federal-policy-guidance/downloads/smd19002.pdf>

## Comments on the Geographic Direct Contracting Model

### Initial Scope and Scale

The National Coalition on Health Care supports limiting the initial launch to four geographies. We recommend initially avoiding contracts covering large geographic areas with large numbers of beneficiaries. There are very few organized physician groups that currently span large geographies. In the past, physician groups and networks that scaled in size quickly to take risk over large geographies experienced financial, governance, and quality of care or access challenges.<sup>4</sup> Partnerships with large plans, technology companies, or other corporate entities can provide resources, but cannot substitute for a strong culture of physician leadership and engaged physicians, which takes time to build.

### General Model Design

#### **Social Determinants of Health**

CMS should clarify whether and how DCEs may provide supplemental benefits similar to those that MA plans can now provide. A physician group and affiliated delivery system can be in a good position to identify unmet social and economic needs and either co-locate or refer out to services using care team members. DCEs that include nonprofit hospitals can leverage the community health needs assessments and community benefit programs of those institutions, along with other community services. Even with capitation, however, DCEs may not have sufficient resources to provide ongoing intensive case management or to supplement funding for local partners.

Most Medicare beneficiaries who are not enrolled in Part C are enrolled in supplemental coverage to defray their cost-sharing responsibilities in Parts A and B. There is another group that is also eligible for Medicaid, with Medicaid paying for its Medicare cost-sharing. There is a small group that does not have any supplemental coverage. Medicare APMs should tailor benefits and services to account for this variation in coverage and review other indicators of beneficiary ability to pay to target supplemental benefits. Supplemental benefits should be designed to ensure beneficiaries have timely access to the benefits they need, and are targeted with extra support to manage conditions or circumstances that put them at risk of hospitalization and other acute care, or loss of function.

If the DCE is taking responsibility for dual-eligible beneficiaries in the geography, it will need to meet with state Medicaid officials to notify them of the intent to apply for the geographic model, and designate a leader with accountability for ongoing coordination with the state Medicaid agency and any MCO it designates, and for developing linkages with the MCO and appropriate community service agencies, transportation vendors, etc.

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<sup>4</sup> see Cassalino, et al. "Benefits of and Barriers to Large Medical Group Practice in the United States", *JAMA Network*, 2003 <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/215993>

## **Evaluation Considerations**

Factors to consider in identifying comparison groups for evaluation purposes include size of geography, population density of Medicare beneficiaries, and Medicare Advantage and ACO penetration rates. In addition, beneficiary characteristics should be closely matched. Outcomes should be evaluated by race, income, and geography. Robust use of consumer experience surveys and patient reported outcomes, which can be administered by third parties and not place a burden on physician practices, should be included for oversight, performance, and evaluation purposes.

### Questions Related to Selection of Target Regions

CMS should initially prioritize the DC model for regions with high costs, but relatively low MA and advanced APM penetration. Applicants willing to serve less densely populated areas bordering higher-cost areas could promote competition and bring new provider choices into new areas.

High-performing regional Medicare Advantage plans and integrated delivery systems could leverage their capabilities to take risk in nearby less densely populated areas. These integrated delivery systems could develop partnerships with rural and small town providers for specialty care, telehealth, and even workforce solutions. To interest entities to participate in the model in lower cost and less densely populated geographies, a smaller discount would likely be needed. Other important contracting questions arise: will the DCE be able to leave providers out of its core network, even if it's taking accountability for all of the unaligned beneficiaries in a geography? Will the DCE be able to pay out-of-network hospitals and physicians Medicare rates? As these regional systems expand, will there be any safeguards to prevent them from gaining greater contracting leverage with commercial payers?

Efficient providers in low cost areas have complained that models with benchmarks based on their historic costs penalize their efficiency; these providers may therefore be interested in a capitated geographic direct contracting model that includes a broader benchmark of costs and a prospective payment approach.

Some state medical schools and academic medical centers (AMCs) are dedicated to supporting rural areas. These states and their medical school/AMC partners may want to develop a DC model that could preserve rural health and strengthen rural health workforces.

### Applicant Eligibility and Selection Criteria

#### **Organizational criteria**

The applicant should demonstrate that it has a core network of contracted or employed/affiliated physicians and other participants with a physical presence and history in the communities or nearby communities where it is applying to serve. Applicants for geographic direct contracting should have, as their core participants, an established medical group, ACO, or integrated health system that has been an ongoing entity serving the community or nearby community for at least

four years. The applicant should have a track record of reported quality measures, either in the MA quality stars, Medicare ACO, or other program that collects standardized measures. To promote stability and minimize model-hopping, the DCE should be required to remain in the contract for at least one full year. High voluntary turnover of participants could signal dissatisfaction among physicians, and may indicate disruption in beneficiary care relationships.

Other entities that may have geographic scale to serve as DCEs include retail pharmacies that participate in Part D and offer in-store clinics. If such entities can show they have an integrated physician group or groups, and strong physician leadership of clinical care in the DCE, this could be a worthwhile model to test.

If the applicant includes a health plan or a financial firm, they should share risk with the participating physicians and contribute to the reserves or fiscal guarantee required by CMS. The DCE should meet any state reserve requirements if it also takes responsibility for paying claims.

### **Experience in risk sharing, information sharing**

Eligibility for the first DC cohort should be limited to applicants with experience in risk sharing, either in Medicare Advantage or a Medicare model with downside risk. The applicant should demonstrate a high degree of clinical and financial integration, including shared clinical and referral protocols, shared care teams, and 24 hour clinical advice access. Clinical leadership roles and responsibilities should be described in the application. The applicant should demonstrate that it has agreements with key clinical partners in acute, post-acute, and hospice and palliative care.

An applicant should have a record of excellent stewardship of protected health information (PHI). It should use data to perform risk stratification and patient outreach, and to develop tools to support timely care in appropriate settings. The applicant should demonstrate the capacity to exchange electronic health information (HIE) among participants, and to alert providers in real time when a beneficiary is in the emergency department, or has been admitted or discharged, and to promote care coordination, and minimize duplicate, avoidable tests or visits. The applicant should show that it can give regular feedback to clinicians and care teams about care gaps, utilization of services, and clinical and patient experience of care measures (i.e., CAHPS survey).

### Questions Related to Beneficiary Alignment

Random alignment of beneficiaries could disrupt existing patient-clinician relationships. It may be more workable to randomly assign beneficiaries who do not have a primary care provider based on CMS attribution methods. Beneficiaries already aligned with a NextGen ACO in the same geography, for example, should not be considered unaligned for purposes of assigning beneficiaries to the DCE, nor should they appear on any lists that CMS shares with the DCE. DCEs should not be permitted to draw geographic service areas to avoid dual-eligible or other high needs beneficiaries. If there are beneficiaries who do not have primary care providers based on review of claims, they could be passively aligned to the DCE while retaining the ability to opt out.

Applicants may want to serve dual-eligible beneficiaries, or other high-needs patients, with a different dedicated network of participant providers, similar to a MA SNP model. Many of the successful models serving dual-eligible beneficiaries use salaried physicians and care teams with small patient panels who are dedicated to caring for patients with particular conditions and diseases.

## **Beneficiary Incentives**

Preserving beneficiary freedom of choice is a statutory requirement for CMMI payment models covering beneficiaries in traditional Medicare, yet many beneficiaries face obstacles in exercising freedom of choice. Those obstacles include transportation and other access barriers, and turnover in and availability of providers. Leaving a physician panel or practice is a risky decision if few physicians in the community are accepting new patients. Information is not readily available to beneficiaries from trusted intermediaries to help them choose the providers who have better outcomes for beneficiaries like them. DCEs should be permitted to offer services and information to help prospective or aligned beneficiaries have timely access to the DCE network providers most appropriate for their needs. Such incentives should be focused on high-need beneficiaries and should be pre-approved by CMMI, along with all marketing materials that will be used for voluntary alignment.

Incentives should be needs based, and take the form of low or no-cost transportation to and from visits, subsidies for devices, apps, and/or telecommunication services to provide reliable connection with the care team, waivers or discounts for cost-sharing of high value services, food, and memberships and transportation to senior centers or other clubs that promote activity and social interaction. Detailed records at the beneficiary level should be kept to track cost and utilization of these benefits. Avoid the use of gift cards, vouchers, or coupons that are not directly tied to needed and appropriate health care services or healthy food.

## Program Integrity and Beneficiary Protections

The growing number of payment models with voluntary alignment may lead to aggressive marketing tactics, so it is important for CMMI to establish clear guardrails for all marketing materials and even physician communication that relates to voluntary alignment. CMMI should consider establishing an open enrollment period (OEP) that aligns with the Medicare Advantage OEP for all Medicare APMs. At the end of OEP, active marketing and outreach would stop until the next OEP (APMs could still provide marketing information at request of beneficiaries). All participants in APMs and the APM itself should be required to remain in their contracted model for at least twelve months.

DCEs should be required to establish complaint lines and grievance procedures. CMS should increase support for independent, knowledgeable counseling organizations, such as the State Health Insurance and Assistance Programs (SHIPs) as the complexity of APMs increases and the choices available to beneficiaries expand. CMS should establish an ombudsman program dedicated to addressing the issues arising as beneficiaries navigate the complex landscape of voluntary APMs.

To combat risk avoidance strategies by DCEs and their participants, CMMI should review utilization data regularly to identify access barriers and hospitalization rates for ambulatory sensitive conditions. Secret shopper tests could be deployed to ensure that high needs beneficiaries do not encounter delays or barriers to finding physicians accepting new patients. CMMI should also invite state Medicaid leaders to coordinate oversight for dually eligible beneficiaries. CAHPS surveys are another tool that can reveal beneficiary access or dissatisfaction issues.

Any exceptions to the Stark referral law and anti-kickback rules that are granted for NextGen ACOs should also be permitted for the approved DCEs for those providers who are participants in the group or other entity that is sharing risk.

### Questions Related to Payment

Since the inception of the Medicare ACO program and CMMI value-based payment models, the National Coalition has supported the policy goal of “level playing field” and eventual alignment of certain model design features across the Medicare Advantage program, ACOs, and other models covering beneficiaries enrolled in fee-for-service. The DC models take a big step in that direction. We agree that the historical total cost of care for a geographically aligned population should be used to set the spending target for the geographic model. We agree that national trends should be used to update annual payments prospectively, but geographic rebasing should be done using regional costs (similar to MA) at a frequency of at least every three years.

Medicare Advantage is likely to remain the most attractive option in many geographies. The MA quality “stars” bonus is applied on the entire Part A and Part B benchmark (and can be as much as 10%), while the bonus for advanced APMs, including the DC model, will only apply to the Part B professional component. Because of the variation across geographies in terms of size, average costs, and delivery system characteristics, CMMI should be open to different discount rates. For assessing performance, a single national cost trend rate should be applied to DCEs.

The geographic benchmark should be updated to reflect the actual change in the average per capita costs of all beneficiaries in traditional Medicare in the relevant geography, including those covered by other APMs. After 3 to 5 years, CMMI should look across models to determine whether a competitive approach across payment models could be developed to nudge beneficiaries to choose high-value models, including by terminating models that are not consistently producing value for beneficiaries and the Medicare program.

If applicants come forward who are qualified and financially equipped to take responsibility and risk for Part D spending, they should be eligible to participate. As mentioned in the eligibility section, they should have a strong partnership with a medical group that has full authority over clinical care and decision-making.

Since the ACO program and other models covered by CMMI retain freedom of choice of provider, these models should be permitted to engage beneficiaries to stay in-network for their care. Membership cards

with contact information for making appointments and for after-hours care could be used to by the DCE to encourage and supporting staying in network. CMMI should provide guidance and oversight of these strategies to ensure that engagement tactics reward patients for gaining skills in self-care, for example.

CMS should clarify whether DCEs can provide similar care coordination services and functions as are currently permitted and encouraged in Medicare Advantage, including services that may not be covered currently under Part B. The DCE may want to create a chronic care management program (CCM) that is more robust than currently covered by Part B. Other waivers that have been granted to ACOs in two-sided risk arrangements should be granted to DCEs, and others should be considered. Waiving requirements of direct supervision, for example, should be considered for certain services at the request of DCEs who have a highly reliable, digitally connected, team-based care delivery system.

As described, the “notional” account policy seems like a reasonable optional approach for the DCE model, especially in the first few years. CMS should clarify whether DCEs that take full capitation will have any tools to deal with hospitals that refuse to contract with them or demand high markups above Medicare rates. Will DCEs have to demonstrate they have contracts with hospitals before receiving full capitation? As with MA plans, will they be able to pay out of network hospitals Medicare rates? If they take the full capitation option but don’t pay claims themselves, is it all or nothing? Or can they pay claims for some but not all providers?

Thank you and CMMI Director Adam Boehler for your leadership and responsiveness to stakeholders. We are pleased to see the direct contracting model take shape, and believe that if designed thoughtfully and launched carefully, it can accelerate the pace of value-based models and support new care models that produce better outcomes for beneficiaries and a more sustainable cost trend for Medicare.

Please do not hesitate to reach out to Ann Kempinski, Senior Advisor ([akempinski@nchc.org](mailto:akempinski@nchc.org)) , with any questions, or to me directly at [JRother@nchc.org](mailto:JRother@nchc.org).

Sincerely,



John Rother

President and CEO