



May 25, 2018

VIA ELECTRONIC MAIL

Adam Boehler
Deputy Administrator and Director, Center for Medicare & Medicaid Innovation
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Re: CMMI Direct Provider Contracting Request for Information

Dear Deputy Administrator Boehler:

The Health Care Transformation Task Force (“HCTTF or Task Force”)¹ thanks the Center for Medicare and Medicaid Innovation (“CMMI”) for the opportunity to respond to the Direct Provider Contracting (“DPC”) Request for Information (“RFI”). As a leading private sector consortium comprised of over 40 organizations, the HCTTF is committed to adopting payment reforms that promote a competitive marketplace for value-based health care and allow health care organizations to move from a payment system that rewards volume of services to one that rewards value of care.

As a broad-based group of health care stakeholders, the Task Force strongly supports the transition to value-based payment and care delivery, and we stand ready to serve as a resource for CMS. Our membership’s dedication to high quality, affordable care is strong, and our membership is unique. We bring together purchasers/employers, payers, providers, and patients/consumers to work collaboratively to help accelerate the transition to value-based care. In total, we represent over 40 distinct organizations that are deeply invested in advancing value-based payment models.

Our members have built, operated, and participated in various value-based payment models, including payment arrangements in Medicare Advantage and commercial lines that involve aspects of direct provider contracting, as well as Medicare FFS models that aim to strengthen primary care and establish primary care as the foundation for patient-centered care, such as Medicare Shared Savings Program (“MSSP”), Next Generation Accountable Care Organizations (“ACOs”) and the Comprehensive Primary Care Plus (“CPC+”) model. We believe these models hold great promise for achieving necessary

¹ The Task Force is a group of private sector stakeholders that wish to accelerate the pace of delivery system transformation. Representing a diverse set of organizations from various segments of the industry – including providers, health plans, employers, and consumers – we share a common commitment to transform our respective businesses and clinical models to deliver the triple aim of better health, better care, and reduced costs. Our member organizations aspire to have 75 percent of their business in triple aim focused, value-based arrangements by 2020. We strive to provide a critical mass of policy, operational, and technical support from the private sector that, when combined with the work being done by CMS and other public and private stakeholders, can increase the momentum of delivery system transformation.

improvements in patient experience, desired outcomes, and lowered health care expenditures. Yet, the current CMMI portfolio provides limited entry options for physicians, non-physician practitioners, and physician group practices to participate in alternative payment models. Additionally, the portfolio offers few opportunities for mature organizations to take on more advanced risk and accountability for total cost of care and outcomes for Medicare FFS beneficiaries. We appreciate that CMS has recognized these gaps and solicited input from the public in the CMMI New Direction RFI last fall and this current RFI.

This letter provides CMS with thoughtful considerations about how to implement a new model grounded in our significant collective experience with existing value models, and our hope is that CMMI will benefit from our substantive feedback. We also offer questions in addition to those already posed in the RFI that we encourage CMS to consider about how a DPC model could operate successfully in Medicare FFS and attract sufficient providers and beneficiaries to participate while improving quality and outcomes and lowering costs.

Many of our members have relevant experience managing physician-led medical groups, ACOs and clinically-integrated networks (CINs), establishing preferred provider networks, and participating in hybrid direct primary care models. **Based upon our thorough review of a potential model as envisioned by this RFI, it would be most effective to nest such a model within a framework of accountability for total cost of care and patient outcomes, similar to existing full- or partial-risk provider arrangements in Medicare Advantage.** There are many important considerations from the experience of these providers and payers that have participated in primary care full- or sub-capitation arrangements in the commercial market that have led to our conclusion about the importance of total cost of care accountability.

Past primary care capitation efforts failed in part due to having been unsuccessful at counteracting financial incentives to limit care (stinting) or “cherry-picking” healthier patients or “lemon-dropping” complex patients who are high utilizers. Capping primary care to contain an already small percentage of overall health spending can also lead to cost-shifting to higher-cost settings (e.g., emergency departments) when not paired with a robust accountability structure for quality and total cost of care. Finally, it should not be overlooked that managing a capitation model also introduces significant new administrative complexities – especially for small practices – to manage two different reimbursement systems in parallel (FFS billing and capitation encounter data). It will be important for CMS to address the feasibility of mitigating against these challenges within the construct of a DPC model.

As our New Direction RFI response stated, the HCTTF supports the CMMI structure for testing innovative payment and clinical models because it supports an iterative approach to model testing. A critical focus of CMMI should be using the lessons learned from providers’ experience and federal evaluation of the existing alternative payment models (“APMs”) to make improvements to those models that are showing genuine, long term promise. There are aspects of direct provider contracting described in this RFI that have the potential to attract more physician practices to these models and enable a greater proportion of practices to accept two-sided risk if incorporated into the program.

Because of the number of significant open questions about this model’s design, **we appreciate the opportunity to provide feedback on the RFI and urge CMS also to seek public comment on any proposed DPC model or modifications to existing programs that emanate from this RFI process.** We encourage CMS to include stakeholders – including beneficiaries with no other “stake” in healthcare

payment or delivery – as partners in the design process in a more substantive way than through the public comment process, such as technical expert panels.

I. Responses to Direct Provider Contracting RFI Questions

The comments herein reflect a desire to provide CMS with thoughtful feedback about the design of a new primary care-focused DPC model in Medicare FFS that incorporates financial accountability for total cost of care, quality, and patient experience. We look forward to future opportunities to review a further developed model and support CMS in the model design and refinement.

A. *Questions Related to Provider/State Participation*

To attract a wide variety of practices, including small, independent practices and/or physicians, CMS should supply sufficient technical information when proposing new payment models to allow stakeholders to realistically evaluate payment impact. CMS should be forthcoming with detailed information about the financial model so that providers can perform or procure their own financial analysis and make informed decisions about model participation. Likewise, payment model methodologies (including all components of those methodologies) should be transparent to patients and all health care providers involved in care for patients under a direct provider contracting payment model.

Capitation models add administrative burden because primary care practices must set up a different system to manage capitated payments. Smaller practices may not have the capital or desire to implement and manage a separate system for this type of demonstration. Therefore, a wide range of supporting organizations dedicated to providing services, integrating and/or coordinating the work of practicing physicians and health care providers across care settings should be allowed to convene practices.

While we support new options for providers to participate in Advanced APMs, there should also be parameters to prevent under-prepared providers from pursuing new models too soon. **CMS should require practices to demonstrate foundational medical home capabilities to be eligible to participate in a DPC model.** We strongly recommend that as entities take on financial accountability for quality performance and value, and assume financial risk, they must likewise be able to demonstrate that they promote and support sustainable, effective, evidence-based, accessible, and patient- and family-centered care models. CMS should consider requirements for DPC practices like those for practices participating in CPC+, including:

- a. Access and continuity (e.g. Same day access, 24/7 telemedicine access and e-consults)
- b. Proactive care management
- c. Comprehensive coordination with specialists and hospitals
- d. Patient and family engagement
- e. Integrated care team approach
- f. Adopt certified EHR technology

Capitation or sub-capitation models are only successful when proper incentives are in place to promote a high-quality, accessible, coordinated, and patient-centered care model by tying payment to outcomes measures, including patient-reported outcomes measures. Clinical decision-making based solely upon cost considerations will not best serve patients and could lead to patient access hurdles. We

also strongly support the creation of an APM Ombudsman program as a complement to the Medicare Beneficiary Ombudsman and urge CMS to move forward with establishing this function without further delay to ensure beneficiaries have a clear and direct channel for providing feedback about the model to CMS.

CMS should provide physicians and/or practices with sufficient technical assistance, as well as monthly updates and analysis on performance, including quality data. Other types of data that would be informative include claims data for services that are provided to enrolled beneficiaries for services provided by non-DPC providers, historical claims data on enrolled beneficiaries, and monthly financial reports to DPC practices; these data elements would allow practices to track the care beneficiaries receive outside the DPC practice, allow practices to anticipate the cost of care for enrollees, and track spending, respectively. CMS should also consider how to most effectively streamline reporting and reconciliation requirements for other initiatives such as ACOs, Bundled Payments for Care Improvement – Advanced, and CPC+. Synchronization of models is critical to reducing provider burden and promoting broader uptake of all models.

B. Questions Related to Beneficiary Participation

CMS should ensure that beneficiaries have access to clear and accurate information and materials that help them understand what the DPC model is, how the model of payment and care functions, what attestation means to them, and their rights with respect to accessing care from other providers. Active enrollment does not constitute consumer engagement. Beneficiaries should have direct access to their health information; CMS should seek to identify tools that can help beneficiaries and their family members/caregivers access their information in an easily readable and accessible format. Furthermore, beneficiaries should be allowed to share their personal health data with third-party sources in as close to real-time as feasible, and at no cost.

We believe there should be a minimum annual enrollment period, like Medicare Advantage, and the program must protect against cherry-picking or lemon-dropping by limiting a provider's ability to disenroll or refuse to enroll a beneficiary. Under current Medicare Advantage arrangements, beneficiaries are typically allowed to change plans once per year during open enrollment. Similarly, beneficiaries attributed to Medicare ACOs are assigned, either prospectively or retrospectively, once a year. We recommend that the DPC model follow a similar process and allow Medicare FFS beneficiaries to switch between DPC practices during an annual open enrollment period; however, beneficiaries should be allowed to opt out of the program entirely at any time. Practices should have at least 12 months to develop the necessary tools, processes, infrastructure, and outreach strategy while they have "shadow" payments/settlements; CMS can support by providing template outreach materials and hosting open-door sessions.

Beneficiaries should also not be limited from seeking care outside the practice but could be offered incentives to stay within the DPC or preferred provider network. The RFI does not opine on the likely incentives that would encourage beneficiaries to join or stay enrolled with a DPC practice. In commercial models, reducing out-of-pocket expenses is a meaningful incentive. The Task Force supports policies that lower the out-of-pocket cost burden for beneficiaries in the form of lower Part B premiums and cost-sharing that reflect the amount and level of acuity of care, not necessarily nominal cash incentives or gift cards. For example, waiving cost-sharing for items/services that treat a chronic condition or prevent the progression of a chronic disease, which more directly addresses the needs of

those with chronic illness by correlating with each patient's out-of-pocket burden. However, there are challenges to effectively engaging Medicare FFS beneficiaries with lower co-pays. The vast majority of Medicare beneficiaries have supplemental Medigap coverage which covers Part B coinsurance and deductible requirements, making it a less effective benefit or mechanism for beneficiaries to enroll and receive care from a DPC and preferred network.

C. Questions Related to Payment

Any sub-capitation model should incorporate financial accountability for total cost of care, quality, and outcomes to more fully meet the goals of the Triple Aim and reduce incentives for cost-shifting. The level of risk should at least align with the nominal risk threshold for Advanced APM models established under the Quality Payment Program, which is three percent. CMS already uses this model in the CPC+ and ACO programs; the models can be strengthened to be more attractive to independent provider groups.

We also support a prospective risk adjustment model in alignment with Medicare Advantage practices (e.g., HCC scoring), including consideration for functional status, disease severity, socioeconomic factors, and the following parameters:

- a. Do not include DPC beneficiaries in the regional comparison. Drawing from experience with the ACO model, when CMS compares the risk-adjusted costs of ACO beneficiaries in a given year with the risk-adjusted costs of all assignable beneficiaries, it decreases the regional efficiency of the ACO in direct proportion to its market share in the region. This can be devastating to an ACO's financial prospects, especially in rural areas where a small ACO can have significant market share, and the same would be true in DPC.
- b. Remove limitations on HCC score growth or other risk adjustment methodologies. By capping the growth in HCC scores for a defined attributed population, risk adjustment in performance benchmarks is not reflective of the population a provider is managing year to year. This discrepancy can contribute to adverse incentives for program participants.
- c. Apply the same risk methodology to both the DPC beneficiaries and the regional benchmark comparison group, as applicable. For example, in the MSSP program, CMS caps the risk score for the ACO but not for the comparison group, therefore allowing the denominator risk score to increase without accounting for real increases in risk for the ACO's continuously enrolled population.

CMS should also consider additional payment structures to encourage practices to partner with community-based organizations, social service and public health agencies and to address the social-determinants of health. Multi-payer models, including financially aligned Medicare-Medicaid models, can benefit both physicians and beneficiaries.

D. Questions Related to General Model Design

Appropriate care measures should be present as a component of the PBPM payment. CMS should prioritize outcomes-focused measures, as opposed to process-oriented quality measures, to measure both disease-specific and quality of life outcomes and align measures across existing models. CMS could also encourage alignment with commercial payers by adopting certain high-value performance metrics from existing Medicare Advantage contracts.

CMS should also incorporate incentives for the collection of data to enable the further development of patient-reported outcomes measures, and incorporate into the agreements with providers patient-reported outcomes that are both clinically appropriate and are not overly administratively burdensome. CMS should invest in engaging patients in the development of provider performance measures that are relevant to them and consistently and transparently reported by all public and private payers.

The CPC+ program, specifically Track 2, is similar to the DPC model outlined in this RFI. CMS could consider adding a third track with more stringent requirements for inclusion of E&M code management in a single PBPM payment, with refined metrics for performance measurement and a larger practice incentive payment. CMS could also build upon the Next Generation ACO population-based payment concept to offer prospective payments to members of a high-performing network inclusive of primary care. Designing this model as another track under CPC+ or Next Gen may mitigate the potential disruption to existing APMs (*as explained further in section F*) and is more likely to succeed.

E. Questions Related to Program Integrity and Beneficiary Protections

It is critically important that CMS ensure beneficiaries receive care of high quality in a DPC model and that stinting on needed care does not occur. Clinical decision-making based solely upon cost considerations will not best serve patients; inclusion of performance-related quality data in payment for services is a key mechanism to protect against stinting on care and promote continuous value improvement. As discussed above, CMS should include quality metrics in its contractual requirements that are focused on outcomes measures – with an emphasis on patient-reported satisfaction and functionality, as well as disease-specific measure sets that have been broadly tested and recommended by the International Consortium for Health Outcomes Measurement (ICHOM). CMS should also encourage ready access to care, including via e-visit and tele-consults. However, we caution CMS to be particularly mindful of how this kind of model would work for low-income or other vulnerable populations that may have limited access to a phone or internet capabilities.

To safeguard against undue influence to enroll with a particular DPC practice, CMS should provide model marketing tools and guidance on permissible communications to ensure that beneficiaries have access to clear and accurate information about their care options and rights under any DPC model. Before beneficiaries can be expected to select their chosen primary care provider's practice, they must have access to materials that help them understand what the direct provider contracting model is, how the model of payment and care functions, what attestation means to them, and their rights with respect to accessing care from other providers. CMS should also invest in training and resources for 1-800-MEDICARE staff to be able to answer beneficiaries' questions about the model.

CMS should set strict standards and clear disincentives for organizations to engage in cherry picking or lemon dropping beneficiaries through regular audit. Practices should not be allowed to engage in targeted marketing to existing patients based on health status. 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.

F. Questions Related to Existing ACO Initiatives

CMS could pursue the stated objectives of a DPC model – including enhanced beneficiary-provider relationship and active beneficiary choice – by refining and building upon existing payment models that promote care coordination across the continuum of care, such as accountable care organizations or the CPC+ program. The policy objective should be to enhance existing coordinated care models and avoid alternatives that could disrupt participation in those models. Given the multitude of Advanced APMs mid-evaluation, CMS should design any new models in a way that does not disrupt participation in and evaluation of existing programs already in place.

We strongly urge CMS to take actions to strengthen the ACO model to encourage two-side financial risk. CMS should make refinement to existing ACO initiatives to better accommodate physician-led ACOs and identify opportunities to incorporate the components of direct provider contracting into two-sided risk ACOs. For example, CMS could build a direct prospective payment component into the Track 3 and Next Gen ACO program. This could build upon the Next Gen ACO population-based payment concept to provide upfront capital to invest in care delivery transformation to better engage both small practices and beneficiaries. Primary care is foundation for success in ACOs; creating a mutually exclusive direct provider contracting model could detract from investment in that model at a critical inflection point.

The HCTTF also believes CMS should enhance its approach to regulatory relief for ACOs and other APM participants by streamlining the waiver process. Inconsistent waiver availability across APMs creates unnecessary burden on providers to implement. The ability for providers to be successful in value-based payment models depends on several factors, and one key factor is the capacity to operate under a regulatory framework that is conducive to effective, efficient, patient-centered and high-quality care, while preserving consumer protections and safeguards against fraud. We strongly recommend providers who bear downside risk should have the opportunity to leverage all of the waivers Medicare allows, regardless of the level of risk assumed. These flexibilities including the telehealth and SNF 3 Day waiver are essential to successfully reducing the cost of care, improving care access, and increasing quality.

II. Questions about Direct Provider Contracting in Medicare FFS

It is encouraging to see CMS consider increased investment in historically undervalued primary care services as well as developing Advanced APM options for small provider groups and providers that are interested in taking on greater financial accountability for Medicare expenditures with the flexibility for providers to deliver high-quality, patient-centered care. There are a few key components of the proposed model as described in the RFI that raised questions for our group, and we offer these clarifying questions for CMS to consider for purposes of providing broader context. We would welcome the opportunity to engage with CMS in working through these model design considerations:

- a. The RFI states the primary distinction between a DPC model (or models) and existing primary care models (including ACOs and CPC+) is a greater emphasis on the central role of the beneficiary in selecting a primary care practice, and the practices' ability to take on two-sided financial risk.
 - i. **How does a “direct provider contracting” model offer a sufficiently unique concept to test as a distinct model?**

- ii. **What are the estimated quantitative benefits to providers and beneficiaries?**
- b. For the purposes of a DPC model test, CMS describes that beneficiaries would voluntarily enroll with the participating practice as their main source of care for a defined set of services.
- i. **What additional administrative capacity (e.g., additional FTEs) does CMS estimate small group practices would need to take on enrollment responsibilities?**
 - ii. **What entity will be responsible for ensuring beneficiaries understand the distinction among the various Medicare FFS alternative payment models that allow for voluntary alignment and Medicare Advantage enrollment?**
 - iii. **What functions will CMS perform to assist beneficiaries in understanding what a DPC model is, how this new care model functions, what attestation means to them, and what their rights are with respect to accessing care inside and outside of the DPC model?**
 - iv. **If the voluntary enrollment does not produce a minimum number of beneficiaries to support a viable model test, would the model incorporate a hybrid claims attribution approach?**
- c. The RFI describes a Medicare FFSDPC model grounded in a fixed capitation (per beneficiary per month) payment to practices to deliver a defined set of primary care services to enrolled beneficiaries.
- i. **Does CMS anticipate savings on the primary care spend?**
 - ii. **How will CMS address and monitor utilization management by providers receiving fixed capitation payments?**
 - iii. **If CMS sets the PBPM higher than historical primary care spending, what would the estimated savings need to be on the carved-out services to offset the additional expenditures to produce net savings for the program?**
 - iv. **Could CMS design the model evaluation in a way that could account for future savings (in addition to performance year savings) to Medicare through accessible primary care and earlier intervention of progressing condition?**
- d. CMS also notes that existing CMMI models already involve aspects of “direct provider contracting,” including in the ACO and CPC+ models, as well as Medicare Advantage and commercial payer arrangements.
- i. **How has CMS applied lessons learned from existing direct provider contracting arrangements (including CPC+) to inform the model design and how does CMS plan to incorporate ongoing feedback from these programs in further design of the model?**

Additionally, there are various iterations and components of direct primary care in the employer-sponsored and individual commercial market that would not appear viable for a Medicare FFS population. We oppose models that increases beneficiary co-payments or allows participating practices to “balance bill” Medicare beneficiaries, thereby increasing the financial burdens on these individuals.

The HCTTF appreciates the opportunity to share this statement with CMS and stands ready to work together in the transformation to value-based payment and care delivery. Please contact HCTTF

Executive Director Jeff Micklos (jeff.micklos@hcttf.org or 202.774.1415) or HCTTF Director of Payment Reform Models Clare Pierce-Wrobel (clare.wrobel@hcttf.org or 202.774.1565) with questions related to this statement.

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