May 28, 2019

VIA ELECTRONIC MAIL

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

Re: Direct Contracting Request for Information – Geographic PBP Model Option

Dear Director Boehler:

The Health Care Transformation Task Force (HCTTF or Task Force) thanks the Centers for Medicare and Medicaid Services for the recently announced Direct Contracting model and for the opportunity to provide our input on the Geographic Population-Based Payment (PBP) model option through this Request for Information (RFI).

The Task Force is an industry consortium representing a diverse set of organizations from various segments of the industry – including providers, health plans, employers, and consumers – all committed to adopting payment reforms that promote a competitive marketplace for value-based health care and allow health care organizations to move from a system that incentivizes volume of services to one that rewards value of care. Our member organizations aspire to have 75 percent of their business in value-based arrangements by the end of 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.

Our members have built, operated, and participated in various alternative payment models, including payment arrangements in Medicare Advantage and commercial lines that involve aspects of direct 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, Next Generation Accountable Care Organizations, and the Comprehensive Primary Care Plus model. We believe these models hold great promise for achieving necessary improvements in patient experience, desired outcomes, and reduced health care expenditures. We have also regularly called on CMS to develop additional 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 is open to additional stakeholder feedback in designing the proposed Geographic PBP model option. Our perspectives shared in this letter come from Task Force members viewing themselves as potential Direct Contracting Entities (DCEs) as well as partners that would collaborate with DCEs.

I. Reactions to the Direct Contracting Model Announcement

We appreciate that CMS incorporated our input shared in response to CMMI's 2018 Direct Provider Contracting Request for Information.[1] In that letter, we encouraged CMS to nest an advanced primary care model within a framework of accountability for total cost of care and patient outcomes. 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. These organizations have found that past primary care capitation efforts failed because the primary care capitation was set at inconsequential percentages and failed to counteract financial incentives to limit care or drop complex patients. The Professional and Global PBP Direct Contracting models should address these shortcomings by providing expectations for how primary care is to be transformed in addition to establishing enhanced primary care capitation payments and providing a welcome opportunity for organizations to leverage their experience with managing population health risk in the commercial market.

II. Design and Operational Considerations for Geographic Population Based-Payment Model

The Geographic PBP RFI raises several interesting and challenging design considerations; in particular, the Task Force considered how DCEs would interact with existing APMs given the proposed scope of the Geographic PBP model. Our comments offered herein reflect a desire for continued collaboration to help CMS to best operationalize this model in a way that leverages rather than replaces the growing number of Medicare alternative payment model arrangements that are showing promising results.

A. General Model Design

The Task Force supports CMS in creating new opportunities for DCEs to address beneficiary needs related to social determinants of health, including food, housing, and transportation. Health equity should be an explicit goal of social determinants of health activities, which should include multi-sector and patient-centered approaches. There are several activities that the model could incentivize if the benchmark is priced appropriately, including screening for unmet social needs and collecting information on social risk factors through Z codes (while protecting individual privacy and confidentiality); establishing closed-loop referrals to social service providers; integrated behavioral health services; non-face-to-face chronic care management; employ community health workers to serve as a bridge between the community and the health care and social service systems; and possibly even direct provision of social services. CMS should consider incorporating measures into the payment structure that would encourage

[1] https://hcttf.org/cms_direct_provider_contracting_rfi/

DCEs and providers to partner with community-based organizations and social service and public health agencies to address the social determinants of health through screening and referral.

New opportunities for success in terms of community-based initiatives should be community-driven, reflecting the voices and views of patients and targeted region/community. There are many current industry initiatives to establish standards and support use cases for social needs screening and referral including the Gravity Project[2] and the Accountable Health Communities model; CMS could encourage DCE providers to coordinate with and inform these efforts. As discussed elsewhere in this letter, provision of services would depend on what waivers would be available to DCEs to engage community based-entities and pay for services not otherwise covered under Part A or Part B; provision of services not otherwise incorporated in the historic benchmark should be considered when establishing the benchmark and considering a DCE's proposed discount.

B. Selection of target regions

CMS does not specify how Geographic PBP DCEs will integrate with preexisting Medicare APMs in the selected target regions. To avoid model overlap, CMS should finalize selection criteria for Geographic PBP DCEs with low penetration of alternative payment models. If the selected target regions do include existing Medicare APM participants, we encourage CMS to establish policies to exclude beneficiaries from alignment to the Geographic PBP DCE and maintain attribution to existing APMs to lessen impact on the model evaluation. This would provide predictability for current APM participants that have made significant investments towards long term success which are only starting to bear fruit; in this scenario, the DCE's financial benchmark would need to account for unique features of a population previously unaligned to any alternative payment model. Existing APM participants should also have the option to voluntarily convert to this model. If CMS desires to consolidate all Medicare FFS activity under a DCE in a region, we urge CMS to permit the DCE to assume an existing model Participation Agreement through a delegation from CMMI. HCTTF would not support any effort to alter or terminate existing APM Participation Agreements in a selected DCE region.

C. DCE Eligibility

CMS is proposing that DCEs in this arrangement take significant financial risk; CMS should therefore consider an organization's demonstrated experience and financial capability to manage these types of risk arrangements as a key criterion for selection.

With a multitude of Advanced APMs mid-evaluation, CMS should design the Geographic PBP model in a way that does not disrupt participation in and evaluation of existing programs already in place. Providers participating in Medicare ACOs, bundled payment initiatives, and other CMMI models have made significant investments in care redesign and infrastructure to improve care and lower costs for Medicare beneficiaries. The policy objective should be to enhance those existing coordinated care models and avoid alternatives that could disrupt participation in those models.

[2] https://confluence.hl7.org/display/PC/The+Gravity+Project+Home

Notably, the RFI solicits input about the responsibilities and criteria associated with DCEs and does not comprehensively describe the anticipated role of downstream providers that would be delivering care to aligned beneficiaries. CMS should specify what regulatory flexibilities will be available and what requirements will be expected of providers in Geographic PBP regions in the Request for Applications in order to provide full and upfront transparency of the expectations for Medicare FFS providers.

D. Beneficiary alignment

The RFI expresses CMS's desire to have two or more DCEs compete in a particular region. However, it is not clear what competitive benefit would be realized with two DCEs operating in the same region, especially if the beneficiaries are randomly assigned to one DCE. Random assignment creates a higher likelihood of confusing beneficiaries about their care options. Alignment should be primarily grounded in a beneficiary's usual source of care, akin to ACO alignment approaches, and consider a DCE's contractual relationships with downstream providers. Conversely, CMS must provide clarity on policies for out-migration of aligned populations.

Regardless of the number of DCEs in a given region and the alignment methodology, CMS should ensure that beneficiaries have access to clear and accurate information and materials that assist beneficiaries in understanding what the Geographic PBP model is, how this new care model functions, what their rights are with respect to accessing care inside and outside of the target region. Active enrollment does not constitute consumer engagement. CMS should clearly specify what steps the agency will take in engage consumers, and what functions will be the responsibility of the DCEs. For example, will the CMS efforts use new vendors, or rely on existing consumer organizations and information vehicles (e.g., 1-800-MEDICARE)? What entity will field questions from beneficiaries throughout the life of the program? We urge CMS to engage beneficiaries and consumer advocates directly in designing and implementing the model and related consumer engagement functions, and seek regular feedback to inform improvements.

E. Program integrity & beneficiary protection

CMS should clarify what waivers will be available to health care providers in the target region and those providers that contract directly with a DCE. The HCTTF has encouraged CMS to 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 assignment model or level of risk assumed. These flexibilities (including the telehealth and SNF Three Day waiver) are essential to successfully reducing the cost of care, improving care access, and increasing quality. Should CMS move forward with random assignment of beneficiaries to a DCE in a region with two DCEs, CMS should consider waiving certain marketing and communication guidelines so that providers may establish relationships with the aligned beneficiaries.

At the same time, it is critically important that CMS ensure beneficiaries receive care of high quality in a Geographic PBP model and that DCEs have strong incentives to provide that care. Appropriate care measures should be present as a component of the benchmark payment. 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 access to care and promote continuous value improvement. 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.

Also, beneficiaries should not be limited from seeking care outside the target region but could be offered incentives to stay within the DCE's preferred provider network. The RFI does not opine on the likely incentives that would encourage beneficiaries to join or stay enrolled with a DCE or to seek care from a preferred provider in the target region. 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, support behavioral integration, advanced care planning, and transitional care management services which more directly address beneficiaries' unique needs by correlating with each patient's out-of-pocket burden. However, there are challenges to effectively engaging Medicare FFS beneficiaries with lower co-pays. Most Medicare beneficiaries have supplemental coverage (e.g., Medigap, Medicaid) which covers Part B coinsurance and deductible requirements, making it a less effective benefit or mechanism for beneficiaries to receive care from a preferred provider in the target region. CMS should allow DCEs to offer a Medigap wrap product plan and/or encourage DCEs to partner with a commercial Medigap carrier to design and offer such a product.

F. Payment

We urge CMS to balance the certainty of model design and benchmark with the flexibility for DCEs to modify proposed discounts on occasion rather than locking in one discount for the entirety of the performance period. The Geographic PBP model is explicitly structured to attract participants with little experience provisioning care to Medicare FFS beneficiaries; therefore CMS should share release baseline information on the eligible population (baseline spend, historical trend, population characteristics) before DCEs commit to the program. Applicants that propose a discount to the benchmark for a geographically aligned population prior to the start of the model will inevitably learn new things about that newly aligned population and continually refine their approach to best care for those beneficiaries. As one example, the DCE could incentivize downstream providers to screen for social needs in the early performance years, and later structure the discount to support supplemental benefits responsive to the newly identified needs of that population.

It is unclear whether CMS plans to calculate the benchmark using a cohort methodology; we would urge CMS to reconsider using a cohort approach due to the myriad methodological challenges this would create and instead pursue the cross-sectional approach used in other ACO

models today. CMS should also offer additional opportunities for stakeholder input about payment methodology elements such as risk adjustment once those details are available.

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The HCTTF is eager to work with CMS to achieve sustainable change in value-based care, which requires alignment between the private and public sectors. We stand ready to work together to complete the journey to a person–centered health care system that promotes choice and emphasizes high quality, efficiency, and affordable care. Please contact HCTTF's Executive Director Jeff Micklos (jeff.micklos@hcttf.org or 202.774.1415) or Senior Director Clare Pierce-Wrobel (clare.wrobel@hcttf.org or 202.774.1565) with any questions about or follow up to this letter.

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