MHPA Comments
CMS' RFI on Direct Provider Contracting Models
May 24, 2018

May 25, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted Electronically to: DPC@cms.hhs.gov and via online submission

Re: Request for Information (RFI) on Direct Provider Contracting (DPC) Models

Dear Administrator Verma:

Medicaid Health Plans of America (MHPA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid's (CMS) Request for Information on Direct Provider Contracting (DPC) Models to be tested through the Center for Medicare and Medicaid Innovation (Innovation Center). MHPA appreciates CMS' continued interest in developing new ways to transform how care is paid for and delivered in the Medicaid and Medicare Programs.

MHPA is the national trade association representing 90+ private-sector health plans that contract with state Medicaid agencies in 39 states plus DC to provide comprehensive, high-quality health care to more than 24 million Medicaid enrollees in a coordinated and cost-effective way. According to a recent analysis by PWC, 73 percent of all Medicaid enrollees received their care through a private Medicaid health plan in 2017 (up from 66 percent in 2014),[1] this number continues to rise annually as more states turn to the expertise of managed care plans to help manage health care for a growing number of Medicaid enrollees with diverse needs.

Our member plans are actively engaged in working with states and providers to improve the delivery of care to Medicaid beneficiaries through innovative strategies that include value-based payment programs. Further, we continue to support provider contracting strategies that improve access to and delivery of primary care services. MHPA's member plans are meaningfully transforming care delivery in Medicaid through state and locally based strategies that more effectively meet the needs of the beneficiaries they serve.

While MHPA appreciates CMS' interest in expanding alternative payment models for providers, we are concerned that implementing a DPC model in Medicaid will have negative implications for beneficiaries. Specifically, a DPC model in Medicaid is likely to create beneficiary confusion and may impact access to services. Further, we are concerned that implementing a model in Medicaid will detract resources and focus from managed care programs that provide more comprehensive, coordinated coverage for this population.

[1] Gottlieb, Ari, *The Complicated State of Medicaid in the United States: Stability Amidst Considerable Future Uncertainty,* PWC, October 2017.

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MHPA and its member plans offer the following overarching comments on a DPC model in Medicaid and include more specific comments in response to select questions from the RFI below:

- **Medicaid managed care organizations (MCOs) are best positioned to improve care delivery and lead innovation in Medicaid.** Medicaid MCOs currently are developing and implementing new payment models and have a depth of experience in partnering with Medicaid providers directly to align care improvement goals in serving Medicaid beneficiaries. Medicaid MCOs are also effective at implementing new delivery models through localized, innovative contracting strategies with providers. Medicaid MCOs are connected to the communities they serve and are better able to identify and address the unique healthcare needs of their member populations.

- **MHPA is concerned that a DPC model may have negative implications for beneficiary care coordination and access.** While MHPA realizes that one of CMS' goals for a DPC model is to increase beneficiary access to physician services, MHPA is concerned that such a model in Medicaid might not sufficiently ensure that these vulnerable beneficiaries were receiving complete, coordinated care—which they currently receive through managed care. Additionally, MHPA is concerned that beneficiary protections against steering enrollment and stinting on needed care cannot be designed to fully protect beneficiaries. We are also concerned about provider participation and their ability to safely take on risk to ensure continued access.

- **If CMS proceeds with testing a DPC model in Medicaid, the model must include sufficient beneficiary safeguards and not disrupt access to Medicaid MCOs.** Medicaid MCOs offer Medicaid beneficiaries high quality, comprehensive care delivery. Any DPC model should not interfere with access to and enrollment in plans. MHPA believes that at the very least, if CMS moves forward with a DPC model in Medicaid, they should include safeguards for beneficiaries including monitoring access, cost, and quality of care under the model. Additionally, MHPA believes that a model should not undermine the role of Medicaid MCOs and should only be tested in areas where Medicaid MCOs are not available.

Finally, MHPA requests that if CMS moves forward with any version of a DPC model that the Agency provide greater clarity on –and more specific details about– the actual model design, implementation, and evaluation and allow for stakeholder input and comment before testing. While MHPA appreciates the opportunity to provide initial input on a possible model for CMS to test, we strongly believe that CMS should allow stakeholders the ability to comment on a complete model design before implementation.

Detailed Response

Below MHPA addresses select questions from the RFI including 1-2, 4, 6-7, 9, 11, 13-19.

Questions Related to Provider/State Participation

1. **How can a DPC model be designed to attract a wide variety of practices, including small, independent practices, and/or physicians? Specifically, is it feasible or desirable for practices to be able to participate independently or, instead, through a convening organization such as an ACO, physician network, or other arrangement?**

MHPA believes that Medicaid MCOs are best able to implement and disseminate new payment and delivery models in Medicaid that most appropriately meet the needs of their communities. However, if CMS does test a DPC model in Medicaid, they should limit it to areas where Medicaid MCOs are not able to participate.

MHPA is concerned that without appropriate safeguards, beneficiary access to providers could be negatively impacted. MHPA suggests that CMS take steps to ensure that participating provider groups are able to meet any requirements of participation—especially any requirements to take on financial risk. This will also help protect beneficiary access by ensuring that providers are able to fulfill obligations under any model that is tested.

2. **What features should CMS require practices to demonstrate in order for practices to be able to participate in a DPC model (e.g., use of certified Electronic Health Record (EHR) technology, certain organizational structure requirements, certain safeguards to ensure beneficiaries receive high quality and necessary care, minimum percent of revenue in similar arrangements, experience with patient enrollment, staffing and staff competencies, level of risk assumption, repayment/reserve requirements)? Should these features or requirements vary for those practices that are already part of similar arrangements with other payers versus those that are new to such arrangements? If so, please provide specific examples of features or requirements CMS should include in a DPC model and, if applicable, for which practice types.**

At a minimum MHPA suggests that any DPC model should have features that keep the model on a level-playing field with Medicaid MCOs. This would include requiring sufficient organizational structure requirements, ability to assume risk, have reserve requirements, meet quality and care requirements, and have the capabilities to track and be responsible for enrollees. Providers should also be able to meet any data or submission requirements needed to effectively administer, monitor, and evaluate a model.

Most importantly, MHPA believes that there should be strong beneficiary protections in place to ensure beneficiaries receive needed, quality care and that they are not being skewed in enrollment or disenrollment decisions. MHPA encourages CMS to implement safeguards to protect against risk selection of beneficiaries including against cherry picking or leaving out high-cost, high-risk members that could impact a provider group's ability to meet savings goals.

4. **Which Medicaid State Plan and other Medicaid authorities do States require to implement DPC arrangements in their Medicaid programs? What supports or technical assistance would States need from CMS to establish DPC arrangements in Medicaid?**

In general, MHPA does not support the testing of a DPC model in Medicaid. MHPA believes that Medicaid MCOs are best positioned to develop and implement meaningful, locally-based payment and delivery reform strategies that address the needs of Medicaid beneficiaries.

If CMS does decide to move forward with a DPC model, MHPA encourages the Agency to ensure that the model is implemented in a way that establishes a level playing field with the requirements that Medicaid MCOs must meet. Further, MHPA suggests that testing of the model be limited to a state or states that do not have Medicaid managed care programs so as not to undermine the more comprehensive, care coordination and delivery improvements available in Medicaid MCOs.

Questions Related to Beneficiary Participation

6. **Medicare FFS beneficiaries have freedom of choice of any Medicare provider or supplier, including under all current Innovation Center models. Given this, should there be limits under a DPC model on when a beneficiary can enroll or disenroll with a practice for the purposes of the model (while still retaining freedom of choice of provider or supplier even while enrolled in the DPC practice), or how frequently beneficiaries can change practices for the purposes of adjusting PBPM payments under the DPC model? If the practice is accountable for all or a portion of the total cost of care for a beneficiary, should there be a minimum enrollment period for a beneficiary? Under what circumstances, if any, should a provider or supplier be able to refuse to enroll or choose to disenroll a beneficiary?**

MHPA believes that any DPC Model should have beneficiary protections related to enrollment, including an opt-out provision, allowing beneficiaries to select the care that best meets their needs. This is especially important for Medicaid enrollees who might find enrollment in a FFS model confusing and/or that it creates limitations in access to providers or care. Additionally, the model should parallel Medicaid MCO enrollment processes to ensure a level-playing field.

7. **What support do practices need to conduct outreach to their patients and enroll them under a DPC model? How much time would practices need to "ramp up" and how can CMS best facilitate the process? How should beneficiaries be incentivized to enroll? Is active enrollment sufficient to ensure beneficiary engagement? Should beneficiaries who have chosen to enroll in a practice under a DPC model be required to enter into an agreement with their DPC-participating health care provider, and, if so, would this provide a useful or sufficient mechanism for active beneficiary engagement, or should DPC providers be permitted to use additional beneficiary engagement incentives (e.g., nominal cash incentives, gift cards)? What other tools would be helpful for beneficiaries to become more engaged and active consumers of health care services together with their family members and caregivers (e.g., tools to access to their health information, mechanisms to provide feedback on patient experience)?**

MHPA believes that ensuring Medicaid beneficiaries are fully informed about their enrollment decisions and rights—and the potential impact of the model on their care delivery and health—would be a necessary beneficiary protection and encourage more direct engagement of beneficiaries in their care. We do not support the use of incentives– such as nominal cash incentives or gift cards

–for enrollment purposes by providers, as providers already have sufficient influence on care decisions.

MHPA also supports the use of an "agreement" between providers and beneficiaries to clarify potential coverage changes under the model and outline beneficiary protections, including the ability to "opt-out" if the beneficiary choses to do so.

MHPA requests that if CMS implements a DPC model in Medicaid that they try to not unfairly advantage DPC model enrollment over enrollment in more comprehensive coverage options like Medicaid MCOs.

Questions Related to Payment

9. To ensure a consistent and predictable cash flow mechanism to practices, CMS is considering paying a PBPM payment to practices participating in a potential DPC model test. Which currently covered Medicare services, supplies, tests or procedures should be included in the monthly PBPM payment? (CMS would appreciate specific Current Procedural Terminology (CPT®1)/Healthcare Common Procedure Coding System (HCPCS) codes as examples, as well as ICD-10-CM diagnosis codes and/or ICD-10-PCS procedure codes, if applicable.) Should items and services furnished by providers and suppliers other than the DPC-participating practice be included? Should monthly payments to DPC-participating practices be risk adjusted and/or geographically adjusted, and, if so, how? What adjustments, such as risk adjustment approaches for patient characteristics, should be considered for calculating the PBPM payment?

MHPA encourages the Agency to carefully define the services covered by a PBPM payment and to monitor that providers are not limiting access to certain services or substituting lower-value care under any DPC model. Additionally, MHPA supports the use of geographic or health risk adjustment to help prevent providers—who may be actively encouraging or discouraging enrollment –from cherry picking beneficiaries.

11. Should practices be at risk financially ("upside and downside risk") for all or a portion of the total cost of care for Medicare beneficiaries enrolled in their practice, including for services beyond those covered under the monthly PBPM payment? If so, what services should be included and how should the level of risk be determined? What are the potential mechanisms for and amount of savings in total cost of care that practices anticipate in a DPC model? In addition, should a DPC model offer graduated levels of risk for smaller or newer practices?

While some provider groups may be able to take on risk, smaller provider groups or independent provider groups are likely to bear a higher administrative burden associated with moving to a new payment arrangement. CMS should ensure that providers have appropriate levels of reserves and are able to predict exposure before it engages in risk arrangements with providers.

Questions Related to General Model Design

13. As part of the Agency's guiding principles in considering new models, CMS is committed to reducing burdensome requirements. However, there are certain aspects of any model for which CMS may need practice and/or beneficiary data, including for purposes of calculating coinsurance/deductible amounts, obtaining encounter data and other information for risk adjustment, assessing quality performance, monitoring practices for compliance and program integrity, and conducting an independent evaluation. How can CMS best gather this necessary data while limiting burden to model participants? Are there specific data collection mechanisms, or existing tools that could be leveraged that would make this less burdensome to physicians, practices, and beneficiaries? How can CMS foster alignment between requirements for a DPC model and commercial payer arrangements to reduce burden for practices?

First, MHPA's members work with provider groups to better streamline and reduce providers' administrative burdens. We believe that Medicaid MCOs partnering with provider groups helps streamline information collection and reporting demands on providers.

However, if CMS moves forward with a DPC model in Medicaid, MHPA believes providers should be required to collect and report all information necessary to demonstrate they are monitoring enrollments, providing needed care and services, offering high-quality services and are complying with any requirements of the program. Further, CMS must collect sufficient information to evaluate this model's performance.

14. Should quality performance of DPC-participating practices be determined and benchmarked in a different way under a potential DPC model than it has been in ACO initiatives, the CPC+ Model, or other current CMS initiatives? How should performance on quality be factored into payment and/or determinations of performance-based incentives for total cost of care? What specific quality measures should be used or included?

MHPA thinks quality measurement is an important element to any DPC model that CMS may test and that quality should be tied to payments to better incentivize providers to deliver high-quality care. MHPA suggests that this be done similarly to existing models in order to streamline quality measurement programs and align them across programs. MHPA also thinks CMS should make information about provider practices participating in a DPC program publicly available.

15. What other DPC models should CMS consider? Are there other direct contracting arrangements in the commercial sector and/or with Medicare Advantage plans that CMS should consider testing in FFS Medicare and/or Medicaid? Are there particular considerations for Medicaid, or for dually eligible beneficiaries, that CMS should factor in to designing incentives for beneficiaries and health care providers, eligibility requirements, and/or payment structure? Are there ways in which CMS could restructure and/or modify any current initiatives to meet the objectives of a DPC model?

MHPA reiterates its concerns with testing any DPC model in Medicaid. Medicaid and dual eligible beneficiaries are among the most vulnerable populations. Dual eligible beneficiaries in particular are in need of greater coordination of benefits and care and a DPC model is unlikely sufficient to address these needs. MHPA encourages CMS to encourage enrollment of dual eligible into more integrated offerings such as dual eligible special needs plans or Medicare-Medicaid plans.

Questions Related to Program Integrity and Beneficiary Protections

16. CMS wants to ensure that beneficiaries receive necessary care of high quality in a DPC model and that stinting on needed care does not occur. What safeguards can be put in place to help ensure this? What monitoring methods can CMS employ to determine if beneficiaries are receiving the care that they need at the right time? What data or methods would be needed to support these efforts?

While MHPA does not support a DPC model in Medicaid, if CMS moves forward with such a test, CMS must collect and monitor claims and encounter data to ensure beneficiaries continue to receive needed care under any model. Additionally, MHPA encourages the agency to have sufficient penalties to discourage providers from skimping on care.

Additionally, MHPA remains concerned that there could be negative implications for beneficiary care in the short run. While the goal of the DPC model is to promote improved coordination and physician access, it could take a while for providers to adjust to the necessary care management required to be successful in this type of model. Research has shown that a considerable amount of time can pass before costs actually decrease in a risk-based model, which could limit the ability of providers to receive performance incentives as well as offset any added administrative costs.

17. What safeguards can CMS use to ensure that beneficiaries are not unduly influenced to enroll with a particular DPC practice?

MHPA is very concerned that there could be undue influence on beneficiary enrollment or disenrollment decisions from providers. MHPA strongly encourages CMS to include strong protections against this and include penalties for providers that unfairly influence beneficiary decisions.

18. CMS wants to ensure that all beneficiaries have an equal opportunity to enroll with a practice participating in a DPC model. How can CMS ensure that a DPC-participating practice does not engage in activities that would attract primarily healthy beneficiaries ("cherry picking") or discourage enrollment by beneficiaries that have complex medical needs or would otherwise be considered high risk ("lemon dropping")? What additional beneficiary protections may be needed under a DPC model?

MHPA is especially concerned that providers might try to "cherry pick" in the Medicaid program to avoid more costly patients or populations. A DPC model should be open to all eligible

Medicaid beneficiaries. MHPA encourages CMS to monitor provider enrollment processes and patient profiles and to compare to general Medicaid population to identify potential instances of cherry picking or risk selection by providers.

19. Giving valuable incentives to beneficiaries to influence their enrollment with a particular DPC practice would raise quality of care, program cost, and competition concerns. Providers and suppliers may try to offset the cost of the incentives by providing medically unnecessary services or by substituting cheaper or lower quality services. Also, the ability to use incentives may favor larger health care providers with greater financial resources, putting smaller or rural providers at a competitive disadvantage. What safeguards should CMS put in place to ensure that any beneficiary incentives provided in a DPC model would not negatively impact quality of care, program costs, and competition?

MHPA does not favor the use of incentives with Medicaid beneficiaries. We remain concerned that incentives could unfairly encourage beneficiaries to enroll and create an uneven playing field with Medicaid MCOs. Incentives should not be allowed for any DPC Model in Medicaid.

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MHPA thanks CMS for the opportunity to provide feedback on a DPC model. We appreciate CMS continued efforts to create valuable new forms of care delivery in Medicaid. Our member plans are committed to partnering with CMS in this important effort.

Sincerely,

Jeff Myers
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