

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

May 25, 2018

Submitted electronically to DPC@cms.hhs.gov

Center for Medicare and Medicaid Innovation
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244-8016

Re: Request for Information on Direct Provider Contracting Models

Justice in Aging appreciates the opportunity to provide a response to the above-referenced Request for Information (RFI) issued by the Center for Medicare and Medicaid Innovation (CMMI) concerning potential direct provider contracting (DPC) models.

Justice in Aging is an advocacy organization with the mission of improving the lives of low income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income beneficiaries, including those dually eligible for both programs.

We offer a general comment on the issues raised in the RFI and have organized the rest of our comments around the specific questions in the RFI, focusing on those questions where the experiences of beneficiary advocates for low-income older adults are most relevant.

General Comment

We appreciate that CMMI is issuing this RFI at the initial stages of its consideration of DPC models. Because the description of the proposed models is so broad, our comments necessarily focus on questions that need to be answered and consumer protections that need to be included in any DPC model. We strongly urge that CMMI afford additional opportunities for robust stakeholder input as the agency's direction becomes clearer and more specific, and before any such models are implemented.

As beneficiary advocates, we urge CMMI to address four critical concerns as it moves forward.

1. Prioritizing improvement in quality of care

We urge CMMI to clarify that the goal of any DPC model should be to improve the quality of care, not simply to change payment models. This is especially critical in the context of allowing providers more

WASHINGTON

1444 Eye Street, NW, Suite 1100
Washington, DC 20005
202-289-6976

LOS ANGELES

3660 Wilshire Boulevard, Suite 718
Los Angeles, CA 90010
213-639-0930

OAKLAND

1330 Broadway, Suite 525
Oakland, CA 94612
510-663-1055

flexibility, where the quality of care and beneficiary experience could be easily overshadowed by the goals of reducing expenditures and provider burden.

2. Ensuring that all Medicare beneficiaries have equal access to any demonstration regardless of income status

Medicare benefits are of little value to individuals if they cannot afford to access them. CMS should not develop any model that shuts low or moderate-income beneficiaries out of the model because they cannot afford to participate. While the RFI does not lay out specific proposals, there are several points where the agency appears to be contemplating permitting arrangements such as balance billing and contracts with beneficiaries that would follow concierge practice models. Further, the reference to beneficiary engagement tools as part of allowing beneficiaries and their families “to take ownership of the beneficiary’s health” appears to contemplate financial incentives and disincentives.

Most people with Medicare live on modest incomes. In 2016, the median income of Medicare beneficiaries was just over \$26,000. The majority of Medicare beneficiaries cannot pay extra for Medicare services. Allowing such payments in a demonstration means that those with modest incomes simply cannot participate. Such designs would segment the Medicare population into those who can afford additional payments for certain services and those who cannot. This subverts the universal nature of the Medicare benefit and denies equal access to those who are not able to shoulder additional costs. We are particularly concerned by the RFI reference to “enhanced access to providers,” which sounds like incorporating concierge medicine—including concierge charges-- into the Medicare program. We ask that CMMI concentrate instead on developing models that enhance the quality of care and improve access across the spectrum of Medicare beneficiaries, including those who cannot afford to pay extra.

These same cautions are even more pronounced with considering a DPC model in the Medicaid context. Medicaid beneficiaries currently are shielded from all but nominal co-insurance charges for all Medicaid services. Their low income requires that protection. No DPC model should incorporate financial elements that alter this core protection for the most vulnerable beneficiary population.

We ask that CMS avoid any segmentation of beneficiaries based on ability to pay. CMMI should lay out its proposals in detail so that all stakeholders can evaluate the impact of DPC models on Medicare beneficiaries at all income levels.

3. Protecting beneficiary choice

Beneficiary choice, particularly choice of a primary care provider (PCP), is a central value in Medicare. A focus of the RFI is providing additional flexibility to DPC providers and practices. In contrast, the RFI contemplates various options to limit choice and flexibility for beneficiaries. The RFI, for example, asks about possible passive enrollment and enrollment lock-ins in order to ensure adequate enrollment numbers and simplify methodologies for CMS payments to DPC practices.

In Original Medicare, the beneficiary has a choice of any Medicare provider. In Medicare Advantage,

plans are required to meet network adequacy standards and to allow a change at any time within the network so that provider choice remains robust.

Lock-ins or other limits on beneficiary choice in a practice group with a limited number of providers is quite different and a serious concern. All Medicare beneficiaries should have an opportunity to choose a PCP—or any provider-- and to change that choice at any time. This need for adequate beneficiary choice is heightened because Medicare beneficiaries, by virtue of their age or disability, often experience significant and sudden changes in health status. The Medicare program should not create models that impede their opportunities to respond to changing needs.

4. Providing adequate oversight and monitoring

Throughout the Medicare program, it has been clear that program success depends on vigorous oversight of marketing, service delivery and quality. Beneficiaries are the ones that bear the burden when marketing violations occur, when quality standards are not met, and when access to benefits is denied. We have very serious concerns about the capacity of CMS to adequately monitor the performance of a myriad of small and medium size practice groups. Without ongoing, real time monitoring, beneficiaries are at substantial risk.

Having said all that, we do appreciate that CMMI is considering many different models to improve care, including models that are provider-based. We note for example the dual eligible demonstration managed fee-for-service models in Washington and Colorado, both of which had provider-based designs, rather than using health insurance managed care models. A preliminary evaluation of the Washington model suggests that it generated statistically significant savings.¹ We continue to urge CMS to carefully test different approaches, always with the goal of improving beneficiary experience and outcomes. We ask, however, that CMS do so with caution and in ways that ensure adequate protection for the Medicare beneficiaries enrolled in new demonstration models, and include vigorous monitoring, beneficiary engagement and feedback, and effective evaluation. Particularly with this demonstration, which would involve numerous smaller practices, an effective demonstration would need a significant commitment of CMS resources, both for oversight, monitoring and evaluation, and also for technical assistance and consultation. The remainder of this submission addresses specific questions in the RFI.

Questions Related to Beneficiary Participation

6. Beneficiary Freedom of Choice

This section asks whether limitations on beneficiary freedom of choice are appropriate in the DPC model, focusing particularly on possible limits to how frequently a beneficiary could enroll or disenroll

¹ See RTI International, Report for Washington Managed Fee-for-Service Final Demonstration Year 1 and Preliminary Demonstration Year 2 Medicare Savings Estimates (July 2017) available at www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAEvalMedicareCostYr1FinalYr2Preliminary072817.pdf.

from a DPC practice.

We object to any limitation on beneficiary freedom of choice in a demonstration. Demonstrations are by their very nature experiments. Beneficiaries have real and often urgent health needs and they should be confident that participation in a demonstration will not limit their access to Medicare-covered care when they need it. If enrollment in a demonstration turns out not to be appropriate to meet an individual's needs, the beneficiary must be able to opt out and revert to fee-for-service Medicare or other models. Although CMS and providers take risks in testing new delivery models, beneficiaries should not be required to risk their health while demonstrations are tested.

Further, the core of the demonstrations proposed appears to be the relationship between the beneficiary and the primary care provider (PCP). The relationship between a beneficiary and a PCP, more than any other professional relationship between doctor and patient, is the most personal. It relies on trust and, to some extent, personal chemistry. If for any reason a beneficiary wishes to change PCPs, the beneficiary should have the absolute right to do so. Only having options of alternative PCPs within a relatively small provider group is not acceptable. Beneficiary freedom of choice is a bedrock principle of the Medicare program.² Design of these models must start with the beneficiary's needs, and then address how provider payment can be structured without compromising beneficiary rights.

Also, as a practical matter, we question the premise that limiting the right of beneficiaries to leave a demonstration would have any real impact on its financial viability. Experience with both Medicare Advantage and Medicare Part D shows that inertia is a strong factor once a beneficiary chooses how to receive benefits. Where there has been significant disenrollment, such as at the start of some dual eligible demonstrations, the issue has been primarily that trusted providers were not part of demonstration networks, and therefore some beneficiaries disenrolled to remain with those providers. Since the models proposed here would be centered on existing relationships with PCPs and would not impinge on the right to seek out other specialists (assuming that is correct), we expect that attrition would be very low.

Further, we would have deep concerns about any model where a provider can to reject a prospective enrollee or disenroll a current enrollee, as such models would be rife with the potential for discrimination against those with the most complex or expensive needs.

7. Enrollment

In this section, CMMI asks about incentives, including financial incentives, for beneficiaries to enroll and about tools for beneficiary engagement, mentioning specifically potential agreements between beneficiaries and their DPC-participating health care provider. The section also raises the question of whether active enrollment is sufficient, implying the possibility of a passive process. It also asks about

² See 42 U.S.C. Sec. 1395a(a) (Section 1802 of the Social Security Act).

mechanisms to provide consumer feedback.

The issues raised in this section are particularly concerning. When beneficiaries are passively enrolled, they are often unaware of the enrollment.³ As the financial alignment demonstration has shown, passive enrollment can generate distrust and confusion among beneficiaries.⁴

Moreover, the layering of passive enrollment, possible lock-ins, and possible requirements for beneficiaries to enter into unspecified agreements with their provider suggests a model that is the exact opposite of beneficiary empowerment. We also are wary of gift cards and other gimmicks to encourage enrollment or engagement. A beneficiary should be deciding whether to participate in a delivery model based on the beneficiary's informed evaluation of how appropriately the model responds to the beneficiary's needs and preferences. Incentives that distract from or distort that evaluation are inappropriate and should not be permitted.

We must note that part of our concern here is that we do not understand from the RFI what exactly the benefits are that would induce an individual to join. Like the ACO models, this appears to be a proposal to test payment variations that would encourage more flexible and focused engagement with patients, greater use of technology for patient records and in communications with patients, and other best practices, many of which are already being adopted in primary care practices. The RFI does not describe additional services beyond what other Medicare beneficiaries receive. If, as with ACO's, "joining" would simply mean staying with your provider while there are payment changes on the back end, then there does not seem to be much inducement needed. If, however, "joining" involves a trade-off, such as accepting balance billing or consenting to some other form of additional payment, then we have serious concerns. Our primary concern is that CMMI could carve out a model only available to that minority of Medicare beneficiaries who have the affluence to afford it, eroding the universality of the Medicare benefit.

Finally, in any model, CMS should develop mechanisms for beneficiaries to provide feedback on their experience. Even models that are aimed at changing the payment on the back end would benefit from knowing whether those changes are seamless from the beneficiary perspective and how, if at all, care is enhanced or harmed. Tools that allow beneficiaries to provide feedback in real time and easily file formal grievances would be welcomed. Any such mechanisms must be accessible to people with disabilities and those with limited English proficiency.

8. Cost-sharing

The RFI asks about the potential interaction between a potential DPC model and Medigap or other supplemental coverage. We anticipate significant difficulties if DPC provider groups were permitted to

³ United States Government Accountability Office, "Additional Oversight Needed of CMS's Demonstration to Coordinate the Care of Dual-Eligible Beneficiaries," (December 2015), available at <https://www.gao.gov/assets/680/674340.pdf>.

⁴ See, e.g., Focus Group Findings, *supra* note 1.

enter into financial contracts with their Medicare patients or permitted to balance bill for services. If each DPC practice determined its own billing structure, Medigap insurers would not have predictability in setting rates across the board. We also wonder whether an individual's decision to change from one DPC practice to another would mean an adjustment in Medigap premium charges.

We further urge CMMI to consider how model designs would interact with and affect the improper billing protections for Qualified Medicare Beneficiaries (QMBs). There are several elements to consider.

First, QMBs are protected from any charges for Medicare-covered services. Thus, they could not be charged a fixed fee for covered primary care services. They also would not experience any additional benefit from any design where reducing or eliminating cost-sharing is the inducement for beneficiaries to participate in the DPC model.

Second, we believe it is important that any DPC model be designed to ensure that providers do not discriminate against QMBs because of their protected status. We ask that practices participating in DPC models must make a contractual commitment that all their providers will accept QMB patients. This provision would be similar to that applied to in-network Medicare Advantage providers, who are required by contract not to discriminate against plan members based on their source of payment.⁵

Finally, to get providers and provider groups to participate on those terms, however, may require some adjustment in capitated payments so that DPC provider groups with significant numbers of QMB patients are compensated fairly.

QUESTIONS RELATED TO PAYMENT

9. Risk Adjustment

This section asks about adjustment in payments to practices based on health risk, geographical location or other factors.

In addition to risk adjustment based on health status, we also think CMMI should consider adjustments, not specifically for risk, but for other factors that affect cost of providing quality of care. For example, the 2018 Physician Fee Schedule added a payment code for prolonged preventive services (HCPCS Codes G513 and G0514).⁶ Payments could be adjusted for additional time and costs for patients who require an interpreter, or adjustment for additional time required when treating an individual with disabilities, or an individual who is homebound. We also raise the issue of adjustment for QMB status as discussed above.

10-11. Downside Risk

These questions ask about the extent to which DPC practices should be exposed to downside risks and what safeguards could address those risks.

We are concerned about how smaller practices can handle downside risks since they do not have

⁵ See Medicare Managed Care Manual, Ch. 4 at 10.6, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf.

⁶ Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018, 82 Fed. Reg. 219 (Nov. 15, 2017), at 53079.

patient populations large enough to spread risk widely. We ask that CMMI carefully vet potential practices and develop payment designs carefully. Beneficiaries face significant disruption when a practice shuts its doors or abruptly withdraws from a Medicare demonstration.

QUESTIONS RELATED TO GENERAL MODEL DESIGN

15. Other models

This section asks if CMS should consider other models, or modifications to existing initiatives that could meet the objectives of a DPC model. It also asks about any particular considerations for Medicaid or for dually eligible beneficiaries that CMS should factor in to designing models.

In response to the question of other possible models, we urge CMMI to consider modifications to fee-for-service payment schedules that would support practices that better serve beneficiaries. Payments for care coordination, for telephone and email consultations and other steps could be alternative ways to improve delivery in a cost-effective manner.

Looking at Medicaid and dual eligible issues, we have already noted the need to take into consideration the protections that QMBs receive from billing for Medicare services and the need to ensure that models do not discriminate against QMBs. Services for dual eligibles must consider the availability of Medicaid covered services and complement, rather than duplicate those services. We also urge that all providers in a DPC model should be required to enroll in Medicaid at least as prescribing or ordering providers. If they do not, then their dual eligible patients will be unable to get prescribed services, durable medical equipment, or drugs that are covered by their Medicaid benefit.

QUESTIONS RELATED TO PROGRAM INTEGRITY AND BENEFICIARY PROTECTIONS

16. Safeguards and Monitoring

This section asks about monitoring, data collection and other steps needed to ensure that high quality services are delivered.

We have seen with the dual eligible demonstrations and other models that, though data collection is an important element in program evaluation, it is a slow process that is inadequate to address more immediate issues in real time. There need to be additional safeguards such as ombuds or similar complaint mechanisms as well as formal grievance procedures. In the dual eligible demonstrations, the ombuds has proved to be an effective mechanism for spotting broader problems as well as addressing individual needs.

Besides issues of maintaining quality of services, CMMI must carefully monitor access to care. If a DPC includes any lock-in or if a DPC contractor has authority to deny a service, then an appeals route would be imperative to ensure the due process rights of beneficiaries. CMMI also needs to consider how to integrate CMS's current formal appeal processes into the DCP model.

17. Enrollment Safeguards

This section asks about safeguards needed to ensure that beneficiaries are not unduly influenced to enroll with a particular DPC practice.

We would particularly warn against allowing practices to market using brokers or other paid promoters. Much of the marketing abuses we see in Medicare Advantage arises from such third parties. Inducements to enrollment should also be carefully regulated and, more generally, prohibited.

CMMI should also consider safeguards regarding continued enrollment. For example, DPC practices could be required to issue something along the lines of the Annual Notice of Change (ANOC) issued by managed care plans. The ANOC would describe any planned changes in payments or coverage and would help the beneficiary to evaluate whether the DPC practice is continuing to meet the beneficiary's needs. There also should be rules about when and under what circumstances a DPC practice can change charges or scope of services covered, the notice required, etc.

18. Equal Opportunities for Enrollment

This section asks about measures needed to ensure that all beneficiaries have an equal opportunity to enroll with a DPC practice and to prevent activities to skew membership to healthy beneficiaries.

We share CMMI's concerns about activities that would encourage plans to seek to serve healthier beneficiaries and avoid those with complex needs. As noted in our response to Item 8 above, we have further concerns that practices may attempt to discriminate against QMBs and dual eligible beneficiaries as well. We seriously question CMS's ability to monitor DPC practices sufficiently to prevent these practices. In both Part C and Part D, we have seen CMS stretched to oversee the practices of large plans operated by national companies, a problem evidenced by the continuing findings in program audits of ongoing violations of CMS rules.⁷ Unless CMS dedicates disproportionately large resources to these models, we do not see how the agency is going to be able to keep track of the extent to which multiple individual DPC practices are following the rules, gaming the system, or serving their Medicare patients well.

CONCLUSION

Our response to the RFI consists primarily of concerns and cautions based on the limited specificity in the proposal. We reiterate our request that CMMI offer additional opportunities to comment as the agency's analysis evolves.

Thank you for the opportunity to submit comments. If any questions arise concerning this submission, please contact me at jgoldberg@justiceinaging.org.

Sincerely,



Jennifer Goldberg
Directing Attorney

⁷ See CMS 2017 Program Audit Enforcement Report, available at www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/ProgramAudits.html.