



Getting Medicare right

May 25, 2018

VIA ELECTRONIC SUBMISSION

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

**Re: Request for Information on Direct Provider Contracting Models**

Dear Director Boehler:

The Medicare Rights Center (Medicare Rights) appreciates the opportunity to comment on the Center for Medicare & Medicaid Innovation (CMMI) Request for Information (RFI) on Direct Provider Contracting (DPC) Models.

Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Medicare Rights provides services and resources to three million people with Medicare, family caregivers, and professionals each year.

The following comments are informed by our experience assisting people as they navigate the Medicare program. We caution that it is difficult to provide meaningful feedback on potential policies that hinge on specific details unless we see those details. As the RFI is largely silent on such specifics, our comments may recommend guardrails for roads CMMI does not intend to travel, and may fail to fully consider a model the agency does intend to pursue. Therefore, while we are pleased to offer general comments in response to this RFI, we respectfully request opportunities to provide more targeted input through future calls for public comment on the DPC model or models.

**General Comments**

Maintain Beneficiary Protections

Under current law, Medicare has several financial protections in place that are designed to safeguard Medicare beneficiaries from unexpected and confusing charges for medical care and services, including limitations on

balance billing and conditions on private contracting. We are concerned this RFI is a step in the direction of undermining these constraints, to the detriment of people with Medicare.

Though the RFI does not expressly call for the elimination of key Medicare beneficiary protections, it also does not expressly limit the scope of a potential DPC model (or models). This ambiguity creates the need for stakeholders to consider and provide comment on the array of approaches CMMI might take.

Accordingly, we begin our comments by clearly expressing our staunch opposition to any Medicare demonstration or program-wide policy change that would allow Medicare providers to enter into private contracts with beneficiaries to establish payment for Medicare-covered services. Such arrangements would shift costs onto people with Medicare, erode predictability and affordability, and threaten access to needed services. Medicare must be a bedrock of access to care for older adults and people with disabilities no matter their income.

While Medicare Rights encourages the pursuit and testing of innovative models that will improve beneficiary health, responsibly manage program spending, and reduce unnecessary burdens on providers, we urge CMMI to do so in a way that preserves and prioritizes beneficiary health and access to care. This includes ensuring that all current consumer financial protections remain in place. Beneficiaries must not face higher out-of-pocket expenses, greater risk, or restricted access to care because of their participation in a DPC or any other model.

### Beneficiary Participation in Model Development

Medicare Rights is pleased to be able to comment on this RFI at such an early stage of model development. As we stated in our “Consumer Protections in New Medicare Payment and Delivery Models: A Checklist,” with the AARP Public Policy Institute, models need early and ongoing input from stakeholders to ensure important considerations are part of their very foundations.<sup>1</sup>

To this end, we urge CMMI to make certain consumers a fundamental part of DPC model design, monitoring, and evaluation. People with Medicare are a valuable but often overlooked resource and CMMI can improve a model’s design and efficacy by building Medicare users’ perspectives, wants, and needs directly into new proposals. Beneficiaries and their family members can provide insights into how to effectively and appropriately communicate with patients, ensure that model evaluation draws on metrics relevant to patients and their families, and help identify ways to avoid inappropriate consumer incentives.

Any changes to Medicare must aim for healthier people, better care, and smarter spending. The experiences of the program’s beneficiaries must always be at the forefront of any policy decisions that affect how Medicare works.

### Request for Ongoing Dialogue

The lack of detail in the RFI limits our ability to provide concrete suggestions or identify specific troubling or praiseworthy elements. As a result, our comments are more general in nature and broad in scope than we would prefer, and may address scenarios or model structures CMMI was not necessarily contemplating. So that stakeholders may best provide meaningful, relevant input, we request that CMMI issue additional RFIs when any

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<sup>1</sup> Julie Carter, “Consumer Protections in New Medicare Payment and Delivery Models: A Checklist,” AARP Public Policy Institute & Medicare Rights Center (November 20, 2017), <https://www.aarp.org/ppi/info-2017/consumer-protections-in-new-medicare-payment-and-delivery-models.html>.

DPC model is coming into focus but before it is formally introduced. Such ongoing stakeholder dialogue will help ensure future models have the greatest possible chance of success.

### **Questions Related to Provider/State Participation**

2. CMMI asks what features should be required of practices to permit their participation in a DPC model. Because this RFI does not identify specific constraints that participation in the model might place on beneficiaries, or what benefits may accrue to participants, it is difficult to anticipate how, for example, a practice's level of financial reserves might impact people with Medicare. To get at this answer, it is necessary to determine how beneficiaries would be affected by enrollment in a DPC model, and how such a model would be structured. Would such enrollment lock in the enrollee in any way? Would the beneficiary be constrained or limited by his or her choice to participate? Would the benefits of enrollment be financial, medical, both, or something else entirely? Absent these specifics, we can generally recommend that where the beneficiary faces any type of lock in or other constraint, the requirements for participation should be relatively high. If the fact of participation, on the other hand, were to be essentially invisible to the beneficiary, then more limited model-specific requirements may be appropriate.

In addition, we agree that practices should demonstrate certain competencies in order to participate in a DPC model. At a minimum, providers should be free from significant sanctions, have the workforce available to handle any increase in patient load, exhibit demonstrated capabilities in care coordination, have mechanisms for meaningful beneficiary engagement, capacity to provide culturally- and linguistically-competent communication, and privacy protocols to effectively protect beneficiary information. Further, DPC providers should be free from conflicts of interest, and should be financially sound enough both to withstand two-sided risk and to be free of extreme incentive to inappropriately skew enrollment, reporting, or care.

### **Questions Related to Beneficiary Participation**

6. CMMI asks whether there should be limits under a DPC model on when a beneficiary can enroll or disenroll from a practice. Importantly, the question clearly states that beneficiaries enrolled in a DPC model should “retain freedom of choice of provider or supplier” consistent with traditional Medicare's fee-for-service model. Medicare Rights supports active choice and engaged participation by all people with Medicare, including a beneficiary's freedom to choose a provider or to participate in a Medicare demonstration program.

To fully answer CMMI's question, however, we need more information about what it might mean for beneficiaries to enroll or to disenroll in a DPC model. For example, would the enrollment be for recordkeeping purposes, or would enrollment create risk—either financially, or by limiting access to care in any way? Medicare Rights opposes models that could increase beneficiary risks. We urge CMMI to design any DPC model with standard Medicare benefits and protections, at a minimum.

CMMI also asks under what circumstances a provider or supplier should be able to deny participation to a beneficiary. We can anticipate very few scenarios in which a provider or supplier having the ability to reject a potential enrollee or to disenroll a current participant would be appropriate, aside from loss of coverage, physical distance, death, or incarceration. We urge CMMI to approach embedding any such flexibilities into a DPC model with great caution. Allowing providers to refuse or drop enrollees could lead to significant “cherry picking,” a

discriminatory practice by which providers target the healthiest or most profitable model participants for enrollment, or “lemon dropping,” where providers discourage enrollment among those with complex medical needs or other high-risk attributes. Such practices would undermine the integrity of the model and the care provided to enrollees.

7. CMMI asks about marketing and outreach strategies that DPC providers may employ to engage potential enrollees. We suggest that CMMI develop model language and templates, as well as a meaningful approval process for marketing materials, to ensure provider communications are appropriate. This level of oversight will help limit inappropriate steering, whether such steering is deliberate or inadvertent. With respect to marketing techniques, DPC providers should—at the very minimum—be held to the same standards as Medicare Advantage plans. Higher standards would likely be more appropriate, since a provider can have a great deal of influence over his or her patients, including potentially steering them into agreements that are not primarily for their benefit.

To further protect beneficiaries and ensure their access to high-quality information, we reiterate our request<sup>2</sup> that CMMI establish an Alternative Payment Models Beneficiary Ombudsman. Charged with bolstering existing consumer assistance systems, the essential components this ombudsman program would be (a) to provide individual information and assistance to beneficiaries, including appeals, troubleshooting, and resolving beneficiary problems, including billing; (b) to empower and engage with consumers to help build better systems; and (c) to track questions and complaints, and provide systemic data and feedback to CMMI about what is working and what can be improved.

CMMI must also update its existing tools and resources to reflect any new DPC model or models. This includes developing customized, model-specific scripts for 1-800-MEDICARE, so that callers can get the answers and information they need in a timely manner. As one of the most visible resources for Medicare beneficiaries, 1-800-MEDICARE is well-positioned to play a vital role in keeping enrollees and potential enrollees informed of the model’s purpose and of any potential changes they may see. In addition to informational purposes, this resource can serve as an oversight tool. CMMI could establish a process for auditing model-related calls to 1-800-MEDICARE, including any follow up.

Similarly, State Health Insurance Assistance Programs (SHIPs) should receive training and information on any new model. SHIPs are perfectly placed to help with model enrollment or other issues but must first understand the model themselves. Importantly, SHIP programs must be sufficiently resourced to meet these new, specific counseling needs, which would come in addition to the local, one-on-one assistance they are already providing to help beneficiaries navigate their Medicare coverage options and understand their rights.

The trainings and scripts that CMMI develops for 1-800-MEDICARE and SHIP counselors should also be available to providers to help them explain the model to enrollees in language that is easily understood, consistent with other CMS resources, and culturally and linguistically competent.

CMMI also questions whether active enrollment is sufficient to ensure beneficiary engagement, and whether beneficiaries who wish to participate should “be required to enter into an agreement with their DPC-participating

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<sup>2</sup> Medicare Rights Center, “RE: Medicare Program: Cancellation of Advancing Care Coordination through Episode Payment and Cardiac Rehabilitation Incentive Payment Models; Changes to Comprehensive Care for Joint Replacement Payment Model (CMS-5524-P)” (October 16, 2017), <http://medicarerights.org/pdf/102617-cms-leter-epm-cardiac-ombuds.pdf>.

health care provider.” This language is extremely concerning, as it suggests beneficiaries might be required to individually assess or bargain with providers to obtain services and set payment rates, rather than being able to rely on Medicare to protect their interests, as they do now. As stated earlier, Medicare Rights does not support private contracting or balance billing arrangements that would take the place of full Medicare coverage, interfere with such coverage, or otherwise constrain or expose beneficiaries to additional risks or financial liability. An agreement by a provider to accept Medicare payment includes an agreement that limits the provider’s ability to bill the beneficiary. That is a core protection of the Medicare program, and it must not be undermined in this or any other proposed policy.

CMMI also asks about beneficiary engagement and potential incentives. These questions underscore why CMMI must make including people with Medicare in this conversation a priority now—before any further model development occurs. Medicare beneficiaries can explain which incentives they would find persuasive, help CMMI determine how incentives and other design elements may distort a model’s appeal to various populations, and help the agency anticipate unintended consequences. For example, does the model eliminate cost sharing with no other financial benefit? If so, such a model may not draw many Qualified Medicare Beneficiaries who are not ultimately liable for Medicare cost sharing. Or it may disproportionately attract beneficiaries who have Medigap policies that cover their cost sharing. These enrollees may drop their Medigap coverage to join a DPC without fully understanding the consequences of doing so—leaving them with no affordable way to resume Medigap coverage if their DPC participation were to end.

Fundamentally, it is important that beneficiaries not be lured into joining a model that is not in their best interest. We oppose incentives that function solely as inducements for enrollment, but realize that even thoughtful incentive designs have risks and drawbacks. Rather than focus on beneficiary incentives, then, we suggest CMMI focus on provider incentives. Doing so would make robust risk adjustment extremely important, as a successful model must properly encourage providers to provide appropriate care to beneficiaries with every permutation of health status, functional status, income, and social factor.

Finally, CMMI asks what other tools might encourage beneficiaries to be active consumers. Here, we again recommend that people with Medicare be involved in every step of model design, monitoring, and evaluation. The needs and priorities of Medicare beneficiaries should be “baked in” to the model’s structure, not overlaid on an existing structure. For beneficiary participation to be meaningful it must be engaging and ongoing, rather than limited in scope, duration, or intensity. As the model is implemented, CMMI can involve beneficiaries by ensuring they have opportunities and mechanisms to be fully engaged at all levels of care, including access to robust model and provider data, as well as to their own health information. Most of all, beneficiaries and their chosen representatives must always be respected partners in care decisions.

**8.** CMMI questions benefit cost sharing within a DPC model and identifies the possibility of a “fixed fee [being] paid to the practice.” Coming as it does in the context of cost sharing, this suggests that CMMI may put forth a model under which beneficiaries would pay a fixed fee to the practice. We reiterate our objection to any model design that would increase Medicare beneficiaries’ out-of-pocket costs, and we urge CMMI to ensure that any fixed fee come instead of cost sharing, not in excess of or addition to it.

Further, because a fixed fee is akin to beneficiary-funded capitation, it carries the same risks as other capitated models to create misaligned provider incentives. Specifically, by divorcing the volume of care delivered from the

payment for that care, capitation can result in providers offering beneficiaries less care than they may need, since additional care does not result in additional income. These risks emphasize the importance of robust provider oversight to ensure that DPC practices do not stint on care.

As discussed above, incentives that limit beneficiary cost sharing will necessarily be less appealing to people who do not currently pay cost sharing and may lead to unintended Medigap consequences. Creating a broadly appealing but non-coercive and non-targeted incentive structure is a delicate but necessary task that must be built on both evidence and the feedback of Medicare recipients.

As such, we reiterate our opposition to incentives that function as gifts to induce enrollment, and our request that both now and as a model comes into focus, CMMI consult people with Medicare and their advocates on all matters related to proper incentive alignment.

### **Questions Related to Payment**

**9.** CMMI invites input on what services should be included in the fixed per beneficiary per month (PBPM) payment for DPC providers. If a model creates a new cost structure under which some or all Medicare-covered services would instead be covered by the PBPM payment, it will be vital that beneficiaries understand these changes—and in particular their financial obligations for the PBPM-covered services—as well as for any other services, supplies, tests, or procedures that fall outside the model’s payment. Beneficiaries may become confused about how the various payment scenarios interact, and CMMI must develop and distribute timely, accurate education and outreach materials to mitigate this confusion. In addition, if differing models covering different services were to spring from this RFI, that would expand the already daunting range of coverage choices people with Medicare must navigate. Not only would such a system burden beneficiaries, it would also likely lead to a paralysis of choice, with some beneficiaries choosing not to choose. If CMMI’s goal is for beneficiaries to make an active, informed choice to enroll in a DPC model, presenting them with a confusing array of plans and models that encourage no action would be counterproductive.

How CMMI determines and structures the PBPM payment will influence both provider participation rates and whether practices feel incentivized to provide appropriate care to a wide variety of patients, or to only the healthiest and most profitable. We urge CMMI to ensure that all decisions about provider payments be made with the goal of encouraging the provision of appropriate care to all people with Medicare.

### **Questions Related to General Model Design**

**14.** CMMI asks about approaches to quality measurement, including what specific quality measures should be used or included in a DPC model. Capitated payment models such as the one CMMI is considering can create incentives for providers to stint on care, causing beneficiaries to lose access to needed services. This makes a robust set of quality measures that are patient centered and patient reported absolutely vital. Providers must not be encouraged to provide inadequate care.

Quality measures should include improvement measures, patient reported outcome measures, patient satisfaction measures, grievance and appeals measures, and patient quality of life measures. The model should include a quality threshold that providers must meet before they are given any bonuses or other incentives, and provide a clear notice of any conflict of interest between providers and other entities. Data on quality measures must be

easily understood by and readily available not only to beneficiaries but also to their families, caregivers, and advocates.

We again urge that beneficiaries be involved at all levels of model design, from these initial development stages to eventual implementation and assessment.

### **Questions Related to Program Integrity and Beneficiary Protections**

**16.** CMMI is seeking input on what safeguards and monitoring methods could be put in place to ensure that beneficiaries receive needed, high quality care. As stated above, a model that relies on capitation must have a heavy focus on beneficiary-reported outcomes and satisfaction measures to ensure people with Medicare are receiving the care they need. Easily understood metrics akin to Star Ratings should be publicly available so that beneficiaries and others can better interpret and evaluate the quality of a DPC practice. Such metrics should not require independent research but should instead be clear to beneficiaries at the moment they are making the enrollment decision. For example, enrollment documents could include the rating itself, a flag for low ratings, an explanation of what the ratings reflect, and information about what a low rating could mean for the beneficiary's care.

Stinting on care, cherry picking, and lemon dropping are constant threats to care for beneficiaries with chronic or complex conditions and confounding social determinants of health. A DPC model must grapple with these risks up front and must incorporate both beneficiary and expert feedback into the model design to ensure that care is based on clinical evidence (that can include value) as well as beneficiary needs and desires.

A strong, easily navigated grievance and appeals process must also be included in any DPC model. Beneficiary and advocate input should help assess the ease of navigability in the real world. Such a process should provide protections that are at least as robust as the existing Medicare processes, and notice of appeal rights should be included in all communications with beneficiaries. In addition, measures reflecting grievances and appeals must be included in the model's design to help beneficiaries understand the potential issues the participating practices are facing.

**17.** CMMI asks what safeguards can prevent beneficiaries from being "unduly influenced to enroll with a specific DPC practice." We reiterate that a focus on beneficiaries taking control of their health care must not lead to a reduction in beneficiary protections. In addition to adhering to current safeguards, like the prohibition against balance billing, a DPC model must include strict rules around discriminatory enrollment practices, including forbidding or severely curtailing providers' ability to reject or disenroll members based on their health needs, as discussed earlier in our comments. CMMI must provide adequate oversight, monitoring the patient mix of each practice closely for evidence of selective enrollment, and reviewing the recent claims history of new enrollees. Discriminatory behavior must not be tolerated, and a proven record of such discrimination should lead to a practice facing significant sanctions, including loss of participation in a DPC or other model.

Providers have a special relationship with their patients that they must not exploit or otherwise use as a tool for inappropriate steering. The model must not allow DPC practices to market aggressively to current patients. We again suggest that CMMI develop and provide templates for beneficiary communications to prevent such steering and inappropriate marketing. While robust risk adjustment will disincentivize some cherry picking, it cannot prevent beneficiaries from feeling pressured to join a DPC practice.

We again suggest that establishing an Alternative Payment Models Beneficiary Ombudsman would be a constructive step toward protecting and prioritizing enrollees, and that 1-800-MEDICARE and SHIPs should be given CMMI-approved materials to help them assist beneficiaries navigate DPC model enrollment. Contact information for these entities should be included in model-related provider communications.

**18.** CMMI asks about cherry picking and the establishment of additional beneficiary protections that may be needed under a DPC model. Because of the nature of the provider-patient relationship, having providers at the forefront of marketing efforts or other communications is fraught with potential for damaging influence, either purposeful or inadvertent. There must be limits on when and how providers market DPC participation to beneficiaries. It cannot happen during an office visit, for example, when patients are at their most vulnerable.

The use of CMMI-provided templates or CMMI-approved communications; strict marketing limitations, including rules around rating metrics; user-friendly, culturally- and linguistically-competent information about the model's financial implications, potential benefits, and drawbacks; as well as contact information for support from ombudsman programs, 1-800-MEDICARE, SHIPs, and in-model staff would help ensure that beneficiaries understand what enrollment might mean for them.

Importantly, aggressive CMMI oversight to protect beneficiaries from discrimination, improper steering, and financial harm must be part of any model's design. Beneficiaries must have access to robust and easily navigated grievance and appeals processes and must be able to trust that their voices are being heard.

However, even with these and other beneficiary protections in place, it will still be critical that the model itself not jeopardize beneficiary affordability or access to care. People with Medicare must not be penalized for their willingness to participate in a DPC model.

**19.** CMMI asks about safeguards around beneficiary incentives. If a DPC or any other payment model is to be successful, it must have a risk adjustment system in place that properly aligns incentives and limits gaming. Accordingly, the structure of the payment model will determine the extent to which it is susceptible to manipulation. Lack of adequate risk adjustment, for example, would incentivize practices to enroll healthier beneficiaries with more favorable social determinants of health. This makes it essential for CMMI to understand the exact interaction of provider incentives, stinting on care, and beneficiary cherry picking. We urge CMMI to engage experts and perform rigorous evaluations of data from earlier models and demonstrations to determine how risk and incentives can best be structured.

We reiterate that beneficiary incentives must not solely be gifts or promotions to encourage enrollment, and that provider incentives must be appropriately tied to outcomes, with robust risk adjustment. Any arrangements that may encourage providers to stint on care must be strictly scrutinized.

**20.** CMMI asks how to protect beneficiaries from risks such as identity theft. DPC providers should have rigorous protocols to protect beneficiary information and privacy in place as a condition of their participation in a model. Information on how beneficiary privacy will be protected, how any collected data may be used, and what a beneficiary's rights and choices are should be included in provider communications about a model's benefits and drawbacks.



Specifically, before and after enrollment, beneficiaries should be told which data are shared with whom—for example, whether data sharing means that employees of all affiliated providers can see the beneficiary’s personal data, such as doctors’ notes, test results, and financial information. Further, patients should be allowed to view and correct their personal data. For example, they may need to update their medical history or indicate a change in medications.

### **Questions Related to Existing ACO Initiatives**

**21.** CMMI asks about the potential need for additional waivers “as a means of providing regulatory relief necessary for purposes of testing the model” in order to encourage participation, especially with two-sided risk. While this question is posed in the context of existing ACO initiatives, such an approach could have broader implications. We are specifically concerned that CMMI seems to suggest participation in a risk-bearing DPC model might be incentivized through a relaxation of current regulations, potentially including those in place to protect Medicare beneficiaries’ health and financial interests. Such safeguards are foundational to the Medicare program, and must not be waived or otherwise diluted.

In closing, thank you for requesting input on this important topic, and in particular at the early stages of the model development process. As a DPC model takes shape, we again encourage CMMI to offer additional, more tailored opportunities for public stakeholder engagement.

Thank you for your consideration. We look forward to working together to advance innovations in benefit design and care delivery that prioritize people with Medicare. For additional information, please contact Lindsey Copeland, Federal Policy Director at [LCopeland@medicarerights.org](mailto:LCopeland@medicarerights.org) or 202-637-0961 and Julie Carter, Federal Policy Associate at [JCarter@medicarerights.org](mailto:JCarter@medicarerights.org) or 202-637-0962.

Sincerely,



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