



May 28, 2019

VIA ELECTRONIC SUBMISSION

Adam Boehler  
Director, Center for Medicare and Medicaid Innovation  
Centers for Medicare & Medicaid Services  
200 Independence Ave, SW  
Washington, DC 20201

**Re: Request for Information on Direct Contracting—Geographic Population-Based Payment Model Option**

Dear Director Boehler:

The Medicare Rights Center (Medicare Rights) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI) Request for Information (RFI) on Direct Contracting—Geographic Population-Based Payment Model Option.

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.

**General Comments**

As with all models that could change how people with Medicare access, pay for, or understand their health care, the first step is to ensure that all beneficiaries have the same consumer protections, including limitations on balance billing, conditions on private contracting, and no increase to out-of-pocket costs. We are heartened to see the RFI reiterate that Medicare FFS beneficiaries aligned to DCEs participating in the Geographic PBP model option would retain all of their Original Medicare benefits, including freedom of choice of any Medicare provider or supplier, even if the provider or supplier does not have an arrangement with the DCE.

As with all models that are based on increasing consumerism and shopping, this model must have strong guardrails and fail-safes to ensure that the choices beneficiaries make cannot lead to catastrophic outcomes for their health or financial stability. Overemphasis on shopping can create a system where only the savviest consumers get a reasonable deal and everyone else struggles to get their needs met. More must be done to protect against this risk.

While we were pleased to see that CMS sought feedback through the initial RFI and later stakeholder engagement and appreciated the opportunity to respond to the initial RFI, it is unclear whether beneficiaries and their representatives have continued to play a role in the design process. As we stated in the RFI and 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 consumer stakeholders to ensure important considerations are part of their very foundations.<sup>1</sup>

Beneficiaries, families, caregivers, and advocates 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.

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

**1. How might DCEs in the Geographic PBP model option address beneficiary needs related to social determinants of health (such as food, housing, and transportation) with particular attention to whether the geographic scale contemplated under the payment model option creates new opportunities for success in terms of community-based initiatives? What barriers might prevent DCEs from addressing these social determinants of health? Are there additional incentives that CMS could offer to DCEs to motivate these entities to address social determinants of health?**

We are intrigued by the potential to address beneficiary needs related to social determinants of health, including food, housing, and transportation needs. We see this as an opportunity to bring these needed services into Traditional Medicare, though we hope to see further options for people with Medicare who are not in the range of one of the DCEs.

A coalition of consumer advocacy organizations that includes Medicare Rights has developed a framework for addressing the social determinants of health (SDOH) sensitively and competently.<sup>2</sup> Pursuing innovative solutions within the Medicare program must be done with the utmost care to ensure that all approaches are person-centered, involve multi-sector partnerships, and have health equity as an explicit goal. There are several activities that the model could incentivize, including screening for unmet social needs, establishing closed-loop referrals to social service providers, and even direct provision of social services. CMS should consider incorporating measures into the payment

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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>.

<sup>2</sup> National Partnership for Women and Families, “A Consumer Advocacy Framework for Addressing Social Determinants of Health,” available at: <http://www.nationalpartnership.org/our-work/resources/health-care/social-determinants-of-health>.

structure that would encourage DCEs and providers to partner with community-based organizations and social service and public health agencies to address the SDOH through screening and referral. DCEs should also be encouraged to create dedicated positions focused on health equities within the entity's entire system.

Importantly, DCEs should be encouraged to employ workers from the communities they serve to ensure that the communities have voices within the system. Each DCE should tailor its services to meet the needs of the community it serves and rely on trusted community partners for guidance into what community-led interventions and engagements make the most sense.

In addition, DCEs must have a framework for how they will integrate data from the community with clinical data, demonstrated capabilities in care coordination, mechanisms for meaningful beneficiary engagement, capacity to provide culturally- and linguistically-competent communication, and rigorous privacy protocols to effectively protect beneficiary information as a condition of their participation. It is vital that DCEs be held responsible for the privacy and security of any data they collect regarding SDOHs as well as health care. And there must be safeguards in place to ensure that any information collected will be used solely for the benefit of the consumer, not for marketing and certainly not for any discriminatory purpose. Information on how beneficiary privacy will be protected, how any collected data may be used, and what a beneficiary's rights and choices are, including opting out, should be included in provider communications about model benefits and drawbacks.

### **Questions Related to Selection of Target Regions**

**2. What are the benefits and/or risks to access, quality, or cost associated with the implementation of the Geographic PBP model option in a target region that includes a rural area? What safeguards might CMS consider to preserve access and quality for beneficiaries in rural areas in a Geographic PBP target region? How would rural market forces (for example, out-migration, hospital closures, and mergers/acquisitions) affect the DCE's ability to lower cost and improve quality under the payment model option?**

By contracting directly with DCEs to account for total costs of care, CMS may spur greater consolidation of providers. This is especially problematic in rural areas where the effect of holding down wages may cause permanent economic instability to the area and where a lack of provider choices may cause access issues. While cost containment is an understandable goal of the model, these costs must not be borne by workers who have been cut off from competing workplaces.

Consolidation is also a problematic trend for the health system as a whole. While hospital systems, for example, may gain efficiencies through consolidation and may be able to hold down administrative costs or even costs of care, this does not necessarily result in a reduction in prices for patients or higher quality of care. Indeed, economic theory would suggest that a provider with fewer competitors has a more wide-open field for price increases than a provider with numerous competitors, regardless of the provider's quality. Approaches that increase the attractiveness of rural target areas may exacerbate this trend and create new or worsening issues for the communities within the region.

## Questions Related to DCE Eligibility

**1. What are the benefits and/or disadvantages of the DCE selection criteria under consideration for the Geographic PBP model option, described above? What other selection criteria and core competencies should CMS consider requiring applicants to address? Please describe the benefits of including such additional selection criteria. What criteria are of the greatest importance and therefore should receive the greatest weight in our selection decisions?**

In addition to the list of criteria given, the DCEs must be free from conflicts of interest and from any significant history of sanction, penalty, or termination from Medicare, Medicaid, the Veterans' Administration, professional licensing, or similar authorities, obligations, rules, or laws. The DCEs should both be financially sound enough both to withstand two-sided risk and to be free of extreme incentive to inappropriately skew enrollment, reporting, or care. In addition, they must exhibit demonstrated capabilities in care coordination for older adults or people with disabilities and have mechanisms for meaningful beneficiary engagement, capacity to provide culturally- and linguistically-competent communication, and privacy protocols to effectively protect beneficiary information as a condition of their participation. 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, correct, and update their personal data. For example, they may need to update their medical history or indicate a change in medications.

It is vital that DCEs be held responsible for the privacy and security of any data they collect regarding SDOHs as well as health. And there must be safeguards in place to ensure that any information collected will be used solely for the benefit of the consumer, not for marketing and certainly not for any discriminatory purpose. Information on how beneficiary privacy will be protected, how any collected data may be used, and what a beneficiary's rights and choices are, including opting out, should be included in provider communications about model benefits and drawbacks.

**3. Should we consider allowing States to participate as a Geographic PBP DCE or in partnership with a Geographic PBP DCE? What would be the pros and cons associated with allowing State participation?**

The RFI identifies a criterion for selecting DCEs that they demonstrate “the level of engagement with and support from state Medicaid agencies to ensure that Medicare savings generated under DC are not a result of cost-shifting to Medicaid.”<sup>3</sup> We support this criterion and also suggest that safeguards be put into place to ensure that a state with authority to function as a DCE could not cost shift onto Medicare from existing Medicaid program services.

## Questions Related to Beneficiary Alignment

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<sup>3</sup> RFI p 4.

**2. Are there transparency/notification requirements, in addition to or in lieu of the requirements described above, that CMS should consider to protect beneficiary freedom of choice of any Medicare provider or supplier for beneficiaries aligned to a DCE participating in the Geographic PBP model option?**

CMS should provide consumer-tested written notices that they retain their freedom of choice in order to avoid potential confusion or steering.

**3. How might DCEs inform beneficiaries of the payment model option and engage them in their care? What barriers would DCEs face in engaging with beneficiaries in their target region?**

Beneficiaries may become confused about how the Geographic PBP scenarios interact with their Medicare coverage, as well as their Medigap or any other additional coverage. CMS should develop and test timely, accurate education and outreach materials to mitigate this confusion, even if the interaction would otherwise be completely invisible to the beneficiary.

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

**1. What monitoring methods can CMS employ to ensure beneficiary access to care is not compromised and that beneficiaries are receiving the appropriate level of care? What data or methods would be needed to support these efforts?**

To further protect beneficiaries and ensure their access to high-quality information, we reiterate our request<sup>4</sup> that CMMI establish an Alternative Payment Models Beneficiary Ombudsman. Charged with bolstering existing consumer assistance systems, the essential components of this ombudsman program would be (a) to provide individual information and assistance to beneficiaries, including appeals, troubleshooting, and resolving beneficiary problems, and 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 CMS about what is working and what can be improved.

CMS must also update its existing tools and resources to reflect new 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. CMS could establish a process for auditing calls to 1-800-MEDICARE for complaints about the model and develop a standardized process for following up on any such complaints.

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<sup>4</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>.

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.

A model that relies on capitation must have a heavy focus on beneficiary-reported outcomes and satisfaction to ensure beneficiaries are receiving the care they need. 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 new model must grapple with these risks up front and must be carefully designed with both beneficiary and expert feedback to ensure that care is based on clinical evidence (that can include value) and beneficiary needs and desires.

A strong, easily navigated grievance and appeals process must be included in any 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.

A robust set of quality measures that are patient centered and patient reported absolutely vital, including 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 and readily available to beneficiaries and also to their families, caregivers, and advocates.

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

## **2. What regulatory flexibilities or operational activities would be needed to promote DCE success and how might such flexibilities affect program integrity of the Medicare program?**

We object to any incentivizing of participation through a relaxation of current regulations that protect Medicare beneficiaries' health and financial interests. Such safeguards are foundational to the Medicare program, and must not be waived or otherwise diluted.

## **3. Providing incentives to beneficiaries to positively influence their behavior and healthcare decision-making could implicate the fraud and abuse laws and potentially raise quality of care, program cost,**

**or competition concerns, particularly if the incentives would cause beneficiaries to be aligned to one DCE over another entity participating in DC or another CMS initiative. What safeguards should CMS put in place to ensure that any beneficiary incentives provided do not negatively impact quality of care, program costs, or competition?**

Through consumer testing and consultation, Medicare beneficiaries can explain which incentives they would find persuasive and help CMS determine how incentive design can distort the model's appeal to or define a model's appropriateness for various populations. 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 even thoughtful incentive designs have risks and drawbacks. Incentives should not be used to advertise or promote a DCE and must not be a reward for alignment. The larger the incentive, the greater the distorting potential.

A DPE must not be permitted to offer incentives that would be likely to lead to cherry-picked alignment. CMS must provide adequate oversight, monitoring the patient mix of each DPE 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 significant sanctions and termination from the program.

Importantly, 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 DPEs to market aggressively, especially to patients in vulnerable settings. We again suggest CMS-developed and tested templates for beneficiary communications to prevent such steering and inappropriate marketing.

We also again suggest that establishing an Alternative Payment Models Beneficiary Ombudsman would be a good step toward protecting and prioritizing enrollees, and that 1-800-MEDICARE and SHIPs should be given CMS-developed materials to help them assist beneficiaries.

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

Importantly, aggressive CMS 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.

### **Questions Related to Payment**

**5. If DCEs were to enter into their own downstream payment arrangement with healthcare providers, how should cost sharing amounts be determined and collected from beneficiaries?**

For any model under which beneficiaries would pay something other than standard Medicare cost sharing, we reiterate our insistence that it must not increase beneficiary out-of-pocket costs. People with Medicare must not be subject to unexpected billing, either before or after they receive care.

### **Conclusion**

Thank you for this opportunity to provide comment. As with all models, consumer protections and beneficiary needs and safety—both physical and financial—must be at the forefront. 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, Senior Federal Policy Associate at [JCarter@medicarerights.org](mailto:JCarter@medicarerights.org) or 202-637-0962.

Sincerely,

A handwritten signature in black ink that reads "Fred Riccardi". The signature is written in a cursive style with a large initial "F".

Fred Riccardi  
President  
Medicare Rights Center