



Date: May 25, 2018

To: Seema Verma, Administrator
Centers for Medicare and Medicaid Services
United States Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Submitted via electronic submission to DPC@cms.hhs.gov.

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

From: Cheryl Phillips, M.D.
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Dear Ms. Verma:

The SNP Alliance appreciates the opportunity to provide comments in response to the Request for Information on Direct Provider Contracting Models

The SNP Alliance is a national leadership organization dedicated to improving total quality and cost performance through specialized managed care and advancing integration of health care for individuals who are dually eligible for Medicare and Medicaid. As an invitation only leadership group, our membership includes representation from many of the nation's leading health plan organizations. We represent 24 organizations of special needs plans and Medicare/Medicaid plans serving 1.6 million enrollees. Our members serve over 50 percent of Special Needs Plans (SNPs) enrollees with representation from all SNP types, including those serving: (1) beneficiaries dually eligible for Medicare and Medicaid benefits (D-SNPs); (2) those diagnosed with a severe or disabling chronic condition (C-SNPs); and (3) those living in or eligible for nursing home care (I-SNPs).

We acknowledge and appreciate the expressed goal of CMS to provide flexible, accessible and high-quality care to beneficiaries that may chose this proposed direct provider contracting model. We also appreciate the interest of physician and non-physician practitioners to participate in an alternative payment model. We also acknowledge a second goal of the DPC model would be to reduce expenditures. Rather than respond to the specific questions posed in the RFI, the SNP Alliance will respond to the two overarching objectives by identifying issues, concerns, and factors for consideration.

With regard to the first objective, the SNP Alliance has long promoted that the very foundation of improving care for high-risk and complex needs populations is through integrated care and services. We are most certainly pleased with the recent Bipartisan Budget Act of 2018 that outlined the “Requirements for Integration” for plans serving those dually eligible for Medicare and Medicaid. And we also believe that true integration goes beyond to include alignment of benefits, sharing of information, coordination of care across setting and providers, and effective care planning that is person-centered and based on an individual’s goals of care.

We do have many concerns with the proposed Direct Provider Contracting model. How would such a model promote care integration? If separate providers and provider types are initiating direct contracts with CMS, how do services coordinate across settings and providers? The SNP Alliance is also concerned with the potential that such contracts could be specialty-driven, thus focusing on single disease categories, rather than the broader needs of the individuals served. Would the providers even know if the population contracted with them are also contracting for other services with other providers? And if these contracts applied to both Medicare services and Medicaid services, each with separate contracts, how would states and plans ever achieve true care integration for those dually eligible? Furthermore, what would prevent providers from “cherry-picking” or selecting beneficiaries with less complex needs?

Secondly, who determines what services are needed for a given beneficiary? For example, if the individual with complex needs contracts with a primary care physician group, is it up to the physician group to assess for long term service and support needs (LTSS), or does the beneficiary, themselves, need to initiate separate service contracts? Many of those individuals with complex care and support needs may be least able to negotiate such a complex set of steps, let alone even know what services may be available or appropriate for them.

Lastly, what oversight would be in place to assure not only quality of the services provided, but what protections would be in place to assure that enrolled patients received the scope of services they needed – beyond what may be provided by the contracted provider?

While we recognize the benefit of having an alternative payment model that assumes risk for an entire population, we also recognize that in order to do this the entity assuming risk must be able to do a comprehensive assessment, have access to the full array of covered services the individual may need, and the ability to coordinate information across settings providers, and the individual (or designated family/caregiver).

Merely creating provider contracts where smaller units of providers (physician and non-physician) can participate in two-sided risk does not, by itself, assure appropriate and coordinated care for many vulnerable individuals with complex medical, functional, and/or social support needs.

The second objective of the DPC model is to reduce expenditures. The payment mechanism under consideration appears to be a capitated payment model where payment would be made on a monthly basis for each beneficiary assigned to the group. One question posed in the RFI is whether the payments would need to be risk adjusted. Quite clearly, the answer is yes. Otherwise, the physician

groups could either benefit inappropriately through favorable selection or be seriously harmed through the attraction of beneficiaries who were much sicker and therefore more costly than average.

Developing a fair and successful capitated model would be challenging and CMS needs to be sensitive to the regulatory framework that needs to be put in place to address the problems and abuses that can arise. Managed care plans, including the membership of the SNP Alliance have had substantial experience in developing a broad range of risk sharing arrangement with provider groups and panels. The immediate challenge in capitating a primary care physician group, which appears to be one of the objectives of the DPC model is slippage. Many specialists, in fact, also provide primary care services in a range of situations. A managed care plan that capitates primary care practices needs to build safeguard to assure that the group is not exploiting the objectives of the model by referring patients to groups for which they can receive payment under Medicare fee-for-service. Thus, to address this concern, if the model's payment mechanism is limited to a capitation for primary care services there would need to be safeguards in place to protect against exploitation. The other option would be to put the primary care provider on risk for some or all of specialty and possibly institutional services.

A second issue, which the RFI alludes to, is whether the size of the group and the patient size affects the viability of the concept. Again, quite clearly the answer is yes because there needs to be a large enough pool of revenue from the DPC model to avoid the substantial risk that the costs to furnish services to the beneficiaries far exceeds the expected costs (and revenue) for reasons beyond the control of the physician group. CMS has substantial experience evaluating risk in the context of the MA physician incentive regulations (§422.208). These regulations focus on the risk arising from services that are not provided by the physician group in question. In response to the question posed by CMS in the RFI, the SNP Alliance believes that the model would need to include risk for services not provided by the primary care physicians to achieve the goal of reducing expenditures. The risk typically includes both downside and upside risk to be successful.

The physician incentive regulations provide a framework for identifying the amount of risk that can be assumed by a physician group before the risk is "substantial" and stop loss coverage is needed. The question the SNP Alliance poses is whether physician groups would be willing to participate in a program like this where there may be substantial downside risk.

For the DPC model to potentially be workable from a financial perspective, the beneficiaries need to be "locked in" to the physician group for the designated services. This fact alone demands the consideration of enormous public policy issues related to educating beneficiaries of this restriction, creating new appeals structures, establishing marketing guidelines to assure that prospective beneficiaries are objectively informed of the benefits/risks of their participation, and the drafting of member materials that provides to beneficiaries all the information they need to know to navigate these arrangements.

In the context of consideration of the viability of the DPC model, a review of the regulatory structure under the MA program would be worthwhile. The SNP Alliance suspects that a substantial regulatory structure would need to be put in place in order to establish the necessary beneficiary protections, meet the needs of provider groups and achieve CMS' objectives. Another issue to consider is how

can this model motivate beneficiaries to agree to the restrictions. In the MA program, MAOs offer additional supplemental benefits and care coordination programs to engage beneficiaries. Further, SNPs design specialized programs to meet the needs of their targeted enrollment categories. It is unclear how the DPC model will be able to attract beneficiaries who will agree to a limited lock-in.

For the above reasons, the SNP Alliance has significant concerns with regard to the viability of the DPC model as well as the potential harm that might be caused to beneficiaries who are dually eligible or who have complex needs. The four key questions we pose are: (1) how will this program promote the quality of care of beneficiaries with complex needs, (2) will beneficiaries be sufficiently motivated to participate in the program; (3) will physician groups be willing to participate if the model is designed in the manner we are suggesting, which demands the assumption of substantial risk, and (4) if a substantial regulatory structure needs to be put in place to support the program, wouldn't it be more efficient to explore different payment models through the Medicare Advantage program.

We would welcome the opportunity to discuss our comments directly with CMS. Any questions or requests for additional information may be sent to cphillips@snpalliance.org or by calling (202) 204-8003.

Respectfully,



Cheryl Phillips, M.D.
President and CEO Special Needs Plan Alliance