



Center for Medicare and Medicaid Innovation

Request for Information on Direct Provider Contracting Models

Agency/Office: Department of Health and Human Services

Centers for Medicare & Medicaid Services

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Type of Notice: Request for Information (RFI)

SUMMARY: The Centers for Medicare & Medicaid Services (CMS) currently offers initiatives aimed to improve primary care delivery, beneficiary experience, and accountability for the cost and quality of care. These include the Medicare Shared Savings Program, as well as several Center for Medicare and Medicaid Innovation (Innovation Center) models, including the Comprehensive Primary Care Plus Model, the Next Generation ACO Model, and the State Innovation Models Initiative. CMS is seeking input on direct provider contracting between payers and primary care or multi-specialty group practices to inform potential testing of this approach within the Medicare fee-for-service (FFS) program, Medicare Part C program (also known as Medicare Advantage), and Medicaid (for example via State-based approaches). Direct provider contracting would enhance the beneficiary-physician relationship by providing a platform for physician group practices to provide flexible, accessible, and high quality care to beneficiaries that have actively chosen this type of care model. CMS seeks input from all stakeholders about their experiences with, and perspectives on, direct provider contracting and how CMS can use direct provider contracting models to reduce expenditures and preserve or enhance the quality of care for Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries. Additionally, this RFI solicits stakeholder input on how direct provider contracting would interact with, enhance, and/or refine current accountable care organization (ACO) initiatives, such as the Medicare Shared Savings Program.

DATES: *Comment Date:* To be assured consideration, comments must be received by 11:59 EDT on May 25, 2018.

ADDRESSES: Comments should be submitted electronically to DPC@cms.hhs.gov.

FOR FURTHER INFORMATION CONTACT: DPC@cms.hhs.gov with "RFI" in the subject line.

Respondents are encouraged to provide complete but concise responses to the questions listed in the sections outlined below. Respondents are also encouraged to identify the specific questions they are responding to in their submission. Please note that a response to every question is not necessary for us to consider the responses. Additionally, respondents may identify and comment on other issues that they believe are important for CMS to consider in designing these models.

BACKGROUND: Section 1115A of the Social Security Act created the Center for Medicare and Medicaid Innovation (the "Innovation Center") and authorized the Secretary of Health and Human Services to test innovative payment and service delivery models that have the potential to reduce program expenditures while preserving or enhancing the quality of care for Medicare, Medicaid, and CHIP beneficiaries.

CMS seeks to test innovative person-centered and market-driven approaches that empower beneficiaries as consumers, increase choices and competition to drive quality, reduce costs and improve outcomes. For more information on the Innovation Center's current models and guiding principles for a new direction, please visit <http://innovation.cms.gov>.

CMS seeks responses to this RFI from beneficiary and advocacy groups, beneficiaries and caregivers, primary care and specialty providers, health plans and supplemental insurers, State governments, research and policy experts, industry associations, professional associations, and other interested members of the public.

CONTACT INFORMATION: Please provide the name, organization, address, contact number, and email address of the commenter. Note: While CMS asks for this information, it is not required for the comment(s) to be considered.

REQUEST FOR INFORMATION: Direct Provider Contracting

Under its current portfolio of models, CMS has implemented a number of initiatives related to primary care with opportunities for participation by primary care physicians and physician group practices more broadly. For example, the Innovation Center's Comprehensive Primary Care Plus (CPC+) Model is a national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation. CPC+ includes two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the United States. CPC+ builds on the experience of the Comprehensive Primary Care (CPC) initiative, which was tested from 2012 through 2016. CMS also offers opportunities for physicians and other healthcare providers to form network-like entities through accountable care organization (ACO) initiatives, including a national ACO program called the Medicare Shared Savings Program, as well as the Innovation Center's Medicare ACO Track 1+ Model and Next Generation ACO Model. ACOs are formed by physicians and other Medicare providers and suppliers and are held accountable for the quality, cost, and experience of care for an assigned or aligned population of Medicare FFS beneficiaries. While ACOs may include a range of provider and supplier types and may offer a range of services and supports, primary care physicians form

the foundation of ACOs, as beneficiaries are generally assigned or aligned to an ACO through a determination of where they received the most primary care services.

CMS understands there may be physicians, non-physician practitioners, and physician group practices looking for additional options to participate in an alternative payment model and with a desire to transform their practice and engage with patients in a way in which current initiatives have not previously offered. CMS is considering a set of potential model tests designed to reduce expenditures while preserving or enhancing the quality of care under the general category of direct provider contracting (DPC), through which CMS would directly contract with Medicare providers and suppliers, such as physician group practices, and these providers and suppliers would agree to be accountable for the cost and quality of care of a defined beneficiary population. A DPC model (or models) would differ from existing primary care models by placing greater emphasis on the central role of the beneficiary in selecting a primary care practice, with beneficiary engagement tools to empower beneficiaries, their families, and their caregivers to take ownership of the beneficiary's health, while offering practices the ability to take on two-sided financial risk. The model(s) would also provide the flexibility for health care providers to focus on furnishing high-quality healthcare to their patients.

The goals of a DPC model (or models) would be to reduce expenditures while preserving or enhancing quality of care by testing a model where beneficiaries voluntarily enroll in a practice participating in a DPC model, together with 1) enhanced access to physicians' (and potentially other) services for beneficiaries, 2) reductions in administrative burden on providers and suppliers for billing, and/or 3) a revenue stream that would aim to give providers and suppliers more flexibility in how and where they care for their patients.

CMS is aware of a wide range of payment arrangements that involve aspects of "direct provider contracting," from the existing ACO initiatives and CPC+ Model test to capitation arrangements between primary care providers and commercial insurers or Medicare Advantage plans, to arrangements in the private sector where, for example, patients contract directly with physicians and group practices. Given this range of activities, a DPC model (or models) could be tested in an iterative manner with additional options added over time. For purposes of beginning a DPC model test, CMS could contract directly with participating practices, such as primary care practices or larger multi-specialty groups, to establish the practice as the main source of care for services ranging from solely primary care to a wide range of professional services for beneficiaries that voluntarily elect to enroll with the practice. CMS could later consider additional DPC model tests and encourages commenters to provide information on the types of DPC arrangements they would be interested in seeing tested in Medicare FFS or potentially in Medicare Advantage (to the extent Medicare Advantage plans do not have incentives to use such arrangements already). We are also interested in input regarding how States may include DPC arrangements in their respective Medicaid programs.

Under a primary care-focused DPC model, CMS could enter into arrangements with primary care practices under which CMS would pay these participating practices a fixed per beneficiary per month (PBPM) payment to cover the primary care services the practice would be expected to

furnish under the model, which may include office visits, certain office-based procedures, and other non-visit-based services covered under the Physician Fee Schedule, and flexibility in how otherwise billable services are delivered. In addition to the fixed revenue of the PBPM payment, practices could have the opportunity to earn performance-based incentives for total cost of care and quality. Finally, CMS could test ways to reduce administrative burden through innovative changes to claims submission processes for services included in the PBPM payment under these models.

Given the range of offerings already available to physicians and physician group practices in the Innovation Center's existing model portfolio, CMS is interested in stakeholder feedback regarding gaps that a potential DPC model (or models) could fill, as well as if there are parameters CMS could test to strengthen our existing initiatives.

QUESTIONS: Commenters are requested to provide responses to the following questions that are most relevant to their interest and experience. *A response to every question is not required for the comment(s) to be considered.* Additionally, commenters may identify and comment on other issues that they believe are significant for CMS to consider.

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?
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 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.
3. What support would physicians and/or practices need from CMS to participate in a DPC model (e.g., technical assistance around health IT implementation, administrative workflow support)? What types of data (e.g., claims data for items and services furnished by non-DPC practice providers and suppliers, financial feedback reports for DPC practices) would physicians and/or practices need and with what frequency, and to support which specific activities? What types of support would practices need to effectively understand and utilize this data? How should CMS consider and/or address the initial upfront investment that physicians and practices bear when joining a new initiative?

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?
5. CMS is also interested in understanding the experience of physicians and practices that are currently entirely dedicated to direct primary care and/or DPC-type arrangements. For purposes of this question, direct primary care arrangements may include those arrangements where physicians or practices contract directly with patients for primary care services, arrangements where practices contract with a payer for a fixed primary care payment, or other arrangements. Please share information about: how your practice defines direct primary care; whether your practice ever participated in Medicare; whether your practice ever participated in any fee-for-service payment arrangements with third-party payers; how you made the transition to solely direct contracting arrangements (if applicable); and key lessons learned in moving away from fee-for-service entirely (if applicable).

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?
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)?

8. The Medicare program, specifically Medicare Part B, has certain beneficiary cost-sharing requirements, including Part B premiums, a Part B deductible, and 20 percent coinsurance for most Part B services once the deductible is met. CMS understands that existing DPC arrangements outside the Medicare FFS program may include parameters such as no coinsurance or deductible for getting services from the DPC-participating practice or a fixed fee paid to the practice for primary care services. Given the existing structure of Medicare FFS, are these types of incentives necessary to test a DPC initiative? If so, how would they interact with Medicare supplemental (Medigap) or other supplemental coverage? Are there any other payment considerations or arrangements CMS should take into account?

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?
10. How could CMS structure the PBPM payment such that practices of varying sizes would be able to participate? What, if any, financial safeguards or protections should be offered to practices in cases where DPC-enrolled beneficiaries use a greater than anticipated intensity or volume of services either furnished by the practice itself or furnished by other health care providers?
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?

¹ The Current Procedural Terminology (CPT®) is a registered trademark of the American Medical Association (AMA).

12. What additional payment structures could be used that would benefit both physicians and beneficiaries?

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?
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?
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?

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

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?
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?
20. How can CMS protect beneficiaries from potential risks, such as identity theft, that could arise in association with a potential DPC model?

Questions Related to Existing ACO Initiatives

21. For stakeholders that have experience working with CMS as a participant in one of our ACO initiatives, how can we strengthen such initiatives to potentially attract more physician practices and/or enable a greater proportion of practices to accept two-sided financial risk? What additional waivers would be necessary (e.g., to facilitate more coordinated care in the right setting for a given patient or as a means of providing regulatory relief necessary for purposes of testing the model)? Are there refinements and/or additional provisions that CMS should consider adding to existing initiatives to address some of the goals of DPC, as described above?
22. Different types of ACOs (e.g., hospital-led versus physician-led) may face different challenges and have shown different levels of success in ACO initiatives to date. Would a DPC model help address certain physician practice-specific needs or would physician practices prefer refinements to existing ACO initiatives to better accommodate physician-led ACOs?

SPECIAL NOTE TO RESPONDENTS: Whenever possible, respondents are asked to draw their responses from objective, empirical, and actionable evidence and to cite this evidence within their responses.

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY. This RFI is issued solely for information and planning purposes; it does not constitute a Request for Proposal, application, or proposal abstract. This RFI does not commit the Government to contract for any supplies or services or make a grant award. Further, CMS is not seeking proposals through this RFI and will

not accept unsolicited proposals. Respondents are advised that the U.S. Government will not pay for any information or administrative costs incurred in response to this RFI; all costs associated with responding to this RFI will be solely at the interested party's expense. Not responding to this RFI does not preclude participation in any future procurement, if conducted. It is the responsibility of the potential respondents to monitor this RFI announcement for additional information pertaining to this request.

Please note that CMS will not respond to questions about the policy issues raised in this RFI. CMS may or may not choose to contact individual respondents. Such communications would only serve to further clarify written responses. Contractor support personnel may be used to review RFI responses.

Responses to this notice are not offers and cannot be accepted by the Government to form a binding contract or issue a grant. Information obtained as a result of this RFI may be used by the Government for program planning on a non-attribution basis. Respondents should not include any information that might be considered proprietary or confidential. This RFI should not be construed as a commitment or authorization to incur cost for which payment would be required or sought. All submissions become Government property and will not be returned. CMS may publically post the comments received, or a summary thereof.