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May 25, 2018

The Honorable Adam Boehler
Director
Center for Medicare and Medicaid Innovation
200 Independence Ave, SW
Washington, DC 20201

Via Electronic Submission: <https://innovation.cms.gov/Files/x/dpc-rfi.pdf>

Dear Director Boehler:

Thank you for the opportunity to provide feedback to the Center for Medicare and Medicaid Innovation (CMMI) on the Request for Information (RFI) on Direct Provider Contracting (DPC) Models. AARP, with its nearly 38 million members in all 50 States, the District of Columbia, and the U.S. territories, is a nonpartisan, nonprofit, nationwide organization that helps people turn their goals and dreams into real possibilities, strengthens communities and fights for the issues that matter most to families such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse.

We are committed to ensuring older Americans have affordable access to high-quality, high-value health care. In particular, we have worked to improve quality and cost in Medicare, and ensure the beneficiary's perspective is part of care delivery. As Medicare transitions towards greater use of alternative payment models (APMs), it is essential that the individual and family-caregiver perspective is incorporated into new models of care. How Medicare reimburses providers greatly impacts how care is delivered. Therefore, we respond to selected questions from the RFI to help guide your consideration of DPC models and ensure new models are truly person-centered.

In general, we emphasize that the DPC model should be a demonstration project from which CMMI can learn. We urge that any DPC model and demonstration project be small in scope and deliberately designed to test different concepts, rather than introduce permanent and wide-scale changes. Importantly, the DPC model should not replace or undermine the opportunity to evaluate and learn from other innovative models currently being tested, such as the Comprehensive Primary Care Plus program.

Because the DPC model described in the RFI is quite general, it is not possible to fully anticipate the ways it might potentially benefit or harm Medicare beneficiaries. We urge

CMMI to provide an opportunity for stakeholder feedback on specific DPC program design details, after a specific design has been developed.

Further discussion of these topics, and others, can be found in our response to the CMMI New Direction RFI in November 2017. We also encourage you to review the checklist developed by AARP: Consumer Protections in New Medicare Payment and Delivery Models.¹

Responses to the Request for Information

Question 6: Criteria for beneficiary participation in DPC models

We agree that Medicare beneficiaries should maintain their freedom of choice. Part of participating in the DPC model should be a clear understanding of what the model is, and how it is different from traditional fee-for-service. Moreover, participation in DPC models must be voluntary with affirmative consent, not automatic with opt-out. The burden should be on the provider to educate their patient about the specific features of the DCP model the provider is offering, including any financial implications for the provider and the patient. If providers engage with patients to explain the model, beneficiaries may feel more involved in their care and could hold providers more accountable for meeting expectations.

Finally, we strongly recommend requiring that if a provider offers participation in a DPC model to one person, then the provider must offer participation to all their Medicare patients. The provider should not be permitted to select among his or her patient population who will receive the DPC capitated payment. This beneficiary protection is important to ensure equitable access to the services offered in a provider's DPC model, and to prevent providers from potentially "cherry picking" patients for enrollment in its DCP model.

Question 7: Beneficiary outreach and enrollment in DPC models

A Medicare beneficiary should give affirmative consent to participate in the model, but no other formal agreement should be entered into. Receiving quality care should not be conditional. Again, the provider should be responsible for involving beneficiaries in their care and promoting beneficiary engagement. If providers are to receive a per-beneficiary per-month payment (PBPM) for taking care of the person, then part of that involves building relationships with the beneficiary and their family caregiver. Provider-person relationships should not be replaced with "agreements."

Providers must give patients clear information explaining how their DPC model works, including any cost-sharing or other costs that may affect patients, along with information about their rights as patients (e.g., the right to decline to participate, to drop out at a later date, to seek care from other providers, etc.) and about where they can get more information. Additionally, if DPC demonstrations allow for the use of incentives, such as

¹ <https://www.aarp.org/ppi/info-2017/consumer-protections-in-new-medicare-payment-and-delivery-models.html>

cash, to promote beneficiary engagement, then those incentives should be part of the research design. Use of incentives should be tested against a control, and engagement and outcomes should be measured for evaluation.

As noted above, AARP has published a checklist of consumer protections in new Medicare payment and delivery models. It discusses concrete steps CMS, plans, and providers can take to make it easier for consumers to engage in their care delivery. We urge CMS and the Innovation Center to implement the following recommendations:

- *Develop standard consumer communication templates for CMS and providers.* Templates should be developed jointly with focus groups and experts to include information about the model's design, how it affects consumers' cost and care, how it affects providers, and what are consumer rights and options.
- *Develop customized scripts for 1-800-MEDICARE.* These scripts would help ensure that consumers can access model-specific information from a widely known and trusted source.
- *Develop model-specific training for State Health Insurance Assistance Programs (SHIPs).* Trainings would capitalize on SHIPs valuable individualized services and their connections to state-specific resources.
- *Ensure meaningful consumer participation in model design, monitoring, and evaluation.* By building consumers' perspectives directly into new models and consulting regularly with consumers and providers, CMS can improve how models function for consumers.
- *Avoid unintended consequences of beneficiary incentives in model design.* Incentives that increase patient costs may drive them away from needed care.
- *Establish an independent ombudsman program.* Such a program or programs would assist with consumer issues and questions and help monitor model successes and challenges.
- *Publicize all audit and evaluation results and incoming data in a timely manner.* These transparent data would permit consumers, their families, and third parties to assess success and challenges with models, plans, and providers.
- *Share with consumers meaningful information about financial incentives included in model designs.* Understanding their providers' incentives will allow consumers to trust the model.

Question 8: Beneficiary cost-sharing in DPC models

AARP believes that there should not be any cost-sharing for per-beneficiary per-month payments (PBPM), and that beneficiaries should only pay cost-sharing for services they physically receive. It is unfair and confusing to beneficiaries to bill Medicare beneficiaries each month for *not* going to the doctor. The PBPM payment to providers is intended to enhance care and incentivize providers to reduce costs through coordination and efficient utilization, and is not meant to be an additional financial burden on individuals. Moreover, charging a copay or coinsurance discourages beneficiaries from participating in DPC

models, and would cause considerable confusion over bills for services they unknowingly received. Furthermore, as we elaborate in Question 12, in no way should a DPC model be used to allow for balance billing or private contracting with beneficiaries. The DPC demonstration is an opportunity to test capitated payments to providers – it should not be used as a way to shift higher costs onto beneficiaries.

Question 11: Provider financial risk in DPC models

CMS asked whether providers should be at risk for all or a portion of total cost of care for Medicare beneficiaries enrolled in their practice, including services beyond those covered by the monthly PBPM payment. At the start of a demonstration, AARP would support putting providers at two-sided risk for a certain percentage of the cost of Medicare services each provider delivers directly to a beneficiary. For example, a primary care provider might receive a specified percentage of the Medicare fee-schedule amount for services delivered directly plus an estimated payment of the balance as a PBPM amount. After gaining experience with this approach, assuming all goes well, the PBPM payment might be increased to cover a greater share, potentially up to 100%, of the expected cost of services delivered directly by each provider.

However, AARP would not support putting providers at risk for the entire cost of all services (Parts A, B, and D) rendered to an individual beneficiary indirectly by other providers. We are concerned that this type of approach to provider risk-bearing would create unduly strong incentives for providers to discourage beneficiaries from seeking needed care. In extreme cases, beneficiary access to timely and appropriate care could be seriously compromised.

Question 12: Additional payment structures

The Medicare program currently protects consumers with rules that limit how much physicians, and other health professionals who accept Medicare, can charge Medicare patients. These rules provide important financial protection for Medicare beneficiaries. AARP strongly opposes waiving these protections.

Two types of Medicare protections should be maintained: limits on balance billing and limits on private contracting.

Medicare's Limits on Balance Billing

The amount a Medicare beneficiary with traditional Medicare may have to pay for a physician's or other health professional's services depends on the provider's level of participation in the Medicare program. The vast majority of physicians – about 95 percent – are “participating providers,” which means they agree to accept Medicare's approved payment amounts as full payment for the Medicare-covered services they provide for all Medicare patients they see. Patients may be billed for any Medicare cost-sharing (such as deductibles, copayments, and co-insurance) that applies, but they cannot be balance-billed for additional charges.

A small proportion of physicians – about 4 percent – accept Medicare insurance but are “non-participating providers.” These providers are allowed to balance-bill patients, but by law the amount they balance-bill cannot exceed 15 percent of the Medicare-approved payment amounts for non-participating physicians (which are 95% of the amount for participating physicians). The Medicare beneficiary is responsible for paying the additional balance billing amount, along with any deductible and standard coinsurance amounts that may apply.

Medicare’s Limits on Private Contracting

Less than 1 percent of physicians choose to completely opt out of Medicare and instead have “private contracts” with Medicare beneficiaries. These doctors choose not to accept any payments from the Medicare program at all. Medicare beneficiaries who want to use these physicians’ services must agree to a “private contract” and pay all of the charges for contracted services

A key protection for beneficiaries is the requirement that physicians who enter into private contracts must do so for all Medicare beneficiaries they treat and for all Medicare-covered services; they may not pick and choose the patients or services for which they will bill Medicare. These rules prevent doctors from choosing patients based on the severity of their illness or other characteristics or charging different patients different amounts. These rules also reduce the likelihood of fraudulent billing, help maintain access to care for Medicare beneficiaries, and protect patients from high out-of-pocket costs.

Advocates of weakening Medicare’s balance billing and private contracting protections for consumers have suggested that these rules make it difficult for Medicare patients to find doctors who accept Medicare. Research, however, indicates that Medicare beneficiaries have good access to physician services – similar to, or better than, privately insured people ages 50–64. According to the Medicare Payment Advisory Commission, most Medicare beneficiaries report that they never have to wait longer than they want to get an appointment. In 2015, 82 percent of Medicare beneficiaries needing an appointment for illness or injury during the past 12 months reported that they never had to wait longer than they wanted, as did 72 percent of those seeking an appointment for routine care.

Further, while some people with Medicare, like some people with private insurance, do encounter difficulties obtaining physician services, allowing physicians to charge Medicare beneficiaries higher amounts in balance bills or through more private contracts will not solve these problems. As described above, almost all physicians see Medicare patients and accept Medicare insurance.

Medicare’s rules for balance billing and private contracting are important financial protections for Medicare beneficiaries. Half of all beneficiaries in traditional Medicare already spend about 18 percent of their income on premiums and other medical expenses. Without Medicare’s consumer protections, Medicare beneficiaries would face higher out-of-pocket costs from balance billing and private contracts. Higher payments would be difficult

for many beneficiaries to absorb. Higher payments would also likely lead to more limited access to physicians for many beneficiaries, as well as greater financial distress, especially for people with high health care needs. Patients would experience considerable uncertainty about how much services would cost, which could cause some to forego necessary care, and others to incur unexpected, unaffordable out-of-pocket costs.

Question 13: Data reporting of DPC models

As with any demonstration project, it is imperative that data and information be collected in order to evaluate the model’s effectiveness at reducing spending and/or improving care. We urge that CMMI not lessen reporting requirements or weaken quality measurement. In fact, DPC models may even provide a unique opportunity to enhance and expand the collection of patient-reported measures due to the defined beneficiary populations linked to particular providers or models.

Question 16: Beneficiary quality of care safeguards

As with any bundled payment or capitated payment model, AARP is concerned that receiving a lump sum for total services provided may encourage some providers to stint on care in order to produce greater savings. We urge CMMI to develop a dedicated hotline, appeals process, and ombudsman so that Medicare beneficiaries and their family-caregivers have recourse to deal with problems in care delivery.

Question 18: Beneficiary access protections

AARP shares your concern that providers may “cherry pick” healthy beneficiaries and “lemon drop” complex or high-risk beneficiaries in order to improve their financial margins and quality scores. We recommend risk adjusting the PBPM payment for patients with multiple chronic conditions. We also urge CMMI to require that providers who offer participation in a DPC model to one Medicare beneficiary must offer it to all Medicare beneficiaries (as we discuss under Question 6 above). CMMI should monitor providers’ enrollment patterns to ensure that those beneficiaries who participate in their DPC model reflect the provider’s patient population.

Thank you for the opportunity to provide a consumer and family-caregiver perspective as you consider new payment models. If you have any questions, please contact me or have your staff contact Andrew Scholnick of our Government Affairs team at ascholnick@aarp.org or 202-434-3770.

Sincerely,



David Certner
Legislative Counsel and Policy Director