May 31, 2018

Submitted via email to DPC@cms.hhs.gov

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Center for Medicare and Medicaid Innovation
7500 Security Boulevard
Baltimore, MD
21244-1850

RE: Request for Information on Direct Provider Contracting Models

To whom it may concern,

The American Benefits Council ("the Council") applauds the Centers for Medicare and Medicaid Innovation for requesting comments about direct provider contracting to inform potential testing of this approach within Medicare-fee-for-service, Medicare Advantage, and Medicaid. Large employers have been leading the way to greater health care innovation for decades and this letter shares the experiences of employers that have implemented direct provider contracting. Innovative employers can attest to the potential of direct provider contracting models to reduce expenditures and preserve or enhance the quality of care. We hope this information will be valuable in ensuring coordination among providers, employers, and the federal government, and improving health care delivery, experience and accountability for all.

The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council's members either sponsor directly or provide services to retirement and health plans that cover more than 100 million Americans.

According to the U.S. Census Bureau, more than 178 million Americans currently have employer-sponsored health coverage[1] – over half of all Americans. On average,

[1] Health Insurance Coverage in the United States 2016, United States Census Bureau, 2017.

employers pay 82 percent of the cost of coverage.[2] This is a value for employers, employees, the federal government and taxpayers. In fact, when we compared the total amount employers paid for group health insurance in 2016 ($691.3 billion) to the value of the tax expenditure that same year ($155.3 billion), we found that employees received $4.45 worth of benefits for every $1 of forgone tax revenue. In other words, for every $1 of tax expenditure employers spent $4.45 to finance health benefits.[3]

Employers, like other health care purchasers, have been plagued by ever-increasing health care costs. Frustrated by paying for the volume of health services delivered rather than the value received, and by the uncoordinated and fragmented care their workers receive, employers are taking meaningful action to transform the health care system. This is the message of **Leading the Way: Employer Innovations in Health Coverage**, a recent report from the Council and Mercer. Employers have pioneered strategies that directly address the biggest cost drivers in the US health care system: the relatively small number of high-cost claims that drive such a large percentage of spending, increasing unit prices resulting from marketplace consolidation, misplaced incentives, waste, inefficiency, uneven quality of care and lack of transparency. These appear to be the very problems CMMI is also working to solve. Employer innovations can lead the way to greater value in health care spending by the private sector and government alike.

Our response is centered on the theme of how private sector innovations can be deployed to modernize Medicare and Medicaid, creating efficiencies and economies of scale that also help employers. Many of these employer innovations have met with startling success and — if scaled and encouraged — have the potential to improve the health care system as a whole. The ability to achieve large-scale improvements to our health care system exponentially increases when private sector employers are working hand in glove with policy makers and public payers (like Medicare, Medicaid, State Employee Health Plans, the Office of Personnel Management/Federal Employee Health Benefits Program and the exchanges) to implement these innovations. We hope this focus on private sector innovations will help expedite larger-scale success.

The following is a brief summary of employers featured in our report, *Leading the Way: Employer Innovations in Health Coverage*, that have implemented direct provider contracting as well as answers to select questions posed in the RFI.

CHANGING THE WAY PROVIDERS ARE PAID TO ACHIEVE LOWER COST, BETTER VALUE

Intel contracted with health systems in key markets to create accountable care

[2] Employer Health Benefits 2017 Annual Survey, The Kaiser Family Foundation and Health Research & Educational Trust, September 2017.
[3] From the forthcoming publication, American Benefits Legacy: The Unique Value of Employer-Sponsored Benefits, American Benefits Council, 2018

organizations in which payment reflects performance on cost, quality and patient experience measures. With an emphasis on care coordination, **the Connected Care program is achieving higher member satisfaction, lower cost trend and overall lower spending per member.**

ARLP is combating opaque pricing and inconsistent care by partnering with facilities that have proven track records in performing services for contracted prices. For example, **an outpatient facility will perform a knee replacement for $27,000, whereas a local hospital might charge $87,000.** ARLP pays members' travel expenses.

The Alliance (a not-for-profit employer-owned cooperative) steers members to centers of excellence and high-performance networks by offering an optional richer benefit and a patient experience manager to assist with the process. Providers meet quality criteria and are reimbursed using prospective payment bundles. **Savings have been significant — on average, $12,000 for a joint replacement surgery and 20% for imaging.**

SUPPORTING EMPLOYEES IN NAVIGATING THE HEALTH SYSTEM

Walgreens shifted the burden of finding quality, cost-effective providers from plan members to care coordinators within the health plan. These coordinators discuss options and costs with members, who can earn cash incentives to choose lower-cost providers. The health plan is incentivized as well, with a percentage of savings relative to market trend. **The program expected to save 4% of total medical claims.**

Boeing takes an active role in designing coverage options that bend the health care cost curve and meet the needs of their diverse population, such as through direct contracting with provider systems, bundled payment arrangements, and first-in-class wellness programs. Over the last decade, Boeing invested in innovative preferred provider partnerships that focus on delivering coordinated, high quality and intensive primary care. The success of those partnerships is measured through improved clinical and member satisfaction outcomes as well as shared savings with their partners. Boeing now has four Preferred Partnerships in Seattle, Southern California, St. Louis, and Charleston, functioning like Accountable Care Organizations (ACOs). Over the last several years, Boeing has seen improvement in the health of employees who elect one of their Preferred Partnerships, including a significant change in depression screenings and better control of blood pressure and diabetes. In addition, employees like the customer-focus these programs bring to their health care experience, and re-enroll at high rates.

In areas where the market is not conducive to certain preferred provider partnerships, such as an ACO, Boeing is bringing the same focus on quality, coordinated primary care by investing in direct primary care (DPC) arrangements.

Boeing hopes to leverage the power of DPC to intensify their focus on population health and disease prevention, contracting with providers proven to improve outcomes and rein in costs. In April of this year, Boeing began a partnership with Iora Health in Mesa, Arizona to provide high-impact, relationship-based primary care to local employees, their families and early-retirees. For employees that opt-into the DPC arrangement, Boeing pays a monthly fee for unlimited access to primary care and prevention services. Through the elimination of fee-for-service (FFS) billing, Iora and other DPC groups can focus on patient outcomes and satisfaction, reversing incentives that reward volume over value. This enables Iora to focus on investments that drive better results – such as health coaches that help guide patients towards healthier habits, morning huddles that engage the entire care team in discussing the health status of the clinic's population, social work and behavioral health integration, and innovative information technology platforms that enable the patient access to their medical information and contact with a provider in a moment's notice.

The Iora model has produced meaningful results in the management of chronic conditions. For example, an unpublished Iora study found that inpatient hospital admissions among a cohort of 1,176 Iora Medicare enrollees over an 18-month period decreased by 50%, emergency department visits decreased by 20%, and the total medical spend declined by 12% — this despite the cohort being sicker than average Medicare patients.[4] Satisfaction with Iora practices is also high, receiving a Net Promoter Score (NPS) of 93 on a -100 to 100 scale as part of one DPC employer partnership, when the average NPS for primary care in the U.S. is 4.[5] [6]

IMPROVING EMPLOYEE HEALTH WITH TARGETED PROGRAMS

A tech company found that users of infertility services incurred far higher maternity and newborn claims. By carving out infertility services to a specialty program, **the rate of multiple births from IVF has dropped to less than 3%, whereas the national average is 22%.** The cost for a multiple birth averages about $145,000, compared to about $17,000 for a single birth. User satisfaction is very high.

SPECIFIC QUESTIONS AND ANSWERS FROM THE RFI

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,

[4] https://hbr.org/2017/10/the-innovation-health-care-really-needs-help-people-manage-their-own-health
[5] http://www.iorahealth.com/wp-content/uploads/2014/08/Dartmouth-Case-Study.pdf
[6] http://www.iorahealth.com/real-results/

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?

Patient choice is a critical element in ensuring beneficiaries are an active partner in managing their health care. Employers aim to empower employees with information about price, access, and availability of services to ensure they are fully involved in making their own medical and financial choices. High employee satisfaction in direct contracting plans generally results in high re-enrollment and year-over-year growth in enrollment. An upfront investment in innovative models such as direct primary care, however, is often necessary before achieving a return on investment. Thus, employers with high rates of retention are particularly well-suited for these types of models as employees enrolled in these arrangements are more likely to benefit from the health improvement and cost savings over time. CMMI would be similarly well-positioned to benefit from upfront investments in DPC arrangements for the longer-term health of their managed population.

For one large employer, ACO member enrollment is based on an annual enrollment period, where mid-year changes are allowable only for certain qualifying events as permitted under federal regulations. The ACO provider entities are responsible for the total cost of care for a beneficiary, even when they go out of network. Out of network services incur 40 percent cost-sharing, and reimbursement limits may apply. At no point in time can the ACO provider refuse to enroll or disenroll a beneficiary. Employers work closely with the ACO provider entities to encourage high-touch engagement for ACO members through dedicated teams, websites, provider search tools, onsite events, all aimed at helping members find an in network ACO provider. It is up to the ACO provider teams to reach out to members seeking care outside of the ACO network and is in their best interest as they are held accountable to the overall cost for these members.

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)?

One employer who has adopted DPC aims to provide their employees with consistent communication regarding their enrollment choices, and incentivizes enrollment in direct contracting models by providing coverage not subject to a deductible or other out of pocket costs. Enrollment for this plan is driven by word-of-mouth from employees who have had positive experiences. For example, employees may be driven to DPC arrangements because they are more convenient and user-friendly. The relationship-based model includes increased time spent with the physician, conversations surrounding long-term health and wellbeing, as well as logistical benefits such as extended hours, ready access to urgent care, and access to collaborative care platforms that allow patients access to medical records.

Another large employer uses three tactics to attract employees to pick the ACO plan. First, the employer makes Health Savings Account contributions for new ACO enrollees, with the highest incentive in year one and a reduced incentive in years two and three (first year: $1,000 family, $500 individual; second year: $500 family, $250 individual). Second, this employer also offers lower cost sharing in the ACO, including lower deductibles and out-of-pocket maximums compared to other plans. Third, the ACO benefit design is richer, for example certain medications for management of chronic conditions and depression are covered at no cost. Additionally, all ACOs are required to adhere to various interoperability requirements to ensure providers and patients have the most up-to-date health information to best manage their care needs. Part of the interoperability requirement is offering patient portals to members that include their medical record information. Feedback is provided through the CMS required patient surveys, and ACOs use data on the ACO population as baseline and are held accountable to continuously improve outcomes. Currently, this ACO program has a 94.5% retention rate.

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?**

Lowering or eliminating cost-sharing for high-value services (e.g. covering the monthly fees for access to direct primary care arrangements) is an important driver to incentivize beneficiaries. In particular, providing high-value services below any deductible can ensure that members access critical primary and preventive care, leading to decreased costs down the line such as reduced hospitalizations and emergency room visits. Since inception of DPC in 2004, studies have demonstrated outcomes including high patient satisfaction, reduced costs, and decreased hospital admissions.[7] [8] [9] Others have shown cost reduction potential of up to 20%[10] and reduction in inpatient hospital admissions of 37%.[11] Additionally, replacing fee-for-service with a flat fee that covers comprehensive primary care services reverses the incentives that reward volume over value and undermine the patient-provider relationship.

As mentioned in answering question 7 above, using the benefit design to steer patients into the ACO is an important element to increase enrollment. In addition, some large employers emphasize the importance of primary care by promoting annual wellness exams covered at 100%. All ACO models used by one employer are also required to provide a Patient Centered Medical Home approach to primary care, allowing for quicker access, high quality, and a personalized patient-centered experience. So far, compared to the other plans offered to employees, the ACO plans are delivering more efficient care than national plans, with an overall lower total cost per member (especially higher risk members) while achieving better health outcomes and higher member satisfaction -- clearly a win.

One barrier employers face in implementing these types of programs on a broader scale is that for many employers high deductible health plans coupled with Health Savings Account are the most popular plan choices elected by employees. This limits value-based design opportunities because employees must meet their full deductible before the plan may cover many high-value services. This is an area where policy changes around what is subjected to the deductible would be helpful by allowing more flexibility to drive high-value services. For example, some employers might want to cover primary care services pre-deductible to help further incent members to visit their primary care providers. Other employers might want to offer telemedicine pre-deductible with zero cost-sharing as a way to steer employees to this high-value provider – while charging a higher copay to go to an urgent care facility or an even higher copay for non-emergent use of emergency rooms.

Questions Related to Payment

[7] https://hbr.org/2017/10/the-innovation-health-care-really-needs-help-people-manage-their-own-health

[8] http://www.iorahealth.com/wp-content/uploads/2014/08/Dartmouth-Case-Study.pdf

[9] http://www.apg.org/modules/showdocument.aspx?documentid=4133

[10] Journal American Board of Family Medicine , Nov. 2015

[11] Iora Health Claims Database 2009 - 2016

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?

PBPM payments must adequately allow for appropriately sized patient panels to support the elevated level of care while also ensuring that DPC providers have the appropriate financial incentive to deliver high-quality care and strengthen the doctor-patient relationship.

One large employer partners with delivery systems not individual practices. The delivery system determines how individual practices share in upside and downside risk. For delivery system contracting, this employer has found that most require at least 3000 lives before financial arrangements apply.

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?

Risk-based arrangements are a critical component in successful direct contracting. Building in patient care metrics (even those that may not be linked to cost savings), such as patient satisfaction metrics or valuable health outcomes is important. For example, if a program has a focus on providing increased access to mental health care, this may include metrics around mental health screenings and access to virtual behavioral health care services.

To better align risk and rewards with desired outcomes, one large employer utilizes a value-based compensation structure that includes both shared costs and pay-for-performance and addresses both cost and qualitative factors. This compensation system is based on a global per-member per-month target, with a shared-savings "corridor". The employer and the delivery system partners share risks and rewards if results exceed or fall short of designated target.

Below is an example of how one large employer, Intel, has structured their value-based payment model as well as examples of the quality measures Intel utilizes.

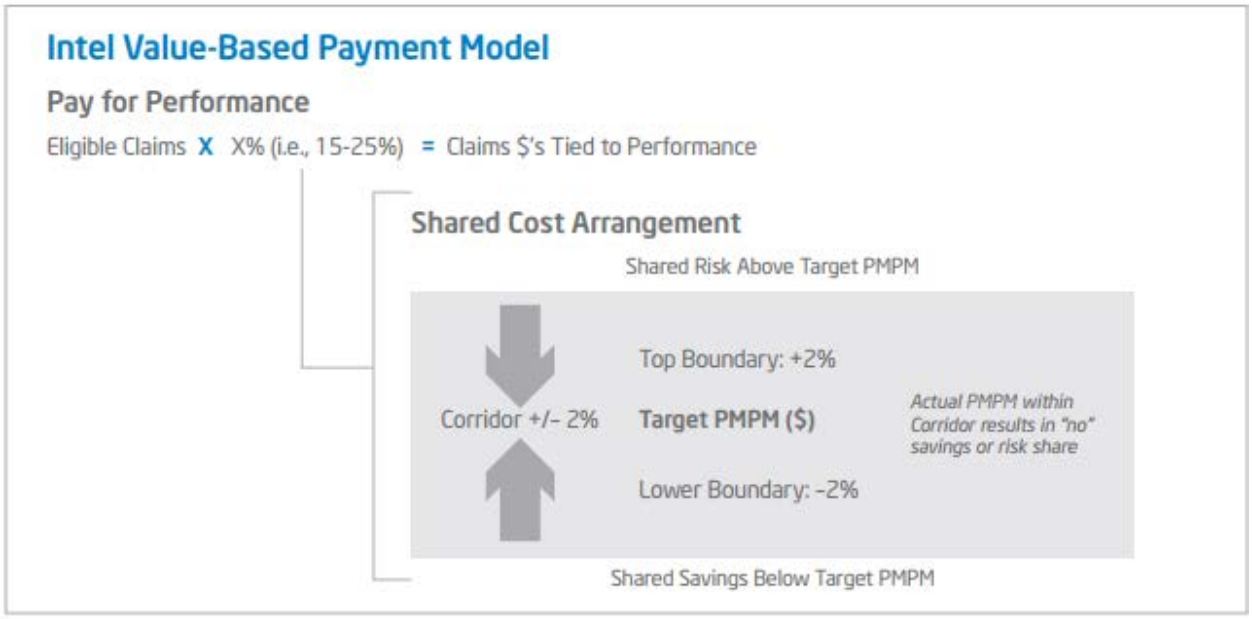

Figure 1. Value-Based Payment Model.

Table 4. Connected Care Sample Measures

Category	Measure	Description
Evidence-based medicine	Diabetes management	Percent of diabetic members attaining hemoglobin A1C level less than 8.0%, LDL level less than 100 mg/dL, and blood pressure less than 140/90 mmHg.
	Depression screening	Percent of adult members completing the depression screening when seen in a PCMH.
Right time, right setting	Nurse call response time	Percent of time nurses return symptom-related calls when requested within four business hours. Calls with urgent symptoms are transferred per protocol with a warm handoff immediately.
Member experience	Patient satisfaction with experience	Overall rating of PMG patient satisfaction using survey question: "Would you recommend?"

The delivery system's bundles vary depending on capability – some delivery systems bring fully integrated solutions; others have carve-out components such as pharmacy benefit managers and third-party administrators. For this employer, behavioral health is carved-in to all delivery systems.

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

Value-Based Insurance Design (VBID) is increasingly used in the commercial market, and evidence suggests that the inclusion of clinically-nuanced VBID elements in health insurance benefit design may be an effective tool to improve the quality and reduce the cost of care for enrollees with chronic diseases. Structuring payments to encourage enrollees to consume high-value clinical services that have the greatest potential to positively impact enrollee health is a core component of a successful approach to population health. In this vein, VBID is aligned with the goals of direct provider contracting such as DPC, which provides access to high-value primary and preventive care.

One employer's ACO model includes upside and downside risk agreements and shared incentives for both the provider and the employer. For example, if the ACO improves health quality outcomes, member experience, and reduces costs they receive a bonus (win), the employer's population got healthier with improved experience and cost reduction (win). ACO provider entities have shared the value that comes when having a direct relationship with a purchaser/employer who is asking for the right improvements: quicker results, pilots to test innovative solutions, leveraging the relationship to grow business strategy in employer-led health care initiatives, etc.

Questions Related to General Model Design

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?

Meaningful and uniform quality measures are at the foundation of value-based purchasing decisions. As more large employers implement innovative payment reforms, like direct contracting or creating an accountable care organization, it would be incredibly helpful to have a uniform set of standardized quality measures. This helps achieve two policy goals:

First, standardized quality measures make it easier for providers participating in new payment programs to have one uniform set of measures on which to report. Some physicians have lamented being required to measure blood pressure three different ways for three different Medicare programs (measured one way for ACOs, another way

for patient centered medical homes, and yet another way for certain bundled payment programs). Providers are already being pulled in many different directions and are pressed for time, policymakers could ease the workload while at the same time improving quality by implementing a standardized measure set.

In addition, standardized quality measures make it easier for patients and employers to identify high performing providers. If every program and provider necessitates its own set of measures, it quickly becomes impossible to compare providers. A uniform measure set -- at a minimum uniform across all Medicare payment programs and demonstrations – would help lay a strong foundation to achieving more meaningful payment reforms. Uniformity in quality measures is essential. However, uniformity alone will not empower consumers to make smart health care decisions. Such measures must also be meaningful to import value-based decisions into the health care system.

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?

One model CMS should consider is a primary care-focused DPC model, which would allow CMS to enter into arrangements with primary care practices under which CMS would pay a fixed PBPM payment to cover primary care services and include flexibility in how otherwise billable services are delivered along with performance-based incentives for total cost of care and quality. Coordinated primary care is a foundation of a strong population health strategy. Investing in robust, patient-centered and relationship-based primary care on the front end will return the investment in the form of reduced cost, increased patient health and satisfaction, and increased employee productivity. This model also reduces administrative burden by extricating these arrangements from the transactional, fee-for-service system which focuses more on documentation and billing than patient care. CMMI's Comprehensive Primary Care Plus (CPC+) Model could potentially be restructured to match or incorporate a primary-care DPC model in which practices are paid PBPM, and there may be potential to include elements of primary-care focused DPC as a part of existing ACO initiatives.

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?

The success of this program will in many ways hinge on whether the correct quality measures are built into the program. If quality is being measured appropriately, that should incentivize the providers to provide the right care at the right time at the right place for the right patient.

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Employers have a vested interest in securing the health and well-being of their workers. They recognize that helping their employees thrive has a measurable impact on virtually every aspect of their business. That's why they invest in innovative strategies to provide their employees with effective and sustainable health benefit programs. Employers continue to innovate and find ways to incentivize the right care provided at the right time in the right place. Yet, the ability to transform the health care system as a whole will exponentially increase if commercial plans and the federal government work together to implement effective payment models.

Please let us know how we can be helpful as this initiative advances.

Sincerely,

Ilyse Schuman

Senior Vice President
Health Policy