



Center for Medicare and Medicaid Innovation

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

Agency/Office: Department of Health and Human Services
Centers for Medicare & Medicaid Services
Center for Medicare and Medicaid Innovation

Type of Notice: Request for Information (RFI)

SUMMARY: The Centers for Medicare & Medicaid Services (CMS) recently announced Direct Contracting (DC), which seeks to improve quality of care and health outcomes for Medicare Fee-for-Service (FFS) beneficiaries, reduce Medicare expenditures through the alignment of financial incentives, and focus on patient choice and care delivery while maintaining access to care for beneficiaries, including complex, chronic and seriously ill populations. DC includes three payment model options for entering into risk-sharing arrangements with CMS. In an effort to further refine one DC payment model option—the Geographic Population-Based Payment (PBP) model option—CMS is now seeking additional input from the public regarding their perspectives on specific design parameters for the Geographic PBP model option.

DATES: *Comment Date:* To be assured consideration, comments must be received by Thursday, May 23, 2019 at 11:59 pm EST.

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

FOR FURTHER INFORMATION CONTACT: DPC@cms.hhs.gov with “Geographic PBP 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 with regards to the design of the Geographic PBP model option of DC.

BACKGROUND: Section 1115A of the Social Security Act created the Center for Medicare and Medicaid Innovation (the “CMS Innovation Center”) 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 Children’s Health Insurance Program (CHIP) beneficiaries.

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

Direct Contracting (DC) creates a new opportunity for CMS to test an evolution of risk-sharing arrangements, leveraging lessons from the Next Generation Accountable Care Organization (NGACO) Model, Medicare Advantage (MA), and certain private sector approaches. DC is part of CMS's strategy to redesign primary care as a pathway to drive broader delivery system reform. Through DC, the CMS Innovation Center plans to test two voluntary risk-sharing payment model options, as well as a third payment model option for which we are seeking additional input: 1) Global PBP that will build on existing NGACO features to offer cash flow selections similar to those found in private sector arrangements between private payers and capitated provider organizations; 2) Professional PBP, a lower-risk payment model option that will provide a capitated payment for enhanced primary care services; and 3) Geographic PBP, for which we are seeking public input, that would offer an opportunity to take total cost of care (TCOC) risk for all Medicare FFS beneficiaries in a defined target region. DC is intended to test whether these risk-based care and payment model structures align financial incentives and offer participants (hereinafter referred to as DC entities (DCEs)) flexibility in engaging healthcare providers and beneficiaries in ways that reduce expenditures and TCOC, and preserve or enhance quality of care for beneficiaries.

CMS sought broad stakeholder input to develop DC, including through the Direct Provider Contracting Model Request for Information (RFI)¹, a Direct Contracting Roundtable, and meetings and external speaking engagements with coalitions representing ACOs, full risk provider organizations, and other stakeholders. DC is intended to be responsive to concerns previously expressed by stakeholders that current risk-based initiatives available through Medicare FFS and the CMS Innovation Center do not borrow sufficiently from private sector approaches, and that they lack access to a true population-based payment structure to drive broad transformation. Stakeholders were also interested in taking on risk for a broad population of beneficiaries defined geographically.

CMS seeks responses to this RFI from beneficiaries and caregivers, beneficiary advocacy groups, primary care and specialty providers, healthcare organizations, 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.

¹ Direct Provider Contracting RFI is located at: <https://innovation.cms.gov/Files/x/dpc-rfi.pdf>

REQUEST FOR INFORMATION: Direct Contracting—Geographic Population-Based Payment Model Option

The Geographic PBP model option would offer entities an opportunity to assume TCOC risk for Medicare FFS beneficiaries in a defined target region. For the first performance year we expect to limit participation to four target regions.

An applicant for the Geographic PBP model option may be a healthcare organization consisting of a direct or affiliated network of healthcare providers, a health plan, or other type of organization that has formal partnerships or other contractual relationships with Medicare-enrolled providers or suppliers in the target region. Under the current model design, each DCE selected for the Geographic PBP model option would be at full risk for the TCOC for Medicare FFS beneficiaries in the target region. Target region, for the purposes of the Geographic PBP model option, means a CMS-approved geographic area that forms the basis for determining which beneficiaries are aligned to a DCE through a geographic alignment methodology. CMS intends to allow an applicant to propose a target region for CMS approval, subject to certain requirements, including but not limited to that the target region must have a minimum of 75,000 Medicare beneficiaries residing within the target region, yield or exceed minimum savings targets in the form of a discount which we currently contemplate would be on the order of 3-5%, align with administrative (e.g., city, county) and/or statistical (e.g., MSA) geographic units, and factor in the natural boundaries of the target region and health care seeking patterns of the Medicare FFS population within that region.

Under the current model design, a DCE's TCOC accountability would be calculated based on the historical Medicare Parts A and B per capita spending in the target region. CMS would determine the Geographic PBP benchmark by calculating these historical expenditures for geographically aligned beneficiaries during a baseline period; trending these historical expenditures forward to the performance year; applying a geographic adjustment factor; and discounting the benchmark.

CMS would select one or more DCEs per target region, favoring target regions with at least two DCEs to encourage competition. Geographic PBP DCEs would be paid on a capitated basis with the option for the DCE to contract with healthcare providers and pay these providers directly for any services used by aligned beneficiaries in the target region. For other healthcare providers in the target area that do not contract with the DCE, CMS would continue to make FFS payments with those payments reconciled against the DCE's benchmark. Alternatively, while the DCE would remain at full financial risk, the DCE could opt to continue having CMS make FFS claims payments to all healthcare providers in the target region (including healthcare providers with contractual arrangements with the DCE). Under this approach, performance year expenditures would be reconciled against the benchmark as part of final settlement with the DCE. DCEs would be given access to a "notional" account to track these expenditures.

CMS's criteria for the selection of DCEs for the Geographic PBP model option would include, but not be limited to:

- Whether the applicant has a historical presence in the target region as demonstrated by (1) overlap of its health insurance coverage service area with the target region (in the case where the applicant is a health plan); (2) overlap of its direct or affiliated provider network with the target region; and/or (3) contractual relationships with organizations described in (1) and (2).
- Whether the applicant has core competencies in developing and implementing value-based payment approaches and methodologies for healthcare providers (e.g., managing financial risk, either directly or as demonstrated through contractual arrangements with organizations with such experience); implementing complex, multi-stakeholder initiatives (e.g., across healthcare provider, health plan and community stakeholders); and utilizing protected health information to drive towards improved health outcomes.
- Whether the applicant has the ability to perform ongoing data collection, analysis and reporting to support quality improvement and decrease healthcare costs.
- Whether the applicant has the capacity to provide strategic and operational direction and technical assistance to healthcare providers to support health care delivery transformation.
- Whether the applicant has the capacity to manage risk, including being able to demonstrate that it can provide financial guarantees and make repayments to CMS for any financial losses incurred.
- If the applicant is proposing to process claims or otherwise pay contracted healthcare providers, the type and level of experience it has performing this function.
- Whether the applicant's proposed discount meets or exceeds the minimum discount range.
- The potential for savings to CMS, either as absolute savings or through a reduction in cost-growth.
- The size of the applicant's proposed target region and geographically aligned Medicare FFS population.
- The strength of the applicant's strategy for leveraging current CMS models or programs and existing and/or planned delivery system transformation efforts within the target region to support DC success.
- 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.
- The applicant's selection of quality measures and quality improvement goals.
- Relevant experience of the applicant, taking into account formal partnerships or other contractual relationships with healthcare providers or other organizations that have experience in risk-sharing arrangements.

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. Furthermore, DCEs would be required to adhere to certain transparency/notification requirements such as informing beneficiaries when they have been aligned to the DCE, what alignment means in terms of the care that they will receive, and how to opt-out of CMS sharing certain information about them with the DCE.

The purpose of this RFI is to seek further input on the Geographic PBP model option. Specifically, we seek input on the criteria CMS should consider for selecting DCEs, including feedback on the above criteria under consideration; selection criteria for target regions; the types of entities that might be interested in participating as DCEs in the Geographic PBP model option; potential conflicts of interest that might arise and how they might be resolved; beneficiary protection considerations; payment methodology parameters; and general model design questions.

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 with regards to the Geographic PBP model option of DC.

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?
2. Given the geographic basis for the design of the Geographic PBP model option, the evaluation will need to construct a comparison group from areas outside of the payment model option's target regions. While we anticipate there would be ample geographic areas not included as target regions in the Geographic PBP model option, we are seeking input on considerations that CMS should weigh to best identify a comparison group for this payment model option. Additionally, the selection of a target region itself (size, location) could impact the extent to which evaluation results would be representative of the broader Medicare population. Given the unique design of the payment model option relative to prior CMS Innovation Center models, what special evaluation considerations might CMS consider for this payment model option?

Questions Related to Selection of Target Regions

1. What criteria should be considered for selecting the target regions where the Geographic PBP model option would be implemented? For example, are there attributes of target regions, such as low penetration of advanced alternative payment models or higher healthcare costs than the national average, which CMS should consider in selecting target regions for the Geographic PBP model option? What impact would this have on competition in target regions where the Geographic PBP model option is ultimately implemented?

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?

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?
2. What types of entities might participate in the Geographic PBP model option that have not participated in CMS Innovation Center models or other Advanced Alternative Payment Models offered by CMS, such as the Medicare Shared Savings Program, to date? What conflicts of interest issues might arise and how should CMS and/or the DCE address them?
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? Which authorities would States need in order to implement similar risk arrangements in their Medicaid programs? What supports or technical assistance would States need from CMS to establish risk arrangements in Medicaid?

Questions Related to Beneficiary Alignment

1. CMS currently plans to select target regions with at least two DCEs to encourage competition. In the event that there are two or more DCEs in a given target region, we are considering either randomly aligning beneficiaries in the target region to one of the DCEs or allowing beneficiaries in the target region to voluntarily align themselves to a specific DCE. One potential benefit of a random alignment approach is that it could help to reduce reliance on risk adjustment, which is intended to account for differences in health risk in a given population. Where risk is taken on a large population basis, such as in the Geographic PBP model option, we would expect risk to be evenly distributed, making risk adjustment less necessary to account for differences, particularly if beneficiaries are aligned on a randomized basis as between DCEs operating in the same target region. Notwithstanding this interest, we seek information on what alternative alignment methodologies CMS might consider and the relative pros and cons of alternative approaches for beneficiaries and for DCEs operating in the same target region. Are there hybrid approaches to consider? For example, would stratified randomization of the beneficiary's residence be a preferable approach to complete randomization? What

implications would either stratified randomization or allowing for voluntary alignment have on risk adjustment considerations?

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?
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?

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?
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?
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?

Questions Related to Payment

1. CMS would calculate the historical TCOC for a geographically aligned population in order to set the spending target for the DCE, also known as the benchmark. We are interested in feedback regarding adjustments we should consider in calculating the benchmark for the performance year, such as the use of the U.S. Per Capita Cost national trend, other trend factors or specific geographic adjustments.
2. Additionally, we envision applicants will propose a discount to the benchmark for the geographically aligned population. We seek comment on the range of discounts we might expect applicants to propose and why (e.g., by analogy or reference to other experiences). How might we think about requiring applicants to structure these proposed discounts over the life of the model?
3. We are interested in feedback on the payment methods available to DCEs in the Geographic PBP model option. In particular, we would like feedback on the “notional”

account policy, described above, under which DCEs could select to have CMS continue to make FFS claims payments to all healthcare providers in the region. These FFS claims payments would be reconciled against the DCE's benchmark as part of final settlement.

4. Should DCEs' benchmarks include accountability for Part D drug costs? What opportunities and challenges might this provide to entities participating in the Geographic PBP model option? Are there other approaches to control prescription drug costs that we should consider short of incorporating Part D costs into DCEs' benchmarks?
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?
6. How should CMS address utilization of services and costs for beneficiaries aligned to a DCE that occur outside of the DCE's target region?

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 or cooperative agreement 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 or initiative, 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 RFI 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.