September 8, 2021

Ms. Elizabeth Fowler, Ph.D., J.D.
Deputy Administrator and Director
Center for Medicare and Medicaid Innovation
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence, Avenue SW
Washington, DC 20201

RE: CMS Innovation Center Direct Contracting Entity Models

Dear Dr. Fowler:

We are writing today on behalf of member organizations of AHIP, the Association for Community Affiliated Plans (ACAP), the Alliance for Community Health Plans (ACHP), the National MLTSS Health Plan Association, and the SNP Alliance. Together, these five organizations represent virtually all of the managed care organizations that serve nearly 27 million Medicare Advantage (MA) enrollees, including 3.6 million individuals dually eligible for Medicare and Medicaid ("dual eligibles") enrolled in MA plans specially designed for their needs (known as Dual Eligible Special Needs Plans or D-SNPs); 407,539 enrollees in Financial Alignment Demonstration Medicare-Medicaid plans (MMPs); and more than 56 million Medicaid managed care enrollees in the United States.

We are all aligned with the Center for Medicare and Medicaid Innovation's ("Innovation Center") goal of transforming care delivery and moving away from paying for volume toward paying for value. As the Innovation Center considers its path forward for the Direct Contracting (DC) demonstration, we urge it to build off the successes of the aforementioned plans and rely on the deep experience of these organizations to expand access to high-value care to millions of seniors, people with disabilities, and low-income and vulnerable populations within the traditional Medicare program. MA plans, D-SNPs, Medicaid managed care plans, and integrated Medicare-Medicaid plans continue to demonstrate how health insurance providers bring real value to patients, states, and the Centers for Medicare & Medicaid Services (CMS) through their own quality improvement efforts and partnerships with providers. Moreover, CMS and states hold MA

and Medicaid plans to strict standards for care coordination, member protections, nondiscrimination, network adequacy, care model design, and program integrity, all of which support integrated managed care as the preferred and tested vehicle for serving dual eligibles.

Dual eligibles enrolled in MA reported better access to health care and telehealth services during the COVID-19 pandemic, despite tending to be older, sicker, and more racially and ethnically diverse than their dual eligible counterparts in the traditional fee-for-service (FFS) Medicare program.[1] At the same time, MA plans are working with their provider partners to fundamentally change the way care is provided and reimbursed to reward high-quality, low-cost care rather than the volume of services: Over half (53.6%) of health care payments from MA plans were tied to value-based alternative payment models (APMs) in 2018, compared to 40.9% in traditional Medicare.[2]

With respect to Medicaid managed care plans, states are increasingly relying on these plans to deliver and manage the care and services needed by over 56 million Medicaid enrollees. Medicaid managed care plan enrollment more than doubled (121%) from 2010 and 2018.[3] In part, this growth is due to Medicaid managed care plans delivering on quality: More than three quarters of Medicaid plan enrollees are in plans accredited by the National Committee for Quality Assurance (NCQA). Additionally, Medicaid managed care plans have continuously demonstrated their performance delivering quality health care, improving scores on 26 out of 30 (87%) key HEDIS® and CAHPS® quality measures between 2014 and 2018.[4] Medicaid plans also deliver predictability for state budgets and federal matching funds. For example, in managing prescription drug benefits, Medicaid plans achieved $6.5 billion in net savings for states and taxpayers during FFY 2018 as compared with FFS programs.[5] Nearly half of states use Medicaid managed care for enrollees receiving long-term services and supports, making these plans well situated to serve dual-eligible enrollees as Direct Contracting Entities (DCEs).

Our members appreciated the opportunity within the DC Global and Professional (Glo/Pro) options for health insurance providers to bring greater value to beneficiaries enrolled in traditional Medicare. Some members were also poised to submit applications for participation in the DC Geographic (DC Geo) option before it was held for review. We respect the degree to which the Innovation Center was willing to consider recommendations on ways to refine the DC demonstration to better achieve CMS' policy goals and avoid undermining existing integrated models that are working. Accordingly, we were disappointed that the Innovation Center chose to halt new entrants to the DC Glo/Pro options, with few exceptions; did not solicit applications for

---

[1] "Dual Eligibles in Medicare Advantage Faced Fewer COVID-Related Disruptions in Care than Those in Traditional Medicare," NORC at the University of Chicago (May 2021); available at: https://www.norc.org/NewsEventsPublications/PressReleases/Pages/dual-eligibles-in-medicare-advantage-faced-fewer-covid-related-disruptions-in-care-than-those-in-traditional-medicare.aspx.

[2] "APM Measurement Effort," Health Care Payment Learning & Action Network; available at: https://hcp-lan.org/apm-measurement-effort/2019-apm/#1479737966515-d822014b-3f98.

[3] "The Value of Medicaid Managed Care," AHIP (June 2020); available at: https://www.ahip.org/wp-content/uploads/Medicaid_Managed_Care_States_Research_2020.pdf

[4] "The Value of Medicaid Managed Care," AHIP (March 2020) available at; https://www.ahip.org/wp-content/uploads/AHIP-MMCResearch-QualityofCare-2020.pdf

[5] "The Value of Medicaid Managed Care," AHIP (February 2020) available at; https://www.ahip.org/wp-content/uploads/AHIP-MMCResearch_RxDrugs.pdf

the DC Glo/Pro options from Medicaid Managed Care Organization-based (MCO-based) entities; and the future of the Geo option is in question.

As the Innovation Center considers the future of the DC model options and/or potential follow-on demonstrations, we write to continue this dialogue and to: (1) Reiterate our support for innovative payment models; (2) seek assurances regarding plan participation in any new DC model options or related demonstrations; (3) urge the Innovation Center to move forward with opening a Glo/Pro request for applications specifically for Medicaid MCOs, as was intended in CMS' December 2020 announcement; and (4) provide feedback for your consideration during this review period on how to improve the DC model options (or follow-on versions) in a manner that not just preserves but enhances the strengths of dually integrated plans and the benefits they offer to enrollees.

The DC model is intended to preserve Medicare beneficiaries' choice to receive care through traditional Medicare FFS and their usual providers, yet also provide enhanced access to care, care management, and certain other benefit enhancements[6] beyond the existing program (although less than what is available to them in managed care plan options). Accordingly, we disagree with stakeholders who contend the DC model will inherently limit beneficiary choice and/or access to care, but we encourage CMS to monitor for any potential negative impacts on beneficiaries. As an overarching matter, the central tenet of value-based payment models, such as the DC model, is to improve the quality, experience, and cost of care through patient-centric means. The DC model brings a decade of experience to bear starting with the Physician Group Practice demonstration. Through delivery system transformation grounded in patient-centric care, these predecessor models have made significant strides in achieving these goals. Including plans as an additional type of DCE will serve to test if even greater gains can be made, while ensuring access and choice are maintained per the underlying model and goals as well as monitoring.

Preserve Integrated Plan Enrollment

The undersigned organizations strongly support entities providing person-centered care that integrates Medicare and Medicaid benefits, such as MMPs, D-SNPs, Fully Integrated Dual Eligible SNPs (FIDE SNPs), and Highly Integrated Dual Eligible SNPs (HIDE SNPs) (collectively referred to herein as "Integrated Plans"). CMS, state Medicaid programs, and managed care plans have made significant investments to develop and expand Integrated Plans for dual eligible enrollees. In many states, these plans create a single point of contact for Medicare Part A, Part B, and Part D benefits and services; Medicaid-covered wrap-around services; and long-term services and supports. In addition, each dual eligible plan is required to develop a comprehensive, evidence-based model of care (MOC) designed to meet the needs of the plan's population of enrollees, which must be reviewed and approved by CMS. To ameliorate concerns that the DC model could disrupt efforts to further integrate care for dually eligible beneficiaries, we encourage the Innovation Center to develop DC policies that reinforce the strengths of these plans.

[6] Beneficiary enhancements specific to the DC Geo model include vouchers for chronic care management tools, meal programs, and vision/dental services; chronic disease management rewards for beneficiaries who adhere to programs; wellness memberships; electronic alert systems for patients subject to falls or with cognitive impairments; removing the requirement for a three-day inpatient stay prior to admission in a Skilled Nursing Facility (SNF); care management home visits; cost sharing supports; and certain other benefits unavailable in traditional FFS.

We appreciate the Innovation Center's decision to exclude MA plan enrollees from eligibility for DC Geo alignment given the high-quality, coordinated care such enrollees receive through the MA program; however, we recommend it take additional steps to preserve enrollment of people dually eligible for Medicare and Medicaid in Integrated Plans such as D-SNPs.

Beneficiary Alignment to DC Entities

We recognize that the Innovation Center has the difficult task of implementing beneficiary alignment polices across its suite of Medicare and Medicaid innovation models. Guidance must account for complex policy and operational matters, such as geographic overlap among models and with existing program options, different available benefits and services, preservation of beneficiary choice, and empowering beneficiaries to choose providers with whom they have existing relationships. We strongly believe that in accounting for these factors, Integrated Plans address the needs of dual-eligible enrollees far better than DCEs.

The Innovation Center had previously announced its intent to implement the DC Geo model in 10 regions, all of which have a high penetration of Integrated Plans.[7] All areas offer D-SNPs, several include FIDE-SNPs, and four of the 10 have financial alignment demonstration MMPs in operation[8]:

Area	D-SNPs	MMP	Area	D-SNPs	MMP
Atlanta	21	No	Orlando	12	No
Dallas	22	**Yes**	Philadelphia	13	No
Houston	25	**Yes**	Phoenix	10	No
Los Angeles	12	**Yes**	San Diego	5	**Yes**
Miami	16	No	Tampa	15	No

Moreover, several of these jurisdictions are actively encouraging aligned enrollment in the same plan for both Medicare and Medicaid managed care services; for example, Arizona requires its Complete Care Medicaid plans to offer a partner Medicare D-SNP plan to promote alignment to the greatest possible extent.[9]

As documented in the table, all 10 geographic markets proposed for DC Geo implementation have significant numbers of integrated plan options available. Implementing the DC Geo model in these regions, on top of the plethora of MA plans and APMs already in operation, will create additional confusion for beneficiaries and their caregivers.

[7] "Geographic Direct Contracting Model ('Geo') Fact Sheet," CMS (last accessed May 18, 2021); available at: https://innovation.cms.gov/media/document/dc-geo-fact-sheet.

[8] "CMS Special Needs Plan Comprehensive Report," CMS (January 2021); available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data.

[9] "Individuals Covered by Both Medicare and Medicaid (Dual Eligible Members)," Arizona Health Care Cost Containment System; available at: https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/duals.html.

In the interest of promoting greater integration and reducing beneficiary confusion, we recommend that the Innovation Center avoid implementing the DC Geo model in any regions with FIDE/HIDE SNPs or MMPs. Furthermore, in general, we recommend the Innovation Center prioritize and give preference to enrollment in Integrated Plans in markets where there are numerous payment demonstrations, including the DC Geo model and support excluding these beneficiaries from attribution to DCEs.

In proposed markets with MMPs, FIDE-SNPs, and/or HIDE-SNPs currently in operation, we recommend that dual eligible beneficiaries who would be eligible for enrollment into one of these highly integrated models be excluded from alignment to a DCE to preserve their eligibility for a more integrated delivery model. We also note that implementing the DC Geo model in MMP markets would complicate administration and evaluation of model market dynamics. In these areas, MMP penetration may have already altered the standard of care making it more difficult to tease out the effects of one model from the other. The Innovation Center should seek to minimize overlap and continually monitor whether MMP implementation has changed, such as if a particular state's demonstration sunsets or a new state begins participation.

Establish Consistent Patient Protections

Medicaid managed care and MA plans are held to high standards for licensure, solvency, quality, and robust enrollee protections through a framework of federal and state regulations. It is important to preserve these critically important protections, regardless of the model through which a patient receives their care. MA and Medicaid plans provide compelling examples of how enrollee protections can work effectively to serve the interests of members.

Therefore, we recommend that in preparing any additional rules and technical guidance for DCEs, the Innovation Center require strong patient protections and structural and financial safeguards consistent with those provided under a Medicare or Medicaid managed care plan.

The same quality standards, member protections, provider network oversight, MLR requirements, and appeal and grievance processes applicable to Medicare and Medicaid plans should apply to DCEs as well. Oversight of DCE activities should be equivalent to MA and Medicaid plan oversight, including audits of utilization management processes, claims and administrative expenses, appeals and grievances, beneficiary communications, and customer service. In addition, with respect to DCE qualifications, we recommend that the Innovation Center defer to state regulators on standards for licensure and solvency and assure that in states that regulate provider risk bearing, DCEs meet the applicable state requirements for licensure and reserves.

The Innovation Center should engage with state and federal officials overseeing integrated programs for dual-eligible enrollees and take steps to minimize member confusion and ensure that the most integrated delivery models remain viable. If the DC Geo option goes forward in areas with more highly integrated model options, there should be direct engagement and coordination with appropriate state authorities overseeing the integrated options and active collaboration with state Medicaid agencies and other stakeholders to educate dual eligibles about available options and the value of participation in the more integrated models.

Furthermore, we recommend the Innovation Center take steps to address concerns that the DC Geo model may create incentives that cause Geo DCEs and their participant providers to counsel dual eligible enrollees to disenroll from their Integrated Plan and voluntarily align with the DCE. Based on the well-documented and very challenging experiences of patient steering seen in the MMP

demonstrations, particularly in California, we strongly recommend that the Innovation Center establish rules to ensure that a provider be prohibited from actively steering patients to a DCE with which the provider is affiliated. The Innovation Center might consider developing a DCE addendum to the Medicare provider demonstration participation agreement to address potential steering; at a minimum, CMS should pursue a rigorous program of provider and patient outreach and education and implement robust monitoring to assure providers do not steer dual-eligible patients out of Integrated Plans.

Promote Person-Centered Care

Another aspect of enrollee protection relates to person-centered care and care management. The various integrated service delivery models discussed earlier in this letter all make extensive use of MOCs that include individual enrollee assessments, personalized plans of care, and management of care transitions. We recommend that DCEs be required to implement MOCs for dual eligibles like those required of D-SNPs, with similar processes for CMS review and approval. This will help ensure that DCEs have performed the due diligence to adapt their care to the unique needs of individual dual eligibles and possess the capacity and infrastructure to deliver the care management and coordination necessary to competently serve patients aligned to a DCE.

Streamline Performance and Quality Measurement

MA plans, D-SNPs, and MMPs are all measured according to established performance and quality metrics that evaluate and compare plan performance, patient experience and satisfaction, access to care, and health outcomes with peers and standards. Quality measurement of Medicaid plans is more diverse – varying by state – but generally plans are measured on core measure sets developed from National Quality Forum (NQF) endorsed measures. To ensure quality and promote comparability, we recommend the Innovation Center adopt existing, relevant, evidence-based quality measures, such as a subset of those included in the MA Star Ratings or MMP demonstrations and consider other measures for monitoring utilization of services.

Long-Term Vision for Medicare-Medicaid Integration

Finally, we recommend that CMS build on the important foundational work of the CMS Medicare-Medicaid Coordination Office to develop a comprehensive Medicare-Medicaid agenda that expresses the Agency's long-term vision for integration of programs for dual eligibles. The agenda should explore key elements of CMS' strategy for integration initiatives and elaborate on the respective supporting roles that D-SNPs, MMPs, Programs of All-Inclusive Care for the Elderly (PACE) programs, and DC demonstrations would play in achieving that overall strategy. The Innovation Center should implement appropriate safeguards to protect and preserve state innovation of integrated delivery programs, as well as develop incentives that encourage and reward states for actively collaborating in the design, approval, and ongoing oversight and monitoring of the demonstrations.

Conclusion

The DC model shows promise in furthering coordination of person-centered care and services for fee-for-service dual eligibles beneficiaries. We recommend the Innovation Center look to the established models of Integrated Plans in developing and implementing the programmatic and

regulatory structure and operational parameters for any new DC model options or successor demonstrations.

We appreciate your consideration of our comments and recommendations. We look forward to continuing to work with you to promote innovation and strengthen the Medicare and Medicaid programs for the dual eligible population. We would be pleased to provide you with any additional information you may require. Furthermore, we would be happy to jointly meet with you to continue the dialogue. Feel free to reach out to Danielle A. Lloyd, Senior Vice President for Private Market Innovations & Quality Initiatives at AHIP at dlloyd@ahip.org or (202)778-3246.

Sincerely,

Matthew Eyles

President and Chief Executive Officer
AHIP

Ceci Connolly

President and Chief Executive Officer
Alliance for Community Health Plans

MA Murray

Chief Executive Officer
Association for Community Affiliated Plans

Mary Jackell

Executive Director
National MLTSS Health Plan Association

Cheryl Phillips, MD

President and Chief Executive Officer
SNP Alliance