February 20, 2020

Brad Smith
Senior Advisor for Value-Based Transformation
U.S. Department of Health & Human Services
Director of the Center for Medicare & Medicaid Innovation
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Recommendations on Direct Contracting

Dear Director Smith:

The National Association of Accountable Care Organizations (NAACOS) thanks the Center for Medicare and Medicaid Innovation (Innovation Center) for its hard work to create new payment and delivery models that seek to improve health care. Most notably, the Innovation Center's Direct Contracting Model builds upon lessons learned from the Medicare Shared Savings Program (MSSP), Next Generation ACO Model and other important programs, while offering capitation and high levels of risk and reward.

As the largest association of ACOs, NAACOS and its ACO members serve more than 12 million beneficiary lives through hundreds of organizations participating in population health-focused payment and delivery models in Medicare, Medicaid and commercial insurance. NAACOS and its members are deeply committed to the transition to value-based care. NAACOS is an ACO member-led and member-owned non-profit organization that works on behalf of ACOs across the nation to improve the quality of Medicare delivery, population health and outcomes, and healthcare efficiency.

Advancing value-based care has been a priority of Secretary Alex Azar from his first day in office. ACOs, the origin of which dates back to the George W. Bush Administration, have been instrumental in the shift to value-based care. ACOs focus on providing high-quality health care while controlling costs, and many ACOs are embracing value and preparing to assume greater accountability. Importantly, the ACO model also maintains patient choice of clinicians and other providers.

The Innovation Center's work in this area is admirable and appreciated. Since its inception, NAACOS has been supportive of Direct Contracting and launched a Taskforce to help educate the healthcare community about its launch and application. We are pleased the Direct Contracting Model is designed to qualify as an Advanced Alternative Payment Model (Advanced APM), and NAACOS very much wants the see the model succeed. NAACOS responded in May 2018 to CMS's request for information on Direct Provider Contracting and followed with a May 2019 letter responding to initial information released on Direct Contracting. We appreciate that much of our feedback has been incorporated into the model already. We write today to offer additional comments and suggestions, now that further details have been released.

Unfortunately, our members have expressed concerns with several programmatic elements. Foremost, key details on the financial methodology have yet to be released and other important questions remain unanswered. Our members are finding the lack of information a tremendous hindrance to participation.

Our below recommendations on Direct Contracting reflect our desire to see Medicare accountable care models achieve long-term sustainability, enhance care coordination for millions of beneficiaries, lower the growth rate of healthcare spending, and improve the quality of care.

Release More Information As Soon As Possible

Even as the deadline for Direct Contracting's Implementation Period is fast approaching and applications for 2021 are three months away, CMS has not released important details that applicants need to make participation decisions. These include specifics around benchmarking, risk adjustment and capitated payments. Without these details, it's impossible for the healthcare community to make informed decisions about program participation. Direct Contracting Entities (DCEs) will still be analyzing how they'll fit in the program once key details are released and applications are due.

Many ACOs and provider groups will apply for MSSP as well as Direct Contracting so that they can make an educated decision once they have the necessary information. Not providing more information up front creates more administrative burden for providers and the agency. **CMS should issue remaining program details as soon as possible to give potential future DCEs the time they need to understand the model's rules and its impact on their respective organizations.** Without these details and answers to lingering questions, MSSP or non-participation in alternative payment models would be more attractive and stable option compared to Direct Contracting.

CMS should provide a cross-model alignment hierarchy. DCEs need to understand how beneficiaries will be assigned across CMS's numerous alternative payment models. NAACOS continues to believe that total cost of care models should be given assignment priority over other initiatives since they take on responsibility for beneficiaries' care across the care continuum and, accordingly, have the largest impact on patient care. Because beneficiary alignment is integral to setting a DCE's benchmark, DCEs need this information as soon as possible in order to make informed participation decisions.

Among issues that need further explanation:

- DCE's use of capitated payments. Little has been released so far, and DCEs are confused about what is allowed and not. We advocate for CMS to provide DCEs with maximum flexibility with the use of these payments.
- Clarity on the adjustments CMS will make to the Medicare Advantage Rate Book for purposes of benchmarking. DCEs should be able to replicate the adjustments in their modeling using the publicly released rate book.
- DCEs need the details of the new HCC methodology.

Provide Greater Flexibility in the Application Process

Because of the lingering questions and compressed application time frame, we urge CMS to create additional application cycles for DCEs to start in 2022 and later, giving them time to analyze the program and their participation options. In 2016, the initial Next Gen class had 18 ACOs, yet participation ballooned to a high of 58 only two years later because CMS allowed for multiple application cycles after the model launched. Allowing multiple application cycles will increase participation in Innovation Center models in the long-term, so limiting opportunities to join later shouldn't be sacrificed for the sake of higher initial participation.

Because many providers are considering both MSSP and Direct Contracting participation — and applying to both in hopes of picking one later — CMS should align application timelines and participation decision deadlines across the two models to the greatest extent possible. This would help ease the application process and avoid a situation where an ACO is forced to decide on participation in one model without having the full information from another.

CMS should provide specific timelines for changing and updating the Participant and Preferred Provider list for the 2021 performance year. DCEs should be given ample time to update a preliminary participation list in advance of notifying and contracting providers. Until all the details about the participation agreement are known, the DCE cannot commit to a final participation list. There is simply not enough time to meet and explain changes to participating practices. Decisions are made at the group practice level, and potential DCEs need greater transparency in the timelines CMS plans to set.

Allow Primary Care First practices to terminate participation in that model without penalty in order to participate in Direct Contracting. This will allow for the necessary maneuvering that will optimize patient care without penalty.

Increase Shared Saving Rates for Professional DCEs

The 50 percent shared savings rate for Professional DCEs is too low. Given the currently available options in MSSP Enhanced (up to 75 percent with maximum with significantly lower downside risk) and Next Gen (80 percent), the Professional DCE option will be a step backward for the many ACOs currently participating in Next Gen at the 80 percent sharing rate. Under the current design of Professional DCE, ACOs will likely instead choose to participate in MSSP Enhanced, where they achieve greater savings while being subjected to lower risk. **The Innovation Center should increase the shared savings rate for Professional DCEs to 75 percent to make it an attractive option for those DCEs that are not ready for full risk.**

Reduce Steep Discounts

After factoring in the discount, quality withhold, and retention withhold, DCEs will initially receive significantly reduced benchmarks. Starting in 2021, a Global DCE may only receive 91 percent of its benchmark, 93 percent of its benchmark in 2022, and 90 percent by 2025. Discounts currently outlined in Direct Contracting create a very steep climb for participants to achieve savings comparable to MSSP. As currently designed, DCEs would have to create substantially greater savings in Direct Contracting to earn the same level of savings they could realize in the Enhanced Track of MSSP. **Because of this disparity, CMS should minimize these discount levels to make the chances of achieving savings more realistic.**

Because of the lingering uncertainty with the Direct Contracting Model, the Innovation Center should waive the 2 percent "retention withhold." The retention withhold is meant to incentivize DCEs to remain in the model for at least two years. But given the above unanswered questions and compressed application timeline, the Innovation Center is already asking a big commitment of these providers without another withhold. Their commitment to value and willingness to assume risk should serve as a reason to not hold hostage more money from these providers.

Address Conflicts with Different DCE Types and Clarify Overlap

One of the unique, new aspects of Direct Contracting is the different DCE types, which open the door to new types of entrants rather than traditional ACOs. While this is welcomed, it has introduced a number of new questions and issues, including how patients and providers will operate in overlapping DCEs.

CMS should allow Participant Providers to dually participate in both a High Needs and Standard DCE and allow one DCE application with a high-needs subset. Failure to do so will force independent

providers into a position of choosing a subset of their patients, which prevents them from furnishing high quality, coordinated care to a larger patient population. If they choose High Needs, many of their patients with whom they have been working for years will no longer be aligned and will lose the benefits of the comprehensive care model that CMS and ACOs have worked so hard to build. If they choose Standard, providers will not have the resources and benefits to support their higher-needs population that CMS has an interest in serving. Additionally, a DCE that operates different DCE types should be allowed to have one governing body in order to effectively coordinate care for aligned beneficiaries and to reduce administrative burden for providers and the DCE.

CMS should make public the algorithm used to identify high-needs patients to allow applicants to know who and how many of their patients will qualify as "high needs." Without this information, a provider must guess, and it would be terrible if the provider applies for a High Needs DCE only to find out that none or only a handful of patients qualified. That provider will have missed the chance to participate as a Standard DCE, losing the opportunity to continue to care for their entire patient population.

Provide Flexibility with Primary Care Capitation

DCEs should be provided flexibility in accepting the Enhanced portion of the Primary Care Capitation. CMS has stated that Primary Care Capitation will be divided into two components — basic and enhanced — which, together, will comprise the 7 percent Primary Care Capitation payment. While the basic portion will be treated as true capitation (and as a DCE expenditure) for purposes of financial settlement, the enhanced portion will be considered a loan that must be repaid in full by the DCE at the end of each performance year. Some DCEs do not want this loan or the administrative burden of tracking it and repaying it. Accordingly, the enhanced portion of Primary Care Capitation should be optional and DCEs should be able to elect to receive only the basic Primary Care Capitation.

Improve Quality Approach

DCEs are subject to a 5 percent quality withhold, which is a significant increase over the withhold employed in the Next Gen model. Despite the importance of quality and patient satisfaction, many important questions remain. It's still unknown how measures will be weighted or what the Continuous Improvement/Sustained Exceptional Performance criteria will be. **As stated previously, potential DCEs need more information on this important aspect of the program.**

NAACOS is also concerned with the heavy reliance on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey measures. While patient satisfaction is valued, CAHPS measures are not necessarily representative of quality improvement and rely on a small sample size. The imbalance of the current list of Direct Contracting quality measures is concerning, and CMS should include more clinical quality improvement measures which DCEs can act on rather than relying solely on patient satisfaction and hospital utilization measures.

Given the withhold amount and lack of details regarding the quality scoring methodologies, the Innovation Center must make more information available in order for applicants to be able to evaluate the model. Additional details are needed on the quality withholds and other notable quality questions remain. For example, is the 5 percent quality withhold set at 5 percent for each year or is it adjusted based on prior year quality performance? How will quality measures be weighted? When will DCEs have more details on the Continuous Improvement/Sustained Exceptional Performance criteria? These are large dollar amounts at play, but CMS has released very little information on these details to date.

Address Alignment and Data Issues

Stop using the Next Gen alignment algorithm in which specialist can be used for alignment in the event of no other primary care physician services. As the Qualifying APM Participant (QP) thresholds rise, it

becomes more difficult to maintain QP status *and* include a continuum of participating providers. To be successful in Advanced APMs, DCEs need to include as Participant Provider specialists who provide close management of patients with complex chronic conditions and partner closely with primary care. This is the key to success but including them threatens a DCE's ability to meet QP thresholds. Therefore, we request that the Innovation Center use an alignment methodology for Direct Contracting that does not pull in specialists in the event of no other primary care physician services.

CMS should consider alternative mechanisms to feed DCEs data. For example, DCEs should be able to receive data through the ongoing work of the Beneficiary Claims Data API. This will provide DCEs with access to weekly claim feeds and more timely access to data.

Reset beneficiary election to opt of data sharing. Beneficiaries, who have previously opted out of data sharing in an alternative payment model (such as MSSP or Next Gen), are automatically opted out of data sharing when aligned to other initiatives. For instance, a beneficiary that opted out of data sharing in Next Gen will automatically be opted out data sharing for Direct Contracting. Over time, these elections become stale and beneficiaries should be given the opportunity to reassess their willingness to share data.

DCEs should also be granted access to CMS's Health Insurance Portability and Accountability Act [HIPAA] Eligibility Transaction System (HETS) to allow providers to learn of Medicare beneficiary eligibility checks in real-time using a secure connection. Anytime a Medicare beneficiary visits a medical provider, including the emergency department or inpatient hospital, DCEs could be made aware with access to this HETS feed. We request CMS allow a DCE to have access to HETS for their care coordination efforts. Limited testing to DCEs would help address CMS's concerns to wider use, including technological hurdles and so-called false positives from events scheduled in advanced, while give an idea of the work needed by ACOs and CMS to broaden access to the HETS feeds.

Conclusion

NAACOS supports Innovation Center efforts to transform healthcare payment and delivery systems to reward value and incentivizes quality, well-coordinated care. We appreciate the opportunity to provide feedback on how to improve Direct Contracting. NAACOS and the Innovation Center share the goal of wanting the model to be successful, and we believe our above recommendations will create a more attractive option. Thank you for your consideration of our comments.

Sincerely,

Clif Gaus, Sc.D.
President and CEO
National Association of ACOs