Jeff Micklos
Executive Director

March 3, 2020

Sent via Electronic Mail

Pauline Lapin
Director, Seamless Care Models Group
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Re: Direct Contracting Model

Dear Director Lapin:

The Health Care Transformation Task Force (HCTTF or Task Force) is writing to convey our member feedback and highlight opportunities to improve the design and implementation of the Direct Contracting Model.

The Task Force is an industry consortium representing a diverse set of organizations from various segments of the industry – including providers, health plans, employers, and consumers – all committed to adopting payment reforms that promote a competitive marketplace for value-based health care and allow health care organizations to move from a system that incentivizes volume of services to one that rewards value of care. Our member organizations aspire to have 75 percent of their business in value-based arrangements by the end of 2020. We strive to provide a critical mass of policy, operational, and technical support from the private sector that, when combined with the work being done by CMS and others, can increase the pace of delivery system transformation.

Our members have built, operated, and participated in various alternative payment models, including the Next Generation ACO Model and the Medicare Shared Savings Program. We believe these models present key opportunities for providers to invest in improving quality and reducing health care expenditures. We applaud CMS's desire to develop additional opportunities for mature organizations to take on more advanced risk and accountability for total cost of care and outcomes for Medicare beneficiaries. The comments offered here reflect a desire to support CMMI's ongoing efforts to transform our health care system and to help drive successful implementation of the Direct Contracting Model.

We appreciate CMS's efforts to offer providers ongoing opportunities to engage in alternative payment models built from the knowledge gained in the Pioneer and Next Generation ACO Models. Task Force members are actively discussing the Direct Contracting Model opportunity and tracking the release of new information from CMMI. We appreciate CMMI's efforts to explain the model and address questions through a variety of means. However, several key model details have still yet to be publicly released, which is affecting our members' ability to make decisions regarding model participation. Task Force members are also concerned about the model's application process and aspects of its design.

The Direct Contracting Model may offer participants an excellent opportunity to further their adoption of alternative payment models to provide better care at a lower cost, yet the lack of specificity on key model details is currently a barrier to entry for many. The Task Force is concerned that this will result in reduced levels of model participation.

Given the experience of our members operating ACOs, we urge CMMI to consider the recommendations below.

I. Model Application Details

a) Payment model details

Task Force members have received varying estimates for the availability of the adjusted Medicare Advantage (MA) rate book ranging from June to October of 2020. **CMS should make the full details of the financial methodology publicly available by June 2020 at the latest and should extend the application period if this timeline is not feasible**. The rate book information is critical to participation decisions, especially for providers considering participation in MSSP. The lack of information has already caused interested organizations to pass on applying for the initial performance year, thereby foregoing a period of learning and adjustment. In the interim, CMMI should provide potential applicants as much detail as possible on the assumptions underlying adjustments to support impact modeling efforts.

b) Clarify provider eligibility and beneficiary attribution

CMS should clarify details on participant provider eligibility, attestation, and beneficiary attribution. Some Task Force members report being advised by CMMI that any provider (including specialists) billing Primary Care Qualified Evaluation and Management codes could contribute to alignment, while others understand specialist participation to be limited to non-procedural specialists. Our members also cited a lack of clarity around beneficiary attribution. Specifically, the ability to both remove providers and update beneficiary attribution to reflect participant changes after applying to the model

c) Clarify DCE provider attestation requirements

Several Task Force members understood the RFA to require individual attestations from each participant provider and preferred provider rather than a single attestation form from the

DCE. The CMMI model help desk has clarified this issue on a case by case basis, however, a general FAQ is needed to affirm that a single attestation from the DCE is what's required.

d) Align APM application timelines

Many Task Force members interested in the Direct Contracting Model are also active participants in the MSSP program; however, the current model timelines present a challenge for those attempting to evaluate the potential costs and benefits of participating in either model. **CMS needs to better align participation applications and timelines for participating in Direct Contracting and MSSP.** CMS has expressed the goal of expanding provider participation in shared accountability APMs and should coordinate CMMI models and MSSP programs to support this end.

e) Expand participation application opportunities

Considering the magnitude of outstanding stakeholder questions regarding Direct Contracting, CMS should consider extending the application timeline for the Implementation Period or creating a hold harmless transition year during which participants would not be at risk due to the inability to model the impact of participation. CMS should also consider offering the opportunity for additional cohorts in future performance years to allow additional time for participants to evaluate the model opportunity once key information on the benchmarking, risk adjustment, and quality measures is available.

II. Model Overlap

Participant Providers in DC are prohibited from participating in other shared savings models like MSSP after the Implementation Year. Therefore, it is critical for CMS to clarify the proposed timing and policy for updating participant provider lists. Task Force members have stressed the importance of identifying providers participating in MSSP or other models and incorporating that information onto their participant provider lists.

III. Direct Contracting Entity Limitations

CMS has stated that High Needs and Standard DCEs will need to be operated as separate entities under two different TINs. This approach does not align with the practice of care where providers may see a mix of high needs/high risk and low risk patients. **Instead, CMS should allow for alignment between Standard (*i.e.,* Professional and Global) and High Needs DCEs under a single Tax Identification Number (TIN) or for blended capitation rates for high needs beneficiaries treated by Standard DCEs.** As written, this design element presents potential DCEs with a choice between taking on the complexity of creating and managing a new TIN or electing to forgo one DCE track in favor of another. Task Force members believe this approach is neither administratively practical or desirable for delivering high-quality, coordinated patient care as the needs and complexity of patient populations are in constant flux. Additionally, our members are concerned that any new TIN created for the High Needs DCE would be unlikely to have the number of Medicare beneficiaries needed to qualify for the

MACRA Advanced APM bonus creating a further disincentive to participation in the High Needs option.

IV. Financial Methodology

a) Adjust shared savings arrangements to account for model risk

Task Force members recognize and appreciate the need for CMMI models to pass an actuarial review and contribute toward larger Medicare savings goals. That said, the 50 percent shared savings arrangement under the Professional Track combined with the risk corridors have resulted in a shared savings opportunity that is lower than the Next Generation ACO Model and MSSP Enhanced. As an evolution of these earlier models, Direct Contracting should offer greater levels of incentives for participants in addition to greater accountability. **CMS should enhance the shared savings arrangement to provide stronger incentives for the Professional Track.**

b) Modify discount amounts

Relatedly, CMS should temper the discounts for the Global Track. Discounts for the Global Track of the Direct Contracting Model start at 2 percent in the first performance year and increase to 5 percent in the final model year. This is a marked increase in comparison to the Next Generation ACO Models discount of 1.25 percent. Task Force members have expressed concern about the magnitude of these discounts and have noted that, in combination with the PY1 retention withhold, leakage withhold, and quality withholds, the total discount from the benchmark could eclipse 10 percent. The large discounts in combination with the lack of detail on the MA rate book weaken the business case for model participation.

c) *Modify primary care capitation design*

CMS has stated the enhanced capitation amounts in the Primary Care Capitation option will function like a loan and will be recouped in full at the end of the performance year. While they are not included in the expenditures, repayment may ultimately offset any savings a DCE may generate. This may prevent DCEs from using the enhanced capitation to invest in care management or other innovative care delivery efforts, which is contrary to their intent. Additionally, CMS has stated that the 7 percent PCC rate was established assuming an average primary care spend of 3 percent of the benchmark with the remaining 4 percent comprising the enhanced payment. This approach does not account for the variability in actual historical primary care spending and will result in disparate enhanced payment investment opportunities for providers. **To truly invest in primary care, CMS should reconsider the design of the enhanced capitation feature of the Primary Care Capitation option.**

V. Quality Measures

The Direct Contracting Model quality measure set is too heavily reliant on CAHPS survey measures. **CMS should revise the quality measure strategy to align with existing ACO measure sets and focus on issues that are actionable for DCEs and providers.** In our

members' experience, these measures provide little actionable information to support quality improvement efforts. This is due to: (1) the lengthy delay between the delivery of a service and the implementation of the survey, and (2) the inability to track results back to specific high or low performing providers. This is especially concerning given the 5 percent quality withhold built into the model.

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The HCTTF is eager to work with CMS to achieve sustainable change in value-based payment and care delivery, a goal that requires alignment between the private and public sectors and engagement with payers, providers, purchasers, and patients. Please contact Joshua Traylor (Joshua.Traylor@hcttf.org | 202.774.1579) with any questions or comments on this letter.

Sincerely,

Jeff Micklos

cc: Amy Bassano, Deputy Director