July 29, 2021

VIA ELECTRONIC MAIL

Elizabeth Fowler J.D., Ph.D.
Deputy Administrator and Director, Center for Medicare and Medicaid Innovation
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Re: Direct Contracting Model Recommendations

Dear Director Fowler:

The Health Care Transformation Task Force (HCTTF or Task Force) is writing to convey our member feedback on the future of Accountable Care Organizations, Total Cost of Care Models (TCOC), and opportunities for improving the design and implementation of the Direct Contracting Model (DC model) Global and Professional tracks.

The Task Force is an industry consortium representing a diverse set of stakeholders from various segments of the industry – including providers, payers, purchasers, and patient advocacy organizations – 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 the volume of services to one that rewards the value of care. HCTTF member organizations 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 the Centers for Medicare and Medicaid Services (CMS) and others, can increase the pace of delivery system transformation.

Our members have consistently participated in CMS designed alternative payment models (APMs) – including the Next Generation ACO Model and the Medicare Shared Savings Program – and have advocated for the broader adoption of TCOC models. We believe these models are critical for both improving quality and reducing health care expenditures and have consistently supported CMS's efforts to develop more advanced risk models that promote accountability for spending and outcomes for Medicare beneficiaries. The Medicare Payment Advisory Commission (MedPAC), in its June 2021 Report to Congress, cited research showing that total cost of care models (like ACOs and Direct Contracting) "have generated the most consistently favorable financial results among APMs." The comments offered in this letter reflect a desire to support the Center for Medicare and Medicaid Innovation's (CMMI) ongoing efforts

to transform our health care system. Given the experience of our members operating ACOs, we urge CMMI to consider our recommendations for the DC model detailed below.

General Comments

The COVID-19 pandemic has further exposed the flaws of the fee-for-service system and has left many clinicians looking for ways to bolster their practices with more stable financial models that enable them to better care for their patient populations. The value movement is at an important inflection point and CMS can accelerate transformation by signaling strong commitment to advancing TCOC models and providing opportunities for clinicians and practices who are ready to pursue value-based care. While we understand that a review of models is typical during an Administration change, the series of decisions and messaging regarding the Next Generation ACO and DC models has created uncertainty for our members about CMMI's support for these model concepts. This has been especially concerning for those organizations that have shown steadfast commitments to implementing payment reforms. We encourage CMS to make bold, public commitments in support of TCOC models in the near future to provide reassurance for stakeholders working in this area and maintain momentum for APM transformation.

HCTTF understands CMMI's decision to pause the Direct Contracting model and the design issues that precipitated that pause. We believe that now is the time to modify the model and to create an offering that will be attractive to experienced ACOs, including those participating in the Next Generation ACO model. This letter details several recommendations for modifications to the DC Global and Professional model intended to ensure that it focuses on advancing care transformation, supporting connections between patients and providers, and improving population health. Making the modifications recommended below will improve buy-in to the model and create a stronger future for TCOC delivery models.

Specific Comments on Direct Contracting Model's Global & Professional Tracks

I. Model Overlaps and Transitions

Task Force members are active participants in several CMS APMs. When evaluating the Direct Contracting Model opportunity, our members must balance the potential costs and benefits of the DC model alongside the operational costs and complexities of managing the other models they participate in such as the Medicare Shared Savings Program (MSSP). Educating participating providers on the merits of potential model options, building networks, contracting, and related operational activities take dedicated staff time and resources. Misaligned model timelines and incomplete model information make it difficult to manage these limited resources and can result in organizations defaulting to their existing positions rather than attempting to implement new (potentially better) models. **To address these issues CMS should align application requirements and timelines for models targeting similar participant types, in this case Direct Contracting and MSSP. CMS should also prioritize providing additional clarity on the status of the DC Geographic model currently under review so that organizations considering the DC model can take make fully informed participation decisions.**

CMS has stated it has a goal of expanding provider participation in shared accountability APMs and should coordinate CMMI models and MSSP programs to support this end. **In the interest of expanding participation**, **CMS should offer the option to suspend capitated payments to the second cohort (as was done for the first DC model cohort during year 1) and extend this option for the duration of the model.** This would alleviate some of the administrative expenses that do not generate a return for participants as they transition into the new model.

II. Direct Contracting Entity Types and Supporting APM Adoption

Task Force members are concerned that the requirement that High Needs and Standard Direct Contracting Entities (DCEs) operate as separate entities under two different Tax Identification Number (TINs) does not align with the current practice of care. Providers often care for a diverse mix of patients that span both the high needs/high risk and low risk populations. We request CMS clarify the logic behind the decision to implement the high needs and standard DCEs separately. **Additionally, we encourage CMS to consider redesigning this aspect of the DC model to allow for alignment between Standard and High Needs DCEs under a single TIN using a blended capitation rate based on beneficiary level risk adjustment.** This would allow Standard DCEs to receive the additional resources required to treat their high needs patients and better align with existing care delivery relationships. 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, the Task Force notes that the scale and complexity of the DC model may be prohibitive for smaller and less experienced model applicants. The increasing sophistication of CMMI models risks accelerating the divide between the providers with and without experience operating APMs. **Given the potential for APMs to improve quality and efficiency, and the fact that providers without APM experience disproportionately serve under resourced communities, we encourage CMS to evaluate and implement strategies to support providers as they gain the necessary experience and develop the capacity to manage risk.** This includes dedicated infrastructure investments, technical assistance opportunities, and leveraging the expertise of existing organizations with experience supporting provider efforts to implement APMs

III. Clarity on DCE Audit and Compliance Liability

Some Task Force members have inquired about audit and compliance responsibilities and the potential legal exposure a DCE may have for any improper billing on the part of their participant providers. Members are unclear on the DCE audit responsibilities in addition to the audits performed by CMS for claims submitted to Medicare. **CMS should clarify the DCE audit and compliance responsibilities for providers and their responsibilities related to their participating providers' billing practices.**

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) Align benchmarking methodology across DCE types

Task Force members are concerned that the benchmarking approach used in the DC model places experienced APM participant at a competitive disadvantage compared to new entrants to the model and creates incentives for adverse selection behaviors amongst new entrant DCEs. The DC model uses a blend of regional expenditures and aligned beneficiary historical spending to set benchmarks for claims-based aligned beneficiaries to a standard DCE. The benchmark for beneficiaries aligned via claims to a New Entrant DCE is set solely using regional expenditures for the first three years of the model and only implements the blended regional and historical spending methodology in year four and beyond. This benchmarking approach disadvantages organizations with prior success in APMs because the historical spend for their aligned beneficiary population will be lower than the regional benchmark. Furthermore, providers that serve the majority of Medicare beneficiaries in a region will have a large influence on the regional benchmarks they are held to. Consequently, organizations that have successfully reduced spending under prior APMs will have fewer resources for care delivery as compared to new entrants.

This methodology also creates an incentive for new entrants to preferentially recruit patients that are already well managed (potentially by existing ACOs) over poorly managed patients since the actual costs of a well-managed patient are more likely to be below the regional benchmark. HCTTF has consistently called for CMS to ensure that models create a level playing field, avoid penalizing experienced APM participants and incentivize participants to expand the proportion of beneficiaries receiving coordinated care rather than cherry-pick from the existing pool of beneficiaries receiving high quality care. **We encourage CMMI to reconsider the DC model benchmarking approach and align the methodology for both voluntary and claims-based alignment across the standard and new entrant DCE types.**

c) Modify discount amounts

Relatedly, CMS should temper the discounts for the Global Track. Discounts start at 2 percent in the first performance year and increase to 5 percent by the final model year. This is a marked increase in comparison to prior CMS ACO models. Task Force members have expressed concern about the magnitude of these discounts and note that – in combination with the PY1 retention withhold, leakage withhold, and unprecedently large quality withholds – the total benchmark discount could eclipse 10 percent. In the wake of COVID-19 health care

organizations are particularly concerned with managing financial risk and ensuring a positive return on investment. If the goal of the DC model is to bring additional providers into advanced risk arrangements, the scale of the current discounts is likely to cause many organizations to opt for lower risk arrangements rather than join the DC model.

Additionally, members have noted that the structure of these increasing discounts effectively cuts resources to model participants at a time when, after addressing easier care delivery reforms, achieving further efficiencies in care typically becomes more difficult. This issue is further compounded for experienced ACOs that have already invested in eliminating inefficiencies in care while participating in earlier APMs and for efficient ACOs operating in regions that are already low cost. These discount amounts also present a barrier for smaller practices and those operating in under resourced communities further discouraging them from considering the model due to the level of risk and exacerbating the gap between organizations with and without APM experience. **We encourage CMS to consider modifying the discount by applying a flat rate of 2 percent across all years of the model and research additional flexibilities that could be used to support the participation of providers working with under resourced communities. Additionally, we believe that CMS should acknowledge the historical spending reductions of Next Generation ACO participants by removing the discount for the first two years of the model.**

d) Modify primary care capitation design

CMS has stated the enhanced capitation amounts in the Primary Care Capitation option will function like a loan and be recouped in full at the end of each performance year. While they are not included in the expenditures, repayment may ultimately offset any savings a DCE may generate and would be a challenge for smaller organizations with fewer resources. 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. **To truly invest in primary care, CMS should reconsider the design of the enhanced capitation feature of the Primary Care Capitation option by allowing DCEs the option to extend repayment over more than one model year.**

d) Financial guarantee flexibility

In earlier DC model documents, including the Global and Professional track RFA, CMS indicated that DCEs would need to establish a financial guarantee mechanism. CMS offered DCEs four options to meet this requirement: 1) hold funds in escrow, 2) secure a surety bond, 3) establish a line of credit, or 4) propose an alternative methodology to CMS for approval. While CMS was not clear what would be considered sufficient to meet option 4, it did indicate that it was open to providing stakeholders the flexibility to come up with new arrangements. Subsequently, CMS has rescinded this flexibility and limited DCEs to the options of an escrow, line of credit, or surety bond. Some Task Force members have identified alternative strategies that they believe would both meet the guarantee requirements and free up additional resources for investment in care transformation. **We encourage CMS to reconsider the decision to eliminate the alternative methodology option and accept proposals from DCEs.**

V. Quality Measures

Task Force members' have expressed concern that the DC model includes a 5 percent quality withhold which, like the discount amount, is large in comparison to prior CMS payment models and commercial APMs. Additionally, CMS has not provided details on the continuous improvement/sustained exceptional performance (CI/SEP) criteria or the pre-defined quality performance benchmark required for a DCE to earn back the withhold. This makes it difficult for organizations to model their likelihood of meeting quality measure expectations within the DC model.

The scale of the withhold combined with insufficient data on acceptable performance thresholds creates an additional layer of uncertainty and financial risk for potential participants weighing participation in the DC model vs. alternatives like MSSP (for example, a DCE with 20,000 beneficiaries and a PMPM payment of $10,000 would need to fund a discount of $10 million). High performing ACOs typically do not exceed a 5% savings rate and would need to reduce capital to fund this withhold without the ability to reasonably estimate the amount that they would be able to earn back. **We encourage CMS to consider a lower withhold amount of 2.5 percent which we believe would still provide sufficient incentive to meet quality goals and provide details on the anticipated CI/SEP and performance benchmarks necessary to earn back the withhold amounts to assist organizations in making informed participation decisions.**

VI. Risk Adjustment

CMMI has clearly communicated its intent to minimize the impact of HCC coding on financial results. The Task Force supports this effort; however, members have noted that the design of the DC model inadvertently creates strong incentive for DCEs to focus resources on upgrading HCC coding programs. Because many of the new entrants have payer-like coding enterprises, many ACOs will need to invest heavily in coding programs to retain their current financial position. Furthermore, the DC model includes a normalization factor, a risk adjustment cap, and a coding intensity factor adjustment. HCTTF members have observed that the cap and coding intensity factor appear to accomplish similar policy goals. **We urge CMS to clarify the risk adjustment strategy. Additionally, CMS should create a zero percent floor for risk adjustment to reduce the incentive for participants to make large investments in HCC documentation programs solely for the purpose of pursuing favorable comparative risk coding.**

VII. Retention Penalty

The DC model includes a 2 percent retention penalty for participants that leave the model after the first year. This penalty is intended to serve as a disincentive for leaving the program, however, it also presents a further element of financial risk for organizations weighing whether to apply for the model to begin with. The Task Force believes that CMS should prioritize broad participation in the DC model and focus on easing barriers to entry. **To this end, we recommend that CMS eliminate the retention penalty. If a full elimination of this penalty**

is not feasible, we urge CMS to consider waiving the penalty for organizations that decide to leave the DC model to participate in another CMS advanced risk APM.

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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,

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