December 16, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: NAACOS Support for the Global and Professional Direct Contracting Model

Dear Administrator Brooks-LaSure:

The National Association of ACOs (NAACOS) writes to reiterate our support for provider-led Direct Contracting Entities (DCEs) and renew our request to prioritize those types of organizations, giving them incentives to better address equity as you make future refinements to the Global and Professional Direct Contracting Model (GPDC). Provider-led DCEs include traditional ACOs, health systems, independent group practices, federally qualified health centers, skilled nursing facilities, and others like them. We recommend payment model tests for health plans should be through Medicare Advantage, not through payment models in traditional Medicare. Since its founding in 2012, NAACOS has supported organizations in accountable care models, including the Medicare Shared Savings Program (MSSP), Pioneer ACO Model, Next Generation ACO Model, and more recently GPDC.

However, GPDC has come under scrutiny lately from advocates calling for the model to be stopped entirely. We understand a couple of the concerns recently raised, such as not wanting a temporary model to grow too large and wanting the focus of value-based care to be patients as opposed to profits. We expressed many of the same concerns the current critics have about the Geographic Direct Contracting Model and were pleased CMMI paused its implementation. That said, NAACOS believes stopping GPDC would undermine the country's move away from a volume-based, fee-for-service system and damage our collective efforts to transition to a value-based payment system. Population health models are sorely needed to incentivize our health system to care for patients' long-term health needs, and total cost of care models have proven to be superior to other efforts over the last decade in bending the cost curve. As the administration continues to refine the model and begins to consider changes for 2023, we urge the Centers for Medicare and Medicaid Services (CMS) to support only provider-led DCEs. NAACOS has offered several recommendations, some of which we outline again below.

NAACOS represents ACOs and DCEs who collectively represent more than 12 million beneficiary lives under Medicare and commercial contracts. NAACOS and its members are deeply committed to the transition to value-based care. We are an ACO member-led and member-owned non-profit organization

that works on behalf of ACOs and DCEs across the nation to improve the quality of Medicare delivery, population health and outcomes, and healthcare efficiency.

ACOs continue to be the best alternative payment model to control Medicare spending and improve the quality of care. MSSP ACOs in 2020 generated $4.1 billion in gross savings and $1.9 billion after accounting for shared savings payments, which are both program highs. MSSP ACOs also received an average quality score of 97.8 percent, a new program best. The Next Gen ACO Model, the Innovation Center program on which GPDC builds, saved $637 million compared to the CMS-generated benchmark in 2020 and netted $230 million to the Medicare Trust Fund after accounting for shared savings and discounts paid to CMS. Medicare ACOs, including Next Gen and the now expired Pioneer ACOs, have saved Medicare a combined $13.3 billion in gross savings and $4.7 billion in net savings since 2012.

The current GPDC represents the next iteration of high-risk, high-reward accountable care models from the CMS Innovation Center. It builds upon lessons learned from MSSP, Pioneer, and Next Gen models, while sprinkling in concepts learned from Medicare Advantage. The “auto-enrollment” feature, as it has been called, is merely CMS’s mechanism for finding where patients have historically sought care and assigning responsibility for patients’ spending and quality to a DCE if patients have most of their primary care from a provider participating in that DCE. The model offers more benefit enhancements and incentives over traditional Medicare, while protecting traditional Medicare’s hallmark freedom of choice for patients to see any willing provider. There is no prior authorization, and DCEs must inform patients of their assignment to a DCE. Beneficiaries who have declined to enroll in Medicare Advantage maintain all of the rights and freedoms they receive under traditional Medicare. This should not be the end of traditional Medicare, as advocates have recently claimed, but is a way to provide additional beneficiary and provider tools as part of a whole-person care approach.

While NAACOS continues to be supportive of provider-led ACO models, we were dismayed when Direct Contracting dropped the word “Provider” in 2019. That name change accompanied an emphasis on giving favorable treatment to entice new participants, such as payers, to Direct Contracting at the expense of providers who have been on the frontlines of the value transition for the past decade. NAACOS reiterates our recommendation that CMS focus GPDC on providers, keeping them at the center of payment models, instead of implementing programs and policies to attract new players into traditional Medicare. We continue to have concerns about the payer-led DCEs in the current cohort and have hopes that CMMI will not allow some of the features that critics raise to creep into their execution of the model. Furthermore, we urge CMS to limit the size of APMs, including GPDC, to the scale needed to test and evaluate the concepts featured in the model. CMS should be careful to monitor and control overall program and individual DCE growth, based on number of beneficiaries. We also request CMS ensure a balance of DCEs based on controlling ownership (i.e., payer, investor, provider).

We understand that CMS is considering potential changes to take effect in 2023. CMS can do more to entice historically successful ACOs to participate in GPDC. As part of those changes, we believe CMS can better support provider-led DCEs by implementing our below recommendations:

- Create a level playing field between new entrants and historically successful DCEs by making adjustments to the benchmarking methodology
- Reduce the mandatory discount applied to Global DCEs
- Increase the shared savings rate for Professional DCEs to 75 percent
- Increase the cap on risk score growth related to the regional blend
- Use a regional retrospective trend adjustment
- Employ fairer risk adjustment policies to better account for aging populations

- Improve program transparency, including ownership, lives covered, risk level, and choice of capitation selection

Providing DCEs with tools to address equity should also be included in updates to GPDC. Improving health equity can serve the dual purpose of helping deliver high quality care in a cost-effective manner and tackling systemic discrimination, which has led to wide and longstanding gaps in health equity for underserved communities. NAACOS has published two position papers, offering ways to both build in equity within ACO models and updating quality measurement to address equity. Ideas offered include increasing benchmarks to benefit ACOs treating vulnerable populations, adapting Innovation Center models to cover urban areas that meet the definition of a distressed community, developing a Medicare service to allow ACOs to bill for things like beneficiary transportation, and providing additional flexibility with Medicare rules for ACOs to deliver supplemental benefits to patients to help address health equity. GPDC offers a wonderful vehicle in which to test these ideas and others. NAACOS hopes you include them in future iterations of the model.

While supportive of GPDC, NAACOS views the Geographic Direct Contracting Model as problematic. This would automatically assign patients to a Geographic DCE, patients maybe never seen by providers operating under that DCE. This creates questions about patient protections, beneficiary rights, model overlap, and provider incentives. CMS paused “Geo” in March 2021, and we urge you to clarify that CMS no longer intends to move forward with the Geographic Direct Contracting Model.

Additionally, we have heard from certain ACOs that GPDC isn’t appealing to them. The Professional option offers too little reward, and the Global option too much risk. Some Next Gen ACOs also view MSSP’s Enhanced track as a step backward on the value transition, and with that program ending this year, they have had to make difficult decisions about future APM participation. In addition to improving GPDC, NAACOS recommends the agency develop a new full-risk option for ACOs as a second component of the MSSP Enhanced Track. Creating an “Enhanced Plus” option would advance MSSP by providing a permanent option featuring full risk and capitation, which to date has only been available in Innovation Center ACO models, such as the Next Generation ACO Model and parts of GPDC.

NAACOS is disturbed by some of the misinformation about GPDC that has recently been publicized. It is important that CMS and stakeholders, such as NAACOS, combat misinformation so the public understands the benefits of transitioning our healthcare system to one focused on value over volume. Despite some of the concerns being raised by certain advocates, we shouldn’t walk away from what we’ve learned to date, which is that accountable care models work. As you outlined in the recent strategy refresh for the Innovation Center, there are lessons to be applied in future work, and NAACOS remains fully committed to the transition to value-based care and is ready to work with you to achieve our mutual goals. Thank you for your consideration of our feedback and suggested improvements to GPDC.

Sincerely,

Clif Gaus, Sc.D.
President and CEO
NAACOS