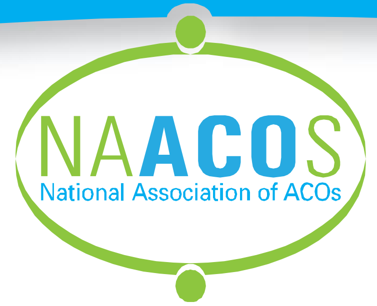

Elizabeth Fowler
Deputy Administrator for the Centers for Medicare & Medicaid Services
Director of the Center for Medicare & Medicaid Innovation
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

July 12, 2021

Dear Director Fowler:

The National Association of ACOs (NAACOS) thanks the Center for Medicare and Medicaid Innovation (Innovation Center) for its continued efforts to change the way health care is paid for and delivered by implementing alternative payment models (APMs) including the Global and Professional Direct Contracting Model (GPDC). As the largest association of accountable care organizations (ACOs) and Direct Contracting Entities (DCEs), representing more than 12 million beneficiary lives through hundreds of Medicare Shared Savings Program (MSSP), Next Generation (Next Gen) ACO Model, GPDC, and commercial ACOs, 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.

We appreciate your recent comments during our spring conference and your commitment to making GPDC a model that provides an opportunity for Direct Contracting Entities (DCEs) to drive value in traditional Medicare. We also feel there is room to improve GPDC as the model moves forward. We hope the feedback detailed in this letter is helpful as you continue your work, and we request the agency implement the recommendations below.

<u>OVERARCHING RECOMMENDATIONS</u>

NAACOS has been engaged with the Direct Contracting Model since its inception. In 2018, the agency released the model initially titling it “Direct Provider Contracting,” only to later drop the word “Provider.” That name change went along with an emphasis on giving favorable treatment to entice new participants, such as payers, to the model at the expense of providers who have been on the frontlines of the value transition for the past decade. NAACOS recommends that CMS focus the overall value transition on providers, keeping them at the center of payment models instead of implementing programs and policies to attract new players into traditional Medicare. We request the Innovation Center purposefully put providers at the center of the Direct Contracting Model.

NAACOS remains concerned that GPDC unfairly penalizes provider organizations that have previously participated in shared savings models and generated savings. Because they have spent years lowering the

cost of care on their patients, the model's benchmarking rules place them at a disadvantage. We urge you to maintain a level playing field for both new entrants to fee-for-service (FFS) APMs and those existing ACOs that, through their investments and commitment to innovation, have already driven value in traditional Medicare.

As the agency develops new APMs, we recommend that any new models should build from prior initiatives and avoid undermining or competing with ongoing initiatives. NAACOS is a strong supporter of innovation in delivery and payment and sees tremendous value in testing new concepts. These tests are key to learning how to best adapt and transform Medicare, and they should be just that – tests – as opposed to broad scale Medicare reform, which would necessitate congressional directives. Therefore, we recommend the Innovation Center limit the size of APMs, including Direct Contracting, to the scale needed to test and scientifically evaluate the concepts featured in the model. The Innovation Center should be careful to monitor and control overall program and individual DCE growth, based on number of beneficiaries. We also request the Innovation Center ensure a balance of DCEs based on controlling ownership (i.e., payer, investor, provider). Managing Direct Contracting, and other APMs in this manner, ensures important program elements can be tested appropriately without going beyond CMS's authority to implement a broad scale change to Medicare absent congressional direction.

Further, successful Innovation Center payment models, or key aspects of those models, should become permanent parts of Medicare. The Next Gen ACO Model tested a number of features that should be incorporated into a permanent part of the MSSP. 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 the 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 Gen ACO Model and parts of GPDC. Key components of the model could include the ideas below and more.

- **100 percent shared savings and loss rates**
- **Participation at the Tax ID Number-National Provider Identifier (TIN-NPI) level** to allow the ACO to create a high-performing network, which is critical for such a high-risk model
- **Benchmarking:** Use rolling historical baseline based on three years, with a regional benchmarking component starting at 50 percent and increasing gradually to 70 percent. Apply a regional-only benchmarking trend to best reflect local market changes. Do not use a minimum savings rate or minimum loss rate and instead apply a 1.5 percent benchmark discount.
- **Options for capitated payments,** including partial and full capitation and the ability to negotiate downstream value-based payment arrangements
- **Offer advanced waivers, including these and more:**
    - **Post Discharge Home Visit Waiver** to create a smooth transition from the hospital to the patient's home and help prevent hospital readmissions
    - **Care Management Home Visit Waiver** to provide visits to beneficiaries at risk of hospitalization in the beneficiary's home proactively to avoid a potential hospitalization
    - **Ability to Tailor Cost Sharing Support for Part B Services** to allow ACOs to reduce financial barriers for beneficiaries, encouraging better adherence to treatment plans. CMS gives Next Gen ACOs the flexibility to identify certain beneficiaries to receive these benefits. ACOs should have maximum flexibility to determine how to implement the benefit.

SPECIFIC DIRECT CONTRACTING RECOMMENDATIONS

We appreciate your emphasis on evaluating and improving Innovation Center models, and as you continue to do so we want to take the opportunity to provide specific feedback on GPDC and request you implement these changes beginning with Performance Year (PY) 2022.

Program Transparency
An important aspect of CMS's work is transparency, which comes in many forms across Medicare. To date, the public information available on DCEs is very limited with this document showing only the organization name, DCE type, and states covered by each DCE. It is important for the Innovation Center to share more information on DCEs, such as what type of organizations they are and how many beneficiary lives are part of their DCE. Moving forward, the Innovation Center should update this information and provide more specific information on DCE growth. Additionally, we urge the Innovation Center to make key primary program data publicly available to enable researchers to evaluate aspects of the program and to support a broad understanding of independent program evaluations. We also request the Innovation Center release information on the DCEs that are approved for the 2022 cohort.

Participation Selections

- 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. The 50 percent shared savings rate for DCEs electing the Professional Risk Sharing Option (Professional DCEs) is too low. The Professional DCE option will be a step backward for many Next Gen ACOs, which offered an 80 percent shared savings rate, or ACOs participating in or considering participation in MSSP Enhanced, which offers up to 75 percent shared savings with significantly less downside risk than GPDC. Increasing the shared savings rate for Professional DCEs will make it a more fair and attractive option.

- Allow greater flexibility for DCEs to switch DCE types and capitation options. Some DCEs wish to switch from the Professional to Global option and from Primary Care Capitation to Total Cost of Care Capitation between PY 1 and 2. We applaud the Innovation Center's decision to allow Professional DCEs to switch to the Global Risk Sharing Option. NAACOS also supports CMS providing greater flexibility for DCEs to switch from Primary Care Capitation to Total Care Capitation on an annual basis.

Performance Year Benchmarks and Risk Adjustment

Historical Baseline

- Flip the weighting of the benchmark years used in historical expenditures to give greater weight to the least recent year. This recommendation would place more weighton 2017 and less weight on 2019, which is the opposite of current policy. Because previously successful ACOs have spent the last several years lowering the cost of care on their patients and in their communities, spending on their DCE-aligned patients will be lower in 2019, which current policy places the most weight on. This unfairly penalizes previously successful ACOs.

Weighting Baseline Years in DCE Benchmarks		
Year	**Current**	**Proposed Revision**
2019	60%	10%
2018	30%	30%
2017	10%	60%

- Add shared savings back into DCE baselines for benchmarking purposes. We ask that the Innovation Center add shared savings earned by a DCE back into its baseline for purposes of setting the performance year benchmark. This removes the penalty for DCEs who have helped Medicare's goal of lowering spending.

- Forego use of the historical baseline expenditures for all DCEs and rely solely on the new Rate Book. Direct Contracting leverages a new Direct Contracting/Kidney Care Choices Rate Book, which NAACOS appreciates. This decreases the reliance on historical expenditures. Rather than starting with 35 percent expenditures for the first three years with a progression toward a maximum of 50 percent, the blend should start at 50 percent and progress to 100 percent regional expenditures by the endof the model.

Regional Blend

- Increase the cap on risk score growth related to the regional blend (currently set 5 percent). While the purpose of this cap is to prevent outliers in risk-score growth, the policy penalizes Standard DCEs with predominantly claims-aligned beneficiaries that are subject to historical baseline expenditures instead of regional rates by capping regional efficiency at 5 percent and then applying the DCE Global Discount. Regionally efficient DCEs should be appropriately rewarded instead of being double penalized (i.e., regional efficiency is capped at 5 percent and then DCE Global Discount of 2 percent is applied). This double penalty will only accelerate as the regional weight and discount increase each year. Rather than choosing an arbitrary number as the cap, we recommend identifying the percentage of participating Standard DCEs that the Innovation Center believes is appropriate to hit a cap (e.g., 10 percent) and then use prior performance year data to set the cap accordingly.

Risk Adjustment

- Reconsider the application of the 3 percent DCE-level cap on risk adjustment. NAACOS recommends revising the risk adjustment methodology so that the 3 percent DCE-level cap is applied after the Coding Intensity Factor. This change would ensure that DCEs caring for higher risk beneficiaries are not hit twice with the limit to the risk score. Additionally, the Innovation Center should consider setting the DCE-level cap based on the percentage of DCEs the Innovation Center believes should be capped over a one- or two-year span. This approach is similar to what we suggest with respect to more appropriately limiting the regional blend, and both approaches would prevent outliers.

- The Innovation Center should extend the model's use of the new Innovation Center-Hierarchical Condition Code (HCC) concurrent risk adjustment model and apply it to high-needs beneficiaries for all DCEs types — not just High Needs Population DCEs. The Innovation Center could identify those beneficiaries aligned to a Standard or New Entrant DCE that meet the high-needs criteria and apply the new risk adjustment model to those beneficiaries while continuing its use of the traditional CMS-HCC prospective risk adjustment model for other beneficiaries. Such a policy would further your goal of reducing the influence of coding practices on benchmarking.

- The Innovation Center should end the risk adjustment policy for voluntarily aligned beneficiaries that incentivizes gaming. Currently, Direct Contracting sets historic spending for voluntarily aligned beneficiaries to regional spending as defined by the DC/KCC Rate Book. Unfortunately, this creates a perverse incentive for DCEs to voluntarily align healthy, low-spending patients, whose true spending will likely be far less than that of the regional average. This also further creates a disparity between MSSP ACOs and DCEs because in the former spending for voluntarily aligned beneficiaries is their historic spending. The Innovation Center should either discontinue this policy or create a level playing field to not promote arbitrage, create programmatic discrepancies, or worsen health disparities.

Retrospective Trend Adjustment

- Use a regional retrospective trend adjustment. GPDC allows the Innovation Center to apply a retrospective adjustment in instances where change in trend is larger than anticipated prior to the start of a performance year. NAACOS appreciates the Innovation Center's recent announcement bringing more transparency to retrospective trend adjustments by stating potential adjustments during the performance year. However, using the national trend is not appropriate as DCE costs vary greatly by region, especially since the beginning of the COVID-19 Public Health Emergency. Accordingly, we ask that the Innovation Center switch to a regional retrospective trend adjustment that more accurately reflects the experience and performance of the DCEs.

Discount for Global Option

- Reduce the mandatory discount applied to Global DCEs. For DCEs selecting the Global Risk Sharing Option (Global DCEs), CMS will realize savings from the model by implementing a discount that collects 2 percent of a DCE's benchmark in P Y 1 and increasing that to 5 percent in PY 5. NAACOS continues to believe this discount is far too high and will be a significant barrier for DCEs to generate savings and will discourage model participation. Increasing the discount to as high as 5 percent places an insurmountable burden on DCEs. In fact, we believe many Next Gen ACOs will either participate in MSSP Enhanced or as a Professional DCE because of the discount. This means forcing ACOs currently at 80 percent or 100 percent risk to select an initiative with significantly reduced risk, which is counterproductive to CMS's goals. We urge a more realistic discount, such as the 2 percent discount used in the Next Gen ACO Model, that could be tied regional efficiency. We believe a lower discount would result in greater savings to the Medicare program, as there would be greater participation in the full-risk Global Risk Sharing Option.

Quality

- We urge the Innovation Center to make further details available regarding the Continuous Improvement/Sustained Exceptional Performance criteria, and how quality benchmarks will be established as soon as possible.

Data Sharing

- Provide claims data for all aligned beneficiaries. CMS provides claims data to DCEs for purposes of "clinical treatment, care management and coordination, quality improvement activities, and provider incentive design and implementation." However, when a Participant Provider ends participation in the model during a performance year, CMS currently terminates sharing of beneficiary-level data for any beneficiary aligned to a DCE through that provider. This policy harms DCEs because they remain accountable for those beneficiaries for the remainder of the year and need claims data for those beneficiaries in order to provide appropriate high-value care. Data is essential to care coordination, and DCEs can use that data in a variety of ways, such as reaching out to patients about necessary clinical interventions, coordinating necessary follow up care, and implementing care management strategies.

  Accordingly, providing claims data for a beneficiary for so long as the beneficiary is aligned to a DCE is the "minimum necessary" for DCEs to meet model requirements and objectives. NAACOS understands that data sharing decisions are made jointly by the Innovation Center, the Office of the General Counsel, and Office of Enterprise Data and Analytics' Data and Information Dissemination Group. We ask that these offices work together to implement an immediate reversal of this policy.

- Implement Use of HETS for Event Notification. CMS's HIPAA Eligibility Transaction System (HETS) allows providers to check Medicare beneficiary eligibility in real-time using a secure connection. CMS should make HETS feeds available to DCEs to better understand, in real-time, where patients seek care in the health system, including at the emergency department or inpatient hospital. Access to critical HETS information in real time would allow DCEs to further enhance care coordination, improve patient outcomes, and reduce costs — all are tenets of advancing value-based payment models. CMS's Interoperability and Patient Access Final Rule requires electronic notifications of patients' admission, discharge and transfer to be sent to community providers, but CMS doesn't require those alerts to be sent to ACOs or DCEs.

Fraud and Abuse Waivers

- CMS and the HHS Office of the Inspector General have historically issued waivers of certain fraud and abuse laws in connection with APMs. Relying on regulations issued in late 2020, CMS and the Office of the Inspector General have declined to issue any such waivers for GPDC. NAACOS understands that the GPDC Participation Agreement formalizes the applicability of parts of the new Federal anti-kickback statute regulations (42 CFR § 1001.952(ii)(1)) to financial arrangements between the DCE and its providers and beneficiary engagement incentives. However, GPDC currently does not provide any waivers related to the Stark laws or the Civil Monetary Penalty for beneficiary inducements. Moreover, in contrast to prior waivers, GPDC does not offer a waiver allowing financial relationships (including model participation and shared savings distribution) with individuals or entities beyond Participant Providers and Preferred Providers. This is problematic for the many DCEs that engage with care management and other organizations and limits the way in which those organizations may be compensated. NAACOS requests that the Innovation Center use the authority granted under section 1115A(d) of the Social Security Act to implement stand-alone fraud and abuse law waivers similar to those issued for the Next Gen Model and the MSSP.

Other Direct Contracting Model Types

- Fully pause implementation of the Geographic Direct Contracting Model. In March, the Innovation Center placed the Geographic Direct Contracting Model under review. NAACOS had previously recommended a pause in the model's implementation, so we appreciated your swift action. "Geo," as it's commonly referred to, would cause undue confusion among beneficiaries, and disrupt ACO providers' established relationships with their patients if a Geo DCE ultimately has financial accountability for traditional Medicare beneficiaries in the region. It would also create concerns about the role of health plans in traditional Medicare and the future direction of APMs within the Innovation Center. It would also further exacerbate our concern about the overlap with other APMs.

  Those concerns remain, so we ask the Innovation Center to fully stop the model and test specific favorable Geo concepts and policies in other APMs. While Geo sought to test concepts such as random assignment of beneficiaries without a primary care home, utilization management and access to real-time claims application programming interface (API), NAACOS believes these features could be incorporated into other ACO models without introducing a new layer of administrative complexity.

- The Innovation Center should pause implementation of the new DCE type that allows Medicaid Managed Care Organizations (MCOs) to manage Medicare FFS expenditures for dually eligible beneficiaries. NAACOS is concerned this DCE type will bifurcate care for these vulnerable

patients. ACOs and DCEs already care for a large number of dual eligible patients, particularly those in long-term care settings. Because patients can only be assigned to one entity, the Innovation Center risks eroding the care already provided to these high-risk patients.

We appreciate the opportunity to provide feedback on how to improve GPDC. NAACOS and the Innovation Center share the goal of wanting these models to be successful, and we believe our above recommendations will create a better, more sustainable model. Thank you for your consideration of our comments.

Sincerely,

Clif Gaus, Sc.D.
President and CEO