December 16, 2020

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

RE: Direct Contracting: Professional and Global Options Performance Year 2021 Financial Methodology; Geographic Option

Dear Director Smith:

The National Association of Accountable Care Organizations (NAACOS) writes to request changes to the Direct Contracting Model. 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.

Two components of the Direct Contracting Model, the Professional and Global Options, are similar to traditional accountable care models, such as the Medicare Shared Savings Program (MSSP) and the Next Generation ACO Model. ACOs in these models have well established track records for generating savings for Medicare and providing beneficiaries with high quality care. We appreciate the Center for Medicare and Medicaid Innovation's (Innovation Center's) work to build off these models with the Professional and Global Options. We were hopeful with the launch of Direct Contracting that many ACOs would participate in the model. However, as time has gone on, we have seen the potential opportunity dwindle for existing ACOs to participate as the model has been steered increasingly to incentivizing new entrants into Medicare and, in some ways, adding a new administrative layer.

In fact, the original name for the model was "Direct Provider Contracting," but the "provider" reference was later dropped. We urge the Innovation Center to implement changes detailed in this letter to put back the provider emphasis into this model. Specifically, to ensure ACOs and providers who are already focused on value-based care have an equitable opportunity to be successful in the

Professional and Global Options, we request the Innovation Center implement changes to the financial methodology for these options.

The third component of the Direct Contracting Model, the Geographic Option, is a greater departure from traditional accountable care models and would add a new layer to Medicare, between the federal government and providers caring for patients. While it is important to continue Medicare's overall transition to value, based on our concerns about the Geographic Option's disruption to provider-patient relationships and new complexity and potential to undermine current, proven accountable care models, we recommend the Innovation Center halt implementation of the Geographic Option.

We provide more detailed feedback below on our recommended changes for the Professional and Global Options and our concerns about the Geographic Option.

PROFESSIONAL AND GLOBAL OPTIONS

As the Innovation Center continues to develop its policies for the launch of Direct Contracting, it must ensure that the model's financial methodology offers an equal opportunity for success for both organizations that have participated in prior Medicare fee-for-service (FFS) accountable care initiatives and those organizations that are wholly new to such programs. Unfortunately, the financial specifications, as currently laid out, will disenfranchise legacy ACOs that have worked for nearly a decade in some cases to lower the cost of care in their communities. These ACOs embraced the transition to value early on and worked with CMS to grow and refine the models so they would be successful long term. These providers were on the forefront of the value transition and took great risk to blaze a trail for other providers to follow. Many did so without financial backing and by investing their own resources with uncertainty about a return on their investment.

Their commitment to clinical transformation and value-based care has advanced the entire healthcare industry and they should be rewarded, not penalized, for these efforts. Penalizing these early adopters sends a message that early adoption and risk taking should not be rewarded, which will have an unfortunate effect of disenfranchising organizations who have been at the heart of the value movement. It is also unclear if some organizations who look to enter FFS Medicare for the first time are doing so with the goal of gaining exposure to beneficiaries to then recruit them to Medicare Advantage. While an understandable business tactic, the Direct Contracting Model should remain focused on the Innovation Center 's overall goals — to improve quality of care and provide savings to the Medicare Trust Fund, not to create an arbitrage opportunity for certain businesses to enhance their portfolios or stocks.

Therefore, to recognize legacy ACOs and provide an equitable opportunity for them to be successful in the Professional and Global Options, we request the Innovation Center implement the following changes. Doing so will support and protect all Professional and Global Direct Contracting Entities (DCEs) wishing to deepen their commitment to the value-based payment.

Historical Expenditures

The proposed benchmarking methodology for claims-aligned beneficiaries in a Standard DCE uses a three-year weighted baseline of historical expenditures. Because the base years are weighted very heavily toward the most recent base year, it will be difficult for experienced organizations to succeed

in Direct Contracting. Experienced ACOs and DCEs have already achieved significant savings through the care provided to their aligned beneficiaries. Because more weight is placed in more recent years where more value has already been delivered, experienced ACOs and DCEs are essentially competing against value they have already delivered in a way that makes participation unsustainable. The use of these weighted baseline years poses an additional disadvantage because (1) the benchmarks have additional significance since they are used in setting capitation amounts; and (2) the DCEs that qualify as New Entrant or High Needs Population DCEs will not be subjected to the use of historical expenditures for at least the first four years of the model. The latter further disadvantages legacy ACOs, who will participate disproportionally as Standard DCEs.

To address this issue, the Innovation Center should flip the weighting of the base years, giving greatest weight to the least recent year.

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

We also 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 is important as it creates a more sustainable model by rewarding, rather than penalizing, DCEs who have helped CMS reach the program's goal of lowering Medicare spending.

Application of Regional Expenditures

NAACOS is pleased that the Innovation Center aimed to align the risk adjustment approach for Direct Contracting with Medicare Advantage and use of a rate book designed to more accurately capture the costs of aligned beneficiaries. **However, the model should take further advantage of this tool and decrease its reliance on historical expenditures. To this end the Innovation Center should consider completely forgoing the use of the historical baseline expenditures for all DCEs and relying solely on the Direct Contracting/Kidney Care Choices (DC/KCC) Rate Book.** If the agency chooses not to do so, we request that the Innovation Center at least give more weight to regional costs and increase the percentage of regional expenditures used in the blended benchmark. 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 end of the model.

During 2020, NAACOS greatly appreciated how CMS acted quickly to adjust value-based payment models such as the MSSP and the Next Generation ACO Model to account for the anomalies and hardships created by the COVID-19 pandemic. The agency has pledged to continue to monitor the effects of the pandemic on Alternative Payment Models (APMs) to ensure that a global health crisis not derail the hard work from both the agency and providers to transition to value. Therefore, NAACOS asks the Innovation Center to consider changes to the DC/KCC Rate Book to account for the impacts of COVID-19. Because the regional rates do not account for underutilization, the Innovation Center should make adjustments to the regional rates to capture the loss of utilization experienced by many DCEs as a result of COVID-19. Moreover, the rate book should be adjusted to account for potentially uneven reductions in utilization even with within a county.

Risk Adjustment

NAACOS appreciates the Innovation Center's development of the new CMMI-Hierarchical Condition Code (CMMI-HCC) concurrent risk adjustment model and goal of reducing the impact of coding. We have long advocated that CMS employ risk adjustment policies that more closely match those used in Medicare Advantage and use a consistent approach to risk adjustment across all Medicare payment models, including in Medicare Advantage. Upon initial review, this new concurrent risk adjustment model appears to be a much better indicator of the risk associated with high-needs beneficiaries. **The Innovation Center should extend the model's use and apply it to high-needs beneficiaries for all DCEs types — not just High Needs Population DCEs.** CMS has prior experience with the limitations of risk adjustment for outlier populations, which was seen with the Independence at Home Model and the Dually Eligible Demonstration, and therefore the agency should use the new tool more broadly than initially planned. The Innovation Center could identify those beneficiaries aligned to a Standard or New Entrant DCE that meets the high-needs criteria and apply the new 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.

Moreover, we believe the application of the DCE-level 3 percent risk score cap in concert with the Coding Intensity Factor (CIF) could result in a benchmark that unjustly underrepresents the health of a DCEs aligned beneficiaries. The stated goal of the CIF — to ensure that the change in normalized payment risk scores across all claims aligned beneficiaries is 0 between the most recent baseline year (2019) and the performance year — demonstrates the problem with this policy. If DCEs hit the 3 percent cap and then the CIF will be dividing it, DCEs will be right back at about 1 percent, which pushes the financial calculations further from MA and makes it harder for DCEs to succeed.

The DCE-level 3 percent risk score cap also favors those DCEs that are new to Medicare accountable care initiatives, with a strategy to drive Voluntary Alignment. Not applying the cap to voluntarily aligned beneficiaries may have the unintended consequence of encouraging DCEs to incentivize beneficiaries to switch providers so as to increase the DCEs' voluntarily aligned population. Such a practice would be harmful not only to existing ACOs/DCEs, but also to the provider-patient relationship. This practice is exacerbated by the long lead time for a beneficiary to become aligned via claims, resulting in a beneficiary's exclusion from the cap for as many as three years. The Innovation Center should structure the application of the cap for voluntarily aligned beneficiaries in a way that distinguishes those beneficiaries who did not have an existing care relationship (and for whom exclusion from the cap is therefore reasonable policy) and those that have had their care managed by a primary caregiver (for who exclusion from the cap is unjustified).

Discount

For Global DCEs, CMS will realize savings from the model by implementing a discount that collects 2 percent of a DCE's benchmark in Performance Year 1 and increasing that to 5 percent in Performance Year 5. **NAACOS continues to believe this discount is too high and will be a significant barrier for DCEs to generate savings and will discourage model participation.** We understand that the Innovation Center must ensure savings to the Medicare program in a full-risk model and recognize that the Next Generation ACO Model employs a 2 percent discount. However, increasing the discount to as high as 5 percent places an insurmountable burden on DCEs. Many DCEs that had hoped to participate in the Global Option were those that have already demonstrated success in shared savings initiatives, but the barrier of these high discounts along with challenging benchmarks

may dissuade many from participating. Therefore, we request the Innovation Center lower the overall discounts for the Global Option.

QP Status for High Needs DCEs

Direct Contracting intends to qualify as an Advanced APM and as such allow Participating Providers to be eligible to qualify for a 5 percent bonus under the Quality Payment Program, assuming they meet other criteria. However, High Needs Population DCEs will inherently include only a small number of patients from a participating organization due to the additional attribution requirements established for those DCEs. High Needs Population DCEs will have almost no chance of hitting the Qualifying APM Participant (QP) thresholds — either a as percent of patients in or payments through the APM. The QP calculations as structured do not make sense for a High Needs DCE and should be modified so these APM entities can qualify for the Advanced APM bonus. **NAACOS urges the Innovation Center to create an exception or alternative calculation for High Needs DCEs so they can be eligible for the Advanced APM bonus, which has been a meaningful driver with incentivizing Advanced APM participation.**

GEOGRAPHIC OPTION

NAACOS strongly supports the continued transition of Medicare Parts A and B away from uncoordinated FFS and toward a system that rewards value, not volume. We believe that as CMS develops new payment models, it must do so in a way that builds upon prior models and maintains a level playing field for both legacy ACOs and organizations that are new to FFS APMs. We recognize that the Geographic Option offers some promising policy components — such as allowing utilization management and providing access to a real-time claims API. However, these features could be incorporated into other accountable care models without creating a new model that introduces another layer of administrative complexity to Medicare.

The Geographic Option raises other significant concerns, including creating confusion among beneficiaries who are compelled to participate in the model. The vast majority of beneficiaries will have no idea what a Geographic DCE is and what mandatory beneficiary participation will mean for their care and existing provider relationships. While we appreciate that beneficiaries will retain their choice of provider, which is a hallmark of current ACO programs, their assignment to a Geographic DCE with which they have had no past relationship will invite considerable confusion and unnecessary complexity. For example, there is the potential for duplicative care or competing care management programs from a Geographic DCE and the providers the patient sees, who may or may not be participating with the Geographic DCE. This could disrupt existing care relationships and potentially create waste in the healthcare system at a time when resources are already stretched thin as we recover from the COVID-19 pandemic.

The Geographic Option also invites new complexity with the interaction of APMs. There is already considerable confusion with the myriad of complex APM overlap rules for existing models. Rather than adding a new layer of complexity that introduces even more confusion about overlap, we request the Innovation Center focus on fixing the existing model overlap issues. Overall, **NAACOS recommends that certain policy goals of the Geographic Option would be better tested and evaluated in the Direct Contracting Model's Professional and Global Options and/or other ACO programs, and we urge the Innovation Center to halt implementation of a Geographic Option at this time.**

CONCLUSION

NAACOS has been a consistent partner in advancing the Innovation Center's APMs since its formation and appreciates your focus on continuing to drive value into Medicare. We believe our above recommendations will increase legacy ACO participation in Direct Contracting Professional and Global Options while helping the program achieve its stated goals of lowering the cost of care while improving quality. If you have any questions, please contact Allison Brennan, Senior Vice President of Government Affairs, NAACOS at abrennen@naacos.com.

Sincerely,

Clif Gaus, Sc.D.
President and CEO
NAACOS