AMERICA'S PHYSICIAN GROUPS
Taking Responsibility for America's Health

June 28, 2020

Brad Smith
Deputy Administrator & Director
Center for Medicare & Medicaid Innovation
U.S. Department of Health & Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Direct Contracting

Dear Deputy Administrator Smith:

America's Physician Groups (APG) applauds the Centers for Medicare and Medicaid Services (CMS) for its years long efforts in promoting value-based care and the transition from volume to value. APG and its member organizations are highly anticipating next year's launch of the direct contracting innovation model. After investigation, we have identified some issues for states in advance of the implementation of the new model that may potentially result in confusion surrounding the insurance regulation aspects of the program. It is also imperative that risk scoring for the new model be as accurate as possible to ensure that participants may accurately capture and diagnose patients. We would ask that CMS appropriately address these discrepancies to ensure that they have no negative effect on the direct contracting model timelines and the transition of the healthcare system to providing high quality care at a lower cost and away from the fee-for-service model.

About America's Physician Groups

APG is a national professional association representing over 300 physician groups that employ or contract with approximately 195,000 physicians that provide care for nearly 45 million patients. Our tagline, "Taking Responsibility for America's Health," represents our members' vision to move away from the antiquated fee-for-service (FFS) reimbursement system where clinicians are paid "per click" for each service rendered rather than on the outcomes of the care provided. Our preferred model of accountable, risk based, and coordinated care avoids incentives for the high utilization associated with FFS reimbursement. APG member organizations are also working diligently to rise to the challenge presented by the COVID-19 pandemic and we appreciate the flexibilities and waivers CMS has afforded us during this time of crisis.

Summary of Recommendations

- **Provide clarity to states regarding their responsibility to address whether state laws apply to risk-bearing provider entities by disseminating to states guiding documentation on the direct contracting features and requirements.**

- **Calculate a more accurate risk score by using a 24-month period of diagnostic data**

- **Provide incentive to participating providers to see attributed patients frequently by allowing risk score increases over the course of the performance contract without a cap during the initial years of the program**

- **Ensure that providers are incented to take additional financial risk during the COVID pandemic by allowing for a retrospective adjustment to the cost benchmark and reducing the program discount in the global DCE model**

- **Ensure telehealth visits are accepted for risk adjustment purposes and claims-based attribution**

- **Ensure a smooth transition into the DCE model for providers currently participating in CPC+, MSSP, and NextGen by addressing Q1 2021 in a manner that doesn't result in a disincentive for starting Direct Contracting in April 2021.**

Many of our member organizations that are planning to participate in the direct contracting model have taken the initiative to reach out to the state agencies in their respective states to determine whether there are applicable licensure requirements. What they have found is a general lack of understanding about the Direct Contracting model, broadly, and specifically as to whether or how the insurance regulations apply to risk bearing provider organizations. The confusion is uniform among the states queried, including departments with extensive experience in dealing with regulatory oversight. The state of Massachusetts, for instance, has an established Risk Bearing Provider Organization certification process and has specifically carved out from regulatory oversight provider organizations that bear downside risk under Medicare Advantage plans. Even that state has not issued guidance as to whether providers bearing risk under the Direct Contracting model will be similiarly carved out from regulatory oversight. Such lack of guidance leaves provider organziations in Massachusetts – and across the country -- uncertain as to whether there are applicable licensure requirements and how to demonstrate exemption and/or compliance.

From our interactions with these multiple state agencies and consistent with what CMS predicted in the Direct Contracting RFA, it is clear that some form of guidance from CMS to the states is needed. **We ask that CMS consider providing states with clarity regarding their responsibility to address whether and how state laws apply to risk bearing provider organizations under the direct contracting model (ideally exempting provider groups from state-based insurance regulation for this program as they do with Medicare Advantage would be our preference)**. This clarity could possibly be provided through a primer or some other easy to understand presentation materials disseminated to states and/or their departments of insurance providing an overview of the direct contracting model.

The risk adjustment process exists in order to ensure that providers are reimbursed appropriately for high cost patients and healthier, lower cost patients alike and to not provide a disincentive for serving lower income and higher need patients. This is particularly important if you wish participants to be signing up new providers and patients. In support of that effort, we recommend that when formulating the risk score model for direct contracting, **scores should reflect the current FFS normalization factor but without a cap applied.** Taking this approach would allow participants to not be held back from appropriately coding the disease burden of its patients.

Calculating risk scores for direct contracting entities will play an integral role in the long-term viability of the direct contracting model**. To calculate the most accurate risk score possible, CMMI should consider**

using concurrent risk scores using a 24-month period of diagnostic data so that the performance year risk score is based on diagnoses from current performance year as well as the the prior year. Using this calculation would allow providers the best opportunity to diagnose patients accurately in order to provide the highest quality care and improve patient outcomes and ensure an accurate benchmark adjustment for participating providers with established patients who age into Medicare during the program year.

CMMI should allow risk scores to increase over the course of the performance contract (without a cap) in order to incentivize direct contracting participants to continue to recruit new providers and patients into the DCE's without a risk of risk adjustment dilution. This strategy would also allow for an accurate capture of patients chronic risk by allowing DCE risk scores to increase over the course of the performance contract. This approach should ensure that entities that grow the number of participating providers over the 5-yr period are not penalized and emphasize the accurate capture of diagnostic based risk in the first year of participation in order to facilitate the maximum quality of care for DCE attributed patients as quickly as possible for the established patient base. If after several years in the program, CMMI decide a cap on risk scores is needed, we would recommend using **Baseline Benchmark year 3 (vs average of benchmark 1 through 3) to more accurately reflect enrollees health status**.

CMMI should factor in the additional uncertainity that providers face when taking downside risk during a global pandemic and consider program adjustments to encourage participation. This includes the consideration of a higher weight on the regional trend adjustment in 2021 due to the localized nature of the pandemic and ensuring that CMMI develops a proactive approach to revisit the 2021 benchmark retrospectively given that the full impact to beneficiary cost trends is unknowable at this point. To further incent providers to take increased cost risk and move into the global DCE model during such unprecented times, CMMI should consider reducing the discount applied to the **benchmark to 1%.**

Telehealth (audio/video) services are becoming of increasing importance to healthcare providers during these times. Providers have had to adapt to the reality of the COVID-19 pandemic by transitioning up to 70 percent of care to telehealth, while some APG member organizations report that up to 80 percent of adult primary care telehealth services are conducted using audio-only technology**. CMMI should ensure that telehealth visits are integrated into the direct contracting model by accepting them for risk adjustment purposes (with established patients that have been attributable to an entity or with at least one in-person visit for the year) as well as for purposes of claims-based attribution.**

Many of our members currently participate in other value-based care models for their traditional Medicare patients. CMMI should develop a transition process for those providers which encourages participation in the DCE models**. Specifically, we request that providers are allowed to continue to participate in their current models through March 31, 2021 and then seamlessly transition to the DCE models, without penalty in April 2021.**

Thank you for your attention to our concerns. We look forward to continuing to work with you throughout this process. Please feel free to contact Valinda Rutledge, Senior Vice President, Federal Affairs, (vrutledge@apg.org) if you have any questions or if America's Physician Groups can provide any assistance as you consider these issues.

Sincerely,

Donald H. Crane
President and CEO
America's Physician Groups