May 17, 2021

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SE, Room 445-G
Washington, DC 20201

Dear Secretary Becerra:

The America's Physician Groups (APG) Direct Contracting Coalition would like to thank you for the years-long effort that your agency and the Centers for Medicare and Medicaid Services (CMS) have shown in promoting value-based care and the transition from volume to value. Continuing to move the healthcare system down the path of providing high quality care at a lower cost and away from the fee-for-service (FFS) model will provide benefits to providers and patients alike. In that regard, as Direct Contracting Entities (DCE), all members of our coalition have been diligent in ensuring that the Direct Contracting model succeeds as an alternative payment model (APM) that offers increased cooperation and coordination among physicians across multiple settings resulting in systemic benefits such as lower hospitalization rates and post-acute care costs. In light of recent Congressional correspondence that you received from Representatives Bill Pascrell, Jr., Mark Pocan, Katie Porter, and Lloyd Doggett, we wanted to share with you aspects of the Direct Contracting model that stand in contrast to the claims made about the risk that it presents to Medicare beneficiaries and present why the Direct Contracting model and all DCE pilot programs must continue to move forward.

Summary Points

- **Direct Contracting uses voluntary alignment to strengthen beneficiary choice**
- **The ability of direct contracting patients to navigate across Medicare fee-for-service differentiates the model from Medicare Advantage in terms of accountability**
- **New benefits within direct contracting will close the gap between original Medicare and Medicare Advantage, a stated goal of the Biden Administration**
- **Direct Contracting opens the door for expansion of primary care into underserved communities that are harmed by the consequences of health inequities and disparities**
- **Primary care practices are receiving increased investment due to the launch of the Direct Contracting Model**
- **Direct Contracting has the potential to extend primary care coverage to more Medicare beneficiaries than any other APM model**

Los Angeles Office • 915 Wilshire Blvd, Suite 1620, Los Angeles, CA 90017 • (213) 624-2274
Sacramento Office • 1215 K Street, Suite 1915, Sacramento, CA 95814 • (916) 443-2274
Washington, DC Office • 1501 M Street NW, Suite 640, Washington, DC 20005 • (202) 212-6891

- **As a capitated model, Direct Contracting offers a unique opportunity to support a model of care that is directly designed to lower healthcare costs**

Comments

Representatives Pascrell, Pocan, Porter, and Doggett recently expressed many concerns to you regarding the level of accountability within the Direct Contracting model and the downstream effect this would have on Medicare beneficiaries and the Medicare program. Direct contracting, for the first time, provides the combination of capitation and full risk, offering participants the ability to provide enhanced quality of care to beneficiaries while ensuring savings to the Medicare program. In the following chart, we have outlined some of the claims included in their recent correspondence juxtaposed with fact-based analysis of the direct contracting model, how it operates, and its benefits for Medicare beneficiaries.

Congressional Correspondence Claim	Direct Contracting Model Fact
Beneficiaries will be auto-enrolled into private plans.	Only those beneficiaries that have an established care relationship with their primary provider and those who voluntarily elect to align to a DCE participate in the program.
It is unclear how CMS will ensure beneficiaries will be able to switch back to traditional Medicare.	Beneficiaries aligned to a DCE remain in traditional Medicare and retain freedom of choice to see any Medicare provider. Beneficiaries also retain all of their Medicare Part A and Part B benefits, without limitation, and may also be able to receive additional benefits at no cost, including reduced co-pays, dental reimbursement, and access to necessary food and transportation. Any beneficiary can opt-out of their alignment to a DCE at any time.
It is unclear how CMS will notify beneficiaries that they are aligned to an ACO.	DCEs provide each beneficiary with a written notice each year explaining that the beneficiary is aligned to the DCE, assuring the beneficiary that he/she retains beneficiary choice, providing contact information for the DCE, and detailing how the beneficiary can opt out of participation.
It is unclear how CMS will monitor DCEs.	DCEs contractually agree to strict reporting requirements and agree to ongoing monitoring and auditing by CMS and is contractors throughout the life of the model.
This is an "insurer DCE model."	This is an ACO model implemented as the successor to the Next Generation ACO model and greater than 90% of participants are provider-led organizations. For the first time, offers these provider DCEs the combination of capitation and full risk, giving the ability to provide enhanced access to care and quality of care to beneficiaries while ensuring savings to Medicare.
The letter's one data point is for "an insurance company."	The letter does not include any factual claim that insurer is one of the few payers participating in the model. The statistic is for the insurer's care across commercial and Medicare Advantage and, thus, is a red herring.
Participants may use HCC codes to inflate risk scores for aligned beneficiaries.	CMS limits any increase in payments on account of payment risk scores by instituting participant level caps

	on payment increases as well as by applying payment adjustments across all participants to ensure no DCE unfairly increases HCC codes for its patients.

The Direct Contracting model has been viewed as the next iteration of the ACO framework, helping primary care providers (PCP) transition to performance-based risk contracting while delivering better value to patients through the coordination of care across multiple settings and the improved care management of patients suffering from significant chronic diseases. **Whereas earlier ACO models did not sufficiently drive providers toward the acceptance of risk and delivering value-based care to Medicare beneficiaries and the Medicare Trust Fund, DCEs build upon the framework that those earlier ACO models, from 2012 Pioneer ACOs to 2016 Next Generation ACOs, set and represent the gradual, evolutionary path toward educating providers on how best to manage a population and accept risk that is tied to quality outcomes.** The Direct Contracting model will also work to provide expanded care to underserved and vulnerable communities and populations nationwide both through its benefits to PCPs and its coordinated model of care and care management of chronic disease. As health equity remains at the forefront of healthcare reform, supporting a model that strengthens care for those that need it the most must be a primary driver of any regulatory decisions.

Within the Direct Contracting model, beneficiary choice is emphasized in a multitude of ways. Firstly through voluntary alignment, the process in which beneficiaries are aligned with DCEs through their own choice of primary care provider through online or paper-based alignment. While DCEs are allowed to proactively communicate with beneficiaries through marketing strategies and through gifts that hold nominal value, beneficiaries are able to reverse their alignment decision at any time. **In fact, new benefits included in direct contracting such as nonskilled Home Health, transportation benefits for beneficiaries, meals as medicine, and enhanced behavioral health benefits will allow DCEs to offer beneficiaries to receive care that more closely resembles the services offered by MA, closing the gap between the two. Ending the disparities between traditional Medicare and MA is a stated goal of the Biden Administration and an opportunity that direct contracting immediately presents.** These new benefits will grant Medicare beneficiaries in DCEs the same consumer protections as other Medicare beneficiaries including appeals for denied services, cost sharing that does not exceed original Medicare and, unlike Medicare Advantage plans, Medicare beneficiaries in DCEs retain the right to receive care from any provider that accepts Medicare.

As conversations around the usefulness of capitation for primary care have developed over the years in Washington, **direct contracting presents an invaluable opportunity to study the effects that the payment system could have on primary care in real-time.** The payment mechanisms that can be used in the Direct Contracting model, total care capitation or primary care only capitation with a glide path that includes increased capitation minimums, will allow CMMI to test the effect that capitation could have on primary care and present usable data to analyze what the long-term benefits could be. **It is our coalition's steadfast belief that access to primary care for Medicare beneficiaries could be expanded greatly through the utilization of the capitated model and thus, direct contracting.**

Indeed, the positive effect that direct contracting can have on primary care is substantial, with primary care groups DCE's offering extended opportunities to manage the health and well being of a population on a longitudinal basis. Direct contracting permits PCPs to receive predictable cash flow in the Medicare FFS program, which will reduce the need in future public health emergencies (PHE) to provide advances or low income loans to practices based on historical FFS payments. Direct contracting places PCPs as the responsible practioners for coordinating and managing total cost of care for a beneficiary and permits PCPs to negotiate a variety of value-based payment models with downstream providers. **The model also opens the door for expansion of primary care into distressed communities and proactively allows PCPs**

to serve underserved communities and minority populations that are harmed by the consequences of Health inequities and disparities. PCPs have no other means but through contracts with payers, MA plans, and through pilots in Federal and State programs to manage a population and assume the risk of total cost of care. Investment from DCEs into primary care is critical as nonprofit hospital systems have absorbed more than 50 percent of primary care practices. Since receiving investment from direct contracting, primary care practices have been able to build world class facilities, attract top tier practioners, develop state of the art technology platforms, robust analytics capabilities, and best in class care management and network development.

Finally, **the capitated model under which direct contracting operates presents a grand opportunity to create and support a system that by design lowers the total cost of care.** The framework holds providers accountable for achieving high quality outcomes through a fixed per person payment and is the only system that ties financial incentives to lowering costs. The model also gives that providers a share of the savings that are needed to allow them to make the infrastructural changes needed to achieve this goal. **As reform efforts in the healthcare space seek the best way to lower costs without negatively affecting patient care, the opportunity represented by direct contracting must be supported and allowed to grow.**

We have worked tirelessly for more than ten years since the Affordable Care Act was enacted to advance APMs and the Direct Contracting model moves toward that goal steadfastly: a capitated payment model supported by robust quality improvement measurement incentives. Curtailing that process will do a major disserve to the country, the providers that have worked hard to make it succeed, and to the Medicare beneficiaries that depend upon it. The opportunity to launch a model of care that will address the nation's need for greater health equity and outcomes for underserved populations and the overall need for stronger primary care cannot be taken for granted. **The Direct Contracting model and its pilot programs must continue to be implemented.**

Thank you for your attention to our concerns. We look forward to continuing to work with you throughout the development of the Direct Contracting model. Please feel free to contact Valinda Rutledge, Executive Vice President, Federal Affairs at APG, (vrutledge@apg.org) if you have any questions or if we can provide any assistance as you consider these issues.

Sincerely,

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

cc: Liz Richter, Acting Administrator, Center for Medicare and Medicaid Services
Elizabeth Fowler, Deputy Administrator, Center for Medicare and Medicaid Innovation