APG DIRECT CONTRACTING COALITION

July 21, 2021

Elizabeth Fowler
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

Dear Deputy Administrator Fowler:

The America's Physician Groups (APG) Direct Contracting Coalition applauds both the Centers for Medicare and Medicaid Services (CMS) and the Center for Medicare and Medicaid Innovation (CMMI) for their years long efforts in promoting value-based care and the transition from volume to value. APG and its member organizations have welcomed the launch of the Global and Professional Direct Contracting innovation model (GPDC) and some of the recent changes that have been made allowing participants from the Next Generation ACO program to apply for participation. After investigation, we have identified some issues for participants that hinder both their individual success and the success of the model overall and have listed some recommendations for how to address said issues and strengthen GPDC. We would ask that CMS and CMMI consider our recommendations closely in order to ensure not only a stronger program for 2022, but also the long-term viability of direct contracting and to continue the transformation of our healthcare system toward providing high quality care at a lower cost and away from the fee-for-service model. **We would like to request a meeting with the DC team to discuss these ideas.**

Summary of Recommendations

- **Provide a glide path into capitation for those less advanced providers who need more time to prepare for the transition away from fee-for-service that is either: 1.) the current path being implemented or 2.) an increasing glide path based on benchmark revenue**
- **Consider implementing the coding intensity factor prior to the +/- 3% symmetrical cap**
- **In order to provide direct contracting entities and their practices with sufficient claims data, provide full 835 and x12 837I/P files directly from MACs in addition to the non-standard flat file that they currently receive**
- **Send an Alignment List Report (ALR) quarterly beneficiary file to DCEs so they may identify voluntary aligned beneficiaries by TIN and NPI (Include HCC by beneficiary)**
- **Add beneficiary granularity risk adjusted capitation payments for APO/PCC/TCC to the Alternative Payment Report, similar to the MA Monthly Membership Report (MMR)**
- **Add geographic specific granularity to the Quarterly Claims Based Quality Report and Quarterly Benchmark Report**
- **Send Rx Claims for DCE beneficiaries who have a PDP in an NCPDP D.0 format**
- **Allow for bulk deletion of provider lists to provide relief of administrative burden for organizations**

- **Provide stronger incentives for DCEs to enter and to provide care to underserved communities**

Comments

Our members have been heavily anticipating the Direct Contracting Model and are excited about the potential that the Model offers both providers and the beneficiarcies. With that being said, there are some pressing issues that should be addressed in the near term that will better guarantee the program's success. Our first area of concern is the payment mechanism for the direct contracting itself, capitation. The types of organizations participating in GPDC have varying levels of experience with global risk and capitation which can make transitioning into this form of payment a heavy administrative burden for those with a background that leans more toward fee-for-service (FFS). **We recommend that CMMI consider added flexibility in the requirements surrounding capitated payments, which could mean continuing on its current path of gradual cuts or a glide path that increases based upon benchmark revenue.** For those solo practitioners and small physician group practices who do not have extensive experience with capitation and have had less time to prepare for participation in such a new model that has had a truncated timeline of implementation, an option should be presented to them allowing them to bill for FFS while gradually transitioning into capitation during the outlier years.

The coding intensity factor should be implemented before the +/-3% symmetrical cap. It is very difficult to have a line of sight to know what the CIF will be for organizations on both ends of the spectrum that are close to either the ceiling or the floor and prepare for the impact in advance. As the aftereffects of the COVID-19 pandemic and its disruption to practice patterns are still being felt, the true impact of the +/-3% could end up being one to two points lower than your anticipated positive ceiling or one to points higher on the negative end depending on the coding adjustment factor. Implementing the CIF before this +/-3% cap creates a floating symmetrical scale that will negatively impact participants. **Therefore, we recommend that CMMI implement the coding intensity factor prior to the symmetrical cap so that GPDC participants have a more clear outlook of what their performance in the program may be. We would also ask that the agency exercise caution in its selection of which performance year it basis coding intensity on.** In the recently released Next Generation ACO results, 2020 coding decreased by five percent. In the contract for GPDC, CMMI reserved the right to use 2019 data instead should 2020 data be heavily impacted by the COVID-19 pandemic. As the agency moves forward with coding adjustments, we recommend taking a look at 2020 and 2019 data closely and informing participants of any decision within a reasonable timeframe.

Our next recommendation pertains to the issue of claims data within the GPDC model and the data file that participants in the model receive. Currently, participants receive a claims reduction file that comes in a non-standard flat file format which does not include vital, pertinent information such as place of service code, APN number (more commonly referred to as a voucher number), tax identification numbers (TIN) on institutional claims, the sequestration amount, Advanced Payment Option (APO) adjustment, Total Care Capitation (TCC) adjustment, Primary Care Capitation (PCC) adjustment, and Chronic Kidney Disease Quarterly Capitated Payment (QCP). The APN is of particular importance due to the fact that the APN number is how billing systems universally take electronic claims and autopost them into organizations' systems. Without having the APN number onhand, participants are forced to manually enter all claims by hand, which results in severe administrative burden and a heavy demand on time. **It is our recommendation that full 835 and x12 837I/P files with encounters including full adjudication details (CAS segment) and balancing be provided to direct contracting entities (DCE), and also to practices, directly from Medicare Administrative Contractors in addition to the flat file format that participants currently receive.** Having this full spectrum of information through a complete claims file will allow participants to reproduce claims and pay providers using their preferred payment mechanism. Doing so will also provide DCEs with the complete data and information that they need in to relieve some

of the burden created by the file system that is currently in use. We also have similar formatting concerns when it comes to Rx Claims for DCE beneficiaries who have a prescription drug plan (PDP). **We ask that CMMI consider sending this information in an NCPDP D.0 format. We also ask that CMMI allow for CMMI for the bulk deletion of provider lists, mirroring its recently implemented a bulk upload functionality in the 4i portal.** This would also provide a measure of relief when it comes to administrative burden for organizations.

In addition to the full 835 and x12 837I/P files, **we ask that CMMI also consider sending an Alignment List Report (ALR) to DCEs so that they participants are able to identify their voluntarily aligned beneficiaries by their TIN and NPI numbers.** An ALR is a quarterly beneficiary file that MSSP currently receive under their programs that would allow for DCEs to provide better, more accurate care. The agency could also add beneficiary granularity risk adjusted capitation payments for APO/PCC/TCC to the Alternative Payment Report, similar to how the Monthly Membership Report (MMR) works within Medicare Advantage, as well as adding geographic specific granularity to the Quarterly Claims Based Quality Report and Quarterly Benchmark Report.

Lastly, we would like to point out that many of the benefits included in the Direct Contracting Model 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, as well as offering services that will help to address the growing disparities in health outcomes nationwide. While these newly added benefits will do much to help the Model serve as a tool in addressing the country's health disparities, more can be done to encourage GPDC participants to seek out those beneficiaries within underserved communities for care. Recently, the Kidney care model worked superbly as an avenue for CMMI to use a model of care to provide quality incentives for participants to address inequities and disparities when disseminating care. Ending the disparities between traditional Medicare and MA and addressing inequality in the healthcare system overall are stated goals of the Biden Administration and direct contracting presents an opportunity to address both of these issues. **We recommend that CMMI provide stronger incentives for participants in the Direct Contracting Model to enter into underserved communities and provide care to these beneficiaries whom need high quality, low cost care the most.**

We believe that these recommendations will helpt to ensure the long-term stability and viability of the Direct Contracting Model and strengthen its benefits for patients and providers alike. CMMI has been an invaluable partner in the development of the direct contracting and we appreciate the investment the agency has made to ensure its success. Providing these entities with additional stability regarding the Model will avoid any added undue burden for healthcare providers in these already uncertain times and continue to move the healthcare system down the path of providing high quality care at a lower cost and away from the fee-for-service model.

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, Executive Vice President, Federal Affairs, (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