APG DIRECT CONTRACTING COALITION

May 4, 2021

Elizabeth Fowler
Deputy Administrator & Director
Center for Medicare & Medicaid Innovation
U.S. Department of Health & Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Deputy Administrator Fowler:

The America's Physician Groups (APG) Direct Contracting Coalition 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. All members of our coalition have been highly anticipating the upcoming launch of the Direct Contracting Model and its Global and Professional Options (GPDC or the Model). We are very invested in seeing direct contracting succeed as an alternative payment model and helping to move healthcare away from volume and toward value. However, the recent cessation of the submission of applications and other issues surrounding the Model has presented us with numerous concerns.

Performance Year One Recommendations

- **Remove the geographic expenditure capitation ceiling's impact on benchmarks**
- **Allow a one-time change to risk score trend of plus or minus 6% for 2022**
- **Publish performance year one quality benchmarking before July 1, 2021**
- **Offer early guidance on any potential trend adjustment updates and more clear timing on when entities could potentially face adjustments**
- **Consider a regional trend versus a national trend in the event of a retrospective trend adjustment**

Future Performance Year Recommendations

- **Reopen the application portal for prospective applicants to apply for the Global and Professional Direct Contracting Model (GPDC) beginning on January 1, 2022**
- **Provide the 837 claims file format to direct contracting entities on a daily basis**
- **Provide an option for more advanced direct contracting entities to do complete claims processing, adjudication, and integrity auditing**
- **Build a process to recognize paper-based voluntarily alignment on an annual basis for all CMS and CMMI ACO or Direct Contracting models**
- **Use the Medicare benefit verification system to identify an assignment to a GPDC as is used in Medicare Advantage**

- **Provide greater clarity and guidance on the application of retrospective trend adjustment**

Our members have been heavily anticipating the Direct Contracting Model and are excited about the potential that the Model offers both providers and the beneficiaries. Participating providers and organizations have also made extensive financial investment in preparing for the launch of the Model, with some of our member groups exiting from other models like CPC+ and Next Gen ACO as well as preemptively managing patients as if they have already been attributed to their practices. It is in this spirit that we reiterate our request that you **provide an opportunity for new prospective applicants to apply for GPDC by reopening the portal for applications in anticipation of a performance year January 1, 2022 start.**

Preventing those organizations who had planned to enter the Model during the second performance year would have the effect of forcing them into other programs such as the Medicare Shared Savings Program (MSSP) where they would be unable to take advantage of GPDC elements such as enhanced benefits for the beneficiaries. The transition from programs such MSSP into GPDC was meant to be a bridge not only for these organizations toward another model of care with greater risk and the ability to pay providers, but for the overall movement toward value.

Another issue that has arisen is that some organizations that have received approval for the first performance year have begun to contact other markets to search for partners within their geographies. This would create an unfair situation for those prospective participants who planned on beginning GPDC, but were prevented from doing so, and are now forced to compete with organizations from outside their regionwithout the opportunity to respond.

The impact of this decision will be most felt by the beneficiaries that stood to gain from the launch of the Model. The capitated payments within GPDC allow for claims payment that facilitates the creation of functional relationships across the care continuum with providers whom our patients can access as well as providing enhanced benefits to those beneficiaries. The design of GPDC reinforces DCE investment in underserved communities by establishing greater access points and engages the network to establish programs beyond what is currently prevalent in Medicare today. Ensuring prolonged, substantial support for value-based models such as GPDC reinforces their viability in both the short and long term and recognizes and preserves the role they play in moving healthcare from volume to value. Keeping a continued focus on improving quality and costs will result in value being integrated into the healthcare delivery system.

<u>Comments on Performance Year One Improvements</u>

A pertinent issue that will have a profound effect on participants in the first performance year of GPDC is that of benchmarking. The geographical spend portion of the benchmark is capped at a 5% plus or minus change over the historical benchmark regardless of it's increasing weight. It is our concern that capping the effect of the geographical expenditures unfairly punishes providers that have steadily increased consistent, value-based care that has lowered costs, serving as a deterrent for any potential future, highly efficient participants. **We recommend that CMMI mitigate the capitation ceiling's impact on the benchmark as it relates to geographical expenditures**, rectifying this potential disincentive.

The risk score trend within GPDC is also cause for concern for the first performance year. 2019 currently serves as the base risk year and the program limits an adjustment of plus or minus 3% per year. This 3% trend cap however does not factor in the two-year variation between the base year and performance year for 2021. In order to address this discrepancy, **we ask that the agency allow for a one-time change of plus or minus 6% for 2022 which will account for the two-year variation**. "Due to COVID-19 design

adjustments, 2020 was a year skipped in the assessment of a given population's acuity. Furthermore, given the pandemic, acuity could have rapidly progressed due to delayed care and treatment."

For quality benchmarking, quality currently currently accounts for a 5% withhold that participants must earn back. 2021 benchmarks for quality scores are not scheduled for release until next year. Due to this delayed release schedule, GPDC entities are unable to ascertain if they have surpassed the 30th percentile that is required in order for them to earn back the 1% pay forperformance portion. **CMMI should consider publishing performance year one benchmarks for quality scores prior to July 1, 2021 so that GPDC entities are granted greater clarity on their progress toward earning back their withholds**. Having access to this information will allow entities to better strategize operationally and provide more certainty financially as they participate in the Model.

Our final concern with the first performance year under the Model surrounds trend adjustment. Trends are derived from USPCC figures and determined before each performance year and established when the DC/KCC Rate Book for the performance year is published. If the adjusted USPCC trend differs from the observed expenditure trend in the DC National Reference Population by at least 1%, CMS may apply a retroactive trend adjustment to the benchmark reflecting the difference, with the agency also reserving the right to adjust the trend retrospectively after the year has already ended. Minimal guidance has been offered to participants from CMMI on when a retrospective trend adjustment will be needed and how it would be applied. While we understand the rationale behind this decision, such a lack of transparency and certainty is damaging for entities as they attempt to participate in the model during the performance year without any way of being able to anticipate potential pitfalls that could arrive at a later date. **We recommend that CMMI offer early guidance on any potential updates and more clear timing on when entities could potentially face adjustments.**

A second aspect of the retrospective trend adjustment will be it's usage of the national trend without accounting for the COVID-19 pandemic recovery's geographical variance. National trending numbers are heavily weighted toward larger metropolitan areas, disregarding regional variation in how healthcare providers and organizations have had to respond to COVID-19 infection in their localities, unfairly punishing some for how their regions were affected by the pandemic while benefiting others who may see quicker recoveries and returns to normal. To account for these differences, **CMMI should consider evaluating the use of a regional trend in the event of a retrospective trend adjustment versus the use of a national trend.** This will take into account regional variance more fairly and result in more equitable adjustments for participating entities.

<u>Comments on Future Performance Year Improvements</u>

As CMMI implements strategies to ensure the short-term viability of GPDC, concerns and possible pitfalls that could arise in the future performance years of the Model can also be addressed presently before they become larger problems. One issue of note is that surrounding the Model's claims process. GPDC encourages payments being made directly to providers through DCEs, which our coalition supports as this flexibility is integral in transforming care. However, the claims process as currently constructed provides claims reduction files on a weekly basis using a file format that does not allow for any type of claims payment. The industry's standard is for claims to be paid through a TPA who only uses an 837 format. Providers are also reliant on Medicare dollars and the current once per week standard can lead to delays in payment. **We ask that CMS consider sending an 837 file to DCEs on a daily basis for processing, in addition to the claims reduction file that is provided by CMMI**. Providing some semblance of familiarity through the availability of an 837 file on a more frequent basis than a once per week snapshot will allow for participants to have a clearer picture of their claims and make for a more stable experience within the Model.

CMMI's current lack of recognition of paper-based voluntarily alignment under MSSP is another issue that looms large. While we are aware that it is CMS' goal to respect beneficiary choice, within CMMI, there exists no mechanism to honor a beneficiaries' choice of a PCP. As the GPDC model attracts participants that engage in voluntary alignment at a higher rate, **we suggest that CMS and CMMI build a process to recognize paper-based voluntarily alignment, on an annual basis at minimum**. Doing so will allow the Model to account for the experience and expertise of its participants and create an system more conducive to their success.

The manner in which beneficiary identification is handled within GPDC is an additional issue that must be addressed. GPDC entities are currently provided with a list of beneficiaries and no other identifiers or notifications while beneficiary alignment to entities is not updated within the Medicare benefit verification system. We are concerned that GPDC entities are left as the only providers who are able to identify patients for the purposes of care coordination, receipt of claims payment, or other resources. Partnering providers are unable to identify beneficiaries so that they may know which claims affect TCC while hospital systems and specialists cannot identify patients for care coordination or data sharing. To rectify this, **we ask that CMS make changes to the Medicare benefit verification model allowing it to identify assignment to a GPDC similar to the manner in which it does for patients who are part of a Medicare Advantage (MA) plan**. While we are aware that reservations about privacy have been an issue in making this change in the past, the ability of MA plans are able to use the Medicare benefit verification system to identify beneficiary assignment. Doing so will also allow for GPDC to perform the payment integrity screenings that are available.

Finally, **we request clarification in the quality calculations for performance years 2023 through 2026. The continuous improvement/sustained exceptional performance (CI/SEP) criteria will determine whether the portion of the quality withhold eligible for earn-back will be at 5% or 2.5%**. This criteria will be used to determine if DCEs are eligible for any additional bonus payments as part of the High Performers Pool (HPP). If this criteria does not take into account the extenuating circumstances surrounding COVID-19, it is our fear that earn-back eligibility for many DCEs will be negatively impacted on an unfair basis.

The successful launch of GPDC will ensure its long-term stability and viability and strengthen its benefits for patients and providers alike. CMMI has been an invaluable partner in the development of the Model and we appreciate the investment the agency has made to ensure its success. Providing these entities with greater certainty and strengthening GPDC's weak points will guarantee that it is ready to move forward as seamlessly as possible when ready. Implementing these changes as soon as possible will give providers time to prepare for participation, avoid any added undue burden 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 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