February 20, 2020

Mr. Brad Smith
Director
Center for Medicare & Medicaid Innovation
Centers for Medicare & Medicaid Services
Department of Health and Human Services

**Re: Direct Contracting Model**

Dear Director Smith:

On behalf of the Premier healthcare alliance serving approximately 4,000 leading hospitals and health systems, hundreds of thousands of clinicians and 175,000 other provider organizations, we appreciate the opportunity to provide feedback on the Direct Contracting model. Premier healthcare alliance, a 2006 Malcolm Baldrige National Quality Award recipient, maintains the nation's most comprehensive repository of hospital clinical, financial and operational information and operates one of the leading healthcare purchasing networks. Our comments primarily reflect the concerns of our hospitals and health systems, their employed physicians and independent physicians aligned with them. Premier runs the largest population health collaboratives in the country, the Population Health Management Collaborative, has worked with well over 200 ACOs.

Premier appreciates CMMI's efforts to put forward a bold new model that moves the Medicare payment system closer to value-based care. The Direct Contracting model builds on many lessons learned from the Medicare Shared Savings Program (MSSP) and the Next Generation ACO (NGACO) model. The model includes many design features that Premier has promoted in the past, such as the opportunity to incorporate both primary care capitation and bundles into an ACO-like structure.

We believe there are opportunities, however, to further strengthen the model to encourage greater participation and ensure participants' success. In particular, changes are needed to create a better pathway between NGACO and Direct Contracting. Below we provide key recommendations to improve the model. We encourage CMMI to take these recommendations into consideration before the start of the performance period.

## INCREASE POTENTIAL FOR SHARED SAVINGS

The Professional Track of Direct Contracting offers participants a lower opportunity for shared savings as compared to NGACO and MSSP. Under this track, participants are eligible for shared savings of up to 50 percent for all savings and losses up to 5 percent of the performance year benchmark. The reduction in savings is compounded by the risk corridor, with available shared savings (or shared losses) decreasing as savings and losses increase (e.g., 35 percent shared savings/losses for gross savings and losses between 5 and 10 percent of the benchmark). Currently, NGACO participants are eligible for shared savings between 80-100 percent, while MSSP Enhanced participants are eligible for savings up to 75 percent.

A higher shared savings rate would attract additional participants as there is more opportunity to achieve savings that can be reinvested in future care enhancements. **At a minimum, the shared savings/losses rate should be comparable to MSSP Enhanced (75 percent).** This will allow ACOs experienced in risk to maintain a comparable opportunity for shared savings while testing primary care capitation within the model.

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## SET MORE REASONABLE DISCOUNTS AND WITHHOLDS

The current withholds and discounts significantly reduce the benchmark; in the Global track the benchmark is reduced 9 percent in year 1 and up to 10 percent in year 5. These reductions are a significant departure from existing models and significantly reduce a Direct Contracting Entity (DCE)'s budgets for providing care. This could make participation challenging for many providers, especially those with historically low spending. To reduce this burden, CMS should:

***Reduce the Discounts in the Global Track.*** CMS plans to apply a discount to the benchmark to ensure savings to Medicare. This discount starts at 2 percent in Performance Year (PY) 1 and increases to 5 percent by PY5. Additionally, CMS will withhold a portion of the monthly capitation payment to cover expected payments made to non-participating providers and suppliers who furnish items and services to aligned beneficiaries (i.e., leakage withhold), further limiting the total budget available to provide care. **CMS should initially set the discount comparable to NGACO (1.25 percent) and then incrementally increase the discount to a maximum of 2 percent.**

***Remove the early termination withhold.*** CMS notes it is incentivizing continued participation under the model by introducing a retention withhold (equal to 2 percent of the performance benchmark), which would be refunded if the participant's agreement is still in effect at the time of PY1 reconciliation. Alternatively, participants can secure a "retention amount" (equivalent to 2 percent of the benchmark) with a financial guarantor. Participants would be required to pay this amount to CMS if they exit the model before the end of PY2.

Oftentimes participants choose to leave a model because of programmatic changes made by CMS. Instead of implementing a retention withhold, CMS should consider implementing an early termination penalty if a participant's decision to terminate is unrelated to a CMS programmatic change or the participant's decision to enter another risk-bearing arrangement (e.g., MSSP Enhanced or another Direct Contracting track). **At a minimum, CMS should waive the termination withhold for entities that have experience with downside risk in CMS models. These entities have already demonstrated a commitment to two-sided risk and have made significant investments to support risk-bearing arrangements.**

***Reduce quality withhold.*** CMS plans to withhold 5 percent of the benchmark, which can be earned back based on quality performance. **CMS should also consider a lower quality withhold or, at a minimum, apply a lower withhold for high-performing participants.**

***Provide options for enhanced payment within primary care capitation.*** The primary care capitation is set at 7 percent of the benchmark, which represents an estimated 3-4 percent primary care payment and an additional enhanced payment. CMS notes that DCEs can use the enhanced primary care payment for other investment and that it will reconcile the primary care spend prior to the risk sharing reconciliation. While providers may benefit from using the enhanced payment for other investment, there is unlikely to be a return on those investments in the performance year. Reconciliation of the enhanced payment creates another aspect of risk within the model that some DCEs do not want. Recognizing that DCEs will vary in their approach to using an enhanced payment, CMS should allow DCEs to request a lower primary care capitation total.

## PROVIDE FULL MODEL DETAILS

Certain aspects of the model are still unknown, such as how CMS plans to adjust the Medicare Advantage (MA) rate book for regional benchmarking or risk adjust the benchmark. Additionally, CMS has provided

limited information on participation agreements and when participants would be able to revise their participant and preferred provider lists.

**CMS should make full model details available immediately in addition to providing technical resources (e.g. capitation implementation methodology).** This information is critical for potential participants to determine their ability to operate in the model and further underscores the need to remove the retention withhold.

**CMS should also allow for a second application cycle to provide potential participants with the opportunity to analyze participation once full information on the model is available.** The current application deadline requires providers to submit applications before full financial details are available. Additionally, many providers have indicated interest in both Direct Contracting and MSSP and are still waiting on details before finalizing their participation. Because of the large overlap across these two models, we encourage CMS to align the application timelines and decision deadlines for both Direct Contracting and MSSP to ensure participants base their selection on full information and not merely a model deadline.

## CREATE A LEVEL PLAYING FIELD BETWEEN NEW ENTRANTS AND EXPERIENCED ENTITIES

Under the model, CMS will use two different benchmarking methodologies depending on a participant's experience with Medicare. Experienced entities, or Standard DCEs, will receive benchmarks based on historical performance for beneficiaries who are aligned through claims. If a beneficiary is voluntarily aligned to the Standard DCE but could be aligned through claims, the benchmark will still default to historical claims. Entities with less experience in Medicare (New Entrants) or entities that serve a high needs population will receive benchmarks based on regional expenditures.

This approach disadvantages entities currently participating in two-sided risk models, since their historical performance will already reflect efficiencies achieved under past models, furthering perpetuating the "race to the bottom" inherent in models.

Last fall, the Learning and Action Network (LAN) announced its goal to move all Medicare fee-for-service beneficiaries to alternative payment models (APMs) by 2025. To support this goal, CMS should focus on encouraging participation across all providers and entities, no matter their level of experience. To do this, CMS should ensure parity across participants and that the model's design does not disadvantage and discourage participation from certain providers, especially those who have already shown a commitment to moving to two-sided risk.

CMS has also indicated that Standard DCEs and High Needs Population DCEs must be separate entities. While we understand CMS' intent is to incentivize participation from entities who care for high needs populations, this structure does not reflect the current state of care. Many NGACO and MSSP participants provide care to beneficiaries who meet the high needs population definition. Under this current framework, these participants will not benefit from receiving a regional benchmark unless they bifurcate their Tax Identification Numbers (TINs) and operations.

**CMS should level the playing field across all entities and use the Adjusted MA rate book approach for all Direct Contracting tracks and entities.** This approach will eliminate the need to separate high needs populations and standard DCEs. (CMS could maintain the High Needs Population DCE track for those entities who require a lower minimum number of aligned beneficiaries.)

## ADDITIONAL CONSIDERATIONS

In addition to our recommendations above, there are several additional modifications CMS should consider:

- ***Allow Preferred Providers to count participation toward Advanced Alternative Payment Model (AAPM) Bonus Incentive.*** Under the current model design, preferred providers who are in capitation arrangements with DCE participants would not have an opportunity to include their participation in determining eligibility for the AAPM bonuses. CMS should allow preferred provider capitation arrangements to count under the Other APM Arrangements. CMS should provide guidance to DCEs for how to structure arrangements in order to meet the Other Payer APM requirements.
- ***Improve availability of data.*** We appreciate CMS efforts to speed data availability for ACOs through the Beneficiary Claims Data Application Programming Interface (BCDA). We encourage CMS to make BCDA available to DCEs and accelerate data access to weekly.
- ***Reset beneficiary opt-out of data.*** CMS will not share data for beneficiaries who have previously opted out of data sharing under other shared savings initiatives. Beneficiaries may have made this decision several years ago. Given the importance of information in managing patient's care, participants should be given another opportunity to assess a patient's willingness to share this information.
- ***Adopt measures similar to ACOs or MA.*** The proposed measure set relies heavily on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, which is based on a small percentage of beneficiaries. Participants receive data once a year and are unable to track this information back to specific providers or patients. As a result, this information is not actionable. CMS should instead adopt a measure set that aligns with existing requirements of ACOs and MA plans, which include outcome-based measures focused on chronic conditions. Aligning the measures will help reduce administrative burden and streamline reporting.
- ***Provide greater clarity on model overlap.*** CMMI has provided little clarity around beneficiary overlap when there are multiple models operating in the same region or participants are engaged in multiple models. CMS should establish clear guidance on model overlap and give precedence to entities managing total cost of care. Additionally, CMS should allow entities more flexibility regarding model overlap. Rather than simply excluding participants from a model based on participation in another model, CMS should allow participants to elect if aligned beneficiaries are excluded from other models.

## CONCLUSION

In closing, the Premier healthcare alliance appreciates the opportunity to submit these comments on the Direct Contracting model. If you have any questions regarding our comments or need more information, please contact Aisha Pittman, vice president, policy, at aisha_pittman@premierinc.com or 202.879.8013.

Sincerely,

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Premier healthcare alliance