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CMMI's Direct Contracting Models: Key Issues and Opportunities

Meeting Summary

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Abstract

This meeting summary reflects the key strategic and technical issues discussed during and in follow-up to a March 2021 Duke-Margolis convening of experts to discuss the key issues and opportunities related to the implementation of the Center for Medicare and Medicaid Innovation's Direct Contracting models. Detailed description of the key issues and opportunities discussed follows, but key messages that emerged from the discussion included:

- The DC Model has considerable potential to meet the health needs of beneficiaries, particularly those without a usual source of care and whose care experiences are usually uncoordinated and therefore at risk for being inefficient and ineffective. Certain strategic and technical issues could be addressed to enhance the likelihood the DC Model is more effective in identifying and connecting these beneficiaries to providers, and in serving as a comprehensive, capitated payment alternative to Medicare Advantage.
- Interest in participating in the DC Model is high among providers and other groups, particularly those with a long history of participating in CMMI models (e.g., many Next Generation ACO participants and advanced physician group practices).
- Given the interest in the DC Model and the general desire in the health care community for information and reassurance regarding CMMI's plans for value-based payment (VBP), it is important for CMMI to publicly state its support for VBP, identify a path forward for continuing the transition to VBP, and continue to provide opportunities for participation in CMMI models in 2022 and beyond.

Introduction

The Center for Medicare and Medicaid Innovation's (CMMI's) Direct Contracting (DC) Model is being implemented during a key time. We're emerging from a pandemic that demonstrated the important role such advanced alternative payment models (APMs) have in ensuring the resilience of our health care system during times of crisis. We're entering CMMI's second decade of operation and examining how the next generation of APMs, including the DC Models, can leverage lessons learned during CMMI's first decade of APM implementation. We're also in the early stages of a new Administration at the start of implementing its vision for continuing our health care system's transition to value-based care. The DC Model has generated substantial interest at this important time, but recent pauses in the implementation of the Geographic DC Model and the acceptance of applications for 2022 for the Global and Professional Options have raised questions about what the future may hold for both the DC model and value-based care more broadly.

In March 2021, the Duke-Margolis Center convened a group of stakeholders, including providers, payers, consumer representatives, and others, to discuss the DC Model and its implications for value-base payment. The goals of the meeting were to (1) discuss key issues, opportunities, and challenges involving the DC Models and (2) explore potential approaches to advance DC program goals in the context of (a) implementing the DC Global and Professional Options and (b)addressing key concerns as CMMI reviews the Geographic DC Model. From the group's discussion, a set of key strategic and technical issues CMMI should consider as it plans for the future of the DC Model were identified.

Strategic issues include the need for greater clarity around the vision CMMI and CMS have for value-based payment (VBP) moving forward; incorporating safeguards to protect beneficiaries' choices and provider relationships; ensuring the DC Model addresses health equities and enables the participation of key provider groups; and enhancing the transparency around model details and data. Technical issues include those related to benchmark development, alignment processes, risk adjustment methods, and other key model features that should also be addressed to ensure the DC Model remains a viable option for providers. These issues and suggestions for approaches to address each are described below.

Strategic Issues

The strategic issues discussed at the meeting centered around the future of the DC Model under a new Administration and how the model may better meet its beneficiary- and provider-related goals. These issues relate to both the DC Model Global and Professional Options and the Geographic DC model and are described in detail below.

Issue: Uncertainty regarding CMMI and CMS vision and plan for value-based payment
With the change in Administration and announced delays for some CMMI models (including the Geographic DC Model), there is a sense of uncertainty among providers, payers, and other stakeholders regarding how CMMI and CMS will implement their vision for VBP. Related to the DC Model, there was interest among providers in applying to participate in the DC Global/Professional Options for Performance Year 2022. The recent announcement that new applications for the model would not be accepted for has only further heightened concerns about the future of the DC Model, as well as others including the Next Generation ACO Model. Together, these threatened models constitute the bulk of advanced primary care/population health opportunities in the traditional Medicare program. Without a clear vision for the future of these models, potential participants are having difficulty planning for further investments and actions on their path toward value-based care reforms. This may cause providers and payers to delay starting or continuing their transition toward VBP.

Potential approaches to address uncertainty:

- Articulate and communicate a vision for VBP and a plan for how the continued transition to VBP will be achieved through CMS programs and CMMI's portfolio of models. This vision should address key questions including:
    - Portfolio and Program level: How are programs and models meant to interact and complement one another? How does the portfolio provide an entry to advanced primary care and population health for a variety of provider types (e.g., small, rural, and safety-net providers) and a pathway for progressing into more advanced VBP models?
        - In particular, the comprehensive primary care and population accountability models could collectively give all beneficiaries the option of more advanced and coordinated care – particularly beneficiaries with complex health needs and limited resources. The portfolio of models should support the diverse range of providers in diverse market conditions to develop the capabilities needed to deliver this advanced and coordinated care and succeed under VBP.
    - Model level: What problem does this model try to solve and for what population of beneficiaries? What population of providers is this model meant to attract? Is this model an entry point into VBP, a step toward more advanced VBP models, or an advanced VBP model (i.e., an end-goal in the transition to VBP)?

- For example, Primary Care First and physician-led Medicare Shared Savings Program options could help provider groups move into alternative payment models, with a path to progress further toward partially capitated payment in more advanced versions (e.g., Next Generation ACO, a primary care capitation option, etc.). The Professional and Global Options could support providers who want to shift fully away from FFS, and could enable more providers to do so by facilitating partnerships with organizations that can provide needed capital and expertise. Shifts at the regional level, particularly in areas where ACOs have not grown, could be piloted through the Geo DC model and/or other regional supports like multipayer collaboratives and successors to the Accountable Health Communities model.

- Direct Contracting Interim steps: While further assessment of these programs may take some time, clarity from CMS soon about key issues would be helpful for planning and for demonstrating a commitment to the model or at least model goals. This is particularly important for participants in the Next Generation ACO model. Specific steps could include:
  - Open up DC Model participation opportunities for 2022. CMMI could note that while important model details remain to be worked out and changes to the model may need to be made during the early phases of model implementation, there will be at least a limited opportunity for direct contracting entities (DCEs), perhaps those with a demonstrated ability to succeed under advanced APMs (e.g., Next Generation ACO participants), to apply for and start model participation in 2022. This could be done on a more limited basis (e.g. focusing in regions with relatively low ACO participation) and limiting DCEs to provider-based organizations and organizations other than health plans with experience in supporting providers in VBP arrangements.
  - If opening up participation for 2022 is not feasible, extending the Next Generation ACO model for another year could help keep organizations that may have no other feasible options stay in a CMMI model and continue their VBP participation. To address concerns regarding the lack of savings achieved under the Next Generation ACO model, modifications could be implemented, such as changes in the discount rate or cap on shared savings that can be achieved.

Issue: Potential for negative impact on beneficiary relationships and choice

Getting more beneficiaries into established relationships with a primary care provider and enhancing beneficiary engagement are key goals of the DC Models, but some are concerned about the model's potential impact on existing beneficiary-provider relationships in non-DCE models and beneficiary choice.

Some of the specific elements under the Global and Professional Options (e.g., preferential pricing for voluntary alignment) may encourage DCEs to disrupt established provider-beneficiary relationships, instead of encouraging DCEs to seek out and establish relationships with beneficiaries who do not currently have a relationship with a provider.

The Geographic DC Model has raised more basic concerns that it is in conflict with the practice of allowing Medicare beneficiaries to choose their providers, especially for individuals dually eligible for Medicare and Medicaid, who have traditionally had the opportunity to opt out of programs and services that do not meet their needs. CMMI could address this not only by stating clearly that beneficiaries must

continue to have the same access to all providers as before, and implementing steps through beneficiary surveys and monitoring beneficiary complaints to detect any such issues when these programs ramp up.

The participation of commercial payers in the DC Model has also raised concerns about disrupted relationships. Some are concerned that allowing private payers to participate may result in these payers leveraging their considerable Medicare Advantage (MA) recruitment resources and capabilities for enhancing risk adjustment factor scores to potentially disrupt beneficiaries' existing relationships with providers and to shift more beneficiaries into MA plans that might increase program costs.

In addition, communicating with beneficiaries about VBP concepts and models is challenging and there is limited guidance on the most effective communication methods. Meeting participants shared experiences of how communication with beneficiaries about VBP (e.g., informing the beneficiary of their provider's participation in a VBP model) often results in beneficiary confusion or even skepticism that the information shared is not part of a scamming effort. Without more effort to identify the most effective communication methods, and CMS support for such communication, similar confusion could occur when DC Model DCEs attempt to reach out to beneficiaries. This confusion may negatively impact beneficiaries' experiences with their providers and their ability to make an informed choice about participating actively in these models and selecting a provider.

Potential approaches to protect beneficiary relationships and choice

- Highlight the importance of beneficiary access to effective primary care and care coordination, and identify areas with lower access to such providers, to increase the impact of DC and related models
- When a beneficiary is aligned to a new provider, transfer accountability for the beneficiary's complete claims history to the new provider (i.e., avoid opportunities for significant benchmark resets) as way to limit the potential incentive to disrupt established beneficiary-provider relationships
- Develop a method for identifying beneficiaries without an established provider relationship and design models with favorable incentives for DC providers to align with those beneficiaries
- Align risk adjustment methods with advanced ACO programs, to provide similar limits on the potential for more extensive risk factor coding to increase program costs
- Consider design features that would prevent inappropriate marketing and shifts into Medicare Advantage through DC providers (e.g., explicit marketing restrictions and firewalls for health plans that support DCEs)
- Facilitate the sharing of lessons learned (e.g., through a learning collaborative) regarding effective approaches to voluntary alignment
    - What approaches are DCEs taking? What challenges are they encountering? What capabilities do DCEs need in order to be successful with voluntary alignment?
- Convene multi-stakeholder groups that include beneficiaries and consumer groups as part of the Geographic DC Model review to ensure the beneficiary voice is a part of the model redesign
- Gather more data on beneficiary awareness of and experiences with the DC Model and other CMMI models and identify opportunities to improve communications with beneficiaries regarding VBP
- Provide support for training navigators, including in community-based organizations, to help educate beneficiaries about options and increase trust in Medicare's care coordination programs

Issue: Limited ability of DC Model to include key provider groups and address health inequities
In order to enhance the DC Model's ability to get more beneficiaries into an established relationship with a provider, the model needs to be accessible to a more diverse set of providers or needs to be clearly complemented by the other models that support comprehensive primary care. Part of the DC Model's intent is to provide a mechanism to bring more capital and resources to enable providers to succeed in advanced, accountable primary care. However, some of the model's current requirements (e.g., risk-based capital, claims payment capabilities) are viewed as significant barriers to entry by some providers who do not see a path to obtaining such capital support, especially safety-net providers and those serving low-income communities.

The DC Model would also benefit from a more explicit focus on addressing the social determinants of health (SDoH) known to have a significant impact on well-being and health outcomes. Addressing SDoH-related needs will require DCEs to either develop new capabilities or partner with community-based organizations (CBOs) experienced in addressing such needs. Partnering with CBOs will likely be the most efficient and effective approach for DCEs, but the current structure of the DC Model does not provide a clear pathway for developing and sustaining these partnerships.

Potential approaches to include key provider groups and better address SDoH-related needs

- Develop and implement on-ramps to model participation for key provider groups
  - Limit administrative requirements (e.g., claims payment capabilities) for certain provider groups (e.g., safety-net providers)
  - Offer up-front payments to help providers develop the capabilities needed to succeed under VBP (as in the ACO Investment Model program)
- Enable CBOs to be partners with DCEs and assist with beneficiary alignment
- Require stratification of the DC Model's quality measures by race, ethnicity and other key markers to identify potential disparities in care quality and outcomes
- Consider the inclusion of quality measures focused on SDoH-related needs and outcomes in the DC Model's measure set, or bonuses for DCEs that serve beneficiaries from neighborhoods with high Social Vulnerability Index scores
- Identify opportunities and support data sharing and other infrastructure for DCE partnerships with CBOs focused on addressing SDoH-related needs; look to other programs and models (e.g., North Carolina Medicaid's Health Opportunities Pilot) for potential approaches

Issue: Limited data sharing and transparency increase the burden of DC Model participation
Limitations in CMMI's sharing of data and information related to key model elements (e.g., algorithms for attribution, benchmarking, and risk adjustment) result in avoidable burdens and uncertainty associated with model participation. Without more complete data on relevant beneficiaries and greater transparency regarding the model's algorithms, providers and others interested in participation have only limited capacity to simulate how their attribution, benchmarking, and so on might look under a given model. Uncertainty about these estimates can have a significant impact on model participation. Meeting participants reported that some of the Professional and Global Options participants have been surprised by a 20% difference between the number of beneficiaries attributed to them by CMMI and their own attribution estimates. Such discrepancies can have a significant impact on whether or not a model participant is able to enter or stay in the model or achieve the goals of the model.

Potential approaches to enhance data sharing and transparency

- Publish the algorithms or source code detailing the DC Model's benchmarking, attribution, and risk adjustment methods
- Ensure DCEs, particularly High-Needs Population DCEs, have access to the data needed to identify potential beneficiaries for voluntary alignment
- Make more DC Model-related data available via the Virtual Research Data Center or other mechanisms to the model's participants and to researchers
- Increase model participant awareness and use of available data tools (e.g., CMS Developer Tools)
- Enable bulk data sharing for beneficiaries who choose to allow it via Medicare's Blue Button interface, and allow transmission of full data at time of patient enrollment (for all advanced primary care APMs not just DCEs)
- For the longer term, develop a unifying technology policy that spans across CMMI models regarding data sharing and transparency and technology supports that reduce the tech-related costs and burdens of model participation

Technical Issues

In addition to strategic issues, a number of technical issues for each model were mentioned throughout the meeting, as well as during pre-meeting interviews. A summary of those issues and potential approaches to address each is included in Table 1 (see next page).

Table 1. Technical Issues to Consider and Address for the Direct Contracting Models

Global and Professional Options	
Issues	**Potential Approaches to Address Issues**
Benchmarks: • Benchmarking approaches may disadvantage Standard DCEs, which are more likely to be experienced VBP providers that have worked to reduce expenditures	• Align benchmarks to recognize improvements from previous APMs
Risk Adjustment: • Concerns that coding intensity will be inappropriately used to receive greater risk adjustment benefits	• Align steps to ensure accurate risk adjustment even with changes in coding intensity
Benefit enhancements: • Scope, coordination, execution will likely vary across DCEs, and may have a range of beneficiary impacts	• Evaluate use and impact of benefit enhancements to better understand impact on beneficiary experience and outcomes
Assistance: • Lack of a dedicated point of contact at the Medicare Administrative Contractor (MAC) who is knowledgeable about the model and available to help when there are issues	• Instruct MACs to set up lead coordination points for DC models in their jurisdiction

Alignment:
• Challenges identifying patients who meet clinical needs criteria for High Needs DCEs, especially for DCEs that do not have access to claims data
• Providers, especially new-entrant and high-needs DCEs, may struggle to reach the minimum number of beneficiaries via voluntary alignment
• Potential for beneficiary attrition given the lag time between a DCE's initial alignment of a beneficiary and CMS's confirmation
• Potential for delays in service delivery under prospective plus alignment, because the beneficiary may not be aligned to a DCE until the quarter after they complete their voluntary alignment form
	• Enhance data sharing and access with DCEs
	  ○ Allow DCEs to participate under a corrective action plan as a short-term step
	  ○ Increase transparency around data and algorithms as a longer-term solution
	• Implement faster alignment confirmation processes
	• Consider incentives or benchmark adjustments to favor alignment of beneficiaries who do not have a clear relationship with a primary care provider, especially beneficiaries who have evidence of poorly coordinated care and preventable complications

Global and Professional Options (continued)	
Issues	**Potential Approaches to Address Issues**
Transparency: • Lack of public information on participation agreements, quality measures, and financial models • Restrictions on participants' ability to share information about their experience under the model	• Accelerate finalization and public sharing of model information to provide more time for DCEs to plan and implement. • Allow and encourage information sharing by model participants to help enhance awareness of and interest in the DC Models
Geographic Model	
Issues	**Potential Approaches to Address Issues**
Alignment: • Random alignment may result in inefficient provider-beneficiary matching (e.g., beneficiary matched to a DCE with greater access to preferred providers on the other side of town as opposed to the DCE in their own neighborhood) • Caps on claims attribution may contribute to care fragmentation	• Consider including factors to weight physical location or assessment of provider presence in beneficiary's neighborhood during the alignment process
Supplemental Benefits: • Lack of clarity regarding how DCEs will fund these benefits	• Clarify expectations and possible options for supplement benefit funding
Ensuring Network Adequacy: • Concerns care would be heavily geared toward telehealth and remote monitoring, leaving beneficiaries without a place to go when they need it	• Clarify or increase network adequacy requirements and track measures of beneficiary use of services (virtual and in-person) and beneficiary experience with care
Quality Measures: • Concerns regarding measurement burden	• Ensure measures are aligned with other models • Include measures and measurement reporting requirements that can help identify and address racial and ethnic disparities in quality and outcomes
Impact on Dually-Eligible Individuals: • Concerns regarding potential disruption to dually-eligible individuals' participation in existing programs (e.g., state programs, Special Needs Plans [SNPs])	• Clarify DCE responsibility re: coordination of Medicare and Medicaid services • Ensure DCE implementation supports and complements other initiatives to improve care coordination for dually eligible beneficiaries, such as fully integrated managed care organizations

Disclosures
Mark B. McClellan, MD, PhD, is an independent director on the boards of Johnson & Johnson, Cigna, Alignment Healthcare, and PrognomIQ; co-chairs the Guiding Committee for the Health Care Payment Learning and Action Network; and receives fees for serving as an advisor for Arsenal Capital Partners, Blackstone Life Sciences, and MITRE.

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Appendix

We would like to thank the following individuals and organizations for participating in this meeting. We greatly appreciate their time and contributions. The specific viewpoints or recommendations described in this summary do not necessarily reflect the viewpoints of the individuals below nor their organizations.

Romilla Batra, SCAN Health Plan

Cristina Boccuti, West Health

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Emily Stewart, Community Catalyst

Justin Timbie, RAND Corporation

Sophia Tripoli, Families USA