Direct Contracting Program Update

Unlikely to Be Halted Near-Term & Webinar Feb 17 at 2:00 PM EST

- **Capitol Street will feature Jay Keese on Thurs Feb 17 to discuss the Direct Contracting**. Mr. Keese runs the Direct Contracting Coalition. He will discuss the primary care-centric goals of the current administration.

    - TITLE "Direct Contracting & Primary Care Policy Update & Outlook"
    - DATE & TIME Thurs Feb 17 at 2:00 pm ET
    - DURATION: 30-45 mins
    - SPEAKER(S) Guest Speaker, Jay Keese, Executive Director, Direct Contracting Coalition
    - RSVP REQUIRED to Claire for details (Claire@capitol-street.com)

- **About Jay Keese, Executive Director of the Direct Primary Care Coalition**. Keese is also CEO of Capitol Advocates, a Washington DC based policy and government relations firm specializing in healthcare issues. Jay works with physicians, employers, payers, health IT firms and states on critical delivery system reforms such as direct primary care, accountable care organizations, and patient-centered medical homes. Jay played a role in shaping many of these innovative reforms in the Affordable Care Act and has helped implement them with the Centers for Medicare and Medicaid Services (CMS) Innovation Center (CMMI). Along with pioneers in the Direct Primary Care (DPC) movement, Jay laid the policy framework for the growth and expansion of DPC by designing legislation passed in the Affordable Care Act establishing membership fee-based DPC Medical Homes as an important value-based delivery reform, a part of essential health benefits offered by employers and to individuals. He has also been instrumental in the passage of over 25 state laws and regulations defining DPC as a medical service not regulated as health insurance. Jay also drafted and helped pass legislation in the U.S. House in July 2018 to clarify IRS regulations on the treatment of DPC plans to make the model more compatible with Health Savings Accounts (HSAs) paired with High Deductible Health Plans (HDHP).

- **Negative direct contracting headlines will likely persist:** There is a letter circulating from 20 very progressive members asking for CMMI to halt the program, as Elizabeth Warren (D-MA, Senate Finance) excoriates the pilot in early Feb. As we said back in December when the Intercept article surfaced (here), we do not see HHS halting the program. CMMI leadership has been front and center at recent conferences and such supporting primary care, ACOs, and the demonstration goals overall. At the same time, CMMI has exhibited concern over MA and risk coding growth.

- **In our opinion, Congressional Republicans will only want to grow Direct Contracting**, We believe the House and quite possibly the Senate will flip in the mid-term elections. Started by the Trump administration, other things equal, we see a split Congress opting to move forward on Direct Contracting. Tweaks are certainly possible once data are available. Furthermore, HHS has expressed support for the ideas and goals of the model (See bullet below).

- **It would be very difficult to cut loose 500 K+ direct contracting beneficiaries enrolled**. It doesn't make a whole lot of sense to separate beneficiaries from their physician and care plan. When do we see the CMMI model preliminary data? Performance periods for DCE were pushed back due to COVID. However, we will start to see data flow in the June 2022 through Jan 2023, give or take. Government contractors are performing evaluations, like they do for all CMMI pilot programs.

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- **Biden administration leadership has supported DCE.** See below for Jan 24 conference commentary/bullets from our memo summarizing the high points of the event.
    - **CMMI Leader Elizabeth Fowler stated support for Direct Contracting, investing in primary care**. Fowler said CMMI supports providing quality care by investing in primary care, and preventing hospitalization as well as lower value care.
    - **Fowler noted that Direct Contracting is <u>not</u> capitated care**. Specifically, Fowler noted that Direct Contracting is unlike capitated insurance models that may include restrictions to care via prior authorization (PA) and narrow networks. In fact the direct contracting (DC) models include access to <u>new</u> benefit enhancements, such as home health, cost-sharing support for Part B services.
    - **CMMI looks at cost, and Center looks at Medicare spending from a Trust Fund perspective.** CMMI leadership wants to discuss and focus on patient affordability e.g., reducing OOP costs. CMMI is aiming to speak with providers and stakeholders that have not engaged with CMMI, to understand why they have not partnered with the government. Accepting downside risk can be challenging.

- **<u>OUR TAKE:</u>** We do not see CMMI halting a pilot that has not had the time to produce results, despite progressive calls to stop the program. HHS leadership has openly embraced primary, accountable care and the goals are delineated in the CMMI Strategic plan (2030 goal: Put all MMM folks in an accountable care arrangement). CMMI noted at the Value Based Pay Summit (Jan 24-26, 2022) that that throughout 2022 the Center will continue engaging with Listening Session(s) and meetings with all stakeholders, including patients. Model development sometimes takes between 18 months and 2 years. The CMMI is proud to be sharing as much about their thinking as possible, and will continue to do so, and will inject health equity considerations into all models. CMMI also want to learn what works and what helps real people: For instance, has had some feedback that "accountable" care can mean that care has been withheld, and could mean "skimping" to some Americans versus care coordination. The term 'equity' may not resonate with patients, as well. This is a marathon, not a sprint, and we will keep apprised of Center updates, as well as potential Congressional and other changes.

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Background

- In late January the Value-Based Payment summit convened Healthcare Value Week (virtual). Centers for Medicare and Medicaid Services (CMMI) leadership participated in a summit. Keynotes, panels and other interviews are archived and can be found (here).

- **CMMI leadership referenced its long-term strategic plan and the 5 pillars of focus**. The Center for Medicare and Medicaid Services (CMMI) released a strategic plan (here) in 2021, and reiterated its vocal support of value-based care, with broad goals of accountable, equitable, patient-centric care by 2030. (1) Drive accountable care by 2030 to all beneficiaries (Medicare and vast majority of Medicaid) to ensure they are in a relationship with accountability around care/cost (2) Advance health equity (3) Support innovation (model participants) (4) Timely data & healthcare price transparency (5) Overall healthcare transformation

- **As CMMI looks at cost, the Center looks at Medicare spending from a Trust Fund perspective.** CMMI leadership wants to discuss and focus on patient affordability e.g., reducing OOP costs. CMMI is aiming to speak with providers and stakeholders that have not engaged with CMMI, to understand why they have not partnered with the government. Accepting downside risk can be challenging.

- **CMMI Leader Elizabeth Fowler stated support for Direct Contracting, investing in primary care**. Fowler said CMMI supports providing quality care by investing in primary care, and preventing hospitalization as well as lower value care.

- **Direct Contracting is not capitated care**. Specifically, Fowler noted that Direct Contracting is unlike capitated insurance models that may include restrictions to care via prior authorization (PA) and narrow networks. In fact the direct contracting (DC) models include access to new benefit enhancements, such as home health, cost-sharing support for Part B services.

- **CMMI wants to make sure that each of its models count, and this will take time …. New models take 18 months - 2 years to develop & implement**. Fowler notes that a handful of models have showed cost savings over the decade tenure of CMMI. The group has launched more than 50 alternative payment models while only 6 have shown statistically significant savings to tax payers and Medicare. 4 models were authorized to be extended: (1) Home Health value based payment (VBP) (2) Pioneer ACOs (3) Prior Authorization for non-emergency services (4) Diabetes Prevention Program (DPP).

- **There will be a bigger shift in how CMMI defines success in its pilots**. The agency wants with 95% confidence that a model will generate savings on a net basis. Also important that the government drives toward health system transformation. Other measures are important: could include things like functional status, # days at home, market impacts e.g., model adopted by other payers and providers.

- **CMMI leadership again notes concerning upcoding trends in Medicare Advantage (MA).** CMMI notes that innovation should be around care delivery, and not just gaming the system with upcoding (here). CMMI Director has stated this in multiple settings previously i.e., that providers need to deliver care better instead of finding ways to maximize revenues through coding.

- **Don't forget Health Equity.** CMMI held a listening session on December with transcript and slides (see here for more) on its website. Equity is a key priority, especially given lessons learned from COVID. Every model is seen through the lens of caring for those in underserved areas, with access

barriers. CMMI officials today noted that the equity agenda includes enabling technical support, strengthening data collection, recruiting providers that have not participated in CMMI models in the past, ensuring that provider selection and enrollee process is not a barrier nor is it a challenge.

- **OUR TAKE -- THESE THINGS TAKE TIME:** CMMI noted that throughout 2022 the Center will continue engaging with Listening Session(s) and meetings with all stakeholders, including patients. Model development sometimes takes between 18 months and 2 years. The CMMI is proud to be sharing as much about their thinking as possible, and will continue to do so, as they did today at this conference with about a half dozen CMMI officials in various speaking roles. They also want to learn what works and what helps real people. CMMI, for instance, has had some feedback that "accountable" care can mean that care has been withheld, and could mean "skimping" to some Americans versus care coordination. The term equity may not resonate with patients, as well. This is a marathon, not a sprint, and we will keep apprised of Center updates, as well as potential Congressional and other changes.