ACCOUNTABLE CARE LEARNING COLLABORATIVE AT WESTERN GOVERNORS UNIVERSITY

CMMI Announces Direct Contracting Model's First Cohort and Postponement of Second Cohort

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Last week, the Center for Medicare & Medicaid Innovation (CMMI) announced the list of organizations participating in the Global and Professional tracks of the Direct Contracting Model, now referred to as the Global and Professional Direct Contracting (GPDC) Model. The list includes the names of the 53 Direct Contracting Entities (DCEs) which began the first performance year (PY1) of the model on April 1, 2021 (see Figure 1). While CMMI initially intended to open the model up for a second round of applications with a start date of January 2022, it recently announced this application cycle has been postponed indefinitely. However, DCEs that applied previously and deferred their start date will still be permitted to begin next year, and CMMI has indicated it plans to review the model more closely, opening the possibility for future participation options.

> "Direct Contracting is CMMI's most progressive program for meeting the special healthcare needs of 38 million Traditional Medicare beneficiaries. Direct Contracting puts our healthcare system on the cusp of finally achieving for Medicare beneficiaries the Triple Aim of higher quality outcomes, lower costs and access with greater consumer satisfaction. It draws on the best elements of prior CMS/CMMI value-based care initiatives, such as MSSPs and NextGen ACOs, but is a bigger step towards both improving care and eliminating $200 billion of annual excess medical spend in Medicare's $850 billion budget, helping secure Medicare for future generations."
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> "The program offers enhanced benefits for no additional cost while improving access to accountable primary care for Medicare beneficiaries suffering from a fee-for-service payment system that provides little coordinated or preventative care. Direct Contracting incentivizes community-based physicians and health systems to provide comprehensive care coordination, accountable primary care and health and wellness services to eradicate the institutional health disparities that have existed too long in our society for our most vulnerable seniors."
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> ***- Gen Gillespie, Senior Vice President, Lumeris***

FIGURE 1: PARTICIPANT DCE NAMES

1. 360 Health DCE Inc
2. Advanced Illness Partners, LLC
3. ADVANCED VALUE CARE II
4. AdventHealth Senior Care, Inc
5. AKOS MD IPA, LLC
6. American Choice Healthcare, LLC
7. Arizona Health Advantage, Inc
8. Assurity DCE LLC
9. Axceleran DCE1, LLC
10. Axceleran DCE2, LLC
11. Best Value Healthcare, LLC
12. CareConnectMD DCE LLC
13. CareMore Aspire Medical Innovation Partners, PC
14. Castell Direct, LLC
15. CenterWell Care Solutions, Inc.
16. Central Valley Community Partners LLC
17. Clover Health Partners LLC
18. Complete Health Accountable Care LLC
19. Enhanz DCE
20. Genuine Health Direct, LLC
21. Humana Direct Contracting Entity, Inc.
22. ilumed, LLC
23. Iora Health NE DCE, LLC
24. NEVADA CARE CONNECT
25. Nivano Physicians, Inc. IPA
26. Northern Michigan Health Network
27. Oak Street Health Medicare Partners LLC
28. Ohio DCE - Akron, Inc.
29. Ohio DCE - Columbus, Inc.
30. Ohio DCE - SEOH, Inc.
31. On Belay Health Solutions, LLC
32. Oregon Medicare Direct, Inc
33. Pathways Accountable Care, LLC
34. PeaceHealth Direct Contracting LLC
35. Perfect Health DCE, LLC
36. Physicians Healthcare Collaborative
37. Piedmont Health Plus
38. Pittsburgh DCE, Inc.
39. Quality Partners in Care ACO
40. Regal Medical Group
41. Renovis Health LLC
42. Space Coast Independent Practice Association, LLC
43. Subsero Healthcare, LLC
44. Texas DCE, Inc.
45. The MetroHealth System dba Collaborative Care Partners
46. United Physicians Association, Inc
47. VillageMD Arizona ACO, LLC
48. VillageMD Georgia ACO, LLC
49. VillageMD Houston ACO, LLC
50. VillageMD Michigan ACO, LLC
51. VillageMD New Hampshire ACO, LLC
52. VillageMD Primary Providers ACO, LLC
53. Vively Health

The Implementation Period (IP) for the GPDC model began in October of 2020 and ran for six months. This voluntary preparatory period allowed DCEs time to prepare for PY1 by aggregating lives through voluntary alignment, formalizing provider partnerships, and trialing the methodology of the model. DCEs participating in the IP had the opportunity to matriculate into PY1 or could drop out of the model without penalty. DCEs also had the option to forgo the IP and join the model in April at the start of the performance year.

Previous ACLC briefs describe the design of the GPDC model, compare the elements of this model to the MSSP, and analyze the cohort of organizations that participated in the IP. This brief analyzes the PY1 participants — including those joining for the first time, those continuing from the IP, and those who participated in the IP but have not opted to participate in PY1 – and speculates as to why CMMI has decided to delay the second application cycle, despite significant interest from the industry.

EXPLORING THE PY1 PARTICIPANTS

DCE TYPES

CMMI released the names of 53 organizations currently participating in PY1 of the GPDC model, up from the 51 organizations that participated in the IP. However, there has been considerable churn between the IP and PY1, with 21 organizations dropping out or deferring to a 2022 start date and 22 newly joining the model, forgoing the IP (these organizations are explored further in Comparing the IP Cohort to the PY1 Cohort below).

While the DCE Types for the organizations participating in the IP were never released, in this announcement CMMI did specify the classification of each DCE – Standard, New Entrant, or High-Needs Population. In this cohort there are 31 Standard DCEs, 16 New Entrant DCEs, and six High-Needs Population DCEs (see Table 1).

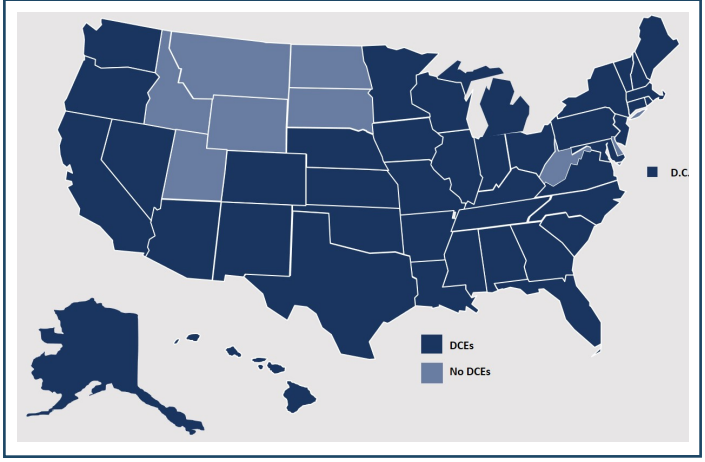
Table 1: DCE Types

DCE Type	Number Participating	Beneficiary Alignment	Minimum Lives	Ideal Applicant
Standard Substantial historical experience serving Medicare fee for service (FFS) beneficiaries	31	Claims & voluntary	5k min beneficiaries all years	Current ACOs
New Entrant Limited experience delivering care to Medicare FFS beneficiaries	16	Voluntary to start	1k min beneficiaries in PY1 (up to 5k by DC's end)	New to FFS (e.g., Medicare Advantage (MA) plans, physician aggregators, etc.)
High-Needs Population Focus on delivering care to complex, high-needs Medicare and dual-eligible beneficiaries	6	Voluntary & claims	250 min beneficiaries in PY1 (up to 1,400 by DC's end)	Providers concentrated on the chronically ill, PACE organizations

PROGRAM FOOTPRINT

In addition to the number of participants, the footprint of the model has changed with the PY1 cohort. The only DCE serving South Dakota beneficiaries, Iowa Health Accountable Care, dropped out of the model after the IP, leaving this state without any GPDC coverage. However, between the IP and PY1, Advanced Value Care II (which operated under the name Advanced Value Care during the IP) and Vively Health expanded the states included in their DCEs, and PeaceHealth Direct Contracting and Clover Health Partners joined for the first time, together adding Alaska, Arkansas, Hawaii, Maine, and Vermont to the list of states where GPDC participants are operating. The map (Figure 2) indicates every state in which DCEs are operating in PY1.

FIGURE 2: MAP OF STATES WHERE DCES OPERATE IN PY1



ORGANIZATION TYPE

An aspect of the GPDC model that has been particularly appealing to industry stakeholders is its ability to engage unique organizations not previously targeted for CMS or CMMI models. DCEs seem to have taken advantage of this highly touted feature of the model. In addition to 37 provider organizations, six payers, seven enablers, and three vendors have joined the model. Additional information on each of these groups of organizations is included below. For a complete breakdown of the distribution of organization types across DCE Type and participation circumstances (Table 2).

Table 2: DCE Organization Types

DCE Type	Participation in IP	Organization Type
Standard	Continuing: 20	Provider: 14
		Payer: 0
		Enabler: 6
		Vendor: 0
	New: 11	Provider: 6
		Payer: 3
		Enabler: 0
		Vendor: 2
New Entrant	Continuing: 9	Provider: 6
		Payer: 1
		Enabler: 1
		Vendor: 1
	New: 7	Provider: 5
		Payer: 2
		Enabler: 0
		Vendor: 0
High-Needs Population	Continuing: 2	Provider: 2
		Payer: 0
		Enabler: 0
		Vendor: 0
	New: 4	Provider: 4
		Payer: 0
		Enabler: 0
		Vendor: 0

Providers

Although a majority of PY1 DCEs are providers, which is typical of most CMS and CMMI models, the types of providers participating are more diverse than in previous models. For instance, Akos MD IPA, a New Entrant DCE joining the program for the first time in PY1, offers telehealth and other virtual services to patients 24-hours a day. Advanced Illness Partners, Nevada Care Connect, and Renovis Health, all joining as High-Needs Population DCEs, focus on delivering care to chronically ill seniors in home and community-based settings. CareConnect MD DCE, another High-Needs Population DCE, is similarly focused on chronically ill seniors, though specializes in nursing home settings.

While providers make up a plurality of participants of every DCE type, the High-Needs Population category is unique in that *only* provider organizations have signed on to operate as this type of DCE, no payers, vendors, or enablers have joined as they have with other DCE types. In addition to the home, community, and nursing facility-based providers mentioned above, Piedmont Health Plus, a federally qualified health center (FQHC) operating in North Carolina is participating as a High-Needs Population DCE as is Assurity DCE, operated by the Apollo Medical Group in Florida.

Payers

Payers may also act as DCEs in the GPDC model. Six of the DCEs participating in PY1 are sponsored by payer organizations: Alignment Healthcare and Humana are each sponsoring two DCEs, and Clover Health and and Anthem, through their provider subsidiary, CareMore. are each sponsoring one. Not surprisingly, each of these payers have significant experience serving MA populations. Humana currently serves nearly 4.5 million MA beneficiaries and Anthem serves 1.2 million, both with plans for further expansion. Clover Health and Alignment Healthcare are newer entrants to the MA market but are similar in that they both offer tech-enabled services to seniors, prioritizing multiple, convenient touchpoints with patients and leveraging artificial intelligence and predictive analytics to manage care needs.

GPDC is especially attractive to MA plans due in part to the alignment in methodology between GPDC and MA, as well as the opportunity it offers these plans to attract new MA beneficiaries. While CMS typically maintains strict guidelines dictating how MA plans can engage with beneficiaries, because DCEs are given the option to attract enrollees through voluntary alignment, they are granted greater flexibilities in their interactions. In the short-term, MA plans attempting to attract Traditional Medicare beneficiaries to their new DCEs may benefit from the exposure, inadvertently increasing enrollment in MA plans. In the long-term, patients who do decide to enroll in a DCE may be more likely to stay with the MA plan sponsoring their DCE at the conclusion of the model rather than to go back into Traditional Medicare, offering yet another pipeline for enrollment growth.

Vendors and Enablers

Value-based enablers and vendors make up the rest of the GPDC PY1 cohort. The role of enablers was discussed in depth in the ACLC's Primary Care Innovation Part II: An Analysis of Major Players and Developments in Advanced Primary Care, but in short, enablers help small, independent practices engage in value-based contracts by providing technology, guidance, and other supportive tools. Seven of the DCEs in PY1 are sponsored by enabler organizations, including five sponsored by agilon health, one by Pathways Accountable Care, and another by On Belay Health Solutions. These organizations do not have prior experience in CMS models, which would make them more likely to participate as New Entrants. However, the provider participants associated with these enablers *do* have experience in CMS models. As such, six of the seven enabler-led DCEs are participating as Standard DCEs, with only On Belay Health Solutions participating as a New Entrant DCE.

The vendor DCE participants offer a variety of services, but primarily leverage the expertise of their staff – made up of clinical personnel as well as policy and compliance experts, lawyers, and analysts – to help providers navigate risk based contracts and optimize their population health efforts. Subsero Healthcare and 360 Health DCE are both participating as Standard DCEs and ilumed is participating as a New Entrant DCE.

COMPARING THE IP COHORT TO THE PY1 COHORT

CONTINUING DCES

Of the 53 DCEs participating in PY1, 31 are continuing on from the IP and 22 are joining the model for the first time. Several of the continuing organizations added additional states to their contract when entering PY1. Advanced Value Care II underwent the most drastic expansion, adding 13 states to its DCE, but American Choice Healthcare, CareMore Aspire Medical Innovation Partners, ilumed, Oak Street Health Medicare Partners, VillageMD Michigan ACO, and Vively Health also expanded to additional states. Though no continuing DCEs dropped states from their contracts between the IP and PY1, agilon health did not carry its New York-based DCE over from the IP. Even after dropping this DCE, the organization is still operating five DCEs in PY1.

Additionally, the names of some continuing DCEs changed between the IP and PY1, including all of the DCEs associated with agilon health, which shifted from naming its DCEs after the provider organization it was partnering with to naming it according to the city or state it operates in (e.g., the organization known as "agilon health & Preferred Primary Care Physicians" in the IP is now "Pittsburgh DCE, Inc.").

NEW DCES

Twenty-two DCEs opted to start PY1 without the benefit of the six-month IP. Within this group are several notable names. As mentioned previously, Humana, which did not participate in the IP, is sponsoring two DCEs – a Standard DCE called Humana Direct Contracting and a New Entrant DCE called CenterWell Care Solutions which is operated by Humana's recently rebranded senior-focused primary care group. Alignment's two DCEs, Axceleran DCE1 and Axceleran DCE2, are also newly entering for PY1, as a New Entrant and a Standard DCE respectively. Another DCE with MA experience, Clover Health Partners, entered as a Standard DCE, also passing up the IP. It is likely that these organizations chose to forgo the

IP due to their robust MA experience. Much of the GPDC methodology is derived from MA and these organizations would not have difficulty aggregating enough lives for participation. Intermountain Healthcare's value-based care platform, Castell, is sponsoring a new Standard DCE called Castell Direct, which is operating exclusively in Nevada.

DCES NOT PARTICIPATING IN PY1

Twenty DCEs that participated in the IP chose not to participate in PY1, including Landmark Primary Care and Aetna Integrated Informatics d/b/a/ ActiveHealth. Some of the organizations not continuing on to PY1 may have dropped out of the GPDC model altogether, deciding after the IP that the financial model was not favorable, that it was too difficult to aggregate sufficient lives, or that the recent uncertainty signaled by CMS warranted investments in other value-based strategies. However, some of these DCEs may have merely deferred their participation to begin in January 2022. After the indefinite deferral of the second application cycle, the second cohort of participants will be made up entirely of deferred DCEs and will likely be much smaller than anticipated.

Many organizations were actively preparing for a second application cycle. A delay in the release of the financial methodology for the model left many prospective participants uncertain, with plans to wait until more information was available before applying. Likewise, many Next Generation ACOs saw GPDC as a natural next step in their value-based evolution and expected to phase into the program in its second year. Without GPDC as an option, these ACOs may end up applying for the MSSP, however, as explored in the ACLC's Choosing Your Path in Value: Direct Contracting vs. MSSP, the financial methodology of GPDC would be more favorable for many of them.

INDUSTRY RESPONSE TO POSTPONEMENT OF SECOND APPLICATION CYCLE

The announcement that CMMI would not be accepting a second round of applications for GPDC came as a shock to industry leaders. Further, the Biden Administration has offered no additional comment regarding the sudden decision or any indication of the timeline for reviewing the model to determine its next steps.

> *"The recent announcement by CMMI to halt new applications to participate in the Global and Professional Direct Contracting alternate payment models is a sudden jolt to current and prospective provider entities committed to advancing value based care."*
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> *"For those of us in the Next Generation ACO program, without a transition path to Direct Contracting, testing advanced payment models might be set back to existing forms of limited risk-bearing such as the Medicare Shared Savings Program (MSSP). However, for both physicians and patients, the regulatory flexibilities, resources and opportunities to drive value in a more accelerated manner are limited by MSSP's constraints."*
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> *"At a time when the Medicare trust fund's solvency is requiring considerable innovation tests towards adopting higher risk-bearing models of care, halting applications for practices ready to go forward will impact doctors and patients who are just recovering from the swing effects of the pandemic. We badly need bigger, bolder alternate payment models to deliver value like the DC model."*
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> ***- Sanjay Doddamani, MD, MBA***
> ***EVP, Chief Physician Executive & Chief Operating Officer***
> ***Southwestern Health Resources***

However, this is not the first adjustment made to CMMI plans for 2021. Regulators paused the Geographic Direct Contracting model last month, as well as other alternative payment models like the Community Health Access and Rural Transformation model (see Figure 3 on next page).

The minimal messaging from the new leadership on its approach to value has led to speculation on the intended strategy of CMS. While the last three administrations have all been proponents of value-based care and sought to advance industry adoption, each has modified, cancelled and created new models in line with their priorities. Included in the model update from CMS was a statement on CMMI's commitment to value-based care as well as integrated care for dual eligible populations and health equity, signaling the overarching priorities of the Department of Health and Human Services under the new administration. Some key stakeholders in value-based care have conjectured that this pause could be an opportunity for CMS to align models more closely to their priorities around equity, access, and population health. Others have speculated that CMS may be pausing to lay out a more aggressive strategy for advancing value. Further, CMS is still awaiting the confirmation of Chiquita Brooks-LaSure, President Biden's nominee for CMS Administrator, who may value the opportunity

to provide her input on the model and the strategy of the agency going forward. Two days before the announcement, two former CMS leaders who oversaw the development and early leadership of CMMI in the Obama administration recommended in an opinion piece that the current administration use its authority to make the ACO model mandatory for all Medicare-participating clinicians and hospitals.

Though disappointed, NAACOS President and CEO Clif Gaus, congratulated the 53 entities that will be participating in Direct Contracting but alerted CMS to Next Generation ACOs who will likely need clarification on their participation in high-risk, accountable care models. Others have urged CMMI to improve the direct contracting opportunities during the pause by reducing discounts, establishing pathways for implementation of capitated payments, and testing alignment, among other recommendations. Next Generation ACOs also tweeted a recommendation for CMS to extend their model, slated to sunset this year, for one additional year to get closer to permanence within MSSP. Others have called for the Next Generation ACO model to become permanent, which could give ACOs pursuing full-risk a long-term home.

Until CMS or the Biden Administration release a more detailed plan for their approach to value-based care the future of these programs is uncertain. An indifferent approach to value from Secretary Price under the Trump Administration resulted in a deceleration of value-based models, in the public and commercial spaces. However, the industry has since matured and the clinical and economic fallout of the COVID-19 pandemic has reaffirmed the advantages of value-based payment for providers, indicating the market may be more resilient in the face of uncertainty than in the past.

FIGURE 3: RECENT CMMI MODEL DELAYS AND UPDATES

Primary Care First

- Second cohort will begin January 2022
- Applications for second cohort now open
  - Practice applications deadline extended to May 21, 2021
  - Payer applications deadline extended to June 18, 2021.
  - Seriously Ill Population component under review

Kidney Care Choices

- First performance year delayed to January 2022
- Implementation period began October 2020

Direct Contracting Geographic

- Under review

Radiation Oncology

- Initially delayed by CMS to July 2021
- Consolidated Appropriations Act (HR 133) delayed model further to January 2022

Community Health Access and Rural Transformation

- Request for applications for ACO Transformation Track delayed to Spring 2022
- Application for Community Transformation Track due May 11, 2021

> *"I don't think this is the last word on the Direct Contracting program or the CMS commitment to get to advanced, population-focused alternative payment models. I hope that concerns that CMMI has about the model can be addressed going forward, because it could be an important component of efforts to get to high value care for all Medicare beneficiaries."*
>
> *- Mark McClellan, MD, PhD*
> *Founding Director of the Duke-Margolis Center for Health Policy at Duke University and Co-founder of the ACLC*

ABOUT THE ACLC

The Accountable Care Learning Collaborative (ACLC) is a non-profit organization with a mission to accelerate the readiness of health care organizations to succeed in value-based payment models. Founded by former Secretary of Health and Human Services, Gov. Mike Leavitt, and former Administrator of the Centers for Medicare and Medicaid Services, Dr. Mark McClellan, the ACLC serves as the foundation for health care stakeholders across the industry to collaborate on improving the care delivery system. To learn more about the ACLC, visit accountablecareLC.org.