May 7, 2019

The Honorable Alex Azar II
Secretary
U.S. Department of Health & Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
US Department of Health & Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Advancing the Next Generation Accountable Care Organization Model

Dear Secretary Azar and Administrator Verma:

The undersigned organizations write to urge the Department of Health & Human Services (HHS) to make the Next Generation Accountable Care Organization (Next Gen ACO) Model a permanent, voluntary program within the Medicare Shared Savings Program. In addition, the CMS Center for Medicare & Medicaid Innovation (Innovation Center) should implement program changes that will increase the model's stability and sustain robust participation. These changes are particularly important as the Innovation Center will soon open the application cycle for the new Direct Contracting Model. Many Next Gen ACOs are currently weighing their participation options. Having assurance that their model would continue past the current sunset date of December 31, 2020 would benefit Next Gen ACOs and those interested in joining the existing program or the new Direct Contracting Model.

We strongly support the Innovation Center's work in developing the Direct Contracting Model, which will provide another accountable care option for those ready for capitation and high levels of risk and reward. We look forward submitting additional feedback on the Direct Contracting Model and working with our members and the Centers for Medicare & Medicaid Services (CMS) to support its successful implementation. Our recommendations in this letter reflect our unified desire to see Medicare ACO programs achieve the long-term sustainability necessary to enhance care coordination for millions of beneficiaries, lower the growth rate of healthcare spending and improve quality in the Medicare program. We believe the Next Generation ACO Model provides an important step on the risk progression from the current Medicare Shared Savings Program (MSSP) Pathways to Success options to the new Direct Contract Model.

Make the Model a Permanent Option for Medicare ACOs

The Next Gen model started in 2016 as a five-year Innovation Center demonstration. At the end of 2018, 51 Next Gen ACOs cared for nearly 2 million Medicare beneficiaries. In a relatively short time, these ACOs have proven to be a pillar of success with Administrator Verma praising the performance of Next Gen ACOs as a model for movement to two-sided risk.[1]

Section 1115A of the Affordable Care Act created the Innovation Center, and subsection (c) gives HHS authority, through rulemaking, to expand models if the Secretary and CMS Chief Actuary determine demonstrations reduce spending without hurting quality or improve quality without increasing

[1] https://www.cms.gov/newsroom/press-releases/acos-taking-risk-innovative-payment-model-generate-savings-patients-and-taxpayers

spending.[2] **Evidence shows the Next Gen model has achieved both the spending reduction and quality improvement criteria needed to be certified as a permanent Medicare program.** The first-year evaluation report showed Next Gen ACOs reduced Medicare spending by $100 million and $62 million after accounting for shared savings and losses. Furthermore, quality was improved in the form of fewer acute care hospital stays and more annual wellness visits.[3] Initial analysis of second-year results show Next Gen ACOs netted at least $165 million to Medicare in 2017. We are eager to see the formal second-year evaluation and third-year spending and quality data, which are expected to show continued positive achievements.

HHS has set precedent by expanding two Innovation Center demonstrations. In 2015, the Pioneer ACO Model, which began in 2012 with 32 ACOs, was certified by the CMS Office of the Actuary to reduce net Medicare spending.[4] CMS later designed Track 3 of the MSSP after the successful Pioneer program. Pioneer ACOs generated two-year savings to Medicare of approximately $384 million, or almost 3 percent of beneficiary spending. The only other program to demonstrate quantifiable savings to allow for expansion is the Medicare Diabetes Prevention Program.

We support the new Pathways to Success model and believe that the addition of Next Gen adds a valuable option. The Enhanced Track has substantial risk from the Basic Track, but Next Gen facilitates an intermediate step between Pathways to Success and the new Direct Contracting Model. Next Gen has different benchmarking and risk corridors than the Enhanced Track, which allows participants to better prepare for transition to Direct Contracting Models. Additionally, our respective Next Gen participant members have requested additional time beyond the current end date. Next Gen ACOs are among the most advanced and committed providers in the country, and they need to be applauded and supported in their commitment to the value movement.

Given the notable contributions from Next Gen ACOs and that the model meets the criteria for expansion, we request HHS act quickly to make this model a permanent part of the MSSP so that ACOs can continue participation and build upon the initial success. We also urge you to implement other program changes detailed below, which will drive continued participation and further success.

Recommended Policy Changes to Improve the Next Gen Model

Permit full primary care capitation within Next Generation ACOs

CMS expanded payment capitation within the Next Gen model with the introduction of the all-inclusive population-based payment (AIPBP) option. AIPBP reduces the role of fee-for-service (FFS), allowing Next Gen ACOs to better negotiate participating provider contracts and reduce costs. However, AIPBP is not true capitation. The AIPBP prospectively pays providers an estimation of total spending based on historical utilization and reconciles payments against claims. The reconciliation against spend limits ACOs' ability to develop payment arrangements that are not based on the underlying FFS system. While the AIPBP is a step to help ACOs gain experience with capitation-like approaches, some ACOs are currently prepared to accept full financial risk for all or portions of their assigned Medicare population.

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[2] https://www.ssa.gov/OP_Home/ssact/title11/1115A.htm
[3] https://innovation.cms.gov/Files/reports/nextgenaco-fg-firstannrpt.pdf
[4] https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/Pioneer-Certification-2015-04-10.pdf

CMS should incorporate true capitated payment approaches within the Next Gen model, starting with primary care capitation. The Next Gen ACO model is the program best equipped to provide the next steps toward full capitation offered in the DC model.

Risk Adjustment

Accurate risk adjustment removes or minimizes differences in health and other risk factors that impact performance but may be outside the ACO's control. With an aging population that generally faces worsening health conditions over time, it is unreasonable – if not impossible – for ACOs to maintain the same risk scores year over year. The Next Gen ACO Model should use a risk adjustment approach similar to Medicare Advantage. The coding adjustment factor already in place in the Next Gen Model should be sufficient to address coding intensity concerns. Including a cap and a coding adjustment factor is duplicative and penalizes ACOs. **Therefore, ACOs should not face an unrealistic cap on risk score increases but would have risk scores adjusted annually through a Medicare Advantage-like process designed to address changes in coding practices.** In the long-term, the same risk adjustment approach should be used across Medicare, creating parity and emphasizing the need to come to consensus on the most appropriate methodology.

Address model overlap

The rollout of several APMs within a relatively short time frame often results in portions of the patient population qualifying for multiple models. The increasing number of APMs tested simultaneously by CMS elevates the need to ensure that models are complementary. Because model overlap impacts the financial performance of providers who participate in multiple models, CMS should give precedence to the total-cost-of-care models, such as Next Gen ACOs, that may experience material financial harm in absence of protections. Specifically, CMS should:

- Provide attribution and financial reconciliation preference to longitudinal, total-cost-of-care models, which are at the greatest financial risk.
- Allow Next Gen ACOs to choose if beneficiaries can be aligned to other models, for example if their beneficiaries can also be included in bundled payment APMs.
- Reward APM entities participating in multiple risk-based models. CMS should explore options to reward providers who partner with the Innovation Center on multiple APMs (e.g. increased opportunity for shared savings in some models, additional flexibilities).
- Study the impact of model overlap independently and as part of the evaluation of all CMMI models.

Adjust benchmarks to make model viable for low-cost providers, successful NGACOs

A key challenge for Next Gen ACOs, and APMs more broadly, is that comparisons to historical benchmarks present limitations for providers participating in models that are either in a low-cost region, are the dominant provider in their region, or that have already created substantial savings through their care redesign efforts. The current benchmark approach may lead to successful participants leaving the program over time as a result of benchmarks that are too low to operate in the program. Viable approaches to ensure that a Next Gen ACO's performance is compared to the average spending for similar patients in the region, rather than against its own performance include:

- Removing the ACO's beneficiaries from the historical benchmark calculation, and

- Continuing to allow regional spending to account for the majority of the benchmark determination.

To appropriately realign incentives for the long-term success of the program, **CMS should explore a tiered benchmarking methodology, where benchmarks are increased for low-cost regions and decreased for high-cost regions**. This methodology, similar to the approach used for rate setting in Medicare Advantage, would reward providers in low-cost areas for participating in APMs and encourage additional cost reductions, and reduce benchmarks for providers in high-cost regions that may have a greater ability to reduce costs. It appears that a similar approach will be tested in the new Direct Contracting models.

Promote flexibilities to enhance care coordination and manage risk

Benefit design and flexibility

Next Gen ACOs and other provider-led alternative payment models (APMs) with two-sided risk require the ability to tailor services to the needs of the population. CMS should allow Next Gen ACOs to tailor benefits to incentivize care for certain conditions and populations and to help address social determinants of health (SDoH). Currently, CMS provides these types of flexibilities to Medicare Advantage plans participating in the Innovation Center's Value-based Insurance Design Model, which permits non-uniform benefit design to provide care based on condition and/or socioeconomic status. Subsequently, CMS extended benefit design flexibilities to all Medicare Advantage plans in the 2020 Rate Announcement and Call Letter to permit the provision of supplemental benefits to chronically-ill beneficiaries in the form of non-medical services that may be used to address SDoH. These flexibilities should be allowed, or at a minimum tested, for Next Gen ACOs and other APMs bearing more than nominal risk. In addition to these flexibilities, CMS should reduce documentation, reporting, and auditing requirements associated with implementing existing waivers in order to limit provider burden related to utilizing flexibilities that were granted to promote care coordination and reduce costs.

Creating Preferred Provider Networks

Beneficiary choice is a foundational element of existing Medicare ACO programs. However, for ACOs to effectively manage cost and quality while assuming accountability for beneficiary care, ACOs need to be able to incentivize beneficiaries to receive optimal care consistent with their quality and goals. Therefore, ACOs need to develop networks of preferred providers and offer discounts and other incentives to beneficiaries for using the ACO's preferred providers. This is similar to a Preferred Provider Organization (PPO), which is commonly seen in other payment arrangements and widely used in Medicare Advantage and other commercial plans. ACOs could better manage patient populations by introducing incentives tied to care from preferred providers. This is an important tool to better engage beneficiaries and increase their awareness of properly coordinated care.

Payment mechanisms

Next Gen ACOs can select the payment mechanism of their choice: FFS, FFS plus upfront infrastructure payments (which require repayment to CMS), population-based payments (PBP) and AIPBP. Participants are currently required to select one of the four payment mechanisms. However, benefits may exist to allowing providers to select components of multiple payment mechanisms. For example, a Next Gen ACO may opt for AIPBP payments, but would also benefit from an upfront, repayable infrastructure

investment to support financial risk management. CMS should allow multiple choices of payment mechanisms in the Next Gen ACO model to allow for novel approaches to care.

Account for spending on incentives in benchmarks

ACOs appreciate opportunities to use payment rule waivers and beneficiary incentives. We support simplifying administrative burdens around these waivers and CMS accounting for the costs borne by ACOs to implement these incentives. **Specifically, CMS should allow ACOs to account for these investments by having those expenditures be factored into rebased benchmarks.** For example, Next Gen ACOs starting this year can provide gift cards to assigned patients up to $75 to incentivize use of a chronic disease management program. ACOs must pay for the gift card out of their own funds and these investments should be added into future benchmarks.

Conclusion

We support HHS's efforts to transform healthcare payment and delivery systems to one that better rewards value and incentivizes quality, well-coordinated care. We further appreciate the opportunity to provide feedback on the Next Generation ACO Model. Since its start in 2016, the program has been a beacon of success. We encourage you to capitalize on the opportunity to both make the Next Gen program a permanent option for ACOs while making adjustments to improve upon the impressive results the program has already delivered.

Sincerely,

America's Physician Groups
National Association of ACOs
Premier

CC: Adam Boehler