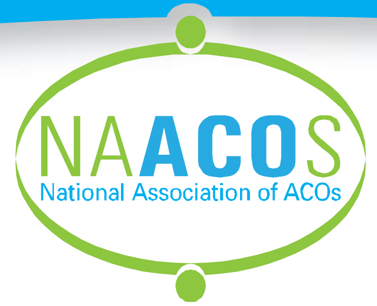

Elizabeth Fowler
Deputy Administrator of the Centers for Medicare & Medicaid Services
Director of the Center for Medicare & Medicaid Innovation
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

April 22, 2021

Dear Director Fowler:

It has been a pleasure working with you over the last few months, and NAACOS looks forward to partnering with you in achieving our mutual goals. We believe a fresh look at the programs of the Center for Medicare and Medicaid Innovation (Innovation Center) will bring needed change to its role in improving Medicare and Medicaid programs for millions of beneficiaries. As you know, payment and delivery system reform remains a challenging endeavor for our healthcare system. Policymakers must balance incentives for providers to participate in mostly voluntary models while crafting programs that will protect beneficiaries and improve quality of care and generate savings for Medicare, Medicaid, and taxpayers.

Fortunately, NAACOS and its members have nearly a decade of experience driving value in fee-for-service (FFS) Medicare and stand ready to help you advance your work and achieve our shared goals of lowering health spending while improving quality. NAACOS represents more than 12 million beneficiary lives through hundreds of organizations participating in population health-focused payment and delivery models in Medicare, Medicaid, and commercial insurance. Models include the Medicare Shared Savings Program (MSSP), the Next Generation ACO Model, the Direct Contracting Model, and alternative payment models (APMs) supported by a myriad of commercial health plans and Medicare Advantage. NAACOS is a member-led and member-owned nonprofit organization that works to improve quality of care, outcomes, and healthcare cost efficiency. We offer the following recommendations to reinforce the transition to value after recent years of challenges and declining participation.

PUT PROVIDERS AT THE CENTER OF REFORMS

NAACOS recommends that CMS and the Innovation Center focus the value transition on providers, keeping them at the center of payment models instead of implementing programs and policies to attract new players into traditional Medicare. NAACOS opposes giving favorable treatment to entice new participants, such as payers, to APMs at the expense of historically successful ACOs and those who have been on the frontlines of the value transition for the past decade. Therefore, to ensure even greater success of Medicare's APMs, we urge you to maintain a level playing field for both new entrants to FFS APMs and those existing ACOs that, through their investments and commitment to innovation, have already driven value into FFS

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Medicare. Moreover, any new models should build from prior initiatives and avoid undermining or competing with ongoing initiatives.

EMPHASIZE TOTAL COST OF CARE MODELS AND FIX APM OVERLAP

Total-cost-of-care models, including ACOs, remain the best way to achieve the Innovation Center's goals. Data from the Medicare Payment Advisory Commission[1], researchers at Harvard University[2], and the analytic firm Dobson DaVanzo and Associates[3]show that ACOs are lowering Medicare spending annually by 1 percent to 2 percent. Knowing Medicare Parts A and B expenditures reached $636 billion in 2018[4], a 2 percent reduction in spending would save nearly $200 billion when compounded over a decade, assuming Medicare spending grows at 4.5 percent per year without ACOs. Aside from demonstrating superior results compared to other medical home and episodic-based payment models, population-focused, total-cost-of-care models, such as ACOs, incentivize all providers to work together and care for the whole patient throughout the care continuum to address patients' social needs, manage comorbidities, and coordinate medications. We urge the Innovation Center to prioritize total cost of care models over others.

As the health care system continues toward value-based payment, it is critical that the Innovation Center devote a strategic and coordinated effort around overlapping patient and provider participation in multiple APMs. Currently, each Innovation Center model devises its own rules for how patient attribution and provider participation in multiple models are permitted. This has resulted in a fragmented and complicated process that also duplicates efforts among participants trying to better coordinate patients' care. NAACOS urges the Innovation Center to devise a coordinated, single policy on model overlap that prioritizes patient attribution to the total-cost-of-care-model. Specifically, we request the Innovation Center exclude ACO patients from bundles unless a collaborative agreement between the bundler and the ACO is in place. While the Innovation Center has been crafting a policy for some time, it has not been finalized for release for public feedback. A center-wide overlap policy is past due.

ADDITIONAL OVERARCHING RECOMMENDATIONS TO SUPPORT THE SHIFT TO VALUE

In addition to the key recommendations of putting providers at the center of payment reform, prioritizing total-cost-of-care models and addressing APM overlap, NAACOS offers additional recommendations to help support the broader Medicare value transition, including that the Innovation Center work with other parts of CMS and HHS to:

- Set a national goal to have a majority of traditional Medicare beneficiaries in an ACO by 2025;
- Deprioritize the rush to risk and build a population health infrastructure;
- Strengthen incentives to attract new ACOs and retain existing ones; and
- Provide meaningful funding to build infrastructure necessary to spur innovation and value through expanded advanced payments and grants.

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[1] http://www.medpac.gov/docs/default-source/reports/jun19_ch6_medpac_reporttocongress_sec.pdf?sfvrsn=0
[2] https://www.nejm.org/doi/full/10.1056/NEJMsa1803388
[3] https://naacos.memberclicks.net/studyofmsspsavings2012-2015
[4] https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/

PROGRAM-SPECIFIC RECOMMENDATIONS
As further detailed below in this letter, key APM-specific recommendations include that the Innovation Center should:

- **Flip the weighting of the benchmark years used in historical expenditures under Direct Contracting to give greater weight to the least recent year**;
- Completely forgo use of historical baseline expenditures **under Direct Contracting** and rely solely on the new rate book;
- Use the new CMMI-Hierarchical Condition Code (CMMI-HCC) concurrent risk adjustment model and apply it to high-needs beneficiaries for all Direct Contracting Entities (DCEs) types;
- Increase the shared savings rate for Professional DCEs to 75 percent to make it an attractive option for those DCEs that are not ready for full risk;
- Employ a more realistic discount for Direct Contracting, such as the 2 percent discount used in the Next Generation ACO Model;
- Either discontinue the policy of setting historic spending for voluntarily aligned beneficiaries to regional spending or otherwise create a level playing field;
- Fully stop the Geographic Direct Contracting Model and introduce appreciated policies worthy of being tested in other APMs;
- Extend the Next Generation ACO Model through 2022, giving time to install it as a permanent option for ACOs, either as a stand-alone track or option within MSSP; and
- Expand eligibility and scale of a new ACO loan program for rural and small ACOs.

CONCLUSION
NAACOS has long partnered with the Innovation Center in advancing our shared goals of reducing Medicare spending while improving the quality of care for traditional Medicare beneficiaries. We look forward to continuing that partnership under your leadership. We believe our recommendations will improve Innovation Center models, increase APM participation and overall accelerate Medicare's movement to value-based care. I've attached a more detailed appendix that might help engender further conversations with Innovation Center staff. If they have any questions, please contact Allison Brennan, Senior Vice President of Government Affairs, NAACOS at abrennen@naacos.com.

Sincerely,

Clif Gaus, Sc.D.
President and CEO

Appendix: Detailed Innovation Center Model Recommendations

GLOBAL AND PROFESSIONAL DIRECT CONTRACTING

Direct Contracting represents an evolution of accountable care models within the Innovation Center. It provides a better bridge to full capitation through the Professional option and grants access to wider range of benefit enhancements. NAACOS has been supportive of the Innovation Center's offering of more options to participate in population-health, accountable care models. NAACOS also remains concerned that some entrants are joining Direct Contracting with the goal of gaining exposure to beneficiaries to then recruit them to Medicare Advantage. Some Direct Contracting Entities (DCEs) have even publicly stated this goal in calls with investors. Innovation Center goals should be to improve the quality of care and provide savings to the Medicare Trust Fund, not to create an arbitrage opportunity for certain businesses to enhance their portfolios or stocks.

We remain concerned that the Professional and Global options of Direct Contracting unfairly penalize provider organizations who have previously participated in shared savings models and generated savings. Because they have spent years lowering the cost of care on their patients, the model's benchmarking rules place them at a disadvantage. Furthermore, polices given to entice New Entrant and High Needs Population DCEs into the model place Standard DCEs – which will predominately be ACOs – at a disadvantage. Fortunately, both of these goals can be corrected in a number of ways and could be done before the start of the 2022 performance years.

- **The Innovation Center should flip the weighting of the benchmark years used in historical expenditures to give greater weight to the least recent year.** This would place more weight on 2017 and less weight on 2019, which is the opposite of current policy. We also ask that the Innovation Center add shared savings earned by a DCE back into its baseline for purposes of setting the performance year benchmark. This removes the penalty for DCEs who have helped CMS reach the program's goal of lowering Medicare spending.

- **The Innovation Center** should forego use of the historical baseline expenditures for all DCEs and relying solely on the new Rate Book. Direct Contracting leverages a new **Direct Contracting/Kidney Care Choices (DC/KCC) Rate Book, which NAACOS appreciates, and decrease the reliance on historical expenditures.** Rather than starting with 35 percent expenditures for the first three years with a progression toward a maximum of 50 percent, the blend should start at 50 percent and progress to 100 percent regional expenditures by the end of the model.

- The Innovation Center should extend the model's use of the new INNOVATION CENTER-Hierarchical Condition Code (INNOVATION CENTER-HCC) concurrent risk adjustment model and apply it to high-needs beneficiaries for all DCEs types — not just High Needs Population DCEs. The Innovation Center could identify those beneficiaries aligned to a Standard or New Entrant DCE that meets the high-needs criteria and apply the new model to those beneficiaries while continuing its use of the traditional CMS-HCC prospective risk adjustment model for other beneficiaries. Such a policy would further your goal of reducing the influence of coding practices on benchmarking.

- The Innovation Center should pause implementation of the new DCE type that allows Medicaid Managed Care Organizations (MCOs) to manage Medicare FFS expenditures for dually eligible beneficiaries. NAACOS is concerned this DCE type will bifurcate care for these vulnerable patients. ACOs and DCEs already care for a large number of dual eligible patients, particularly

those in long-term care settings. Because patients can only be assigned to one entity, the Innovation Center risks eroding the care already provided to these high-risk patients.

- The Innovation Center should increase the shared savings rate for Professional DCEs to 75 percent to make it an attractive option for those DCEs that are not ready for full risk. The 50 percent shared savings rate for Professional DCEs is too low. Given the currently available options in MSSP Enhanced (up to 75 percent with maximum with significantly lower downside risk) and Next Gen (80 percent), the Professional DCE option will be a step backward for the many ACOs.

- The Innovation Center should reduce the mandatory discount applied to Global DCEs. For Global DCEs, CMS will realize savings from the model by implementing a discount that collects 2 percent of a DCE's benchmark in Performance Year 1 and increasing that to 5 percent in Performance Year 5. NAACOS continues to believe this discount is too high and will be a significant barrier for DCEs to generate savings and will discourage model participation. Increasing the discount to as high as 5 percent places an insurmountable burden on DCEs. We urge a more realistic discount, such as the 2 percent discount used in the Next Generation ACO Model.

- The Innovation Center should end the risk adjustment policy for voluntarily aligned beneficiaries that incentivizes gaming. Currently, Direct Contracting sets historic spending for voluntarily aligned beneficiaries to regional spending as defined by the DC/KCC Rate Book. Unfortunately, this creates a perverse incentive for DCEs to voluntarily align healthy, low-spending patients, whose true spending will likely be far less than that of the regional average. This also further creates a disparity between MSSP ACOs and DCEs because in the former spending for voluntarily aligned beneficiaries is their historic spending. The Innovation Center should either discontinue this policy or create a level playing field to not introduce arbitrage, create programmatic discrepancies or worsen health disparities.

- The Innovation Center should allow greater flexibility for DCEs to switch DCE types and capitation options. Some DCEs wish to switch from the Professional to Global option and from Primary Care Capitation to Total Cost of Care Capitation between Performance Years 1 and 2. Unfortunately, the Innovation Center has denied these requests, saying selections must be maintained for the first two years. NAACOS hopes you can allow greater flexibility for DCEs making the switch, since locking DCEs into important selections for 21 months seems unnecessary.

GEOGRAPHIC DIRECT CONTRACTING MODEL

In March, the Innovation Center placed the Geographic Direct Contracting Model under review. NAACOS had previously recommended a pause in the model's implementation, so we appreciated your swift action. "Geo," as it's commonly referred to, would cause undue confusion amongst beneficiaries, and disrupt ACO providers' established relationships with their patients if a Geo DCE ultimately has financial accountability for traditional Medicare beneficiaries in the region. It would also create concerns about the role of health plans in traditional Medicare and the future direction of APMs within the Innovation Center. It would also further exacerbate our concern about the overlap with other APMs. But those concerns remain, so we ask the Innovation Center to further clarify Geo's future by fully stopping the model and introducing appreciated policies worthy of being tested in other APMs. While Geo sought to test concepts such as random assignment of beneficiaries without a primary care home, utilization management and access to real-time claims API, NAACOS believes these features could be incorporated into other ACO models without introducing a new layer of administrative complexity.

NEXT GENERATION ACO MODEL

The Next Generation ACO Model has been one of the most success Innovation Center models to date. The program has generated more than $1 billion in gross savings and $616 million when considering shared savings, shared losses and discounts paid to CMS. In 2019 alone, the last year for which data are available, Next Gens generated $559 million in gross savings and $204 million in net savings. That equates to an average of $452 per beneficiary for the 1.2 million patients in the program.

Unfortunately, Next Gen's success has been underappreciated because the program's successes have not been realized in its formal evaluations. This is because Next Gen's comparison group in the formal evaluations includes beneficiaries assigned to MSSP ACOs, and comparisons between the two do not accurately reflect the impact of the Next Gen program on FFS Medicare, which is the appropriate comparison. Although Next Gen ACOs performed modestly compared with the local comparison groups in formal evaluations, they substantially outperformed national Medicare FFS spending trends. For example, Next Gen ACOs and the local comparison groups reduced Medicare spending by more than 1 percent between the 2016 and 2017 performance years. In contrast, national Medicare spending per beneficiary grew by 3.2 percent over the same period. In Next Gen markets, 40 percent of beneficiaries are either in a Next Gen or Shared Savings Program ACO. That is a very high concentration and likely what is driving the slow growth in the comparison group.

NAACOS urges the Innovation Center to extend the Next Gen ACO Model through 2022, giving time to install it as a permanent option for ACOs, either as a stand-alone track or option within MSSP. The model is scheduled to sunset at the end of 2021. The above results should speak for themselves and substantiate permanentizing the model. However, the Innovation Center's recent decision to cancel a 2022 cohort of starters in Direct Contracting has placed Next Gens in an untenable situation with their only participation option being MSSP Enhanced, absent further action from CMS. Next Gens ACOs generally view MSSP participation as a step backwards, given the fewer benefit enhancements offered and a shared savings rate that tops out at 75 percent. Instead, Next Gen is a better bridge toward capitation offered under Direct Contracting by allowing ACOs to modify downstream payments to participant providers. Next Gens were promised an opportunity to apply to Direct Contracting, so removing this year's application cycle is akin to pulling the rug from under them.

NAACOS surveyed Next Gen ACOs in early April, and 86 percent of survey respondents said CMS making the model permanent was either extremely or very important to their ACO. Survey respondents identified the most favorable aspects of the model as the option for full risk, NPI-level participation, population-based payments, and waivers and benefit enhancements. All of these elements either don't exist or are much more limited within MSSP. The survey was answered by 28 Next Gen ACOs, representing a bulk of the model's participants. As one respondent said, "We are interested in moving towards capitation and continuing to take on increased levels of risk, so [MSSP Enhanced] feels like a step back and not consistent with CMS's overall goals."

Furthermore, a move from a INNOVATION CENTER model to MSSP would severely disrupt patient care and place tremendous administrative burdens on ACOs. Provider organizations have built operations around benefit enhancements, such as home visits and chronic disease management, that would have to be stopped if they moved to MSSP. Because MSSP operates on a full-TIN participation, ACOs would be forced to rework provider networks and contracts, only to be reworked a year later if they eventually move to Direct Contracting. The change to full TIN participation in MSSP will significantly expand the size of some Next Gen ACOs, which would be challenging if the ACO is not prepared to handle a notably larger provider network.

In short, Next Gen ACOs should be offered a stable option to advance value-based care within traditional Medicare, and the model has shown to improve patient outcomes while lowering costs, making a great case that the model be extended through 2022 while a permanent solution is put in place.

CHART MODEL

NAACOS was disappointed to see the ACO Transformation Track of the Innovation Center's Community Health Access and Rural Transformation (CHART) Model delayed by a year. It was poised to receive a great deal of applications this year. Granting ACOs help with up-front investment costs to form and start work as an ACO has been a long-time ask of NAACOS. More needs to be done to help healthcare providers' participation in alternative payment models.

CHART's precursor the ACO Investment Model was one of the most successful Innovation Center models to date, so more needs to be done to recreate its work. NAACOS hopes the Innovation Center will expand eligibility and scale of a new ACO loan program for rural and small ACOs. An innovative CHART 2.0 option for ACOs in the Medicare Shared Savings Program would help foster the growth of new ACOs in underserved communities, improve beneficiary care and create savings for the Medicare program.