NEXTGEN
ACO COALITION

June 23, 2020

The Honorable Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

The Honorable Brad Smith
Director, Center for Medicare & Medicaid Innovation
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Next Generation Accountable Care Organization (ACO) Model Adjustments for COVID-19

Dear Administrator Verma and Deputy Administrator Smith,

On behalf of the Next Generation ACO Coalition, we write to thank you for the flexibilities you have implemented, including extending Next Gen for 2021, and request additional modifications to the program to bolster the move to performance-based risk.

Next Gen is currently the most advanced model in the CMS Innovation Center's performance-based risk portfolio. The model tests higher levels of financial risk, reward, and accountability for patient populations. Since 2016, Next Gen ACOs have been leading the health care system's transformation from volume to value.

Next Gens have rapidly deployed care coordination and care management services to prevent the spread of COVID-19 and care for patients with chronic conditions who are under stay-home orders. Examples include:

- Arranging meal delivery services for patients who struggle with food insecurity;
- Scheduling phone and telehealth visits for patients with chronic conditions;
- Connecting patients to community resources to ensure that their health care and behavioral health needs are met during stay-home orders;

- Educating patients about preventing exposure, slowing the spread of the virus, and accessing the appropriate level of care for testing and treatment, based on their symptoms;
- Setting up drive-through testing, establishing respiratory centers, and purchasing equipment to limit exposure to COVID-19.

We thank you for the flexibilities implemented for Next Gen ACOs to date, including providing financial options for entities to address potential savings and losses in the model due to COVID-19 and continuing Next Gen for one more year. We know that this model, and other performance-based risk models, are best positioned to help our nation recover from this pandemic and to take on the challenges of the future. The COVID-19 pandemic has underscored the vulnerabilities of a fee-for-service (FFS) payment system and the need to transition to more stable payment mechanisms. We request the following actions to continue to provide financial support to entities that are making the leap to value-based care.

Ensure that NGACOs Receive Medicare Access and CHIP Reauthorization Act (MACRA) Advanced Alternative Payment Model (APM) Bonus Payments in a Timely Fashion

Requests:

- Waive application of revenue and patient count thresholds to ensure that all risk-bearing ACOs qualify for advanced APM bonuses;
- Improve transparency and predictability around the APM bonus payment process; and
- Accelerate payment of advanced APM bonuses for 2018 and 2019 performance years to create cash flow for Next Gen ACOs.

<u>Waive the MACRA Thresholds for Advanced APM Bonus Eligibility in 2020</u>

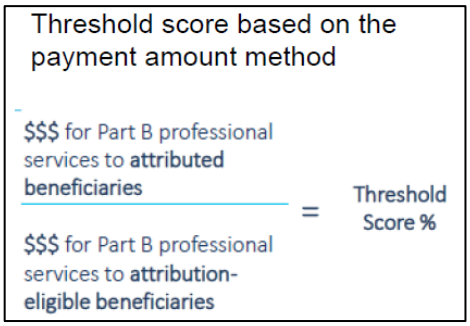
MACRA intended to accelerate the transition of traditional Medicare from FFS to advanced APMs by including a 5% bonus for qualifying participants (QPs) in APMs. To be bonus eligible, alternative payment models must meet certain criteria related to quality, use of electronic health records, and bearing of financial risk. Advanced APM entities must also meet specific threshold criteria—measured either by their percentage of revenue or patients—to achieve QP status. QP status also allows advanced APMs to avoid participation in the Merit-based Incentive Payment System (MIPS). MACRA authors designed these thresholds to ensure increasing levels of participation in advanced APMs over time.

MACRA Thresholds

	2017-2018	2019-2020	2021 & Beyond
Medicare Payments	25%	50%	75%
Medicare Patients	20%	35%	50%

The MACRA statute established payment thresholds but *provided flexibility to the Secretary of HHS to set the patient count thresholds.*[1] CMS subsequently set the patient count thresholds through regulations.[2]

To calculate the thresholds, CMS uses a formula that looks at the attributed beneficiary population over the attribution-eligible population (all beneficiaries that were attributed plus those that could have been but were not attributed). To determine the potentially attributable population, CMS includes beneficiaries that have had at least one evaluation and management service furnished by an eligible clinician or group in the APM.



The attributed population is determined depending on the model. In Next Gen, for example, beneficiaries are generally aligned based on whether they receive the plurality of their primary care services from a Next Gen participant provider.

While the escalating participation thresholds and the 5% incentive payment were intended to encourage greater participation in advanced APMs, the experience on the ground has been the opposite. This is in part because of the interplay between the mechanics of the attribution model in Next Gen and the calculation of the formula for the thresholds. The problem particularly impacts specialists participating in total cost of care models, like Next Gen.

When a specialist is included as a participating provider, CMS aggregates all of the specialist's Medicare Part B claims for covered professional services for purposes of the MACRA threshold. This will include specialty services for patients who are attributed to the ACO, but also includes specialty services for patients who see a different primary care physician and therefore are not attributed to the ACO. Once the specialist provides eligible services, as defined by the QP Attribution Eligibility Criteria, the beneficiary becomes part of the "attribution eligible" denominator. Patients with no connectivity to the ACO will then

[1] "The Secretary may base the determination of whether an eligible professional is a qualifying APM participant . . . by using counts of patients in lieu of using payments and using the same or similar percentage criteria . . . as the Secretary determines appropriate." Social Security Act, 1833(z)(2)(D).
[2] Note that there are other thresholds for consideration, including partially qualifying participant thresholds.

be counted against the ACO in calculation of the MACRA threshold. In some cases, the ACO has no insight into where that patient receives primary care services and no ability to shift those patterns of care.

To address this methodological flaw, ACOs remove specialists, thereby removing the impact that the specialists have on growing the denominator for the threshold calculation. However, this goes against the goals of most ACOs to engage specialists in value-based care, and achieves the exact opposite result of what MACRA intended. In practice, the MACRA thresholds are reducing, rather than increasing, the number of physicians and patients participating in APMs.

Due to the COVID-19 pandemic and the little time it affords to engage in modeling of additional solutions for this problem, we are asking that CMS waive application of the advanced APM thresholds for 2020. This waiver would allow all participating advanced APMs, those in two-sided risk, to qualify for the 5% bonus without regard to the patient or revenue thresholds.

In addition, we had previously expressed concerns about the increase in the thresholds set to take effect in 2021. Even before COVID-19, the 2021 thresholds were nearly impossible for most ACOs to meet. At a minimum, CMS should use its regulatory authority to hold the patient count threshold at the 2020 levels for 2021. Depending on the impact of COVID-19 on contracting practices and persistent data errors in the MACRA calculation, CMS may need to go even further in 2021 to ensure that risk-bearing ACOs receive their advanced APM bonuses and are exempt from MIPS.

<u>Improve Transparency and Predictability of Bonus Payments</u>

The threshold problem is compounded by a lack of transparency in the bonus calculation process. While ACOs are aware of the number of Medicare patients, allowed charges, and covered services attributable to their participating providers, they are not readily informed whether these patients and services are being applied in the ACO's threshold calculations. As discussed above, these calculations are especially important when it comes to attribution of specialist payments and patients. ACOs do not have enough information to determine how their participating providers are performing relative to the MACRA thresholds, and whether they are on track to achieve the incentive payment. A lack of timely, readily available information prevents ACOs from accurately planning and budgeting for future operations and expenses.

We are asking that CMS provide ACOs with additional information, including the ability to determine their near real-time performance relative to the thresholds and the amount paid at the QP level.

Accelerate Payment of Advanced APM Bonuses

Advanced APM bonuses for performance in 2018 should be paid in 2020, and for performance in 2019 would be paid in 2021. We ask that CMS accelerate payment of both years and advance these amounts to risk-bearing ACOs to help them deal with cash flow issues created by COVID-19. As you know, last year, Advanced APM bonuses were not fully paid as of December 2019.

We ask that CMS communicate to Advanced APMs when the bonus will be fully paid, and set that date within the next 30 days for 2018 payments. We request that CMS advance payments of the 2019 performance year bonuses to make those funds available to risk-bearing ACOs in 2020 as well. These funds should be paid before the end of 2020 and CMS should communicate a date by which payments will be made.

Address the Effects of Telehealth Expansion on ACOs

Requests:

- Form a stakeholder working group to design solutions to use telehealth visits for alignment purposes; and
- Allow diagnoses from audio-only visits to count for risk adjustment purposes.

Form a Stakeholder Working Group on Telehealth and Advanced APMs

Due to national and state-based shelter-in-place guidance, patients are cancelling routine primary care appointments and elective procedures. This reduced volume of traditional, in-person services has coincided with a dramatic increase in the number of telehealth visits. Even as COVID-19 begins to subside, a desire to protect patients and prevent further spread of the disease may prevent patients from being able to return to in-person care. However, not every telemedicine contact is appropriate for attribution purposes. Therefore, CMS must use a nuanced approach to counting these visits for attribution purposes. Next Gen ACOs would welcome the opportunity to work with CMS to design a workable approach, such as using weighted, stepwise attribution. In addition, we believe that the alignment dates may need to be expanded to account for the disruption of COVID-19. In short, multiple strategies will likely need to be deployed across 2020 and 2021, and we would welcome the opportunity to work with you to design them.

CMS Should Count Diagnoses from Audio-Only Visits for Risk Adjustment

On April 10, 2020, CMS clarified that Medicare Advantage (MA) organizations may now submit diagnoses from telehealth visits for risk adjustment purposes. However, CMS is still requiring encounters to be conducted via live, audio-visual telecommunications. This interpretation fails to recognize that many patients do not have two-way audio-visual

communication technology available to them and can only be reached using the phone. Providers are currently using audio-only functionality to care for these patients, but diagnoses made during these encounters are not being counted for risk adjustment. We ask that the agency broaden its policy to include audio-only encounters.

Shift Quality Measures to Pay for Reporting for 2020

For the remainder of 2020, Next Gen ACOs will be focused almost exclusively on providing patient care while keeping patients, physicians, and staff safe from COVID-19. Though CMS has expanded telehealth for Medicare ACOs, many quality measures cannot be properly met in remote settings. Please refer to the attached table for more information on these challenges. We therefore request that CMS measure quality on a Pay-for-Reporting basis for PY 2020.

Accelerate the Movement to Performance-Based Risk by Investing in Population Health

We urge the administration to ensure that this once-in-a-hundred-year pandemic does not derail the substantial progress we have made in moving to performance-based risk. Our organizations are experiencing severe economic consequences due to COVID-19. Next Gens are facing workforce reductions and furloughs that place our population health infrastructure at risk. This infrastructure is going to be needed more than ever as the country reopens.

To date, distributions from the $175 billion Provider Relief Fund have almost entirely been based on historical fee-for-service revenue. For example, the General Distributions used a formula based on 2019 fee-for-service revenue for the first tranche and 2018 total patient revenue for the second tranche. These approaches systematically disadvantage organizations like ours, who have reduced FFS claims in traditional Medicare over the past several years. In addition, some ACOs have not received any distribution at all from the Provider Relief Fund because traditional Medicare payments do not flow through the ACO but instead to individual providers—relief fund payments similarly flow to FFS providers, not to the ACO entity.

We are calling for the Department of Health and Human Services to target a $30 per-patient, per-month payment from the Provider Relief Fund to Performance-Based Risk ACOs during the Public Health Emergency (PHE). For January through the end of the PHE, ACOs bearing two-sided financial risk should receive support in the form of these additional payments. Payments should be made to the ACO. This support will allow risk-bearing ACOs to invest in existing needs and hire population health professionals—such as contact tracers and care managers—to contain the virus, and return to the business of care coordination. Importantly, this payment should not count as medical expense in the ACO settlement.

Conclusion

We appreciate all of the steps the agency has taken to strengthen the Next Gen ACO model and the value movement as a whole over the past several months. We know that these models are the key to a strong, stable future for healthcare providers and a higher quality, coordinated care experience for seniors. We look forward to continuing to work with you. Please do not hesitate to contact us with any questions.

Sincerely,

Mara McDermott
Next Generation ACO Coalition

Appendix: Quality Measure Table

2020 Quality Measure	COVID-19 Impact on Performance
Domain 1: All Patient Experience Measures	Large: difficult to evaluate impact on patient experience due to reduced number of in-person visits; likely less satisfaction with overall health care system leading to unfairly skewed, negative results where practices are less likely to meet patient expectations.
All-Cause Unplanned Admissions w/MCCs	Large: fewer contacts with health care providers/less preventive care; fewer pharmacy visits to obtain needed medication; fewer opportunities for physical activity; worse eating habits and dietary options especially for patients with diabetes.
Influenza Immunization	Large: requires in-person shot; cannot be done via telehealth
Mammography	Large: cannot be completed remotely via telehealth.
Controlling High Blood Pressure	Large: fewer office visits, challenging to get vital signs with telehealth visits.
Comprehensive Diabetes Care: A1c Poor Control	Large: fewer contacts with health care providers, fewer pharmacy visits to obtain needed meds; fewer opportunities for physical activity; worse eating habits and dietary options especially for patients with diabetes.
Hospital Readmissions	Medium: hard to determine, hospitals may be overwhelmed for a period of time leading to potentially less frequent rate of readmissions; however, COVID may cause many readmissions for people admitted for other medical issues.
Screenings: Depression, Falls Risk, Colorectal Cancer, Tobacco Use, and Cessation	Medium: generally, these are done at wellness visits, which will likely to be postponed or delayed entirely in 2020. Also, given current stressful circumstances, increase of smoking due to stress and more positive depression screenings directly related to current pandemic conditions.
Depression Remission	Medium: more difficult for follow-up visits; more stress leading to poorer remission rates

Statin Therapy Prevention and Treatment of Cardiovascular Disease	Medium: can be done by home lab via mail order/home delivery although rates of compliance likely to be lower than without the pandemic