November 4, 2022

On September 6, 2022, the Centers for Medicare and Medicaid Services (CMS) released a request for information (RFI) seeking public input on accessing healthcare and related challenges, understanding provider experiences, advancing health equity, and assessing the impact of waivers and flexibilities provided in response to the COVID-19 Public Health Emergency. The following responses were submitted by NAACOS through the RFI portal.

RE: Make Your Voice Heard: Promoting Efficiency and Equity Within CMS Programs RFI
Submitted electronically to: https://www.cms.gov/request-information-make-your-voice-heard

The National Association of ACOs (NAACOS) represents more than 400 accountable care organizations (ACOs) serving over 13 million beneficiaries through a variety of value-based payment and delivery models in Medicare, Medicaid, and commercial insurers. Our ACO members participate in Medicare models including the Medicare Shared Savings Program (MSSP) and the Global and Professional Direct Contracting Model (GPDC) model, among other alternative payment models (APMs). We applaud the agency's efforts to promote efficiency and equity within all CMS programs, and we see policy changes to reduce provider burden and address equity issues as critical to achieving the agency's goal of having all Medicare beneficiaries in an accountable care relationship by 2030. We appreciate the opportunity to provide feedback on the *Make Your Voice Heard: Promoting Efficiency and Equity Within CMS Programs* RFI. NAACOS and its members are committed to providing the highest quality care for patients while advancing population health goals for the communities they serve. If you have any questions, please contact Aisha Pittman, senior vice president, government affairs at aisha_pittman@naacos.com.

ACCESSING HEALTHCARE AND RELATED CHALLENGES

Challenges

Certain CMS policies inhibit ACO success in rural communities

The CMS policy that will require ACOs to report and be assessed on all patients across all payers served by any clinician in the ACO has the unintended consequence of inhibiting success for ACOs serving vulnerable populations. This requirement will result in quality scores that do not accurately reflect the case mix of a population the ACO serves. ACOs who are operating in affluent areas will likely have higher quality scores than ACOs serving vulnerable populations, effectively penalizing ACOs with rural and underserved populations. This is the opposite effect CMS states it hopes to achieve, increasing participation from these populations. ACOs have the potential to create stability in access for rural communities, however these punitive policies will not allow that potential to be realized. NAACOS urges CMS to abandon the requirement for ACOs to report on all-payer data and ensure that ACO policies are designed to support, rather than hinder ACO participation in rural communities.

Recommendations

ACOs improve access

ACOs work to improve quality of care, care coordination, and patient outcomes, and control costs by reducing fragmented and unnecessary care. A key strategy that ACOs employ to achieve these goals is to improve and expand access to primary care, with ACOs implementing primary care-focused initiatives such as expanded care teams, care coordination strategies, and enhanced data and analytics tools for primary care practices. Many ACOs offer extended primary care clinic hours and/or a 24/7 phone line staffed with nurses to answer patients' health questions and help patients determine whether emergency care is needed. Some utilize telehealth and remote patient monitoring tools to manage patients' conditions between in-person appointments. Additionally, ACOs hire outreach coordinators to ensure patients are being seen for appropriate preventive and follow-up care and, nurse care managers to connect with patients, check on their health status, and help them manage their chronic conditions. Evidence from the COVID-19 pandemic showed that independent primary care practices participating in ACOs were better-equipped to respond to the crisis, supported by alternative revenue sources and workflow tools made available through ACO participation (https://doi.org/10.1016/j.hjdsi.2022.100623). Practices rapidly adapted existing ACO infrastructure to meet patients' needs through telehealth capabilities and technology-enabled outreach to vulnerable patients. ACOs also employ patient engagement, proactive outreach, and shared decision-making strategies to create tailored care plans in partnership with patients and their families to ensure patients' conditions are appropriately managed. Given this success, NAACOS encourages CMS to leverage the ACO model to improve access to comprehensive, coordinated primary care and implement policies that support ACO program growth (https://www.naacos.com/cy2023-proposed-rule-coalition-letter).

ACOs can reduce disparities in access and quality

Value-based care models such as ACOs are incentivized to improve quality while controlling costs. Given the strong influence that social drivers of health (SDOH) and unmet social needs have on health outcomes, reducing disparities is critical to this mission. Many ACO strategies address disparities through a focus on patient-centered care and improved care coordination, including increased integration of home and community-based services. Research from the Institute for Accountable Care found that Black, Asian, and Latinx beneficiaries assigned to an ACO generally had better access and preventive care than similar beneficiaries in traditional fee-for-service (FFS) Medicare (Unpublished analysis. Institute for Accountable Care. https://www.institute4ac.org/). While some innovative ACOs have or are developing initiatives to increase access and quality for populations experiencing disparities, financial barriers and resource constraints remain a major hurdle to addressing disparities, especially for smaller ACOs. For example, ACO benchmarks do not account for the fact that historically underserved communities have significant lack of health care access and unmet needs. This has likely contributed to limited ACO participation in rural and underserved areas. CMS should work to eliminate barriers to ACO participation in rural and underserved communities, including:

1. Providing upfront funding to support ACO formation and care delivery transformation.
2. Revising the high and low revenue distinction, which currently penalizes ACOs that include Federally Qualified Health Centers, Rural Health Clinics, and safety net hospitals by designating them as high revenue ACOs. CMS should instead focus on the characteristics of beneficiaries served by an ACO.
3. Adjusting quality requirements to ensure ACOs serving rural and vulnerable populations are not penalized.

4. Ensuring ACO financial policies do not inadvertently penalize ACOs in certain regions or serving certain populations.

UNDERSTANDING PROVIDER EXPERIENCES

Challenges

Quality requirements and provider burnout

CMS policies requiring ACOs to transition to eCQMs or MIPS CQMs by 2025 is adding significant costs and burdens to ACOs and the clinicians serving in ACOs. NAACOS highlighted potential solutions for overcoming this burden in a Digital Quality Task Force paper (https://www.naacos.com/ecqms-for-acos--recommendations-from-the-naacos-digital-quality-measurement-task-force). Given the unintended consequences and added burden, CMS should not move forward with a program-wide eCQM requirement for ACOs without first piloting this approach with a small number of ACOs. CMS must also consider the agency's future digital quality measurement (dQM) goals and how ACO eCQM requirements fit into that larger goal.

Requiring ACOs to report on eCQMs/MIPS CQMs requires ACOs to collect and report on a broader set of patients than they have been evaluated on previously. This all-payer requirement has the potential to penalize ACOs serving high proportions of underserved patients. In this case, ACOs serving these patients may choose to exit the program or limit ACO participant practices to mitigate the negative effects of this requirement. CMS must ensure all-payer performance data is not used for determining payments and should consider alternatives such as relying on all attributed ACO patient or narrowing the patient population.

Further, the current state of data standards and interoperability will not yet fully enable ACOs to meet the eCQM reporting requirements successfully. Electronic Health Record (EHR) certification criteria must support ACOs in what they are required to achieve for electronic clinical quality and digital quality measurement. Additional recommendations in the paper include: CMS must develop additional guidance and standards for ACOs regarding how CMS expects patient matching to be completed; CMS must provide the industry with greater standardization of data to assist in the highly burdensome process of data mapping and other workflow changes that will be necessary to transition to eCQMs and dQMs; and CMS should allow for alternative data completeness standards for ACOs reporting eCQMs or allow for exceptions/exclusions. These improvements must be made before CMS moves forward with a program-wide eCQM requirement for ACOs.

Finally, annual quality measure and specification changes as well as program requirement changes contribute to burnout among clinicians. ACOs must monitor and respond to program changes in the MSSP, Innovation Center models, Quality Payment Program, as well as Medicare Advantage and other payer programs. This forces ACOs to manage to the program rather than focusing on patient management. CMS should seek to align MSSP and Medicare Advantage quality approaches to reduce burden.

Recommendations

ACOs reduce provider burden

The effects of the COVID-19 pandemic, including loss of revenue, workforce shortages, and increased medical mistrust, have exacerbated provider burnout. The ACO model can mitigate some of these challenges by offering additional supports, in the form of alternative revenue sources, enhanced care coordination strategies, and data analytics tools that allow providers to practice medicine in a more patient-centered, proactive, and cost-effective manner. A team-based approach to care delivery alleviates the burden placed on physicians, giving them more time to spend with patients. This can help strengthen the patient-provider relationship, increase patient engagement in care planning, and improve the overall experience of care for providers and their patients.

ACO infrastructure also enables providers to deliver higher quality care, highlighted by ACOs outperforming FFS providers on most quality measures and demonstrating improvement over time. For example, one ACO implemented communication strategies, organizational support, and technological innovations to improve the rate of annual wellness visits (AWVs) for their patient population and were able to increase the rate of AWVs conducted from 44.3 percent to 69.7 percent within only one year following implementation (https://www.ajmc.com/view/increasing-medicare-annual-wellness-visits-in-accountable-care-organizations). This is critical to the mission of improving quality while lowering overall costs, as evidence has shown that increased primary care utilization and investment can lead to fewer hospital and emergency department visits, better patient experience, and lower total cost of care (https://www.chcf.org/resource/primary-care-matters/commercial-study/).

Value-based care models like ACOs must include incentives to provide the right care at the right time and in the right setting. One important incentive that has supported participation in risk-bearing ACOs and other advanced APMs is the 5 percent incentive payment established under the Medicare Access and CHIP Reauthorization Act (MACRA), which is set to expire at the end of 2022. It is critical that providers have access to appropriate incentives to support innovative care delivery practices that improve patient care and reduce overall health care costs. In order to enable ACO program growth, CMS must implement alternative incentives to support providers in the transition to value-based care. While the agency has proposed to provide advance investment payments (AIPs) for certain new ACOs, the eligibility criteria are limiting. We strongly encourage CMS to expand AIP eligibility criteria to include more types of ACOs and more provider types (https://www.naacos.com/naacos-comments-2023-mpfs-proposed-rule).

ADVANCING HEALTH EQUITY

Challenges

SDOH screening and data collection

As CMS considers use of SDOH information for quality and for payment purposes, it is critical that flexibility is provided as many different screening tools are currently available and in use across the country. It is critical that CMS does not use these measures and/or SDOH data to penalize clinicians and that this information is collected one time for both payment and quality evaluation purposes. Currently, there is no additional funding being provided to do this work and often times clinicians may screen for social needs but not have sufficient local resources in the community to connect the patient with as a result of the screening identifying a need. Screening for social needs with no way to address gaps identified in a screening can be harmful to the patient. For example, CMS should not require SDOH screening to be part of an office visit/require collection of Z codes and instead allow clinicians and ACOs

to administer the screening in the way that best suits the patient and providers (e.g., administered by a community health worker). Finally, there must also be a strategy to effectively use this data. CMS must recognize the additional investments required to address social determinants, the burden should not solely fall on clinicians but be supported by social workers, other support staff, and community organizations.

Importance of beneficiary-reported data

Many ACOs lack accurate race, ethnicity, and language (REL) data which would allow ACOs to better understand existing disparities within their patient populations and create tailored interventions. Many ACOs have found that existing data are extremely limited, inaccurate and costly. For example, an ACO purchased commercially available data to combine with EHR data. While accuracy of REL data was improved, it was costly and did not move the closer to collecting standard data. As CMS works to bolster collection of REL data, CMS should:

1. Support providers with training and education on collection of REL data as the lack of training has contributed to inaccurate information
2. Leverage available data from across the federal government, such as the Department of Housing and Urban Development, and across payers.

Recommendations

Quality measurement approaches should be designed to advance health equity

Total cost of care models such as ACOs are incented to improve quality while controlling costs. The upfront investments that ACOs make in health information technology (IT) and infrastructure to provide coordinated care make them uniquely poised to address health inequities. Social risks and social needs cannot be addressed if they are not adequately measured, tracked, and reported. Innovative payment and care delivery models that rely on data provide an opportunity to better understand and highlight existing disparities and the tools to tailor interventions based on individual need.

CMS must consider policy options which could help to advance health equity in health outcomes across ACOs. First, reliable data is critical. Second, health equity solutions will be localized and, therefore, will need to look different in different locations, markets, and populations. Finally, policies should minimize burden associated with additional data collection and reporting requirements and upgrades to EHRs. NAACOS has outlined seven key policy changes CMS must make to advance efforts in ACOs to improve health equity in a position paper (https://www.naacos.com/addressing-equity-in-quality-measurement-for-acos). These policy changes must be implemented in a stepwise manner, starting with incentives to report race/ethnicity data, update patient survey data to incorporate equity, and provide credit for use of SDOH screening tools. Once these foundational steps are complete, CMS should begin to stratify certain quality measures by race/ethnicity and later provide incentives to ACOs for improving inequities.

The above policy recommendations will allow ACOs to advance quality improvement for the underserved. However, ACOs cannot begin to do this work without also providing the tools and resources needed to implement and deploy interventions to reduce inequities and to improve patient care for underserved populations. NAACOS has also provided CMS with additional policy recommendations for program design modifications to achieve these goals (https://www.naacos.com/acos-and-health-equity-position-paper).

Funding integrated social services

Developing and implementing initiatives to address SDOH and health inequities requires significant, sustained funding that many providers, particularly small practices and rural providers, do not have. Moreover, many communities lack sufficient resources to meet patients' nonmedical needs. Social services and CBOs are often underfunded and lack the capacity to meet the needs uncovered by health care providers' screening. Many providers are hesitant to screen for social needs if they have no way to connect patients with services to meet those needs. While some ACOs are working to develop programs to address patients' nonmedical needs, ACOs are limited in their ability to deliver benefits related to transportation, housing, food insecurity, and other social needs due to Medicare payment rules. As population health-focused organizations, ACOs are incentivized to address health equity and SDOH to improve health outcomes. Since ACOs are held accountable for the quality and total cost of care for the populations they serve, they should be provided appropriate resources to meet the needs of their patients. There are several options CMS could pursue to fund integrated social services for ACO patients:

1. Funding for ACOs to develop and expand programs to meet social needs. This could be achieved by expanding recently proposed advance investment payments to all MSSP ACOs working to address health equity.
2. Incorporating beneficiaries' social risk in ACO financial benchmarks. When adequate data sources become available, individual beneficiary-level social risk factor (SRF) data could be included in benchmark calculations. Importantly, any efforts to address health equity in financial benchmarks must not penalize some providers while rewarding others (as in ACO REACH) but rather reflect the needs of the beneficiaries and communities served.
3. Creating a supplemental Medicare benefit to allow ACOs to bill for integrated social services through "chronic social determinants management" services, modeled after chronic care management (CCM) services, that could include programs to meet patients' nonmedical needs. CMS should ensure that requirements for billing such services do not increase provider burden, which would limit uptake.

IMPACT OF THE COVID-19 PHE WAIVERS AND FLEXIBILITIES

Recommendations

Waivers and flexibilities support care delivery transformation

Waivers are a critical component of the ACO program as they allow ACO providers to operate with fewer restrictions leading to a reduction in provider burden and increase in care innovation. However, limitation and burdens associated with existing waivers have hindered their impact. For example, MSSP only has two waivers; telehealth and the 3-day rule for skilled nursing facility stays, while ACOs participating in the REACH model have access to many more waivers. Given their accountability for total cost and quality of care, providers participating in any CMS ACO program should have access to available waivers. CMS should establish a common set of waivers that enable ACOs to:

1. Address SDOH by allowing ACOs to pay for non-Medicare covered services.
2. Allow ACOs to test innovations that are being testes outside of the model. For example, Medicare's Hospital at Home waiver should be available to ACOs when the public health emergency (PHE) ends.
3. Expand telehealth services for all ACOs. While some ACOs have access to telehealth waivers, the PHE provided a more expansive set of waivers for all providers. Outside of the PHE, telehealth is

limited to risk-bearing ACOs who use prospective assignment. Limiting the telehealth benefit to only ACO-assigned patients, as is current non-PHE policy, makes it extremely difficult to implement. Telehealth is a valuable tool for managing population heath and ensuring access to care, and ACOs should have the flexibility to use telehealth regardless of risk and for all ACO providers' patients regardless of patients' assignment to their ACO. ACOs are accountable for total cost of care and quality and thus incented to ensure patients get the right care in the right setting, which mitigates concerns with overuse of telehealth or stinting care that may be present in FFS.