Nov. 5, 2021

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: NAACOS Feedback on the HHS Draft Strategic Plan for Fiscal Years 2022–2026

Dear Secretary Becerra:

The National Association of ACOs (NAACOS) appreciates the opportunity to provide feedback on the department's strategic plan for 2022 through 2026. NAACOS and its members are committed to advancing value-based care models, and in that regard many of our strategic goals align with yours. NAACOS represents hundreds of accountable care organizations (ACOs) participating in a variety of value-based payment and delivery models in Medicare, Medicaid, and with commercial insurers. Serving more than 12 million beneficiaries, our ACOs participate in Medicare models such as the Medicare Shared Savings Program (MSSP), the Next Generation ACO Model (Next Gen), the Global and Professional Direct Contracting Model (GPDC), and other alternative payment models (APMs). NAACOS is a member-led and member-owned nonprofit organization that works to improve quality of care, health outcomes, and healthcare cost efficiency.

Our members share the department's goals of protecting and strengthening equitable access to high quality and affordable health care and improving outcomes for patients. NAACOS is committed to advancing the value-based care movement, and our members want to see an effective, coordinated, patient-centric healthcare system that focuses on keeping all individuals healthy. Our comments below reflect our shared goals, and policy recommendations for the department to implement to further advance these goals.

Strategic Objective 1.2: Reduce costs, improve quality of healthcare services, and ensure access to safe medical devices and drugs

ACO models continue to be one of the most successful value-based models, reaching a significant number of Medicare patients. The goal of value-based care models is to improve quality while reducing costs. The MSSP, the largest of the ACO programs as well as APMs, serves 11.2 million beneficiaries and continues to produce greater savings each year with impressive quality outcomes. In 2019, the MSSP saved Medicare $1.2 billion after accounting for shared savings/loss payments to participants. In 2020, MSSP ACOs collectively generated $1.9 billion in net savings to Medicare and had an average quality score of almost 98 percent. Importantly, this model continues to advance the broader movement to value-based care as the APM accounting for the largest number of participants in Medicare's Quality

Payment Program (QPP). To build on the success of the ACO model and to strengthen primary care and patient-provider relationships, we support the Center for Medicare and Medicaid Innovation's (CMMI) goal to have the majority of traditional Medicare beneficiaries in an ACO by 2030.

NAACOS and its ACO members are committed to continuing the advancement of value-based care and improving health outcomes with high-value care. However, the ACO model has faced significant challenges in recent years and participation in the MSSP has declined. To encourage growth in these important programs and models, we urge CMS to make several modifications to ensure the ongoing success of ACOs, thereby contributing savings to the Medicare Trust Fund and improving outcomes for the Medicare beneficiaries.

Given the success of the ACO model and the need to strongly support the ongoing transition to value-based care and payment, we urge swift action by HHS and CMS to recalibrate the balance of risk and reward for ACOs to bolster ACO growth, and, as a result, savings to Medicare. Among those changes, we request that CMS reverse certain policies finalized in a 2018 MSSP overhaul, which CMS named "Pathways to Success." This overhaul included some damaging provisions such as a cut to the share of savings rates many ACOs are eligible to keep as well as a push for ACOs and their providers to assume financial risk too quickly. As evidenced by declining ACO participation in recent years, these policies have chilled ACO growth, and we request modifications to restore program growth. We also recommend that CMS focus the value transition squarely on providers, keeping them at the center of payment models instead of implementing programs and policies to attract new players into the traditional Medicare space.

Our specific recommendations for restoring robust participation in the premier value-based model are detailed below, including requests to:

- Make adjustments to quality reporting and assessment changes finalized in the final days of the Trump administration, which put financial strains on ACOs.
- Fix ACO benchmarks by removing ACO beneficiaries from regional benchmarking and adjust 2022 benchmarks to account for anomalies resulting from the COVID-19 pandemic.
- Increase the onramp to assuming risk for ACOs to encourage widespread participation.
- Restore shared savings rates to incentivize additional/continued participation.
- **Ensure incentives for APM adoption can be reasonably met.**
- Address the increasing problem of APM overlap by prioritizing ACO models over other APMs.
- Make improvements to the Direct Contracting Model to provide a robust model for our most advanced value-based healthcare organizations.
- Improve and expedite ACOs' access to data to enhance their ability to coordinate beneficiary care.
- Provide telehealth waivers for all ACOs, regardless of risk level or choice of attribution, to allow continued transformation in this space.
- Remove the burdensome beneficiary notification requirement or at a minimum revamp this requirement, which is highly burdensome for ACOs, holds little value to patients and instead creates confusion among beneficiaries.

Detailed Recommendations

Make Adjustments to Quality Reporting and Assessment Changes
In the final days of the Trump administration, CMS made significant changes to the way ACOs are required to report and be evaluated on quality measures for the MSSP. These changes were included in the final 2021 Medicare Physician Fee Schedule Rule (CMS-1734-P), as published in the Federal Register on December 28, 2020. While we appreciate CMS's recently proposed changes to these requirements in the final 2022 Medicare Physician Fee Schedule Rule, including a delay in the mandatory use of electronic clinical quality measures (eCQMs) for ACOs, we feel further changes are necessary to avoid harm to the ACO program.

Quality improvement is a cornerstone of the ACO model. In addition to reducing spending, ACOs must meet quality performance standards to be eligible to receive shared savings payments. ACOs continue to improve quality year over year, which improves patient care and helps to control costs. It is critical that policies to evaluate ACO quality are fair, appropriate, and accurately reflect the work ACOs undertake to improve patient care. While leveraging electronic data sources for quality reporting is an important goal, we have significant concerns about the MSSP quality policies. We believe there is an important opportunity for CMS to revise aspects of the finalized MSSP policies to better support ACOs and promote high-quality patient care.

Specifically, we urge CMS to make the following key policy changes:

- Work with ACOs and the electronic health record (EHR) vendor community to find solutions to data aggregation problems that arise when reporting eCQMs for the population of patients an ACO serves. Until these solutions are widely available, eCQMs should not be mandated for ACOs.
- Revise the new MSSP quality performance standard, which ACOs are evaluated on for purposes of determining shared savings eligibility. It is inappropriate to compare ACO quality performance to quality performance for the Merit-based Incentive Payment System (MIPS). Doing so disadvantages ACOs and makes unfair comparisons. Under the current policy, CMS estimates nearly 20 percent of ACOs could fail to meet the quality performance standard. Even ACOs with a score of 94 out of 100 points could fail the quality requirement and be ineligible to share in savings under these CMS estimates. This is overly punitive, and, more importantly, relies on a flawed methodology.
- Abandon the flawed strategy of aligning ACO quality assessments with MIPS quality assessment structure. Doing so is a step backward for value-based care and makes inappropriate quality comparisons, as the MIPS program is focused on fee-for-service individual clinicians and small group practices while ACOs are focused on caring for a population of patients they serve across many individual clinicians, practices, and hospitals.
- Remove the all-payor requirement for ACOs reporting eCQMs and instead require reporting on a sample of ACO assigned patients meeting the quality measure's denominator criteria. Requiring ACOs to report on all patients for whom the measure applies, regardless of payor, is in some cases not technically feasible at this time. Additionally, the specifications were not designed to be applied at the population health/ACO level, and, therefore, there are many unintended consequences of such a change which will unfairly penalize ACOs, especially those treating vulnerable populations. The shift to all-payor reporting, coupled with interoperability problems, will also make the underlying quality data less accurate.

Our detailed recommendations on this topic are available in our comment letter, available here.

Fix ACO Benchmarks
As a result of COVID-19, ACOs' 2022 spending targets will unfairly evaluate many ACOs. We request CMS modify the benchmarking methodology for certain ACOs due to the unusual nature of 2020, which will serve as one of the three benchmark years for ACOs new to the program or those entering a new agreement period. Specifically, we ask CMS to use a regional trend, which is a better reflection of a local market than a national trend or a blended national-regional trend.

We also urge CMS to allow ACOs the opportunity to elect pre-pandemic years for benchmarks for agreements beginning in Performance Year (PY) 2022. Simply put: The highly unusual circumstances of a global pandemic make it inappropriate to use 2020 as a benchmark year for certain ACOs. While ACOs recorded a very successful year overall in 2020, some were hurt by the pandemic because of MSSP's benchmarking polices. CMS updates final benchmarks to account for actual spending in a performance year using a blended national-regional adjustment. While nationally Medicare spending fell by roughly 7 percent in 2020, some ACOs' local populations continued to have routine office visits and elective procedures as if it were 2019. As a result, many of those ACOs showed losses in 2020.

Analysis conducted by the Institute for Accountable Care earlier this year demonstrated this huge variation in spending between 2019 and 2020. For example, spending in the Boston area fell by more than 12 percent between 2019 and 2020, even when excluding COVID-related costs. Spending fell by more than 11 percent in New York City and Northern New Jersey and by more than 10 percent in Miami. However, spending in places like Idaho and West Texas only fell by a couple of percentage points between 2019 and 2020.

Absent any changes to the methodology, ACOs entering the MSSP in 2022 will have their benchmarks largely based on their historic spending from 2019–2021, which includes two pandemic years. ACOs renewing an agreement in MSSP will also have their benchmarks rebased in 2022 using the same pandemic-stricken years. For some, it would be more appropriate to use pre-pandemic years of 2017–2019 as a baseline and trend those forward, which would provide a more accurate, realistic representation of per patient spending averages than using highly variable, severely impacted pandemic years.

We also request CMS fix other ongoing benchmarking issues. We urge CMS to correct the MSSP benchmarking issue known as the "rural glitch" to more appropriately evaluate ACO performance. The current method compares an ACO's spending to a blend of its historical spending and regional spending. However, including ACO-assigned patients in the regional component makes it necessary for the ACO to 'beat' its own performance twice, thus defeating the purpose of using a regional comparison. While this issue harms any ACO with spending lower than its region, this is particularly problematic when an ACO makes up a large portion of a particular area, which is often the case for ACOs in rural areas. NAACOS has repeatedly called on CMS to fix this benchmarking flaw by removing ACO-assigned beneficiaries from the regional reference population, which should be implemented as soon as possible. Specifically, to do that CMS should remove ACO beneficiaries from calculation of the regional risk-adjusted per member, per year (PMPY) spending. This correction would ensure fair and accurate ACO benchmarks that will reduce Medicare costs and improve quality for beneficiaries, which are two key goals for HHS.

Increase the Onramp for Assuming Risk to Encourage Widespread Participation
The final Pathways to Success Rule included changes to the amount of time ACOs can participate in the MSSP before being required to bear financial risk. This has deterred participation in the program, as evidenced by stagnant MSSP growth since the new requirement was put in place. As of 2021, 477 ACOs are participating in the MSSP, down from a high of 561 in 2018. To encourage the broadest participation

in the largest APM proven to demonstrate savings to the Medicare Trust Fund, we urge CMS to provide ACOs with at least four years of participation in the MSSP before requiring movement to risk-based tracks. Further, we request that CMS make the Enhanced Track, which has the highest levels of risk, optional for ACOs.

Restore Shared Savings Rates to Incentivize Participation
The final Pathways to Success Rule diminished the shared savings an ACO can keep after proving to lower costs to Medicare and the beneficiaries it serves. As noted above, the combination of requiring ACOs to move to risk as well as these diminished shared savings opportunities has stifled growth in the program. We urge CMS to restore shared savings rates to incentivize additional and continued participation in the premier APM. CMS should provide a shared savings rate of at least 50 percent for MSSP ACOs so there is a possibility of return on the significant investments required of participation. ACOs must spend large amounts of funds to participate in the program to pay for infrastructure costs, information technology costs and data analytics tools, as well as increased staffing to support care management efforts, to name a few. Shared savings rates must reflect the enormous costs of participation in the program in order to attract continued participation in the model, which has saved the Trust Fund significantly and more than any other APM.

Ensure Incentives for APM Adoption Can Be Reasonably Met
The advanced APM incentive payments have served as an important tool for attracting clinicians to participate in advanced APMs. However, the increasingly high thresholds needed to earn the bonuses do not reflect the progress of the value-based care movement and have led to unintended consequences (e.g., ACO and practice restructuring). We encourage CMS to utilize its full statutory authority to ease the requirements for qualifying for the advanced APM bonus (i.e., the Qualified APM Participant (QP) threshold) to better match progress to-date. This would ensure clinicians currently participating in risk-bearing APMs will continue to receive these meaningful bonus payments and encourage other clinicians to join advanced APMs. Additionally, we are calling on Congress to ease statutory QP requirements and to extend the advanced APM bonuses an additional six years. To support continued incentives, we ask that CMS release detailed information on the advanced APM incentives paid to date.

Address the Increasing Problem of APM Overlap
To date, CMS and CMMI have deployed a system in which many APMs are tested in order to see what models best demonstrate success. However, the vast proliferation of models has had negative consequences on total cost of care models, which have outperformed other models to date and should therefore be prioritized. Overlapping models create confusion for patients served by multiple models as well as the clinicians participating in such models. Patient assignment and evaluating the impact of a model as examples, have grown increasingly complex as multiple models overlap. CMMI and CMS should work together to prioritize and emphasize continued work and growth in the models that have truly demonstrated success, such as the ACO model. Specifically, we recommend CMS exclude ACO patients from bundles unless a collaborative agreement between the bundler and the ACO is in place.

Make Improvements to the Direct Contracting Model
NAACOS supports GPDC and is committed to its success. The model represents an evolution of accountable care models within CMMI and provides a better bridge to full capitation and grants access to wider range of benefit enhancements. As we've previously stated, we urge CMS to institute needed changes to make the model successful and support those who have been historically successful with value-based care, such as ACOs.

Specifically, we recommend CMS take the following actions:

- Flip the weighting of the benchmark years used in historical expenditures 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-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 Gen ACO Model.
- Either discontinue the policy of setting historic spending for voluntarily aligned beneficiaries to regional spending or otherwise create a level playing field.
- Allow greater flexibility for DCEs to switch DCE types and capitation options.

Develop a Permanent, Advanced Model of the MSSP

Successful CMMI payment models, or key aspects of those models, should become permanent parts of Medicare via the MSSP. The Next Gen ACO Model tested a number of features that should be incorporated into a permanent part of the MSSP. NAACOS recommends the agency develop a new full-risk option for ACOs as a second component of the MSSP Enhanced Track. Creating an "Enhanced Plus" option would advance the MSSP by providing a permanent option featuring full risk and capitation, which to date has only been available in CMMI ACO models, such as Next Gen and parts of GPDC. Key components of the model could include the ideas below and more.

- Provide 100 percent shared savings and loss rates to participants.
- Design participation at the Tax ID Number-National Provider Identifier (TIN-NPI) level to allow the ACO to create a high-performing network, which is critical for such a high-risk model.
- Enhance benchmark accuracy by:
    - Using a rolling historical baseline based on three years, with a regional benchmarking component starting at 50 percent and increasing gradually to 70 percent.
    - Applying a regional-only benchmarking trend to best reflect local market changes.
    - Do not use a minimum savings rate or minimum loss rate and instead apply a 1.5 percent benchmark discount.
- Provide options for capitated payments, including partial and full capitation and the ability to negotiate downstream value-based payment arrangements.
- Offer advanced waivers to give full risk ACOs additional tools to provide the highest quality care, including these and more:
    - Post Discharge Home Visit Waiver to create a smooth transition from the hospital to the patient's home and help prevent hospital readmissions.
    - Care Management Home Visit Waiver to provide visits to beneficiaries at risk of hospitalization in the beneficiary's home proactively to avoid a potential hospitalization.
    - Ability to Tailor Cost Sharing Support for Part B Services to allow ACOs to reduce financial barriers for beneficiaries, encouraging better adherence to treatment plans. CMS gives Next Gen ACOs the flexibility to identify certain beneficiaries to receive these benefits. ACOs should have maximum flexibility to determine how to implement the benefit.

Improve ACOs' Access to Data to Enhance Their Ability to Coordinate Beneficiary Care
CMS's Interoperability and Patient Access Final Rule (CMS-9115-F) requires that hospitals share electronic notifications of patients' admission to, discharge from, or transfer between inpatient hospitals with community providers. However, NAACOS is concerned that CMS's new Conditions of Participation (CoP) requirements rule won't fulfil the agency's stated goal of improving health outcomes, bettering care coordination and reducing costs through better access for patients to their health information. That's because on page 25599 of the final rule regarding the role of ACOs in receiving admission, discharge, and transfer (ADT) notifications, CMS stated that the CoP "does not create an entitlement for any specific provider or intermediary to receive patient event notifications." Subsequent guidance did not go far enough to ensure ACOs have a right to this important patient data. NAACOS urges CMS to correct this flaw to require that ADT alerts be sent to ACOs.

Section 3221 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act modernizes the privacy of treatment records for substance use disorder (SUD) by creating parity between 42 CFR Part 2, which governs SUD privacy, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As the department works to implement the CARES Act, we urge you to address the important issue of claims and data access for providers practicing in APMs. ACOs, for example, are provided claims data at least monthly, and sometimes weekly, through Claim and Claim Line Feed (CCLF) files, but these data lack SUD-related information because of the limits of Part 2 law. Without access to such claims data, ACOs and other APM participants risk treating the whole patient with only part of their data, potentially harming patient care and outcomes. By aligning Part 2 with HIPAA, the CARES Act allows sharing of this important data after initial patient consent, which will allow CMS to deliver this critical information to providers operating in ACOs. We urge you to work with your HHS partners to send SUD-related claims data to providers practicing in ACOs and other APMs to help support their work in population health management.

CMS's HIPAA Eligibility Transaction System (HETS) allows providers to check Medicare beneficiary eligibility in real-time using a secure connection. CMS should make HETS feeds available to ACOs and Medicare providers participating in APMs to better understand, in real-time, where patients seek care in the health system. ACOs' access to critical HETS information in real time would allow ACOs to further enhance care coordination, improve patient outcomes, and reduce costs — all are tenets of advancing value-based payment models. For example, a real-time alert to a patient visiting an urgent care center would allow ACOs to intercede to assist the patient in their immediate care needs.

NAACOS developed, with the assistance of technical experts, an outline for an ACO Inquiry Notification System. The system, operated by a registered third party, would serve as a secure, point-of-service notification system. Leveraging real-time data feeds from HETS, the notification system would alert ACOs when one of their assigned patients may be seeking care or receiving services outside the ACO. This would limit customization and provide a simplified, user-driven approach to extract data from the current HETS system. Alternatively, CMS could allow Medicare ACOs the ability to securely access the system independently and monitor for their patients.

Modernize Telehealth Requirements
The COVID-19 pandemic demonstrated the need for CMS to modernize telehealth requirements. We urge CMS to use its statutory authority under 42 U.S.C. 1315a(d)(1) (in the case of CMMI models) and 42 U.S.C. 1395j(f) (in the case of MSSP) to allow all ACOs, regardless of risk level or choice of attribution, the freedom to use telehealth in broader circumstances, including expanding waivers beyond the patient's site of care and geographic location. Doing so in programs like the MSSP and Direct Contracting protects the Medicare Trust Fund as ACOs and DCEs are already at risk for the populations they serve and are

responsible for total costs of caring for patients. Additionally, we request CMS count diagnoses obtained from audio-only telehealth services for risk adjustment purposes, which would more accurately reflect the patient population through risk adjustment, which is a critical tool in making fair evaluations for an ACO's success.

Remove the Burdensome Beneficiary Notification Requirement
When the MSSP launched, a beneficiary notification requirement forced ACOs to contact all assigned patients using a standard CMS form notifying the patient of the ACO's involvement in the MSSP. This created significant confusion among patients and created additional costs for ACOs to send the notification by the required timeline. Due to the confusion and administrative burdens resulting from this requirement, CMS later removed it. Unfortunately, the Trump administration chose to reinstate this flawed requirement, which provides little value to patients, instead creating considerable confusion among beneficiaries. We urge CMS to again remove this burdensome requirement, or at a minimum revamp it to allow for more meaningful communication from ACOs to beneficiaries.

Strategic Objective 1.3: Expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health

Strengthening the ACO model and other total cost of care models provides an important lever by which health inequities can be reduced and social determinants of health can be addressed in a wholistic manner. Improving health equity is critical to delivering high quality care in a cost effective manner, as some research shows that social drivers of health contribute more significantly to health outcomes than medical care.[1] Social risks and social needs cannot be addressed if they are not adequately measured, tracked, and reported.[2] 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. For example, ACOs assume accountability for a population's cost and quality of care, and many are beginning to address patients' social needs such as housing, transportation, and food insecurity as a way to improve health outcomes.[3]

Other examples of initiatives being implemented by ACOs to improve health equity include:

- Leveraging information technology and analytics for targeted outreach to identify patients with unmet needs;
- Identifying discrepancies in patient populations and providing additional interventions to address identified gaps;
- Mapping to identify communities with poor internet access to address the digital divide;
- Focusing on end-stage renal disease (ESRD) and chronic kidney disease (CKD), which disproportionately affect Black patients to shift care to a better, less expensive setting that meets patient needs and preferences;
- Stratifying ambulatory-sensitive admission rates and primary care-sensitive emergency room visits by race/ethnicity to identify inequities; and
- Developing tools to identify and reach out to high-risk patients with trained staff to check for food and housing insecurity and verify that they have access to needed medications.

To continue and build upon these activities, ACOs need appropriate tools, data, financial incentives, and resources to address health equity and develop partnerships with community-based organizations (CBOs). Due to their accountability for the total cost and quality of care for a patient population, ACOs are uniquely positioned to develop and test health equity-focused interventions.

To further ACOs' work in this area, we recommend the following policy changes:

- **Provide funding to support an expansion of social services to address health equity.**
- **Increase benchmarks to benefit ACOs treating vulnerable populations.**
- **Providing ACOs with both grant money and adjusted benchmarks to support this work.**
- **Adapting CMMI's Community Health Access and Rural Transformation (CHART) Model to cover urban areas that meet the definition of a distressed community and focusing on this model as a way to support ACO work in this area.**
- **Developing a supplemental Medicare benefit/service to allow ACOs to bill Medicare for things like beneficiary transportation—as part of a "chronic social determinant management" service (akin to chronic care management codes).**
- **Providing additional flexibility with Medicare rules for ACOs to deliver supplemental benefits to patients to help address health equity.**
- **Ensuring** quality requirements **are thoughtfully designed and implemented to incentivize ACOs to further target quality improvement efforts for populations struggling with health inequities.**
- **Leveraging the ACO model to test expansions in telehealth for the ability to improve access and quality while controlling costs.**
- **Improving ACOs' access to data needed for care coordination.**

These recommendations are discussed in further detail in this NAACOS authored white paper on how to better position ACOs to address health inequities and SDOH.

Strategic Objective 1.4: Drive the integration of behavioral health into the healthcare system to strengthen and expand access to mental health and substance use disorder treatment and recovery services for individuals and families.

Given ACOs' accountability for quality and total cost of care, they are motivated to provide coordinated, integrated care, and integrating behavioral health into population health management strategies could significantly improve outcomes and increase savings for ACOs.[i] While many ACOs have begun integrating behavioral health, there are significant challenges and barriers to successful integration including workforce shortages, especially in rural areas, lack of sustainable funding, and data access issues. In order to help address the shortage of behavioral health providers, NAACOS has recommended testing telehealth expansions within the ACO model. As detailed in our feedback on Strategic Objective 1.2, NAACOS argues that that since ACOs are held accountable for patients and are increasingly at financial risk for their spending and quality, they should be granted waivers to use telehealth more broadly than other providers.

Securing funding for integrated care not reimbursed under a fee-for-service system is another challenge. Additionally, significant upfront investment is required to implement behavioral health information into practice. Therefore, ACOs should be provided with financial incentives to integrate behavioral health. Issues with data access, particularly SUD-related data, were discussed earlier in this letter. Additionally, behavioral health clinicians should be offered incentives to adopt EHRs and facilitate information exchange between providers. [5]

While behavioral health was not incorporated into the original federal ACO architecture, researchers have found significant interest in integrating behavioral health providers into the ACO model and key policy changes could enable ACOs to successfully and sustainably integrate behavioral health.[iii] NAACOS is engaged in continued discussions with our members and other stakeholders to understand challenges

and develop solutions for meaningfully integrating behavioral health into the healthcare system. We look forward to working with the department to ensure that ACOs are able to meet the behavioral health needs of their patient populations.

Conclusion

In conclusion, we stand ready to work with the Department of Health and Human Services to achieve these shared strategic goals and further advance value-based care for all Medicare patients. NAACOS and its members are committed to providing the highest quality care for patients while advancing population health goals for the communities they serve and will be instrumental in achieving these goals. We look forward to our continued work with the Department and the Centers for Medicare and Medicaid Services to further the work of value-based care.

Sincerely,

Clif Gaus, Sc.D.
President and CEO
NAACOS

[1] https://www.ajpmonline.org/article/S0749-3797(15)00514-0/fulltext
[2] https://www.nap.edu/read/12875/chapter/1#xiii
[4] https://www.ajmc.com/view/treating-behavioral-health-disorders-in-an-accountable-care-organization
[5] https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/03/BPC_Behavioral-Health-Integration-report_R03.pdf

[6] https://www.nasmhpd.org/sites/default/files/Assessment%207_Integrating%20Behavioral%20Health%20into%20ACOs.pdf