June 16, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Administrator Brooks-LaSure:

The National Association of ACOs (NAACOS) congratulates you on your confirmation as administrator of the Centers for Medicare & Medicaid Services (CMS). NAACOS and our members are deeply committed to advancing value-based care. As the administration looks to address difficult Medicare solvency issues made worse by the recent pandemic, we stand ready to help you continue to drive forward a healthcare system committed to serving not only patients, but also the health of the community as a whole, through successful value-based models such as the accountable care organization (ACO) model.

NAACOS represents more than 370 ACOs participating in a variety of value-based payment and delivery models in Medicare, Medicaid, and commercial insurers. Serving more than 12 million beneficiaries, our ACOs participate in models such as the Medicare Shared Savings Program (MSSP), the Next Generation Model, the Direct Contracting Model, 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.

ACO models continue to be one of the most successful value-based models, reaching a significant number of Medicare patients. The MSSP, the largest of the ACO programs serving 11.2 million beneficiaries, continues to produce greater savings each year. In 2019, the most recent year for which data is available, the MSSP saved Medicare $2.6 billion total, and $1.2 billion after accounting for shared savings/loss payments to participants. Importantly, this model continues to advance the movement to value-based care and is 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 recommend that CMS set a national goal to have a majority of traditional Medicare beneficiaries in an ACO by 2025.**

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, with participation in the MSSP declining. To encourage growth in these important programs and models, we urge CMS to make several modifications to ensure the ongoing

success of ACOs, and therefore continued savings to the Medicare Trust Fund and improved outcomes for the Medicare beneficiaries they serve.

Given the success of the ACO model and the need to strongly support the ongoing transition to value-based care and payment, we request CMS recalibrate the balance of risk and reward for ACOs to bolster ACO program 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 the ACO "Pathways to Success." This overhaul included some damaging provisions such as a cut to the share of savings 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.

Items Requiring Immediate Action

- Make adjustments to quality reporting and assessment changes finalized in the final days of the Trump administration, which put financial strains on ACOs
- Adjust 2022 ACO benchmarks to account for anomalies resulting from the COVID-19 pandemic and to fix ongoing issues such as the "rural glitch" and risk adjustment flaws
- Increase the onramp to assuming risk for ACOs to encourage widespread participation
- Restore shared savings rates to incentivize additional/continued participation
- Address the increasing problem of APM overlap
- Develop MSSP "Enhanced Plus" MSSP opportunity with full risk and options for capitation
- 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 performance
- Modernize telehealth requirements for ACOs to allow continued transformation in this space among those who are responsible for a patient's total cost of care through their ACO participation
- Remove the burdensome beneficiary notification requirement or at a minimum revamp this burdensome requirement

Detailed Recommendations on Items Requiring Immediate Action

Our detailed recommendations on policy items requiring CMS's immediate action are included below. We look forward to working with you to continue to advance value-based care for all Medicare beneficiaries by making needed improvements to the ACO model.

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. 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 reducing the number of measures and leveraging electronic data sources for quality reporting are important goals, we have significant concerns about the MSSP quality policies finalized in December of 2020. The policy changes lacked adequate input from the patient, ACO, physician and hospital communities, and it is unclear how CMS determined that the Alternative Payment Model Performance Pathways (APP) measures are more appropriate than the current measures on which ACOs are evaluated. Furthermore, the ACO and vendor communities lack key guidance and details necessary to implement the move to reporting of electronic clinical quality measures (eCQMs) and Merit-Based Incentive Payment System (MIPS) CQMs in the unrealistic timeline required by CMS.

We believe there is an important opportunity for CMS to revise aspects of the recently finalized MSSP policies to better support ACOs and promote high quality patient care. Specifically, we urge CMS to delay mandatory eCQM and MIPS CQM reporting for at least three years while the agency further explores the costs and implications of these changes. Additionally, CMS should seek additional input on the MSSP quality measure set, such as through the Measures Application Partnership (MAP) to identify the ideal measure set to continue to drive quality improvement through the MSSP. We also have significant concerns with CMS's decision to broaden reporting and evaluation to all payer data. This is technically difficult for ACOs, which often lack access to this data, and this requirement would evaluate ACOs on patients they may not have contractual agreements to serve. It is unfair to make such a significant change of this manner mid-contract, particularly now that more ACOs than ever have been accelerated to bearing financial risk for their participation in this model. Instead, we urge CMS to limit ACO reporting and evaluation to ACO assigned beneficiaries, as has historically been the case for MSSP. Our detailed letter on this topic sent to the agency earlier this year is available here and includes 11 additional leading healthcare associations who also share our concerns.

Adjust 2022 ACO benchmarks to account for anomalies from the COVID-19 pandemic and fix ongoing benchmark issues such as the "rural glitch" and risk adjustment flaws
As a result of COVID-19, ACOs' 2022 spending targets will unfairly evaluate ACOs. We request CMS modify the benchmarking methodology 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 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 the ACO 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. 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.

Another problematic MSSP methodology that should be addressed is an inconsistency between how CMS handles risk scores for ACOs compared to their region. Specifically, CMS has a policy where the risk score for an ACO's eligibility category cannot increase more than three percent from its most recent benchmark year. For example, an ACO that started in 2019 could have a risk score in the aged/dual eligible category of 1.00 in 2018 and that risk score is not permitted to increase beyond 1.03 through 2024. While NAACOS advocates to increase the three percent cap over five years to a cap of no less than five percent, a more pressing change is to have CMS consistently apply a risk score cap to the region's risk score. Currently, there is no cap on the region's risk score, which unfairly penalizes ACOs. The COVID-19 pandemic introduced increased variation, and data show situations where a region's risk exceeds the cap, essentially creating an automatic penalty for ACO in that market which cannot exceed the cap. While

many, including CMS, did not anticipate this situation from occurring often, it is important to take swift action to fix this and establish fair and consistent policies for ACOs. We urge this policy be fixed retroactively, starting with performance year 2020.

Increase the Onramp for Assuming Risk to Encourage Widespread Participation
The final Pathways to Success Rule included changes to the terms ACOs can participate in the MSSP before being required to bear financial risk. This has deterred participation in the program, as MSSP growth has slowed 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 only 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.

Address the Increasing Problem of APM Overlap
To date, CMS and the Innovation Center have deployed a model 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. The Innovation Center 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.

Develop MSSP "Enhanced Plus" opportunity with full risk and options for capitation
As CMS continues to evolve 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" would advance the MSSP by providing a permanent option featuring full risk, which to date has only been available in Innovation Center ACO models, such as the Next Generation Model and parts of the Direct Contracting Model. Key components of the model could include the ideas below and more.

- **100 percent shared savings and loss rates** with a symmetrical cap on savings and losses between 5 and 15 percent.
- **Participation at the Tax ID Number-National Provider Identifier (TIN-NPI)** level to allow the ACO to create a high-performing network, which is necessary for such a high-risk model.

- **Benchmark:** use rolling historical baseline based on three years, with a regional benchmarking component starting at 50 percent and increasing gradually to 70 percent. Apply 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.
- **Options for capitated payments,** including partial and full capitation and the ability to negotiate downstream value-based payment arrangements.
- **Offer advanced waivers, including:**
    - **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 NGACOs the flexibility to identify certain beneficiaries to receive these benefits. This waiver and the flexibility for the ACO to determine how to implement the benefit are features of the model that should be added to MSSP for ACOs taking on performance-based risk

Make Improvements to the Direct Contracting Model

NAACOS supports the Global and Professional Direct Contracting Model and is committed to its success. The model represents an evolution of accountable care models within the Innovation Center 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 before the start of Performance Year (PY) 2022 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 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
- Allow greater flexibility for DCEs to switch DCE types and capitation options

In addition, NAACOS urges the CMS Innovation Center to fully stop the Geographic Direct Contracting Model and the new DCE type that allows Medicaid Managed Care Organizations (MCOs) to manage Medicare fee-for-service (FFS) expenditures for dually eligible beneficiaries. Instead, CMS should introduce appreciated policies worthy of being tested in other APMs. "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. NAACOS is concerned an MCO DCE type will bifurcate care for these vulnerable patients. ACOs and DCEs already care for a large number of dually 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.

Improve ACOs' Access to Data to Enhance Performance

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 of Health and Human Services (HHS) 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 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. 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 their 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 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. Recently, 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.

Longer-term Issues
In addition to the items requiring immediate action above, we also urge CMS to consider making the following policy changes:

- Conduct ongoing evaluation and adjustments for ACOs in light of COVID-19 as necessary (both quality and financial, settings benchmarks as an example)
- Eliminate the arbitrary high-low revenue distinctions recently introduced in the MSSP and instead apply the low-revenue policies across all ACOs
- Improve the predictability and transparency around Innovation Center models
- Institute changes to the ACO track of the Community Health Access and Rural Transformation (CHART) Model to improve the success of that model
- Use remaining COVID-relief funding to support to move into APMs
- Ensure appropriate incentives are in place per the Medicare and CHIP Reauthorization Act of 2015 (MACRA) to advance and encourage additional participation in APMs and qualify all ACOs as Advanced APMs

Conclusion
In conclusion, we stand ready to work with CMS under your leadership to 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. We would like to meet with you and your staff to discuss these recommendations and how NAACOS can support your efforts to improve health equity and advance value-based care for all Medicare patients. Allison Brennan, Senior Vice President of Government Affairs, will contact your office to formally request a meeting, she can also be reached at 202-725-7129 or abrennan@naacos.com.

Sincerely,

Clif Gaus, Sc.D.
President and CEO
NAACOS