March 21, 2022

Meena Seshamani
Deputy Administrator and Director, Center for Medicare
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

Re: ACO Program Enhancements to Drive Additional Participation in the Premier Value Based Care Model

Dear Deputy Administrator Seshamani:

The National Association of ACOs (NAACOS) writes to urge the Centers for Medicare & Medicaid Services (CMS) to implement enhancements to the Medicare Shared Savings Program (MSSP) to address a concerning trend in participation declines. NAACOS and its members are committed to advancing value-based care models; however, program changes made during the Trump administration have stifled growth and must be addressed to maintain current participation levels and attract new participants. As CMS considers policy changes for 2023, we urge CMS to include the program enhancements detailed below to strengthen the MSSP and encourage growth in value-based care participation.

NAACOS represents hundreds of accountable care organizations (ACOs) participating in a variety of value-based payment and delivery models in Medicare, Medicaid, and commercial insurance. Serving six million beneficiaries, our ACOs participate in Medicare models such as the Medicare Shared Savings Program (MSSP), the Direct Contracting Model (DC), 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. These organizations are committed to value-based care and want to see its continued success. However, the ACO model has faced numerous 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.

The number of ACOs in the MSSP, the country's dominant value-based payment program, only modestly increased to 483 in 2022. This follows multiple years of flat or declining ACO program growth, putting the administration's goal of having all traditional Medicare patients in an accountable care model by 2030 at great risk. Today, there are still fewer patients in ACOs and ACOs in the program than there were in 2020. This is due largely to the effects of the 2018 rulemaking that implemented a major overhaul of the program, the "Pathways to Success." This has forced more ACOs into risk and decreased shared savings

opportunities for those who are successful in the program. Following a high of 561 MSSP ACOs in 2018, participation fell over the next two years and remains at 483 in 2022.

As Medicare spending continues to rise, ACOs have proven to effectively lower costs while increasing quality, making them a patient-focused and sustainable solution to addressing rising Medicare costs. The effects of the Pathways to Success overhaul are being seen now, and we anticipate the impact will only be exacerbated by additional issues ACOs are simultaneously facing, such as the new quality overhaul that CMS projects will cause approximately 20 percent of ACOs to forfeit their shared savings and the Advanced APM bonus expiration at the end of 2022. The confluence of these issues could have a devastating impact on the broader move to value-based care if CMS does not take action to make needed program improvements to reverse the damage done by the Pathways to Success Rule.

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. Our specific recommendations for restoring robust participation in the premier value-based model are detailed below.

Items Requiring Immediate Action

- Adjust flawed quality rules for ACOs
- Make important benchmarking and risk adjustment changes to ensure the long-term sustainability of the program
- Implement policies that address the ongoing issues with COVID-19
- Increase the onramp to assuming risk for ACOs to encourage broader participation
- Restore shared savings rates to incentivize new and continued participation
- Address the increasing problem of APM overlap to prioritize ACOs over other models
- Develop an MSSP "Enhanced Plus" option with full risk and options for capitation
- Improve and expedite ACOs' access to data to enhance performance
- Modernize telehealth requirements for ACOs who are responsible for a patient's total cost of care through their ACO participation
- Ensure appropriate incentives are in place per the Medicare and CHIP Reauthorization Act of 2015 (MACRA) to advance and encourage additional participation in APMs
- Eliminate the arbitrary high-low revenue distinctions
- Reform the beneficiary notification process

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 Assessments

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, transitioning to the APM Performance Pathway (APP) method of scoring ACO quality. In response to NAACOS' concerns, CMS provided additional time for ACOs to transition to electronic quality reporting; however, in the final 2021 Medicare Physician Fee Schedule Rule, CMS moved forward with a new quality scoring approach for all MSSP ACOs, the APP. According to CMS's own estimates, this new scoring approach will result in approximately 20 percent of ACOs failing to meet the established quality standard and, therefore, be ineligible to share in any savings they may generate. This is an overly punitive approach and could have a

chilling effect on the program. Further, this is a large departure from the previous approach which awarded ACOs with a higher quality score a greater shared savings rate, and only ACOs who failed to adequately report quality data would lose out on all shared savings opportunities. To date, ACO quality performance has been very strong and increasing over time, with only a handful of ACOs failing to earn shared savings based on not adequately reporting quality. Under the new approach, an ACO with a score of 95 points out of 100 could ultimately fail to meet the quality threshold in 2024 and therefore be ineligible to share in any savings generated. NAACOS questions the utility of a scoring system that would give ACOs with quality scores in the 90s a failing grade.

Further, the APP's scoring methods are inherently flawed. The APP scoring approach compares an ACO's quality score to Merit-Based Incentive Payment System (MIPS) quality scores, a program that allows clinicians the option to report from a large menu set of measures, while ACOs must report on a pre-determined measure set. In fact, the number of measures included in the assessments are not comparable, and many MIPS clinicians qualify for exemptions from measures for which ACOs cannot. Additionally, under the new approach ACOs will not know their quality targets in advance of the performance year. While this may be acceptable in the MIPS program, where historically payment adjustments have been minimal (less than 2 percent), it is unacceptable in a program such as the MSSP, where potentially millions of dollars are on the line based on this performance.

Quality improvement has been a cornerstone of the ACO model and ACOs have continued to improve quality scores 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. 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 decouple the MSSP quality scoring approach from the MIPS program. Aligning ACO quality assessments with MIPS assessments is a step backward for value-based care. Instead, CMS should look for ways to align the quality approach for value-based payment models, which are the future of healthcare delivery. In making these changes, we also urge CMS to remove the all-payer component of the new quality requirements and instead hold ACOs accountable for assigned patients, as was intended by the program. This will also allow CMS to make comparisons regarding the impact ACOs' work is having on quality improvement as compared to fee-for-service.

While the APP policies are now in effect, the impact of these changes will not be seen until the COVID-19 Public Health Emergency (PHE) expires, which is anticipated in 2022. Therefore, CMS must take immediate action to make adjustments to the flawed APP quality scoring requirements for the MSSP to ensure robust and continued participation by ACOs. Particularly as the Pathways to Success policies are now forcing more ACOs into risk-bearing tracks, CMS cannot expect ACOs to continue to accept financial risk of potentially millions of dollars when they cannot predict how their quality performance may or may not prohibit them from being successful, and when they feel the evaluations being made are stacking the deck against them.

Make important benchmarking and risk adjustment changes to ensure the long-term sustainability of the program

As NAACOS detailed in our comments to the proposed 2022 Medicare Physician Fee Schedule, there are refinements to be made in the benchmarking and risk adjustment policies around MSSP ACOs to create fairer, more equitable financial methodologies for ACOs. For starters, CMS should finally fix the "rural glitch" as it is often called, which systematically penalizes an ACO when it reduces costs. CMS should remove ACO-assigned beneficiaries from the regional reference population. Specifically, to do that CMS

should remove ACO beneficiaries from calculation of the regional risk-adjusted per member per year (PMPY).

Because of the rural glitch, when an ACO lowers the total cost of care for its assigned population, it also reduces the average regional costs and diminishes the positive effect of the regional adjustment. This defeats the purpose of a benchmark that is based in part on regional expenditure data, which CMS has acknowledged is fair and necessary for a viable ACO program long-term. Research conducted by the Institute for Accountable Care has found 90 percent of MSSP ACOs would benefit to some degree by this correction.

To help create fair policies that account for the sickness of ACO patients, CMS should update outdated and unfair risk adjustment policies, by applying a risk adjustment cap of no less than 5 percent and a downward cap no greater than -5 percent. Using MSSP Performance Year (PY) 2017 results, 87 percent of ACOs would have had at least one enrollment type trigger the +/-3 percent cap when looking at the first three years of the agreement period. The average percentage capped in the first performance year of the agreement period is 88 percent, the second performance year is 85 percent, and the third performance year is 92 percent.

Additionally, CMS should align the use of a risk adjustment cap for the ACO and its region, applying a consistent capping policy to both. The inconsistency of capping one and not the other harms ACOs and is patently unfair. For example, if an ACO's risk score goes up 6 percent and the region's risk score also increases 6 percent, the ACO's benchmark is reduced by a devastating 3 percent even though the ACO simply matched its region. Current policy is also driving inequity. Beneficiaries who are in the disabled and the aged-dual categories are, in most combinations, more than twice as likely to be above the cap as those who are in the aged non-dual category.

Lastly, CMS should use a regional-only trend, which is a better reflection of a local market than a national trend or a blended national-regional trend. Relying too heavily on a national trend is especially problematic during a pandemic as it ignores important local market dynamics that differ across the country. This became hugely problematic during the pandemic as many markets saw their regional spending drop by 10 percent or more. Therefore, using the national trend as part of the benchmarking methodology is detrimental and unfair to these ACOs as it does not reflect the pandemic's effect on costs in their regions.

Adjust 2022 ACO benchmarks to account for anomalies from the COVID-19 pandemic
NAACOS continues to be concerned that ACO participation will remain stagnant without making adjustments to benchmarking policies to account for the dramatic drop in utilization resulting from the COVID-19 pandemic. Nationally, Medicare spending fell by roughly 7 percent in 2020. 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. Even with the uptick in telehealth use, stay-at-home orders caused many in-office visits to go missed. Health systems canceled elective procedures. It remains to be seen what spending will look like in 2021 because of the late arrival of the Omicron variant, but we could see a drop in Medicare spending compared to 2019.

NAACOS feels it would be a mistake to base expectations for future spending on years in which there were historic drops in Medicare spending and utilization. MSSP ACOs starting new agreement periods in 2023 will have their benchmarks based on their assigned beneficiaries' spending between 2020–2022 — three pandemic-stricken years. Even with adjustments made via regional spending and a national-

regional trend rate, many ACOs would be in a no-win situation if current benchmarking rules were to still apply.

We reiterate our request for CMS to allow ACOs the opportunity to elect pre-pandemic years for benchmarks for agreements beginning in performance year 2023. Last fall, 11 major healthcare organizations joined NAACOS in making this request. Meanwhile, CMS has modified other Medicare value-based payment programs to not use data from years affected by the COVID-19 pandemic to set future financial and/or quality benchmarks, and we hope the same can apply to MSSP.

Increase the Onramp for Assuming Risk to Encourage Widespread Participation
The 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. In 2022, a modest 483 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 Pathways to Success Rule also 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 upfront 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
The vast proliferation of APMs 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. For example, patient assignment and evaluating the impact of a model have grown increasingly complex due to the overlap of multiple models. 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. We urge CMS to establish transparent and consistent overlap policies that protect and support total cost of care models. 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 100 percent shared savings and loss rates, participation at the Tax ID Number-National Provider Identifier (TIN-NPI) level, options for

capitated payments, offering more advanced waivers including those around home visits and cost-sharing support. Next Gen tested a number of polices that could be incorporated into MSSP to improve CMS's flagship ACO model going forward.

Improve ACOs' Access to Data to Enhance Performance
CMS now requires that hospitals share electronic notifications of patients' admission to, discharge from, or transfer (ADT alerts) between inpatient hospitals with community providers. However, CMS notes that the requirement "does not create an entitlement for any specific provider or intermediary to receive patient event notifications." Subsequent guidance stated that the requirement does not limit a "hospital's ability to notify additional entities based on hospital policy, such as ACO attribution lists." Neither goes far enough to 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. NAACOS urges CMS to correct this flaw to require that ADT alerts be sent to ACOs.

Similarly, CMS's Health Insurance Portability and Accountability Act (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 their patients.

Lastly, the ACO community continues to wait for proposed regulations to implement Section 3221 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, which modernizes the privacy of treatment records for substance use disorder (SUD) by creating parity between HIPAA and 42 CFR Part 2, which governs SUD privacy. As the Department of Health and Human Services (HHS) works to implement the CARES Act, we urge CMS to work with others in the department 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.

Modernize Telehealth Requirements
Congress continues to struggle with expanding Medicare's statutory authority to pay for telehealth care in more circumstances. However, NAACOS believes CMS has the authority now to allow all ACOs, regardless of risk level or choice of attribution, the freedom to use telehealth in broader circumstances through Sec. 1899(f), including expanding waivers beyond the patient's site of care and geographic location. Because MSSP ACOs are accountable for the populations they serve and responsible for their total cost of care, they should be handed tools to manage their populations, including telehealth, without

restraints that are placed on non-accountable organizations. CMS's providing ACOs the power to use telehealth in broader circumstances would further incentivize ACO participation and help CMS reach its goal of having all traditional Medicare patients in an accountable care relationship by 2030.

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

While the Advanced APM incentive payments in MACRA have been instrumental in encouraging participation in Advanced APMs, the pace of adoption has not been as fast as Congress and CMS originally intended. Furthermore, the expiration of the incentive payments at the end of this year and the increasing Qualified APM Participant (QP) thresholds will result in a slower transition to these value-based payment models. In a NAACOS survey, ACOs reported using the Advanced APM bonus for activities such as recruiting new providers to join the ACO, paying physician bonuses, investing in ACO initiatives such as care coordination or data analytics, and supporting their ACO's move to a risk-based model. Without the Advanced APM incentive payment, many participants will struggle to fund these vital components of a risk-bearing Advanced APM.

Additionally, while Medicare ACO models are considered APMs, not all are considered Advanced APMs. We encourage CMS to utilize its full statutory authority to alter the requirements for qualifying as an Advanced APM to better match progress to-date. This includes allowing all MSSP ACOs to be deemed as Advanced APMs by accounting for start-up and ongoing operational costs that are inherent in model participation and do represent true financial risk. With nearly 30 million traditional Medicare patients still in unmanaged and uncoordinated care, we encourage the administration to prioritize an extension of these critical incentive payments to encourage more providers to participate in Advanced APMs that are proven to increase quality and decrease costs.

Eliminate the arbitrary high-low revenue distinctions recently introduced in the MSSP and instead apply the low-revenue policies across all ACOs

The Pathways to Success Rule distinguished high versus low revenue ACOs and began to apply different policies based on high/low revenue status. This distinction is arbitrary and creates an inequitable path to risk, forcing high revenue ACOs to enter risk before their peers. High revenue ACOs are forced to assume higher levels of risk and to take on risk more quickly, creating a disincentive for ACOs who are voluntarily working together to ensure that value-based care succeeds. If CMS continues this policy, it will disincentivize certain providers from entering and/or continuing in the MSSP. Instead, we urge CMS to treat all ACOs equitably by removing the high/low revenue distinction and applying the low-revenue policies across all ACOs.

Reform the Beneficiary Notification Process

CMS requires MSSP ACOs send a form letter to all assigned beneficiaries notifying the patient they are part of an ACO. ACOs must use CMS template language for these notifications, and this language has been found to be confusing to beneficiaries and provides little value. As a result, some beneficiaries choose to opt-out of data sharing without understanding what the data sharing process entails, making it difficult for ACOs to coordinate and manage patients' care effectively. We urge CMS to seek broad stakeholder feedback, with a particular emphasis on beneficiaries and patient advocates, to rewrite the language that is used in these notifications such that patients understand ACOs' work. Explaining the work of ACOs to those unfamiliar can be complicated, and the section in the notification letters on "how ACOs work" is merely a few sentences. There could be, for example, more detail on care coordination efforts ACOs deliver. Instead of placing the burden of sending notification letters on ACOs, which can be a costly process, NAACOS asks that CMS do so. This would also eliminate the issue of patients receiving

notifications from multiple ACOs. Another option is to allow physician offices to give a form to patients using their own language instead of a template provided by CMS. Nonetheless, given the important role patients play in our health system, the process of sending a form letter to all ACO-assigned patients needs to be rethought.

Conclusion

In conclusion, NAACOS is eager to work with CMS to further advance value-based care for all Medicare patients. In order for CMS to meet its stated goals of having all traditional Medicare patients in an accountable care model by 2030, the agency must make improvements to the largest and historically most successful model — the MSSP. The effects of the Pathways to Success changes are undeniable. We must continue to make a business case for value-based care by re-balancing the risks and rewards associated with participation in models like the MSSP. We would like to meet with you and your staff to discuss these recommendations and how NAACOS can support your efforts. 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