October 29, 2020

Brad Smith
Senior Advisor for Value-Based Transformation
U.S. Department of Health & Human Services
Director of the Center for Medicare & Medicaid Innovation
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: The Community Health Access and Rural Transformation (CHART) Model: Accountable Care Organizations (ACO) Transformation Track

Dear Director Smith:

The National Association of Accountable Care Organizations (NAACOS) writes to express our appreciation and support for the recently announced Community Health Access and Rural Transformation (CHART) Model. Roughly 60 million people, one in five Americans, live in a rural area, and the needs facing rural providers are often very different than their urban counterparts. Furthermore, rural providers are disproportionally less involved in value-based payment models. As such, more needs to be done to help rural healthcare providers' participation in alternative payment models (APMs) so their patients receive the benefits of value-based care. That is why the goals of the CHART Model are commendable and ones NAACOS proudly supports. CHART is also a successor of the ACO Investment Model, which has been one of the most successful CMS Innovation Center models. NAACOS has previously called on CMS to restart this model, so we are pleased to see the evolution of the ACO Investment Model through the new CHART Model release.

As the largest association of ACOs, NAACOS and its ACO members serve more than 12 million beneficiary lives through hundreds of organizations participating in population health-focused payment and delivery models in Medicare, Medicaid, and commercial insurance. NAACOS and its members are deeply committed to the transition to value-based care. NAACOS is an ACO member-led and member-owned non-profit organization that works on behalf of ACOs across the nation to improve the quality of healthcare delivery, population health and outcomes, and healthcare efficiency. Our comments reflect our unified desire to support rural-focused APMs, particularly in CHART's ACO Transformation Track. As the Innovation Center works to implement the CHART Model, we ask you adopt the following changes to better support rural ACOs and enhance the success of the model.

Allow current Shared Savings Program ACOs to apply
The Innovation Center should make clear that ACOs currently participating in the Medicare Shared Savings Program (MSSP) will be allowed to join CHART's ACO Transformation Track. While this was

participate would be helpful to those rural providers who have embarked on the journey to value but need support to continue their transformation. It typically takes millions of dollars to invest in start-up and ongoing costs to fund ACOs. The challenges of rural ACOs are particularly notable as they prepare to assume risk. Given the more limited financial resources rural providers have, the advanced funding through the CHART Model would help provide necessary monetary security for those ACOs, allowing them to continue in the program and helping achieve CMS's goal of moving ACOs into risk-bearing models. CMS should not punish rural ACOs who have already made the leap into value-based payments by excluding them from this program. Similarly, CMS should make clear that ACOs can join CHART in a shared savings-only model, specifically MSSP's Levels A and B, to help them get started and then progress along the program's glidepath.

Address MSSP's "rural glitch"

While CHART's ACO Transformation Track will work jointly with MSSP, CMS should take the opportunity to use the Innovation Center's authority to address a flaw with MSSP's regulations. Specifically, the Innovation Center should address MSSP's "rural glitch," which unfairly penalizes ACOs that make up a large percentage of their market and regional reference population. When calculating an ACO's benchmark, CMS should exclude ACO beneficiaries from the regional reference population to prevent the unfortunate situation where an ACO is being directly evaluated against itself, which undermines the point of a benchmark with a regional component. By including ACO-assigned beneficiaries in the regional reference population, the regional cost data is skewed by reflecting ACOs' efforts to coordinate care and reduce expenditures for the ACO population.

Rather than comparing ACOs to themselves and other ACOs, CMS should compare ACO performance relative to fee-for-service (FFS) Medicare by defining the regional population as assignable beneficiaries without ACO-assigned beneficiaries for all ACOs in the region. In an area where the ACO has significant market saturation, it is especially essential to remove the ACO beneficiaries from the regional population to avoid comparing the ACO to itself.

To address those ACOs whose reference populations fall to insufficient levels, we recommend CMS use a modified approach. For example, CMS could increase the weight of the counties that have a lower proportion of resident ACO beneficiaries, and thus higher FFS population. Another option would be for CMS to expand the regional service area to include assignable beneficiaries in adjoining counties until a sufficient comparison group is reached. Yet another option, recommended by the Medicare Payment Advisory Commission in a March 11, 2016 comment letter, would increase the stability of the regional FFS spending calculations by increasing the number of years of data included in the calculation (for example, by using a five-year rolling average for county level spending estimates). In cases where area expenditures are driven largely by the ACOs, CMS could similarly pull in contiguous counties to ensure a fair comparison. These approaches would both address CMS's concern about not having an adequate reference population and would be preferable to the current methodology.

Expand the model to allow more ACO participants

The Innovation Center should allow more than 20 ACOs to join the ACO Transformation Track. CMS's goal for CHART is to expand APM participation for rural providers. If so, the agency shouldn't limit itself to a pre-determined number of participants. Instead, we urge CMS to look at additional applicants and their potential size and allow more ACOs to join the model.

Reduce MSSP's minimum beneficiary requirement

CMS should use the authority of the Innovation Center to allow ACO Transformation Track participants to fall below MSSP's 5,000-beneficiary minimum. Some rural providers struggle to reach this minimum,

which serves as a barrier to APM participation. As such, CMS should seek to waive this 5,000-beneficiary minimum as necessary to encourage CHART Model participation.

Cost-based reimbursement

Rural providers who operate under Medicare's cost-based reimbursement system, such as critical access hospitals, face challenges participating in total-cost-of-care models like ACOs. Because spending for them is more closely tied to utilization, they face a tougher task to lower their benchmark than providers who operate under fixed pricing. If the Innovation Center wants to attract more rural providers into APMs, it must address participation for providers who operate under a cost-based reimbursement system.

Allow broader use of waivers

MSSP has more limited waiver authority than comparable ACO models operating within the Innovation Center. To test the model's ability of offering "operational flexibilities" to providers, CHART should allow greater flexibilities around home visits such as waiver of the homebound requirement for certain conditions and allowing a nurse practitioner to certify a beneficiary for home care. ACOs could be allowed care management home visits. For telehealth, NAACOS has previously asked that CMS allow ACOs greater flexibility by, for example, waiving patient cost-sharing, allowing additional modalities like telephone-only, providing supervision allowances, waiving frequency requirements of telehealth visits, and allowing covered services, such as those CMS says need some level of in-person care delivered in conjunction with telehealth. Again, CMS should take advantage of the Innovation Center's authority to test more waivers to explore whether their use with MSSP could help that model produce greater savings. These types of waivers would be particularly helpful in rural settings and therefore appropriate to test in the CHART Model.

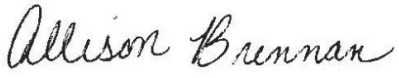
Increase cap on funding levels

CMS has stated it will provide both a one-time upfront payment and per-beneficiary monthly payment for ACO Transformation Track participants. However, funding will be capped at the first 10,000 beneficiaries assigned to the ACO. While we appreciate budgetary constraints that might limit the program's size, NAACOS believes the Innovation Center should remove the artificial limits on how much funding an individual ACO participant might receive. CMS could allow ACOs to exceed the 10,000-beneficiary limit since not all applicants would necessarily be below that cap. Removing this 10,000-beneficiary cap would help bring more rural providers into APMs, which is a stated goal of the Innovation Center.

Conclusion

NAACOS continues to appreciate the opportunity to partner with the Innovation Center in advancing APMs and appreciates your work to create more opportunities for rural providers. As previously stated, rural providers need greater opportunities to join APMs, and the CHART Model will make that a reality. NAACOS was a big supporter of the ACO Investment Model, which has achieved the Innovation Center's goals of lowering Medicare spending, and we are pleased to see the next iteration of it through CHART's ACO Transformation Track. We support the model and believe the above recommendations will help create a better model with more robust participation. Should you have any questions, please contact David Pittman, Health Policy and Communications Advisor, NAACOS, at dpittman@naacos.com.

Sincerely,



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