December 16, 2019

The Honorable Diana DeGette
U.S. House of Representatives
2111 Rayburn House Office Building
Washington, DC 20515

The Honorable Fred Upton
U.S. House of Representatives
2183 Rayburn House Office Building
Washington, DC 20515

Via cures2@mail.house.gov

Re: Cures 2.0 Call to Action

Dear Representatives DeGette and Upton,

The National Association of Accountable Care Organizations (NAACOS) appreciates your efforts to build upon the success of *21st Century Cures Act* and engage in a dialogue concerning a Cures 2.0 initiative. NAACOS works to advance population health-focused payment and delivery models and represents 12 million beneficiary lives through hundreds of organizations participating in models in Medicare, Medicaid, and commercial health plans. This includes the Medicare Shared Savings Program (MSSP), Next Generation ACO Model, Medicare Advantage and alternative payment models supported by a myriad of commercial health plans.

The ACO model is a market-based solution to fragmented and costly care that empowers local physicians, hospitals and other providers to work together and take responsibility for improving quality, enhancing patient experience and reducing waste. Importantly, the ACO model also maintains patient choice of clinicians and other providers. While the origins of Medicare ACOs date back to the George W. Bush Administration, the number of ACOs in Medicare has grown considerably in recent years and includes nearly 550 ACOs in 2019, covering nearly 13 million beneficiaries. ACOs are leading the way in Medicare's shift to value-based care and represent the dominant option for providers to participate in alternative payment models.

According to recent data from the Centers for Medicare & Medicaid Services (CMS), ACOs collectively saved Medicare $1.7 billion last year alone, and $739 million after accounting for shared savings bonuses and collecting shared loss payments. Just this month, an independent evaluation found accountable care organizations (ACOs), Medicare's dominant value-based care initiative serving nearly 11 million seniors, lowered spending by $3.53 billion from 2013 to 2017 and saved $755 million after paying shared savings. Additional research also confirms positive ACO performance. Researchers at Harvard University and the Medicare Payment Advisory Commission have all done such work. All showed ACOs are lowering Medicare spending by 1 percent to 2 percent, which translates into tens of billions of dollars of reduced

Medicare spending when compounded annually. ACOs also demonstrate impressive quality, as evidenced by the almost 93 percent average MSSP quality score for the most recent performance year. With results like this, it is clear that ACOs are transforming our healthcare system through reduced costs and improved quality.

Our below recommendations represent ways in which the Congress can continue to build upon the results of the Medicare ACO program and ensure its continued success.

Allow All ACOs Freedom to Use Telehealth

The 115th Congress enacted through the Bipartisan Budget Act (BBA) some parts of the CONNECT (Creating Opportunities Now for Necessary and Effective Care Technologies) for Health Act of 2017. Specifically, Section 50324 of the BBA allows ACOs who use prospective assignment and participate in a two-sided risk track to expand the use of telehealth by lifting certain geographic and site-of-care statutory restrictions. The enactment of BBA Section 50324 will be critical for ACOs as they seek to fulfill their mission of advancing higher quality, lower cost care for Medicare beneficiaries. Telehealth, including remote monitoring, provides an opportunity to offer vital, cost-effective services to more patients.

However, we urge Congress to expand ACOs' use of telehealth to include both those in one-sided risk tracks and those that use retrospective assignment. If telehealth were granted to all ACOs regardless of risk level or assignment methodology, more providers could be persuaded to enter voluntary ACOs and population-health programs which would have access to tools to better manage patients. Furthermore, expanding access to telehealth would provide ACOs time to optimize use of the technology before taking on financial risk. Previously, NAACOS has called on Congress to allow the home to satisfy the originating site requirement and waive the geographic limitation for the provision of telehealth services under Section 1834(m) of the Social Security Act for ACOs in one-sided risk tracks.

Fixing the ACO "Rural Glitch"

We strongly urge the Congress to act on H.R. 5212, the Accountable Care in Rural America Act, which would help further alternative payment models in rural America by correcting an unintended flaw in Medicare policy that unfairly penalizes ACOs when they reduce costs. CMS generates a financial target, or benchmark, that sets an ACO's performance for spending. CMS considers the historic costs of the ACOs' patients and the costs of patients in the ACO's region. Benchmarks incorporate a regional adjustment to reward practices that have lower costs than their regional peers. However, when ACOs reduce the costs of its patients, they also reduce the region's costs. Therefore, counting all patients in the regional adjustment – including those both in and out of the ACO – penalizes ACOs for reducing costs relative to its regional competitors. While also hurting urban or suburban ACOs, this problem is particularly acute for rural ACOs, who may be the only ACO in the region or the dominate provider in their region.

Congress can correct this "Rural Glitch" by removing ACO patients from the regional reference population, which systematically penalizes rural ACOs when they reduce costs. This change would help rural providers who want to participate in ACOs. NAACOS and 13 other leading healthcare organizations have called upon the House to pass H.R. 5212, which would correct this issue.

Supporting Chronic Care Management

NAACOS urges Congress to act on H.R. 3436, the *Chronic Care Management Improvement Act*, which would ensure that more chronically ill Medicare patients receive access to the best care. Chronic care management (CCM) is a critical part of coordinated care, and as a result, Medicare began reimbursing physicians for CCM under separate codes in the Medicare Physician Fee Schedule. The creation of

separately billable codes, however, created a beneficiary cost-sharing obligation for care management services. Under current policy, Medicare beneficiaries are subject to a 20% co-insurance requirement to receive these services. This cost-sharing requirement creates a barrier to care, as beneficiaries are not accustomed to cost-sharing for non-face-to-face care management services. Consequently, only 684,000 patients out of 35 million Medicare beneficiaries with two or more chronic conditions benefited from CCM services over the first two years of the payment policy.

H.R. 3436 would waive the beneficiary co-insurance amount to facilitate further managing chronic care conditions to improve the health of patients. Providers and care managers report several positive outcomes for beneficiaries who receive CCM services, including improved patient satisfaction and adherence to recommended therapies, improved clinician efficiency, and decreased hospitalizations and emergency department visits. NAACOS requests that you consider this legislation as you formulate Cures 2.0.

Increasing data transparency

Centers for Medicare & Medicaid Innovation (CMMI) models are a laboratory for new payment and delivery designs. To provide ample opportunity to evaluate and learn from these models, there should be increased data transparency from CMMI. Specifically, CMS should release all attribution, performance and claims data for a particular Innovation Center program no later than nine months after the close of the performance year. This data should be made available in public data sets and through the Research Data Assistance Center (ResDAC). In addition, to allow external researchers to replicate program evaluations, CMS data used in formal program evaluations should be released to the public no later than six months after that data is provided to contractors conducting a formal evaluation of a program.

Cover Up-Front Costs of ACO Development

ACO formation can be hamstrung by costs. Investments are needed in clinical and care management, health information technology, population health analytics, reporting, and other administrative costs The average annual cost of a single ACO approaches nearly $2 million. This barrier can be too much to overcome for many providers serving rural and underserved communities.

However, CMS previously offered programs to help fund ACOs' up-front costs, with those payments later recoupled via shared savings. Those ACOs were smaller, mostly rural and primary care-based organizations, according to CMS. These programs, such as the ACO Investment Model (AIM), should be reinstated to help ACOs fund activities and transformations to support ACOs' development.

The program was a great success. Overall, AIM participants lowered Medicare spending by 2.3 percent in their first year and 3 percent in their second year, according to CMS evaluations. Hospital readmissions, emergency room visits, post-acute care visits, among other factors were all decreased. These ACOs have almost entirely repaid CMS those start-up costs, while maintaining quality and leaving established ACOs to help spur Medicare's value-based care movement. Researchers from Harvard Medical School studied 41 AIM ACOs and found they collectively reduced Medicare spending by $131 million relative to a comparison group.

Remove ACOs' "High Revenue" Distinction

Under the Pathways to Success rule, which CMS finalized in December 2018, CMS created a new distinction between "high revenue" and "low revenue" ACOs. CMS calculates the percentage of the total fee-for-service revenue for ACO participants compared to the ACO's benchmark expenditures. CMS tries to distinguish between ACOs who the agency believes have a greater ability to control spending, giving less time in shared-savings only models to "high revenue" ACOs.

NAACOS believes these distinctions are arbitrary and provide disincentives for rural providers to voluntarily work together in value-based care arrangements. We looked at 2016 Medicare claims data to determine the revenue status of certain ACO types. NAACOS found nearly one in five Federally Qualified Health Center- and Rural Health Clinic-affiliated ACOs would have been designated "high revenue" based on 2016 data. As written, this policy creates a disincentive for ACOs working in rural and underserved areas. We call on Congress to eliminate high-low revenue distinction and apply the low revenue policies across all ACOs.

Incentivizing participation in Advanced Alternative Payment Models (APM)

Under the Medicare Access and CHIP Reauthorization Act, eligible clinicians who participate in an Advanced APM and meet certain Qualifying APM Participant (QP) criteria will receive a 5 percent annual lump sum bonus based on performance from 2017 – 2022. Under the current statute, that bonus expires at the end of the 2022 performance year. When the Advanced APM bonus expires, many healthcare providers have much less incentive to participate in these advanced, risk-bearing models. Data so far have shown that Advanced APM participation is lower than what CMS initially projected. Just under 100,000 clinicians reached qualifying QP status in 2017, which is less than 10 percent of all eligible clinicians. For performance years 2018 - 2020 CMS estimates an increase in those qualifying, but the numbers remain low and are disappointing because of our collective goal to move more providers into Advanced APMs. NAACOS believes all providers would have more opportunity and incentive to move to population-health models like ACOs if the 5 percent bonus were extended for six additional years.

Additionally, the Congress should cap the QP payment threshold at 50 percent and modify the related partial QP threshold to be 80 percent of the QP threshold set by HHS. To become a QP, participants must receive at least 50 percent of their Medicare payments or see at least 35 percent of Medicare patients through an Advanced APM; the payment percentage will rise to 75 percent in performance year 2021.

These thresholds are too high and are discouraging Advanced APM participation and leading to unintended consequences of APM Entities limiting participation by certain providers. ACOs in rural areas are often referral centers and see a wide range of patients who may not end up being assigned, thus watering down their QP scores.

Conclusion

Thank you for the opportunity to provide feedback to this important work. Please contact NAACOS staff at advocacy@naacos.com if you have any questions about our comments. We are happy to expound upon these ideas and others.

Sincerely,

Clif Gaus, CEO