June 28, 2021

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
200 Independence Ave., S.W.
Washington, DC 20001

Re: **Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2022 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals**

Dear Administrator Brooks-LaSure:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to the proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2022 Rule (IPPS Rule), [CMS-1752-P], as published in the Federal Register on May 10, 2021.

NAACOS is the largest association of accountable care organizations (ACOs), representing more than 12 million beneficiary lives through more than 370 Medicare Shared Savings Program (MSSP), the Next Generation ACO Model, and commercial ACOs. NAACOS is an ACO member-led and member-owned nonprofit that works on behalf of ACOs across the nation to improve the quality of Medicare delivery, population health, patient outcomes, and healthcare cost efficiency. NAACOS is committed to advancing the value-based care movement and our members, more than many other health care organizations, want to see an effective, coordinated, patient-centric healthcare system that focuses on keeping patients healthy.

NAACOS is pleased to provide comments on three sections of the proposed rule, “Medicare Shared Savings Program—Proposed Policy Changes,” “Closing the Health Equity Gap in CMS Hospital Quality Programs—Request for Information (RFI),” and “Advancing to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in Hospital Quality Programs RFI.”

I. Medicare Shared Savings Program—Proposed Policy Changes

Key comments:

- **CMS should finalize with modification the proposal to allow ACOs to elect to remain in their current level of the Basic glide path in Performance Year (PY) 2022.**
- **CMS should not automatically advance ACOs to the level in which they would have been without this policy and should allow ACOs that elect to remain in their current level to continue to the next level of the glide path.**

We commend CMS for its proposal to permit a "freeze" for ACOs participating in the Basic Track's glide path, thus allowing them to opt out of the automatic level advancement for 2022. As ACOs continue to grapple with the COVID-19 pandemic and public health emergency (PHE), expenditures and utilization continue to be difficult to predict and manage, making it more challenging to shift to risk. In light of this uncertainty, this is a welcome proposal, and we support the goal of this proposal to allow flexibility for ACOs currently participating in the Basic Track. This is a continuation of the policy finalized by CMS as part of the May 2020 interim final rule with comment period (IFC), allowing ACOs to elect to freeze their participation level for 2021, citing the COVID-19 PHE. NAACOS supported[i] this policy, but noted that for PY 2022, ACOs should only move up to the next level in the glide path and not jump to the level they would have been on track for absent the policy change.

Evidence[ii] has shown that it takes time for ACOs to generate savings, and ACOs participating in the MSSP over a longer period experience greater improvement in financial performance. Individual ACO performance has been shown to improve[iii] with length of time in the program, illustrating the need for providers to have time to develop experience in accountable care arrangements before shifting from a shared savings only level to one with downside risk. The MSSP is a voluntary model. While it is important to support ACOs as they progress along the value-based payment continuum, it is important to recognize that ACOs not ready for risk will likely quit the program rather than assume financial risk for which they are unprepared.

While we are supportive of this proposal, we are also concerned that, once 2022 concludes, those ACOs who elect this "freeze" will be placed back on the glide path as if the freeze had not occurred. In other words, this policy creates a cliff for ACOs by requiring those who take a "freeze" to have a dramatic jump in risk the following year. This is contrary to CMS's goal of a gradual increase in risk, which was the intent behind developing the glide path. Given the highly unusual and challenging circumstances brought on by the COVID-19 pandemic, it would be fair and appropriate to maintain the gradual glide path for all ACOs, even those that elect the freeze. Therefore, we urge the agency to augment this proposal to permit those ACOs who elect the "freeze" for 2022 to continue on to the next step in the glide path in 2023, rather than fast forwarding to the stage where they would have been had COVID-19 not occurred.

Additionally, NAACOS is concerned that CMS did not establish a clear time frame within which ACOs would have to decide whether to freeze or continue their advancement on the glide path. CMS acknowledged that the annual MSSP change cycle would begin before the proposed rule is finalized, and there will be "limited opportunity to submit a repayment mechanism, resolve any deficiencies, and have it approved in time for the start of the performance year." This is concerning as ACOs will have insufficient time and information to evaluate a decision and notify CMS. NAACOS recently sent a letter[iv] to CMS requesting the agency extend time frames for the 2022 MSSP application process, and we again call on the agency to provide increased time and flexibility for ACOs throughout the application process to enable informed decision-making.

II. Closing the Health Equity Gap in CMS Hospital Quality Programs—Request for Information

Key comments:
To reduce health inequities among Medicare beneficiaries, CMS should support ACOs' work to target outreach and address the complex needs of underserved populations. ACOs need appropriate tools, data, financial incentives, and resources to address health equity issues and develop partnerships with community organizations. To do so, CMS should implement these recommendations:

- **Create new opportunities for ACOs to address health equity issues by**
  - **Providing additional flexibility with Medicare rules for ACOs to deliver supplemental benefits to patients to help address health equity**
  - **Providing funding to support an expansion of social services to address health equity**
- **Ensure quality reporting is thoughtfully designed and implemented to avoid penalizing ACOs treating patient populations struggling with health inequities**
- **Leverage the ACO model to test expansions in telehealth for the ability to improve access and quality while controlling costs**
- **Lift 42 CFR Part 2 restrictions to support care coordination and improve patient care**

NAACOS appreciates the opportunity to submit comments on how to make reporting of health inequities based on social risk factors more comprehensive and actionable. Like CMS, NAACOS is committed to reducing health disparities, and we aim to support ACOs in their efforts to improve and maintain the health of populations and reduce gaps in health equity by addressing social needs and social drivers of health. We strongly support the use of data to target interventions toward populations and individuals in need.

Strengthening ACO and other total cost of care models provides an important opportunity to reduce health inequities and transition our health system to a culture of value. Improving health equity is critical to delivering high quality care in a cost-effective manner and focusing on the broader concept of an individual's overall health, as social drivers of health contribute significantly to achieving better health outcomes. These social factors cannot be addressed if they are not adequately identified, measured, tracked, and reported.

Many ACOs have been doing important work to address social needs and inequities among their patient populations. Financial incentives related to improving quality performance can be targeted to providers serving large proportions of minority and vulnerable populations, thus reducing inequities. Studies have shown that ACOs are increasingly working to address patients' nonmedical needs to improve their health, such as partnering with other organizations in the community to meet housing and transportation needs and address food insecurity.[v] Some specific examples of ACO initiatives to address 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 and African American 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

- Developing tools to identify and reach out to high-risk patients with trained staff to check for food 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 organizations. To do so, CMS should implement the recommendations below.

1. *Create new opportunities for ACOs to address health equity*

Provide additional flexibility with Medicare rules for providers to deliver supplemental benefits to patients to help address health equity issues:

In order for ACOs to be able to test innovative approaches to improving health equity, additional flexibility with Medicare rules for providers to deliver supplemental benefits to patients is necessary.

For example, this memo[vi] shares information on flexibility for providing transportation to patients. NAACOS was very pleased to see this guidance from the Department of Health and Human Services (HHS) Office of Inspector General, providing flexibility from the federal healthcare program anti-kickback statute. We recommend HHS and CMS provide additional flexibilities to allow ACOs to deliver other benefits such as those related to housing or food insecurity.

There is precedent in Medicare for allowing such flexibilities, recently illustrated by new policies in Medicare Advantage (MA) that allow premium dollars to go towards addressing social needs. The Bipartisan Budget Act of 2018 expanded the types of benefits that may be offered by MA plans for chronically ill patients.[vii] These supplemental benefits may include things like meals, food and produce, transportation for non-medical needs, pest control, indoor air quality equipment, social needs, complementary therapies, structural home modifications, services supporting self-direction, and/or general supports for living. Because ACOs are accountable for the total health outcomes of the populations they serve and total cost of care, they should be allowed similar flexibilities in how they allocate resources to meet the needs of a certain population.

Provide funding to ACOs to support expanding social services to address health equity issues:

As reflected in the examples above, many ACOs already have initiatives to address health equity and other ACOs are in the process of planning to introduce similar initiatives. However, financial barriers and resource constraints remain a major hurdle to this work. Without additional funding and incentives to do this important work, true progress will not be realized.

One option to address this would be for CMS to provide grants to ACOs to expand their connections with community-based organizations (CBOs) and to enhance ACOs' internal capacity to deliver health services and meet social needs. Additionally, the Center for Medicare and Medicaid Innovation (CMMI) could establish a voluntary model for MSSP ACOs focused on addressing health equity. ACOs would detail to CMMI how they would use upfront funding to address health equity gaps among their patient population. If the ACO generates shared savings, the initial investment could be recouped by CMS, and if it does not generate savings, the funds would be forgiven by CMS as long as the ACO remains in the program. This model would be similar in design to the Community Health and Rural Transformation (CHART) Model, which builds off the ACO Investment Model that was one of the most successful CMMI models to date.

2. *Ensure quality reporting is thoughtfully designed and implemented to avoid penalizing ACOs treating patient populations struggling with health inequities.*

Recent changes to the way ACOs are required to measure and report on quality, finalized in the 2021 Medicare Physician Fee Schedule Rule (CMS-1734-P), may have inadvertent negative impacts on health equity. The rushed implementation of the MSSP quality overhaul has resulted in many unanswered questions about how to satisfy the new requirements for reporting all-payer data and electronic Clinical Quality Measures (eCQMs) and Merit-based Incentive Payment System Clinical Quality Measures Clinical Quality Measures (MIPS CQMs). The lack of standardization across electronic health records (EHRs) will cause significant administrative burden and high costs, which will direct resources away from patient care and equity interventions. This burden comes at a time when ACOs are struggling to deal with the COVID-19 pandemic and related impacts. Additionally, requiring ACOs to report on all patients across all payers rather than just ACO-assigned Medicare beneficiaries may adversely affect ACO practices treating vulnerable populations, such as those with high rates of Medicaid and uninsured patients. For example, many ACOs have relationships with Federally Qualified Health Centers (FQHCs) to provide care to their assigned beneficiaries. Differences in the medical complexity, social needs, or other factors in these populations will skew performance on quality measures and penalize ACOs and ACO practices treating more vulnerable populations at a time when they need the resources the most.

In order to avoid these potentially negative impacts to patient care and health equity, NAACOS makes the following recommendations:

- Delay the mandatory reporting of eCQMs and MIPS CQMs for at least three years
- Limit ACO reporting to ACO assigned beneficiaries only, rather than all patients across payers
- Reassess the appropriateness of the measures included in the Alternative Payment Model (APM) Performance Pathway (APP) measure set and solicit additional input through the Measures Application Partnership (MAP) prior to finalizing a complete set of patient-centered measures for MSSP reporting

NAACOS has highlighted these recommendations and others with additional detail on unanswered questions and concerns in a letter[viii] to HHS Secretary Becerra in May. We encourage these changes be made quickly to ensure that ACOs can equitably and effectively serve their assigned populations.

3. *Leverage the ACO model to test expansions in telehealth for the ability to improve access and quality while controlling costs*

In the wake of the COVID-19 pandemic, ACOs were able to quickly pivot to telehealth and remote patient monitoring to meet the needs of their patients in a safe and accessible manner. Virtual care has provided unprecedented access for patients, but it has become clear that uncertainty as to the future of telehealth under Medicare will halt or reverse further adoption and utilization—to the detriment of both patients and providers. While the digital divide remains an issue for patients without access to reliable broadband services, telehealth has greatly expanded access to primary and specialty care for patients in rural areas with limited access to services.

NAACOS supports broader telehealth coverage and wants to see many of the flexibilities granted during the COVID-19 pandemic be made permanent; however, there are concerns about potential adverse effects on spending and ACO attribution. To ensure that telehealth is expanded in a cost-effective manner that ensures the continued delivery of high-quality care and does not disrupt ongoing patient-provider relationships, we recommend ACOs and other APMs be used to test broader reforms. To prevent a disruption in care continuity, incentives should be provided to have care delivered in virtually

integrated practices as part of an ongoing comprehensive care strategy. Deference should be given to Medicare providers who are accountable for patients' spending, quality, and health outcomes, such as ACOs.

4. *Lift 42 CFR Part 2 restrictions to support care coordination and improve patient care*

NAACOS continues to call for the alignment of 42 CFR Part 2 (Part 2), which governs patient substance abuse treatment records, with the Health Insurance Portability and Accountability Act (HIPAA). This alignment will improve care coordination and quality improvement and allow ACOs and other providers to deliver the kind of patient-centered, well-coordinated care necessary to improve health outcomes and reduce inequities. While substance use disorder (SUD) affects all racial and ethnic groups, Black and Latinx Americans are less likely to complete treatment for SUD.[ix] By equipping providers with the necessary information for coordinated, whole-person care, these disparities can begin to be addressed.

Currently, ACOs lack access to the full suite of necessary information to allow them to achieve the goals of well-coordinated patient care, improved quality, and preventive care required to limit opioid overdose deaths and other adverse events associated with SUD. While ACOs are provided claims data through Claim and Claim Line Feed (CCLF) files, these data lack SUD-related information, thus limiting ACOs' ability to treat the whole person and potentially harming patient care and outcomes. While Section 3221 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act helped to align Part 2 with HIPAA by allowing the sharing of this important data after initial patient consent, implementation has been challenging. NAACOS asserts[x] that current regulations allow CMS to deliver unredacted claims data to ACOs. We urge[xi] 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 and SUD-focused initiatives.

As mentioned previously, many ACOs are implementing new initiatives to address health inequities, but these programs cannot effectively reach the right patients if ACOs do not have the appropriate data to target outreach to vulnerable populations.

III. Advancing to Digital Quality Measurement and the Use of FHIR in Hospital Quality Programs RFI

NAACOS supports the movement toward use of eCQMs and digital quality measure sources to reduce burden in quality reporting among ACOs. We appreciate this opportunity to provide additional input from an ACO standpoint of data collection, reporting and assessment using digital quality measures. There are key differences in submitting eCQMs and digital quality measures at a hospital when compared to reporting those measures at the ACO level. While a hospital often has a single EHR with uniformity regarding how these technology platforms are used, an ACO must bring together data across many different EHRs, each EHR being used in different ways based on the particular practice or hospital location. A survey of MSSP ACOs this spring showed that nearly half of ACOs have at least 11 EHRs, and 37 percent of ACOs reported having more than 15 EHRs. As a result, it is critical that CMS recognize the nuances and challenges that exist for ACOs as a result of having to work across EHRs, which aren't necessarily interoperable.

Similarly, there are key differences when asking a hospital to aggregate digital quality measure information versus an ACO. The focus of data aggregation should be on using data to help clinicians at the point of care. Digital quality measure information should help inform decisions to provide the best care for a patient, or population of patients. However, in order to realize that goal, the data must be

uniformly structured and in an acceptable format across multiple EHRs when requiring ACOs to aggregate data. While the Office of the National Coordinator for Health Information Technology (ONC) requires eCQMs to be collected and reported by 2015 Edition Certified EHRs, there is no requirement for them to be aggregated from disparate systems, nor does guidance exist for eCQMs to be collected in a standard or uniform manner. From our spring survey of ACOs, the biggest barrier cited for movement to eCQM reporting was the lack of EHR standardization.

Additionally, standard workflows do not exist across practices and hospitals. While FHIR standards can be very effective in a setting where one standard EHR and standard workflows are in place, when attempting to aggregate data as an ACO, these standards are not a panacea, and the process is often very costly. EHR vendors would need to be universally interoperable in order to maximize the effectiveness and usefulness of FHIR standards.

We appreciate this opportunity to raise the differences in use of digital quality measurement based on the entity using the information. We look forward to providing additional, more specific feedback on this in the context of use in APP, MIPS, and MSSP through the proposed 2022 Medicare Physician Fee Schedule Rule.

Conclusion:
Thank you for the opportunity to provide comments on CMS' Calendar Year 2022 IPPS proposed rule. Should you have any questions about our comments, please contact Allison Brennan, SVP, Government Affairs at abrennan@naacos.com.

Sincerely,

Clif Gaus
President & CEO
NAACOS

---

[i] https://www.naacos.com/comments-on-covid-19-ifc-2
[ii] https://www.naacos.com/highlights-of-the-2019-aco-program-results
[iii] https://www.healthaffairs.org/do/10.1377/hblog20171120.211043/full/
[iv] https://www.naacos.com/letter-on-application-deadlines
[v] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0727
[vi] https://naacos.memberclicks.net/summary-of-anti-kickback-statute-safe-harbor-for-transportation?servId=7312
[vii] https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf
[viii] https://www.naacos.com/aco-coalition-letter-on-mssp-quality-overhaul
[ix] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3570982/
[x] https://www.naacos.com/naacos-letter-calls-on-cms-and-samhsa-to-provide-acos-access-to-substance-use-disorder-claims-data
[xi] https://www.naacos.com/brooks-lasure-letter