July 7, 2020

Brett Giroir, MD
Office of the Assistant Secretary for Health
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Request for Information; Long Term Monitoring of Health Care System Resilience

Dear Assistant Secretary Giroir:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to the Request for Information (RFI); Long Term Monitoring of Health Care System Resilience. NAACOS is the largest association of accountable care organizations (ACOs), representing more than 6.6 million beneficiary lives through more than 365 Medicare Shared Savings Program (MSSP), 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 care process which focuses on keeping patients healthy. The COVID-19 pandemic and Public Health Emergency (PHE) have put a strain on the health care system, shining a light on the flaws of our current fee-for-service payment model. Now more than ever, the future must move away from fee-for-service models and toward value-based payment models that encourage caring for the patient and community as a whole and provide meaningful incentives to keep patients healthy. Our recommendations reflect our expectation and desire to see ACOs achieve the long-term sustainability necessary to enhance care coordination and health outcomes for Medicare beneficiaries, reduce healthcare costs, and improve quality in the Medicare program. **Strengthening the ACO model and other total cost of care models is an important opportunity to increase the resilience of our health care system and as we recover from COVID-19.**

We appreciate the department's interest, through the questions included in the RFI, to solicit feedback on how to strengthen the U.S. healthcare system to better respond to a pandemic and to improve the resilience of our healthcare system to better serve patients and communities.

Our feedback is in response to questions addressing "Barriers and Opportunities for Health System Resilience," specifically these three questions:

1. *What have been the most significant barriers to assessing, monitoring, and strengthening health system resilience in the United States?*
2. *What policies and programs can be improved to mitigate the risk of COVID-19 and avoid negative impacts on patient outcomes?*
3. *What scientific advances are needed to assess and address vulnerabilities in the U.S. healthcare system during the COVID-19 response and in future disturbances to the healthcare system?*

Despite the tremendous adversity facing our health system, population-focused organizations, like ACOs, are uniquely positioned in a crisis like this because of the years of work spent supporting care coordination and building an infrastructure to support the patients and community they serve. ACOs across America are identifying vulnerable patients at high-risk for COVID-19 using their population management and predictive modeling tools, educating patients about minimizing exposure, making sure they have enough food and medication to stay home, remotely monitoring their underlying conditions, treating cases through telemedicine, and managing post-discharge complications with integrated home health and effective relationships with post-acute providers. This emphasizes the opportunity that value-based care has to increase our health system's resilience during emergencies as well as to improve population health.

The COVID-19 pandemic highlights the need for our payment system to change. Policymakers have worked for almost a decade to change incentives in our health system to encourage keeping patients healthy and shifting to value-based care. Those policies are bearing fruit today as provider organizations and ACOs have built a technology and workforce infrastructure that make them well positioned to care for all of their patients, healthy and sick, across all of their payers.

Medicare ACO programs now care for roughly a fifth of all Medicare beneficiaries, and encompass nearly 500,000 clinicians. There are more than 550 ACOs in the Shared Savings Program and Next Generation ACO Model. Comparing ACO spending to the absence of ACOs found the program lowered Medicare spending by $3.53 billion from 2013 to 2017 and saved $755 million after paying shared savings. **Therefore, to improve our health care system resilience, we must strengthen and move to payment models like the ACO model, which incentivize keeping patients healthy and serving a community and population of patients. Specifically, we request Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) enact the following changes.**

Short-term recommendations

Extend the Public Health Emergency through December

We urge the Secretary of HHS to extend the COVID-19 PHE declaration through at least December 31, 2020. Absent this extension, critical policies implemented to assist health care providers so they can deliver safe and effective care during this challenging time will also expire, with dire consequences to the patients they serve and the health care system as a whole. The policies implemented under the waiver authorities made possible through the PHE declaration allow the health care system to adapt to the unique challenges presented by the COVID-19 pandemic and therefore increase the health care system's resilience during this time.

The COVID-19 PHE was declared to begin on January 31, 2020, in response to an unprecedented global pandemic that has far reaching effects throughout every sector of the health care industry. This PHE

declaration has allowed HHS and CMS to swiftly implement critical policy changes, allowing the health care industry to adapt and change the way they ultimately provide care during this time. These changes have provided essential tools and resources to combat the COVID-19 pandemic, including an unprecedented expansion of telehealth and remote patient monitoring, which has been critical to keeping patients healthy during this crisis, as well as changes to various Alternative Payment Models (APMs) and other value-based programs to protect providers and keep them engaged in their efforts around value-based care during this challenging time.

While in some areas, the COVID-19 PHE may appear to be on the decline, in other areas of the country we are just beginning to see rapid increases in cases and hospitalizations. There is much uncertainty regarding the near-term future as well, as the cold and flu season will likely contribute to additional challenges for the health care system. While the country awaits more available treatments and a vaccine, the PHE policy changes and payment rule waivers implemented thus far by HHS and CMS are serving as a lifeline to the health care industry as providers continue the extraordinary work of combatting COVID-19. We applaud these changes and the department's swift action to provide additional flexibilities and waivers during this unprecedented time. This is not the time to step backward; we must continue to provide these critical tools to the health care industry as we continue to fight the battle against COVID-19. To provide more certainty and assurances to the health care system, we urge the Secretary of HHS to extend the COVID-19 PHE at least through the remainder of the year. We appreciate the extraordinary efforts made by HHS thus far and acknowledge its success in assisting the health care industry work to combat COVID-19 and continue to serve patients. We remain dedicated to providing high quality, coordinated care and feel extending the COVID-19 PHE will be a critical component for achieving that goal.

Make certain telehealth waivers permanent

NAACOS has been a long-time supporter of telehealth, with goals of creating a more efficient, more cost-effective healthcare system. Our recommendations below follow the spirit of our previous calls for policies that enable wider use of telehealth. Making these changes permanent would go a long way to advancing the use of telehealth, which will improve the healthcare system's ability to treat patients and keep them healthy as we recover from the current pandemic.

Remove frequency limitations

In the May 8 interim final rule, CMS used its authority to waive previously established frequency limitations on telehealth services for subsequent inpatient visits (no more than once every three days), subsequent skilled nursing facility visits (no more than once every 30 days), and critical care consultations (no more than once per day). CMS uses annual rulemaking to establish frequency limitations for telehealth services, and NAACOS believes CMS could use this same authority to remove frequency limitations. NAACOS urges CMS to remove regulatorily defined limits on how often a provider can see a patient through telehealth, a change which would further increase access to virtual care, and in turn benefit patient care. Removing these frequency limitations would also decrease regulatory burdens. For these reasons, NAACOS believes CMS should act to remove established frequency limitations on telehealth services.

Distinguish between audio and video services in claims

Understanding that many patients lacked access to video capabilities during the pandemic, CMS used authority granted to it by Congress to waive sections 1834(m)(1) and §410.78(a)(3), which require live, interactive video for telehealth visits. However, CMS later instructed clinicians who bill for Medicare telehealth services to report the place-of-service (POS) code that would have been reported had the service been furnished in-person. Unlike previously, claims should not include the POS code "02-

Telehealth." As such, CMS lacks the ability to distinguish between audio-only telehealth services and video-based telehealth services. Without further action, this will remain true once the PHE ends, although federal law would prohibit the payment of audio-only services without further action from Congress.

CMS should better prepare itself to distinguish between audio-only telehealth services and video-based telehealth services. NAACOS believes that the clinical benefit of video-based telehealth far exceeds that of audio-only visits. As such, Medicare policy shouldn't incentivize audio-only visits in such ways as payment parity with video-based services. To be able to achieve this, CMS first needs to be able to tell when services are audio-only or video-based.

Update ACO attribution as a result of telehealth

CMS uses more than 60 Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes for MSSP assignment and lists them in §425.400(c)(1)(iv). Of these, 51 appear on CMS's list of services eligible to be delivered through telehealth. In the May 8 interim final rule with comment, CMS said it would use remote evaluation of patient video/images (G2010), virtual check-ins (G2012), e-visits (99421-99423), and newly covered telephone E/M services (99441-99443) for ACO patient attribution for Performance Year (PY) 2020 and for any subsequent performance year that starts during the PHE. CMS stated it believes including these telehealth services in MSSP beneficiary assignment would result in a more accurate reflection of where patients receive a plurality of their primary care, a position which NAACOS supports. To further CMS's goal of creating more accurate patient attribution lists that reflect e-visits and virtual check-ins, the agency should permanently add the following codes to MSSP beneficiary assignment: G2010, G2012, 99421-99423, and 99441-99443 to §425.400(c)(1).

Looking beyond the PHE, there may be effects on ACO attribution from increased use of telehealth. NAACOS strongly supports an expansion of telehealth, but HHS should also carefully monitor potential disruptions to existing care relationships as well as negative effects on key APM methodologies such as attribution. Therefore, we urge the agency to study the impact of telehealth changes on ACO assignment and enact necessary policy changes, such as an extended assignment window or varying weight for telehealth services, to ensure that beneficiaries are properly assigned to the appropriate ACO that provides the majority of primary care and serves in a care coordination capacity.

Make virtual check-ins less burdensome

CMS in the 2018 Medicare Physician Fee Schedule added a service it calls a "virtual check-in." These are brief communication technology-based services that allow a physician or other qualified health care professional to check-in via telephone with established patients. Although it's unclear to NAACOS how often these services are used, NAACOS believes that uptake has been slow because of regulatory barriers. For example, CMS set limits around when the service can be delivered (to established patients not originating from a related evaluation and management [E/M] service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours), to whom (established patient), and consent. CMS should to the furthest extent possible remove regulatory barriers to increase uptake of these services.

Expand risk adjustment

On April 10, CMS announced it would count diagnoses from telehealth services for risk adjustment purposes. However, CMS made clear that services counted must be from interactive audio and video telecommunications. As more telehealth is delivered through audio-only technology and as the pandemic stretches on, it will be important for CMS to count diagnoses obtained from audio-only telehealth services for risk adjustment purposes. For many patients, video-based visits are out of reach. Patients

may not have access to the technology or broadband to conduct video-based visits. For these patients, the choice is not between a video visit and a phone visit — it is the choice between an audio visit and no visit. We urge CMS to count diagnoses obtained from audio-only telehealth services for risk adjustment purposes.

Make 2020 ACO quality measures pay-for-reporting

NAACOS recommends that CMS make 2020 ACO quality measures pay-for-reporting to assess the impact of the COVID-19 PHE on quality measures and benchmarks. This will be critically important as patients have avoided seeking care, and in some cases they have not been able to obtain routine preventive care such as mammograms and colonoscopies. ACOs are committed to improving quality of care and feel it is important to continue to report measures to have a full picture of just how large an impact the pandemic has had on patient quality of care. However, given the unprecedented and unpredictable nature of care patterns changing abruptly as a result of COVID-19, ACOs should not be held accountable for measures and standards, such as benchmarks, that were set in previous years. It will also be imperative moving forward that the agency assess the long-term impact of COVID-19 on quality measurement, including specifications. Thus far, it is impossible to predict how the remainder of 2020 and 2021 will unfold, and, therefore, it will require continuous study to assess the impact on quality.

Long term recommendations

Strengthen the Medicare ACO program

The MSSP saw rapid growth in its initial program years, averaging over 105 new ACOs joining from 2012 through 2018. Unfortunately, in PY 2019 and PY 2020, an average of only 38 new ACOs joined the program, indicating a troubling trend for Medicare's largest APM that has produced greater savings than almost all other care coordination models. Strengthening this premier APM will support the shift to value, which has positive effects on population health and improves the performance and resilience of our healthcare system. It is critical that the balance of rewards and risk are fair and meaningful to attract new ACOs and retain existing ACOs in the program. To reverse the troubling trends of fewer ACOs joining and an increasing number leaving the program, NAACOS urges CMS implement the following changes to the MSSP:

- Announce 2021 April or July MSSP class applications;
- Restore growth of MSSP by returning the share of savings for ACOs to at least 50 percent;
- Increase the time until ACOs have to assume risk to a minimum of four years;
- Fix benchmarks (remove ACO beneficiaries from regional cost calculation, add previous savings back, enhance regional component, etc.);
- Eliminate high-low revenue distinction and apply the low revenue policies across ACOs;
- Update risk adjustment so that positive risk score increases would be subject to a cap of no less than 5 percent and negative risk score adjustments would be between 0 and negative 5 percent; and
- Provide advanced funding to ACOs to help them start or continue on the path to value, which could be done by reinstating the successful ACO Investment Model or a similar program.

Address APM Overlap

As the health care system continues to move away from fee-for-service and toward value-based payment, it is critical that HHS devote a strategic and coordinated effort around APM overlap. Currently, each model devises its own rules for how patient attribution and provider participation in multiple models is permitted. This has resulted in a fragmented and complicated process that also duplicates efforts among participants trying to better coordinate a patient's care. NAACOS urges CMS and the

Innovation Center to devise a coordinated, single policy on overlap that prioritizes patient attribution to the total cost of care model. ACOs and other total cost of care models are accountable for the population of patients they serve and all of their patients' costs — not just those isolated to a single condition or episode. Therefore, we feel it is critical that these models are prioritized at a minimum in patient attribution to ensure any other models are done in conjunction with the goals of population health.

Provide ACOs access to valuable and actionable real-time data needed for care coordination
Providing meaningful, actionable data to healthcare providers will improve population health initiatives, such as ACOs, and is essential for a resilient and high-performing healthcare system. CMS earlier this year finalized hospitals' sharing electronic notifications for admission, discharges, and transfers (ADTs), a condition of participation in Medicare and a move NAACOS supported. But sharing these electronic ADT alerts wouldn't provide the universal notification ACOs need. The alerts would lack information on Medicare beneficiary visits to outpatient clinics and other free-standing facilities like imaging centers and ambulatory surgical centers. Understanding where patients seek care in the health system would allow ACO participants to communicate with other providers to work with beneficiaries to ensure optimal treatment, medication adherence, and follow-up care.

The 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, and 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. In order to succeed in value-based care and APMs, providers need to know where patients are receiving care in real-time, since there's a significant delay in this knowledge through claims. Our request related to opening HETS feeds would serve several administrative priorities, including increasing data access, improving the utility of health IT systems, and advancing APMs.

Conclusion

NAACOS appreciates the opportunity to contribute responses to the RFI on healthcare system resilience, and we hope to work closely with HHS and CMS to implement improvements such as those described above. If you have any questions, please contact Allison Brennan, Senior Vice President of Government Affairs, NAACOS at abrennen@naacos.com.

Sincerely,

Clif Gaus, Sc.D.
President and CEO
NAACOS