August 13, 2018

The Honorable Mike Kelly
Member of Congress

The Honorable Markwayne Mullin
Member of Congress

The Honorable Ron Kind
Member of Congress

The Honorable Ami Bera
Member of Congress

Submitted via InnovationCaucus@mail.house.gov

Re: Health Care Innovation Caucus Request for Information (RFI)

Dear Members of the Health Care Innovation Caucus,

As the largest association of Accountable Care Organizations (ACOs) representing more than 5 million beneficiary lives through more than 330 Medicare Shared Savings Program (MSSP), Next Generation, and commercial ACOs, 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 Medicare delivery, population health and outcomes, and health care cost efficiency.

Value-Based Provider Payment Reform

Question 1: Please describe any value-based payment models that you participate in by payer — Medicare, Medicaid, employer coverage?

- ***Which have been most successful at reducing costs and improving quality and access?***
- ***What changes were made in practice management or care delivery as a result of these value based arrangements?***
- ***What effect did you observe on patient outcomes?***

NAACOS Response: As the health care delivery system changes, ACOs are a main driver in the evolution of how care is delivered and paid for in our country. ACOs are a key part of the overall transition to value-based care and payment. ACOs also have a long, bipartisan history – beginning as a demonstration project under the Bush Administration in 2000, expanding during the Obama Administration through the establishment of the MSSP and the Innovation Center's Next Generation ACO Model, and being further reinforced through passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

While there are a number of factors that may impact each model and whether it has been successful, we are seeing a positive impact from ACOs in a number of areas. For example, according to the Centers

for Medicare and Medicaid Services (CMS), in 2016 ACOs generated $836 million in gross savings and $71.4 million in net savings. Additionally, ACOs subject to pay-for-performance quality measures earned an average quality score of 95 percent and saw a decline in inpatient hospital expenditures and utilization as well as decreased home health, Skilled Nursing Facility and imaging expenditures. Lastly, the Medicare Payment Advisory Commission (MedPAC) June 2018 report also found that ACOs saved Medicare hundreds of millions of dollars and that CMS' benchmarks underestimate the program's true savings.

In August of 2017, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) issued a report entitled, "Medicare Program Shared Savings ACOs Have Shown Potential for Reducing Spending and Improving Quality." In the report, the OIG details key findings related to how ACOs are outperforming their fee-for-service (FFS) peers:

- The report found that ACOs outperformed FFS providers on most quality measures and improved quality over time in the program.
- On average, ACOs outperformed FFS providers on 81 percent (22 of 27) of the individual quality measures studied.
- ACOs performed better than 90 percent of all FFS providers when looking at hospital readmissions.
- ACOs outperformed at least 80 percent of FFS providers on the following measures:
    - Hospital Readmissions
    - Screening for Future Fall Risk
    - Primary Care Physicians Qualifying for EHR Incentive Payment
    - Depression Screenings and Follow-Up Plan
- The report also found that ACOs' quality performance continues to outpace FFS providers' quality performance over time.
- ACOs performed better than fee-for-service providers for 73 percent of measures in 2013, 77 percent of measures in 2014, and 86 percent of measures in 2015.

While Medicare has significantly helped the ACO movement to grow, many ACOs are participating in commercial contracts as well as participating in Medicaid accountable care models. The clinical and operational changes that occur through ACOs are often leveraged across a number of payers, which reinforces the ACO's goals and creates positive changes across payers and the ACO's overall patient population. Practice management changes have focused on improving care coordination, preventing adverse outcomes and avoidable hospitalizations, and increasing patient engagement. ACOs focus on addressing care across siloed FFS settings to ensure patients receive the right care in the right setting at the right time. ACOs also invest considerably in health information technology and sophisticated data analytics to identify patient populations in need of increased care coordination and interventions.

Question 2: What barriers in each of the following areas limit the full potential of innovation in Medicare and Medicaid?

- ***Payment and reimbursement***
- ***Policy and regulation***
- ***Data and reporting***

NAACOS Response: NAACOS has made a number of recommended policy changes to improve the ACO program. A comprehensive list is detailed in the regulatory relief section of our comments in response to the proposed 2018 Medicare Physician Fee Schedule, available here. Some of our top policy priorities include urging action to help MSSP ACOs overcome regulatory and reimbursement barriers:

- The MSSP must address flaws in the benchmarks that determine ACO performance, such as those related to allowing risk adjustment scores to increase and correcting flaws with regional benchmarking;
- Issues related to the overlap of competing CMS programs should be remedied in a way that prioritizes population-based payment models such as ACOs;
- ACOs that meet certain criteria related to reducing cost and improving quality should be able to remain in Track 1 for a third three-year agreement period;
- MSSP quality measures and reporting burdens should be minimized so that ACOs are not responsible for reporting over 30 measures. Rather, ACO should be able to focus on fewer, more meaningful measures, especially those related to outcomes;
- ACOs should be permitted to engage with beneficiaries in more meaningful ways and provide incentives for beneficiaries to receive the most effective, highest quality care;
- The MSSP should account for the significant investments ACOs make by including the value of such investments in calculations of ACO risk;
- The MSSP should address shortcomings of two-sided ACO models which require levels of financial risk that are untenable for many ACOs; and
- The MSSP should include all ACOs in as Advanced Alternative Payment Models (APMs) under MACRA.

Additionally, barriers to data must be removed to allow access real-time care coordination information. It is widely recognized that giving timely, actionable data to healthcare providers allows them to work closely with beneficiaries to effectively manage chronic conditions or prevent health conditions from worsening. However, to effectively manage a beneficiary's health, ACOs need more timely and in-depth data.

The Centers for Medicare & Medicaid Services (CMS) provides some data but it is delayed by weeks or months and is therefore not always actionable. The data available in the HIPAA Eligibility Transaction System (HETS) is very meaningful and should be provided in real time to ACOs for their beneficiaries. This would allow ACO providers to communicate with treating providers at the hospital and to work with the beneficiary upon his or her release to ensure optimal treatment, medication adherence and follow up care. We therefore request that Congress work with CMS to develop a mechanism to share more robust health data, including that from HETS, with ACOs in real time to enhance care coordination, improve outcomes and reduce costs.

Question 3: How can we develop better outcomes measures that accurately reflect quality, safety, and value without burdening innovation?

NAACOS Response: We agree with MedPAC that CMS should move toward publicly reporting on a small set of population-based outcome measures concerning preventable hospital admissions and emergency department visits and condition-specific mortality for ACOs. Valid and reliable outcome measures are direct indicators of healthcare quality that should be emphasized, especially in population-based payment models which have the large beneficiary populations necessary to properly evaluate outcomes. However, it is essential that existing methodological issues, such as those related to risk adjustment and attribution, be addressed prior to CMS assigning more weight to outcome measures. Finally, CMS must look to reduce reporting burdens to the greatest extent possible. Allowing ACOs to focus on a smaller set of outcome measures with minimal reporting burdens allows for further time, effort and resources to be focused on patient care. For further information on NAACOS' views on quality measurement, see our website.

Question 5: How have population health, capitation, and direct provider contracting improved patients' health?

NAACOS Response: Population health is a core component of the ACO model and utilizing a population health approach enables patients to receive more coordinated, whole-person care. There are numerous examples of how population health models benefit patients and the Medicare program. For example, results specific to the MSSP, which are also noted above, include that:

- ACOs performed better than 90 percent of all FFS providers when looking at hospital readmissions.
- ACOs outperformed at least 80 percent of FFS providers on the following measures:
    - Hospital Readmissions
    - Screening for Future Fall Risk
    - Primary Care Physicians Qualifying for EHR Incentive Payment
    - Depression Screenings and Follow-Up Plan

Capitation models are a good fit for some providers and offer much more latitude in terms of avoiding complex billing rules and processes in place for FFS providers. For providers that are able to assume the risk levels required of a capitated model, this presents a strong opportunity to fully embrace accountability for cost and quality of care for the patients they serve.

NAACOS generally supports the implementation of Direct Provider Contracting (DPC) Models. We believe that the initial opportunity sponsored by CMS should be focused exclusively on primary care, work in concert with and not exclude ACOs, be voluntary, and should initially be tested on a small scale prior to full implementation. We recently submitted comments to CMS on this issue and discussed in further detail.

Question 6: Are there examples cross payer collaborations — such as employer-Medicare or employer-Medicaid — that have achieved promising results?

NAACOS Response: Cross-payer collaborations that have demonstrated success have usually been related to state-wide policy adopted to enhance delivery system reform. For example, Massachusetts enacted legislation to encourage and certify ACOs for all payers in 2012, overseen by their Health Policy Commission; uniform quality measures and a variety of other improvements are the responsibility of that Commission. Similarly, Vermont has begun state-wide delivery and financing reform involving commercial, Medicaid and Medicare payers that has reported Medicaid savings of $17 million in the first two years of their ACO-based program as well as measurably enhanced quality. The CMS-established demonstrations of services to dually eligible Medicare-Medicaid beneficiaries in 13 states are beginning to report a variety of positive outcomes. In some places, commercial plans and Medicaid programs have cooperated in developing complimentary or identical quality standards. Health IT initiatives in many places around the country rely on collaboration between employer-sponsored insurers, government, providers, and a variety of business and commercial enterprises. This broad buy-in and participation often yields more meaningful results. For example, some states have robust Health Information Exchanges (HIEs) which benefit providers, patients and payers by ensuring proper flow of information which enhances the ability of providers to deliver appropriate care while reducing redundant procedures or services.

Question 8: How can Congress help the Centers for Medicare and Medicaid Innovation (CMMI) Center achieve its purpose of developing and testing innovative payment and delivery models?

NAACOS Response: The Innovation Center has played a significant role in testing various innovative strategies ACOs can deploy to further their mission of reducing health care costs, improving quality, and focusing on population health and outcomes. The Next Generation and Track 1+ ACO Models were established by the Innovation Center and have been instrumental in allowing ACOs to take on risk while allowing the freedom to test new strategies to effectively and efficiently manage care, such as waivers of payment rules like the Skilled Nursing Facility (SNF) Three-day Stay Rule and more flexibility and therefore greater access to telehealth services for the patients ACOs serve.

However, we believe that CMMI can take a number of steps to improve the ACO programs, and welcome Congress' support in this effort. NAACOS urges the Innovation Center to look to ACOs as a national laboratory to test innovative care models and novel strategies within the ACO model. Most importantly, we have urged CMMI to address program overlap issues to ensure that the programs designed and administered by the Center have strategic alignment and do not result in beneficiary attribution problems or other administrative issues. In addition, we have urged CMMI lift barriers to ACO model adoption by:

- Allowing for expanded use of payment rule waivers across ACO models by permitting waivers related to the SNF Three--Day Stay Rule, telehealth, home health and primary care co-payments to all ACOs;
- Allowing ACOs to establish post-acute care networks;
- Providing ACOs with upfront funding for social services as well as transportation services;
- Supporting the integration of mental health and primary care services with increased funding for behavioral health treatment and services; and
- Making changes to the Stark law to provide increased Stark Law protection for ACOs, especially as it pertains to addressing the uncertainty about acceptable arrangements with parties outside of the ACO and for patients beyond traditional Medicare.

More details on CMMI and NAACOS' specific recommendations are available here.

Question 9: What is the ultimate destination for the movement to value in the Medicare program? What should the landscape look like in 2025 and what role does the government play in achieving it?

NAACOS Response: ACOs are a main driver in the evolution of how care is delivered and paid for across the country. Going forward they will continue to play a key part of the overall evolution to value-based care and payment. ACOs are doing a lot of work to change how care is delivered and are focused on new approaches to care coordination, managing patients across different providers and improving quality and outcomes. ACOs are also focused on and evaluated on how they control costs for their patient population.

The ultimate destination for ACOs in Medicare should be to have a robust Medicare ACO program that provides high quality, efficient care to millions of Medicare beneficiaries while providing a payment model that engages providers and keeps them focused on achieving value and enhancing quality. While retaining a healthy one-sided model, Medicare should focus on advancing innovative two-sided ACO models. The government should also collaborate with payers outside of Medicare to support consistent use of definitions and methodologies across value-based care. Similar to the efforts to align quality measures across payers, there will be a need to identify best practices for methodologies and

definitions key to value-based care. This will enable providers to participate more seamlessly in ACO arrangements across payers and patients.

Value-Based Arrangements

Question 10: Please describe any value-based arrangements that you participate in by payer — Medicare, Medicaid, employer coverage?

- ***Which have been most successful at reducing costs?***
- ***What changes were made in practice management or care delivery as a result of these value based arrangements?***
- ***What effect did you observe on patient outcomes?***

NAACOS Response: ACOs have been successful with many clinical, operational and payment transformations as part of their overall shift to accountable care. The ACO concept is built on increasing efficiency and bridging silos across what has traditionally been a fragmented and redundant healthcare system. Efforts to bridge these gaps in care and communication result in patients receiving the right care in the right setting, reducing redundant testing and ultimately resulting in improved patient outcomes. Focusing on care transitions and post-acute care are two key areas for many ACOs, which result in reduced hospital readmissions and proper care management to prevent adverse health outcomes.

In terms of ACO success with reducing costs, this is critically important and deserves more attention and sophisticated evaluation. There is growing evidence that ACOs are saving more money than is reflected by data focused on ACO performance relative to CMS benchmarks. For example, in the June 2018 MedPAC chapter on ACOs, the Commission discusses these results and acknowledges the pitfalls with only looking at ACO performance relative to CMS benchmarks. The address how benchmarks are not the best measure of what spending would have been in the absence of the ACO and thus may not be a good measure of true program savings. MedPAC further acknowledges that ACOs may have saved Medicare from 1 to 2 percent more than indicated by their performance relative to benchmarks. MedPAC notes that MSSP ACOs generally perform well on quality metrics and that the MSSP ACOs on average had strong patient experience results and high-performing readmission results from 2012 to 2016. They also note that Next Generation ACOs have performed well on quality and on cost, based on the results from the first year of that program.

MedPAC discusses how evaluations based on benchmarks differ from evaluations focused on what would have happened without the ACO, which is a point that NAACOS has repeatedly emphasized. Benchmarks are designed to fulfill policy goals, such as to encourage clinicians to participate in ACOs or to increase equity across the country. Therefore, MedPAC notes that "savings" relative to benchmarks will not be the best estimate of true program savings relative to what would have occurred in the absence of the ACO. The Commission reviews a number of insightful evaluations on ACO performance, emphasizing how most studies in literature compare changes in ACO spending with changes in spending for a control group.

For example, the Commission cites research by academics at Harvard, including Michael McWilliams, showing net MSSP savings in 2014 of $287 million or 0.7 percent of spending for ACO beneficiaries and other positive results for Pioneer ACOs. They also cite a study from L&M Policy Research showing $280 million, or 3.7 percent of spending, in savings for the first year of the Pioneer ACO Program. Another analysis by Colla et al in 2016 examined combined performance of MSSP and Pioneer ACOs in 2012 and 2013 and showed net savings of $592 million, or 1.1 percent of the benchmark in 2013. Finally,

MedPAC cites CMS's Office of the Actuary (OACT) evaluation of potentially expanding the Pioneer ACO Model that showed doing so would reduce spending.

Overall MedPAC concludes that given the CMS benchmarking analysis, studies in the literature and work by OACT, it appears the ACO programs have generated positive savings estimated to be up to 2 percent, and that ACOs also have a positive effect on quality. MedPAC notes, "While these savings may appear modest, they are more than most care coordination demonstrations have achieved, including the most recent Comprehensive Primary Care Initiative." In addition to direct savings, the literature shows indirect savings of two kinds: spillover and reduced Medicare Advantage (MA) benchmarks. The spillover effects benefit patients that receive improved care but are not assigned to the ACO. In terms of the reduced MA benchmarks, this is a result of a county's fee for service (FFS) spending being reduced, which ultimately lowers MA benchmarks. The literature shows that a driver of ACO savings comes from decreasing post-acute care utilization.

It's also important to look outside of the federal health care programs to identify value-based care models that are working in commercial markets. Commercial ACO arrangements include significant variation and innovation and are demonstrating positive results, all of which provide valuable lessons. For example, according to United Healthcare's February 2018 Value-Based Care Report, United notes that their employer-sponsored and individual network ACOs are better on 87 percent of the top quality measures than non-ACOs, and these ACOs have 17 percent fewer hospital admissions than non-ACOs. This is one commercial payer example, and hopefully as the Caucus engages with other commercial payers they will share similarly impressive results. There are also a growing number of examples of employers that are contracting directly with ACOs to provide care and maintain costs for their employee patient population. For example Boeing is doing this in four markets.

Question 12: What role should Medicare play in creating value-based arrangements and encouraging manufacturers, payers and providers to take on risk?

NAACOS Response: Given that MACRA intended to encourage clinicians' progression along the value-based care continuum, it is critical that Congress ensure CMS is allowing for appropriate glide paths to risk-based payment models. The unintended consequences of forcing risk before clinicians or organizations are ready to assume such risk will significantly undermine the MSSP program in particular and result in diverting valuable investments in care coordination away from Medicare patients and towards other patients under value-based contracts. Further, the disproportionate emphasis on reducing costs often overshadows the equally important goal of quality improvement that the ACO model offers, which benefits patients and the Medicare program generally. While some Track 1 ACOs have not yet been able to experience a return on the investments they have made, they have generated savings to the government while improving patient care, which studies show has a positive downstream impact on spending but may take years to fully materialize.

While Track 1 is a one-sided (shared savings only) risk model, it is important to note the significant investments ACOs make in start-up and ongoing costs, such as those related to clinical and care management, health IT, population analytics and tracking, and ACO management and administration. NAACOS 2016 survey data show that ACOs invest, on average, $1.6 million annually to operate their ACO. These investments put ACOs at jeopardy of financial losses that have a considerable impact on their organizations, providers and beneficiaries. Congress recognized the principle from the ACO authorizing statute that one of the purposes of creating ACOs is to "encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery." That investment—the cost of switching to a fundamentally different approach to patient care—constitutes

in and of itself a substantial financial risk. ACOs consider and account for their investment costs as risk inherent in MSSP participation and these investments help to fund critical ACO activities designed to achieve the goals of improving beneficiary care and enhancing care coordination to reduce unnecessary spending and hospitalizations.

The MSSP has gained considerable momentum in recent years, and it would be devastating to see a mass exodus of 2012/2013 ACOs in the 2019 performance year if regulations are not changed to allow continued participation in Track 1. The ACO program is voluntary, so forcing ACOs into risk before they have the organizational buy-in to do so will result in ACOs quitting the program and diverting care coordination to patients outside Medicare. This conclusion is supported by a 2018 NAACOS survey, in which 70 percent of the responding Track 1 ACOs reported they are likely to leave the program as a result of being forced into risk. This would be a significant setback for Medicare payment reform efforts and would undermine implementation of the overwhelmingly bipartisan MACRA, which is designed to move providers into alternative payment models such as ACOs. Forcing unprepared ACOS into risk is not in the best interest of beneficiaries, Medicare or ACOs.

Therefore, we strongly urge Congress to instruct CMS to modify regulations to allow ACOs that meet certain criteria related to generating savings or demonstrating quality achievements to continue participating in Track 1 for a third agreement period. Swift action is needed by the agency on this issue, and we urge Congress to work with CMS to revise this flawed policy.

Technology and Health IT

Questions 13 & 14: What impact does health IT and data interoperability have on successfully running value-based payment models and contracting? What are some ways to improve interoperability and the sharing of data? What technology is needed to integrate physician networks to be able to effectively manage a population's health?

NAACOS Response: While both adoption of Electronic Health Records (EHRs) and electronic exchange of information have grown substantially among hospitals, significant obstacles to exchanging electronic health information across the continuum of care persist and, in some cases, routine electronic transfer of information post-discharge has not been achieved by providers and suppliers in many localities and regions throughout the nation.

The ACO model is only successful if providers are able to share patient health information in ways that can allow practitioners to better coordinate the care provided to its patients. Today there remain obstacles to obtaining this critical information. For value-based care models like ACOs, the ability to succeed to their fullest potential is not possible without providing clinicians with the information they need to provide effective transitions of care between hospitals and community providers.

ACOs aim to provide coordinated care to ensure that patients get the right care at the right time and avoid unnecessary duplication of services. In order to provide highly coordinated care, ACOs need critical information about a patient's admission to and discharge from a hospital. NAACOS recommends that Emergency Department (ED) visit and admission information, as well as transfer and discharge information is shared at a minimum as a requirement of CMS health and safety standards for providers and suppliers participating in the Medicare and Medicaid programs (the Conditions of Participation (CoPs), Conditions for Coverage (CfCs), and Requirements for Participation in Medicare.

Specifically, we recommend the following:

1. CMS should adopt the following standards requiring hospitals to release ADT data:
    - **Presentation in Emergency Room/Admissions:** The hospital must send real-time electronic notification that a patient has presented in the emergency room and/or been admitted to practitioner(s) responsible for the admitted patient's care.
    - **Discharge to Home:** The hospital must send real-time electronic notification of discharge to practitioner(s) responsible for the discharged patient's care. The hospital must also electronically send a copy of the discharge instructions and the discharge summary within 48 hours of the patient's discharge.
    - **Transfer of Patients to Another Health Care Facility**: The hospital must send necessary medical information to the receiving facility at the time of transfer and must send a real- time electronic notification of the transfer to the practitioner(s) responsible for the transferred patient's care.
2. CMS should allow hospitals to meet these conditions over time (for example, by phasing in notification for greater numbers of patients over time) using existing health information exchange networks, private sector partners, or direct connections to community practitioners.
3. CMS should require hospitals to make certain information electronically available to patients within 24 hours, such as discharge instructions and a summary of care, including through a designated third-party tool of their choice if desired.

More details on NACCO's specific recommendations Promoting Interoperability and Electronic Health Care Information Exchange are available here.

Question 15: What new technology exists to lower costs, improve efficiency, or improve the quality of care that isn't already widely-deployed?

Technology to adequately share care coordination data exists in the healthcare industry, but the wide variability and lack of sophistication from certain payers inhibits its full potential. As providers are increasingly accountable for patient outcomes, quality and costs, payers – both private and public – need to ensure they are keeping pace with the payment and clinical innovation by providing sophisticated, timely data to providers. It is widely recognized that giving timely, actionable data to healthcare providers allows them to work closely with beneficiaries to effectively manage chronic conditions or prevent health conditions from worsening. Many ACOs are successful because of their focus on care coordination for chronic conditions, emphasis on providing the right care in the right setting and preventing avoidable and costly complications or hospital readmissions.

However, to effectively manage a beneficiary's health, ACOs need more timely and in-depth data. While they may get the necessary data from some payers, others are lacking, including Medicare. CMS provides some data, but it is delayed by weeks or months and is therefore not always actionable. The data available in the HIPAA (Health Insurance Portability and Accountability Act) Eligibility Transaction System (HETS) is very meaningful and should be provided in real time to ACOs for their beneficiaries. This would allow ACO providers to communicate with treating providers at the hospital and to work with the beneficiary upon his or her release to ensure optimal treatment, medication adherence and follow up care. We urge CMS to develop a mechanism to share more robust health data, including that from HETS, with ACOs in real time to enhance care coordination, improve outcomes and reduce costs.

Conclusion

NAACOS looks forwarding to building successful and collaborative partnership with the Caucus. We would welcome the opportunity to participate in staff and member level meetings and helping the Caucus in its work. Should you have any questions about this letter or the ACO programs, please contact Allison Brennan at abrennan@naacos.com.

Sincerely,

Clif Gaus
President & CEO