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RE: Opportunities to Advance Value-Based Care in Rural and Underserved Communities

Dear Deputy Administrator Fowler and Deputy Administrator Seshamani:

The National Association of ACOs (NAACOS) appreciates your leadership to strengthen the Medicare program and accelerate its transition to value-based care. We appreciate the opportunity to share our insights into advancing ACOs and total cost of care arrangements in rural and underserved communities. NAACOS represents more than 430 accountable care organizations (ACOs) in Medicare, Medicaid, and commercial insurance working on behalf of health systems and physician provider organizations across the nation to improve quality of care for patients and reduce health care cost. NAACOS members serve over 9 million beneficiaries in Medicare value-based payment models, including the Medicare Shared Savings Program (MSSP) and the ACO Realizing Equity, Access, and Community Health (REACH) Model, among other alternative payment models (APMs).

A major pathway for improving access to health care in rural and underserved communities is through advancing APMs. Specifically, safety-net providers in APMs are better suited to meet some of the unique challenges in their communities. For example:

- APMs allow providers to build care teams that include nurses, care managers and social workers, increasing access and support for patients. With ongoing health care shortages, clinicians need to increasingly rely on broader care teams to maintain access.
- APMs incent coordinating care across the continuum. Through this coordination providers can better align sites of service by ensuring that patients receive the right care in the setting that is best suited for their social and clinical needs. Moreover, APMs focus on coordination across the continuum rather than consolidation.
- APMs allow clinicians to provide services that are not otherwise billable under fee-for-service (FFS) such as wellness programs, providing transportation, meal support, and cost sharing reductions. Giving providers innovative tools to allows them to tailor care delivery redesign to their populations and improve patient outcomes.

The ACO model is the largest and most successful APM in Medicare with more than 13 million Medicare beneficiaries receiving care through ACOs. In the last decade, we have also seen significant adoption

among safety-net providers, with more than 4,400 Federally Qualified Health Centers (FQHCs), 2,200 Rural Health Clinics (RHCs), and 460 Critical Access Hospitals (CAHs) participating in MSSP or ACO REACH. Safety-net providers are a vital part of APMs and have considerable participation in models today. Roughly a quarter of MSSP ACOs included an FQHC in 2022. They've undoubtedly contributed to the quality improvements and more than $22 billion in savings ACOs have generated to date.

Despite the significant success safety-net providers have achieved in APMs, barriers to participation remain. Given the communities they serve and their unique payment structure within Medicare, success is fundamentally different from other providers participating in APMs. **The Centers for Medicare and Medicaid Services (CMS) has opportunities to reduce barriers for safety-net providers to succeed in APMs.** NAACOS convened a workgroup of its ACO members participating in rural regions and including FQHCs, RHCs, and CAHs as participating providers.

Fundamentally, **we need a new paradigm where safety-net-minded APMs focus on increasing or maintaining access rather than purely reducing costs.** While cost is an important component of any APM, we should consider alternatives for maintaining costs or reducing growth in spending. For example, judging ACO performance based on savings achieved compared to their historical spending may not be appropriate for rural populations or lower cost settings. **Accordingly, we recommend CMS modify existing APMs to better account for safety-net populations (e.g., a set of waivers specific to safety net providers in APMs) or develop new ACO tracks/total cost of care models focused on rural and underserved populations**. For example, we need waivers from the current encounter-based or cost-based reimbursement system. Similarly, an MSSP track just for safety-net providers would be helpful as current MSSP rules inherently sets these ACOs at a disadvantage. Below, we describe the common challenges and solutions for engaging safety-net providers in APMs.

Set Fair and Appropriate Financial Benchmarks

Safety-net providers are challenged by financial benchmarks because their populations have historically lacked access to care or these providers operate under a cost-based reimbursement system that reduces their ability to generate savings. Additional challenges include:

- The cost-based reimbursement payment structure for CAHs creates a paradigm that makes it inherently difficult to participate in shared savings models because CAHs can't be rewarded for lowering utilization. Additionally, roughly 90 percent of CAHs' costs are fixed, so opportunities for spending reductions are limited to start with.
- For rural providers, they are often the dominate provider in their market, so when they lower costs, they subsequently lower the spending in their region and are hurt by ACOs' regional adjustments in benchmarking. This is called the "rural glitch."
- Because of the prospective payment structure, risk coding has not been taught by many rural providers because it's unnecessary. This presents a couple of problems in ACO models.
    - Staff either aren't familiar with or don't spend time on appropriately coding patients.
    - Patients tend to be much sicker than their historic risk scores indicate and therefore hit caps on ACOs' risk scores faster.
- Rural providers are hit harder by risk adjustment polices, including the coding intensity factor in place in the ACO REACH Model.

Solutions

NAACOS and our ACOs with safety-net providers recommend the following ways to mitigate these barriers.

- Consider a global budget or prospective population-based payment for safety-net providers, which provides needed stable and predictable payment.
- Lower discounts or minimum savings rate for rural providers in risk-bearing models.
- Remove the high-low revenue designation in the MSSP that penalizes certain ACOs, especially safety-net providers. The high-low revenue designation is arbitrary and leaves out the very ACOs CMS is trying to attract to the program.
    - In 2020, 71 percent of low-revenue ACOs did not include an FQHC, RHC, or CAH. Conversely, 46 percent of high-revenue ACOs included 5 or more FQHCs, RHCs, or CAHs.
- Account for costs that are specific to rural communities (e.g., air ambulance) within the payment model to avoid penalizing providers for lack of access to certain settings of care.
- Establish guardrails to ensure that the process to set financial benchmarks is transparent and appropriately accounts for regional variations in spending to prevent winners and losers.
- Adapt risk adjustment policies to not disadvantage sicker populations, including providing for considerations for the lack of historical coding by increasing risk caps for rural populations or beneficiaries without historical access to care.
- Account for social risk leveraging existing tools such as regionally adjusted Area Deprivation Index, dual-eligible, and disabled status.

Address Unique Payment Challenges for Safety-Net Providers

Safety-net providers are paid differently than their counterparts across Medicare. Since 2014, FQHCs have been paid based on a prospective payment system, where Medicare sets a national rate for services, which is adjusted based on where the services are delivered. RHCs have a similar all-inclusive rate. CAHs are reimbursed for the cost to deliver services. All three face challenges in operating in population-based models because their reimbursement structure makes it difficult to either provide the appropriate care management services, lower the cost of care for their patients, or both. Additional examples include:

- CAHs employ “swing beds” where the same hospital bed can be used for either acute care or skilled nursing care. This hurts ACOs because swing beds can cost more than a skilled nursing facility or inpatient rehabilitation facility stay where urban counterparts could send patients, placing rural ACOs at a disadvantage.
- FQHCs and RHCs may only bill for one service per day, limiting the care management of patients with multiple chronic conditions and undermining the efficacy of care that ACO models incentivize. This is also burdensome for patients, who sometimes must drive hours to and from a clinic on multiple days for services that could have been delivered in one day.
- Additionally, FQHCs are prohibited from providing annual wellness visits and chronic care management on the same day. This is not patient friendly or conducive to proper care management, especially for patients with multiple chronic conditions, and forces providers to select which services to provide.
- RHCs’ all-inclusive rate requires a “face-to-face” visit with a physician, which is burdensome in provider-starved areas and sometimes unnecessary for patient visits.

Solutions

Shared savings’ approaches in Medicare APMs do not account for these underlying payment systems. To address these issues, CMS should:

- Allow care management services to be billed more than once a month, which is allowed for non-safety-net providers. The primary care management code for safety-net providers, G0511, will

represent 22 services, including remote patient monitoring, chronic care management, and others. CMS should:
    - Allow safety-net providers to bill for G0511 more than once a month to encourage care management, which is critical for success in APMs.
    - Create additional codes and modifiers to differentiate the care management services bundled under G0511.
    - Develop a new or updated coding methodology to allow safety-net providers to better track care management services, which is impossible today with 22 services bundled under G0511.
- Waive the current one-visit, one-service requirement for FQHCs and RHCs. This would allow clinicians to offer multiple care management services to patients in a single visit, eliminating the need for patients to make multiple visits, which can be difficult and time consuming.
- Remove face-to-face billing requirements for certain services like annual wellness visits. This would allow clinicians with an established patient relationship to provide virtual care as needed.
- Incentivize specialized chronic care support in the form of new codes, flexibilities, and higher reimbursement for those care management services. Alternatively, these codes could be carved out of safety-net providers' respective reimbursement systems but included in the ACO expenditures.
- Enhance reimbursement for specialty services in rural areas to ensure APMs in those communities have adequate resources to deliver those services and support patient access to hard-to-find specialty care.

These coding exceptions could be limited to safety-net providers in APMs to encourage greater participation in these payment models.

Define New Approaches for Aligning Patients to Total Cost of Care APMs

In ACOs, patients are assigned to ACOs primarily based on where they receive their primary care. MSSP also requires at least one physician visit during the year to qualify for attribution to that ACO. But ACOs' rules are fundamentally challenging for safety-net providers given the unique operational structure and reimbursement mechanisms under Medicare. For example:

- FQHC billing is done at the facility level, which means patients may come for a visit with a dentist and end up being attributed to the ACO, leading to the ACO struggling to manage their care because patients don't have relationships with medical care teams. Additionally, it's hard to know how patients became attributed to ACOs with FQHCs without custom reports.
- Some ACOs with high numbers of safety-net providers report having their assigned patient populations turn over by 30 percent each year. This turnover makes chronic care management difficult. This churn is because patients don't necessarily come to safety-net providers for chronic care management. They come out of necessity and convenience.
- Safety-net providers, including FQHCs and RHCs, employ a disproportionate number of advanced care providers, and seeing those provider types does not satisfy MSSP's one-physician visit rule for attribution. Safety-net providers struggle with physician shortages, making gaining attributed patients sometimes difficult because of MSSP's physician-visit requirement.

Solutions

CMS should consider the following attribution approaches to aide safety-net providers in ACOs:

- Develop unique attribution steps for safety-net providers in ACOs, including FQHCs and RHCs, for example, by creating workarounds for the statutorily required physician-visit.

- Adopt multi-year alignment approaches as we see in some ACO models in the CMS Innovation Center.
- Provide better data on attribution to participants.

Provide More Technical Support and Flexibility to Innovate Care

Current and past APMs have allowed physicians and other clinicians to change care delivery and improve care coordination. It is essential to offer additional flexibilities and tools to safety-net providers so that they innovate care for their patients and lower barriers to participation. CMS should consider the following recommendations for safety-net providers to continue driving innovation:

- Pilot test quality reporting approaches for ACOs and other APMs to address current implementation challenges with digital quality measurement that could impact access and the delivery of care to rural and underserved populations.
- Offer waivers that address the needs of safety-net providers. For example:
    - Make it easier to provide the Hospital at Home program to expand access to acute care at a lower cost. Current Hospital at Home requirements are extensive and provide a significant obstacle for safety-net providers with limited resources.
    - Improve telehealth access comparable to the COVID-19 public health emergency flexibilities. When providers are responsible for total cost of care and quality concerns of overuse or stinting on in-person care are mitigated.
- Better incentivize the use of telehealth or remove barriers to its use, for example, by counting telehealth visits as a service for ACO REACH's timely follow-up measure. Too often telehealth's use by safety-net providers is an afterthought when creating new codes or drafting telehealth policy.
- Consider exemption to new minimum staffing requirements for providers that operate within an APM. This would encourage APM participation and reduce regulatory burden for providers in APMs.
- Provide more technical support to realize the impact of total cost of care policies on rural providers.

Conclusion

Thank you for the opportunity to provide input on this important issue. NAACOS and its members are committed to providing the highest quality care for patients while advancing population health goals for the communities they serve. We look forward to our continued engagement on reducing barriers to APM participation for safety-net providers. If you have any questions, please contact Aisha Pittman, senior vice president, government affairs at aisha_pittman@naacos.com.

Sincerely,

Clif Gaus, Sc.D.
President and CEO
NAACOS