August 9, 2024

Physician-Focused Payment Model Technical Advisory Committee (PTAC)
Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
Submitted electronically to: PTAC@HHS.gov

RE: Addressing the Needs of Patients with Complex Chronic Conditions or Serious Illnesses in Population-Based Total Cost of Care (PB-TCOC) Models Request for Input (RFI)

Dear Members of the Physician-Focused Payment Model Technical Advisory Committee:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to the request for input on addressing the needs of patients with complex chronic conditions or serious illnesses in population-based total cost of care models. NAACOS is a member-led and member-owned nonprofit of more than 470 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 represents over 9.1 million beneficiary lives through Medicare's population health-focused payment and delivery 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). Patients with complex conditions or serious illness require special considerations in the context of value-based care models and NAACOS appreciates the PTAC's focus on this important topic. Our comments below reflect the concerns of our members and our shared goals to support clinicians in delivering high-quality, efficient, person-centered care to these patient populations.

CONSIDERATIONS FOR COMPLEX OR SERIOUSLY ILL POPULATIONS IN APM DESIGN

Patients with complex chronic conditions or serious illnesses have some of the highest health care costs and some of the greatest opportunities to benefit from the care coordination and wraparound services that value-based care can provide. However, program policies are often not designed with these populations in mind, making it difficult for them to be attributed to and benefit from these models. Similarly, this makes it challenging for health care provider organizations that predominantly serve complex and high needs patients to participate and succeed in value models. For example, program elements of the MSSP have been designed based on the traditional Medicare population writ large. When organizations serving a high proportion of patients with complex chronic conditions or serious illnesses participate, challenges with financial benchmarks, attribution methodologies, and performance measurement arise.

Complex and seriously ill populations are significantly different than the average traditional Medicare population. Attempting to fit these high needs populations into APMs designed for standard populations will always fall short of accounting for their unique needs and circumstances. Due to this, these

beneficiaries have historically had limited participation in APMs. In recent proposed Medicare Physician Fee Schedules, CMS acknowledged that "higher spending populations are increasingly underrepresented in the program and access to ACOs appears inequitable as evidenced by data indicating underserved populations are less likely to be assigned to a Shared Savings Program," and that proposed policies were intended "to encourage growth of ACOs in underserved communities based, in part, on recent observations where the highest earning ACOs had a higher proportion of beneficiaries who were members of racial and ethnic minority communities and included a greater proportion of end-stage renal disease (ESRD), disabled, and aged/dual eligible beneficiaries than the lowest earning ACOs." We suggest that the MSSP changes made to date do not go far enough to gain rapid rates of adoption for providers serving these complex populations. Lessons from organizations serving complex or seriously ill populations in the High Needs Track of ACO REACH and in the MSSP can help inform future model design appropriately tailored to these populations. Future APM design should enable and incentivize participation of organizations providing care to these populations by appropriately accounting for these considerations.

NAACOS recommends the following considerations in model development:

- **Design alternative program policies to account for high-cost, high needs beneficiaries who are significantly different from the average traditional Medicare beneficiary.**
- **Ensure participation criteria do not exclude high needs beneficiaries from benefitting from value-based care models.**
- **Account for the care settings and care delivery models through which these populations are often receiving care in attribution models.**
- **Design financial methodologies specifically for these populations to ensure sustainability and predictability for the participating organizations that serve them.**

Identifying high cost, high needs populations

In the ACO REACH Model, beneficiaries can only be attributed to High Needs Population ACOs if they meet all attribution eligibility criteria and meet additional beneficiary-level eligibility criteria related specific conditions or risk scores (e.g., having a risk score of 3.0 or greater). These criteria can be limiting and prevent beneficiaries served by High Needs ACOs from being attributed to the model. For example, one High Needs ACO found that only 35 to40 percent of their traditional Medicare population met the High Needs eligibility criteria, despite 100 percent of their patients being homebound. Part of the challenge is the timeliness of data CMS uses to determine eligibility. If a beneficiary's health status declines quickly, this would not be reflected in risk scores until significantly later. Given these populations are often in their last years of life and have a higher mortality rate than the average Medicare beneficiary, high needs beneficiaries may not appear to meet these criteria before the end of life. The beneficiary-level eligibility criteria could be improved by incorporating factors that provide more timely information about a beneficiary's status, such as if the patient is homebound or a permanent nursing home resident.

One solution would be to define an APM entity as high needs if most of its patients are high needs. Beneficiary-level criteria could be used to define high needs beneficiaries, and if the APM entity exceeds a certain threshold of high needs beneficiaries it would qualify as high needs and all of its beneficiaries would be subject to the high needs program policies. This method would help identify patients before coding and risk scores have caught up and recognize the differences of organizations that exclusively focus on complex and seriously ill populations. Additionally, current approaches do not account for high needs beneficiaries receiving care from organizations that don't exclusively focus on those populations. High needs beneficiaries served by all ACOs are subject to program policies that do not account for the

specific characteristics of these beneficiaries. Alternative policies for high needs beneficiaries tested through the ACO REACH Model should apply for any ACOs, with policies tailored to those subsets of the ACO's population. Using both a threshold approach for organizations dedicated to caring for high needs beneficiaries and a beneficiary-level approach to support all ACOs in caring for high needs beneficiaries ensures that all high needs beneficiaries can be included in and benefit from these models, regardless of their specific needs or where they choose to receive care.

Accounting for care patterns in attribution methods

Standard claims-based attribution models don't work well for these populations and frequently lead to misalignment to community providers that a beneficiary was previously receiving care from. For example, a beneficiary who was prospectively aligned to a community-based primary care provider and experienced health changes that led them to begin receiving care in a long-term care (LTC) facility, the beneficiary would not be aligned to the providers managing their overall care until at least the next performance year. More timely approaches are needed to attribute high needs patients to the providers managing their care. ACO REACH is testing a more flexible and timely voluntary alignment option, but there are challenges when using it with complex or seriously ill populations. Importantly, providers cannot discuss voluntary alignment with homebound patients, including those residing in assisted living facilities or LTC facilities, which constitute a large portion of high needs beneficiaries. The policy to prohibit discussing voluntary alignment in a patient's home was designed as a protection for average Medicare beneficiaries but has the unintended consequence of excluding complex and seriously ill patients from a model designed to support them. At a minimum, MSSP ACOs serving beneficiaries with complex needs should be allowed to use a paper-based voluntary alignment form to document their primary care clinician selection given that many of these beneficiaries are unable to access Medicare.gov.

Attribution models must also account for the care delivery models employed by organizations serving complex and seriously ill patients, which heavily emphasize a team-based approach. While attribution at the National Provider Identifier (NPI)-level is preferred in most instances, high needs beneficiaries are more often aligning to a particular care type or setting (e.g., nursing home or homebound care providers) where they receive an array of services from a comprehensive team. Unlike patients receiving primary care in an ambulatory care setting, who may have a relationship with an individual clinician and follow that individual if they leave the practice, high needs beneficiaries are more likely to remain with the organization they are receiving care from. Allowing alignment to a practice rather than an individual clinician for these populations would support this approach and prevent beneficiaries from becoming unattributed if an individual provider leaves the organization and the beneficiaries remain with the organization. A more team-based approach to attribution would also alleviate challenges for patients residing in LTC settings, who often receive primary care services from nurse practitioners (NPs) and physician associates (PAs). Currently in MSSP, beneficiaries can only be attributed to an ACO if they have had a physician visit, which impedes attribution for beneficiaries who only see NPs and PAs for primary care.

Creating sustainable and predictable financial incentives

The design of financial methodologies is critical to the success of any APM. Today, CMS uses hierarchical condition code (HCC) risk scores and Medicare enrollment types to determine differential benchmark policies. This approach fails to capture nuances within the traditional Medicare population and CMS should explore different ways to look at subsets of beneficiaries for different benchmark policies. Current benchmarking methodologies typically rely on historical utilization and comparison to national and regional reference populations. Patients with complex chronic conditions or serious illnesses are

often in the top three percent of Medicare spending, making them outliers compared to other beneficiaries in the region and nationally. Despite this, MSSP methodologies cap many benchmark adjustments using a percent of national per capita FFS expenditures for assignable beneficiaries which does not adequately account for a complex population's differences in severity and case mix. As a result, ACOs with high concentrations of complex and seriously ill populations are perceived to be regionally inefficient, receive a lower percent of their prior shared savings for renewal contract benchmarks, and will be eligible for a smaller Health Equity Benchmark Adjustment (HEBA) as proposed in the 2025 Medicare Physician Fee Schedule. These populations also have unique impacts on benchmarks due to their high mortality rates, making historical utilization data less reliable. CMS could establish, and the Medicare Payment Advisory Commission should recommend, separate benchmark and risk adjustment policies for high cost, high needs beneficiaries, similar to how it has established differential payment policies for beneficiaries with ESRD to account for their unique circumstances.

Utilizing relevant quality measures

Many MSSP ACOs serving complex, high needs populations were early adopters of Merit-based Incentive Payment System clinical quality measure (MIPS CQM) reporting. The main reason for this was the ability to move from 10 web interface quality measures, most of which were not relevant to complex populations at the end of life, to three MIPS CQM quality measures, which were more relevant to these populations. In the proposed 2025 Medicare Physician Fee Schedule, CMS will increase the number of CQM measures from three to five, increasing to six measures in Performance Year (PY) 2026 and to eight measures in PY 2028. Many of these "new" measures are not relevant for complex populations at the end of life, e.g. colorectal cancer screening and breast cancer screening. This is an example of CMS policy moving in the wrong direction, especially for ACOs serving complex populations at the end of life. We encourage CMS to leverage the learnings from the simplified quality measurement approach adopted by the ACO REACH program, which focuses on quality outcome measures calculated using administrative claims data and differentiates measures for ACOs exclusively serving high needs subsets of the Medicare fee-for-service population.

CONCLUSION

Thank you for the opportunity to provide feedback on the needs of patients with complex chronic conditions or serious illnesses in population-based total cost of care models. 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 efforts to support the inclusion of complex and seriously ill populations in value-based care models. 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