November 15, 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: Identifying A Pathway Toward Maximizing Participation 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 identifying a pathway toward maximizing participation in population-based total cost of care (TCOC) 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).

We share PTAC's goal of increasing participation in TCOC models like ACOs. Participation has plateaued in recent years, so we must focus on bringing in new participants while retaining others who face barriers to continued participation. To accomplish this, we need models that are stable and predictable, meet providers where they are, reduce regulatory burden, and are aligned across payers to better encourage system-wide transformation.

NAACOS and our ACO members have previously provided detailed input on how to increase participation in TCOC models, particularly among unique provider types. We outline our thinking on various topics below.

Specialist Providers
We know from experience that concurrent participation in episode-based payment models and TCOC models results in a complex set of overlap rules, leading to provider and patient confusion and increased burden. Specialty payment approaches should be designed within TCOC arrangements so that they can create the proper incentives to encourage coordinated care across the care continuum. There must be a focus on allowing providers to work together to achieve optimal patient outcomes. We recommend:

- Sharing data on cost and quality performance for specialists with ACOs.
- Supporting TCOC models with shadow or nested bundled payments for those who elect these arrangements.

- Addressing policy and program design elements that currently prohibit specialty integration, including quality measure reporting, the high-low revenue distinction in MSSP, and National Provider Identifier (NPI)-level participation.

Complex or Seriously Ill Populations

Many of today's TCOC models were designed based on the traditional Medicare population writ large. For organizations that serve a high proportion of patients with complex chronic conditions or serious illnesses participate, challenges with financial benchmarks, attribution methodologies, and performance measurement arise, creating barriers to their APM participation. In a letter earlier this year to the PTAC, NAACOS recommended several considerations in model development to account for high-cost, high needs beneficiaries, including:

- Design alternative program policies to account for high-cost, high needs beneficiaries who are significantly different from the average traditional Medicare beneficiary.
- Use beneficiary-level criteria 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.
- Adjust attribution models to account for the care delivery models employed by organizations serving complex and seriously ill patients, which heavily emphasize a team-based approach.
- Design financial methodologies specifically for these populations to ensure sustainability and predictability for the participating organizations that serve them.

Rural and Underserved Communities

Special considerations need to be made for Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Critical Access Hospitals (CAHs) because of their unique payment structures. CAHs are paid under a cost-based reimbursement system. FQHCs and RHCs are paid a pre-set amount for each patient visit, which can limit the delivery of care management services, and often deal with face-to-face requirements. Because of these barriers, NAACOS has recommended a new paradigm where safety-net-minded APMs focus on increasing or maintaining access rather than purely reducing costs. Judging performance on savings achieved compared to historical spending is inappropriate for rural and lower-cost settings. Additional recommendations include:

- Provide waivers from the current encounter-based or cost-based reimbursement system.
- Offer lower discounts or minimum savings rates for rural providers in risk-bearing models.
- Waive the current restriction that prevents providing multiple services in one visit and along with face-to-face billing requirements for FQHCs and RHCs in APMs.
- Modify attribution approaches to account for facility-based billing, high patient turnover, and disproportionate number of advanced care providers that rural and safety-net providers employ.

Benchmarks

Additional work needs to be undertaken to address the long-term financial viability of TCOC models. TCOC models face the unsustainable dilemma of lower financial benchmarks over time as they continue to lower the cost of care on their patient populations. This "ratchet effect" is introduced because benchmarks are based predominantly on historical spending. Policies that aim to reduce the impact of the ratchet (e.g., prior savings adjustment, regional adjustment, accountable care prospective trend (ACPT)) do not go far enough. Models, like ACO REACH, that employ a rate book-approach to benchmarks do not appear to achieve actuarial savings required by law. Comparing APM performance to a dwindling fee-for-service (FFS) population limits innovative model design. Instead, CMS should seek multi-stakeholder input on the overall financial goals of APMs, reasonable comparison groups for

defining success, and redesigning benchmarks to attract new participants and maintain current participants.

Multipayer Alignment and Adjustments

Because traditional Medicare APMs can be such a small percentage of a health system's or physician practice's revenue, many have value-based care contracts across lines of business. Complying with multiple value arrangements across several payers with different policies can be burdensome. As such, CMS should work with stakeholders to identify elements that can be aligned, to the extent possible, with TCOC model elements, including quality measurement and reporting, financial benchmarking and risk adjustment, beneficiary alignment, and data collection and reporting. CMS should implement this approach in their models and build incentives for Medicare Advantage plans to rapidly do the same. Such alignment would reduce duplicative work for providers and streamline efforts to maximize patient outcomes. NAACOS in partnership with the American Medical Association (AMA) and AHIP developed a playbook of best practices to spur adoption and alignment.

Data Transparency

TCOC model participants need actionable, timely, and reliable data to help inform proactive care decisions, which are critical to succeeding in TCOC arrangements. NAACOS,in partnership with AMA and AHIP best practices for data sharing. Relevant recommendations include:

- Creating an interoperable data ecosystem by adopting consistent content and exchange standards to simplify and expand data sharing.
- Empower model participants by sharing complete, accurate, and consistent data that paints a more comprehensive picture of a patient or population.
- Collect and share data to identify and address health disparities as well as barriers to care beyond the clinical setting.
- Share data early, often, and in accessible ways, to improve care.
- Make available detailed information on how data were derived to foster trust in data received, used, and by which performance is measured.

Beneficiary Engagement

Increasing beneficiary engagement in accountable care and effectively communicating the benefits of these models is critical to expanding participation. However, currently patients in ACOs or other APMs often are unaware of their inclusion in models and the benefits they provide. NAACOS and the Health Care Transformation Task Force (HCTTF) convened a roundtable of ACOs and patient and consumer advocacy organizations, which developed recommendations to improve beneficiary education and engagement. Key recommendations include:

- Tailor beneficiary communications to different patient populations.
- Improve voluntary alignment and expand waivers that provide direct benefits to patients.
- Incorporate input from patients, family caregivers, and communities to promote person-centeredness and advance population health goals.

Conclusion

NAACOS looks forward to continuing to work with the Innovation Center, CMS, and PTAC on this issue to find ways to maximize participation in TCOC arrangements. We thank PTAC for its attention to this issue. If you have any questions, please contact Aisha Pittman, senior vice president, government affairs at aisha_pittman@naacos.com.

Sincerely,
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