October 5, 2023

The Honorable Jason Smith
Chairman
House Committee on Ways and Means
United States House of Representatives
1139 Longworth House Office Building
Washington, DC 20515
Submitted electronically to: WMAccessRFI@mail.house.gov

RE: Request for Information: Improving Access to Health Care in Rural and Underserved Areas

Dear Chairman Smith:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to the House Ways and Means Committee's Request for Information on Improving Access to Health Care in Rural and Underserved Areas. NAACOS represents more than 400 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 8 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).

NAACOS appreciates the committee's leadership and commitment to improving access to health care in rural and underserved communities. Our comments reflect the views of our members and our shared goals of improving access to health care in rural and underserved communities.

A major pathway for improving access to health care in rural and underserved areas is through advancing APMs. Over the last two decades, APMs have demonstrated that when providers are accountable for costs and quality and provided flexibility from fee-for-service (FFS) constraints, they are able to generate savings for taxpayers and improve beneficiary care. Specifically, rural providers in APMs are better suited to meet some of the unique challenges in rural 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 FFS such as wellness programs, patient transportation, meals programs, and cost sharing reductions. This allows providers to use innovative tools to improve patient outcomes.

To improve access to health care in rural and underserved settings, Congress should create more pathways for providers in rural settings to adopt APMs. 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 rural 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. Rural providers are a vital part of APMs and have considerable participation in models today. They've undoubtedly contributed to the quality improvements and more than $21 billion in savings ACOs have generated to date.

Rural providers have achieved successes in APMs despite significant barriers and limitations. ACOs and other APMs focus on achieving savings on historical spending. This approach may not be appropriate for rural populations where lower cost settings may not be available or underserved populations who may have historical lower costs due to lack of access. **We need a new paradigm where APMs focus on increasing or maintaining access over cost reductions.** While cost is an important component of any APM we should consider approaches for maintaining costs or reducing growth in spending. Accordingly, we recommend Congress work with the Centers for Medicare and Medicaid Services (CMS) to modify existing APMs to better account for rural and underserved populations (e.g., a rural and underserved focused track within MSSP) or develop new total cost of care models focused on rural and underserved populations. Below we describe the common challenges and solutions for engaging providers that serve rural and underserved populations in APMs.

Ensure Financial Incentives Encourage the Adoption of APMs
Appropriate financial incentives help attract physicians and other clinicians to participate in advanced APMs and reward those that continue to move forward on their value transitions. The advanced APM incentive payments have provided financial support that helps rural practices join and remain in payment models that involve down-side risk. Many practices also reinvest these payments to help expand services for patients.

In 2022, Congress included a 12-month extension of MACRA's advanced APM incentive payment in the Consolidated Appropriations Act of 2023. While this short-term extension ensures that the nearly 300,000 clinicians working to improve the quality and cost-effectiveness of care continue to have the financial resources to do so, it will expire at the end of 2023.

Lawmakers should support the bipartisan Value in Health Care Act (H.R. 5013), which includes a two-year extension of MACRA's original 5 percent advanced APM incentives and adjusts the one-size-fits-all approach to qualification thresholds to ensure that providers will continue to participate in APMs.

Address Unique Payment Challenges for Providers Serving Rural and Underserved Populations
As noted above, rural and safety net providers operate under unique billing and reimbursement requirements that present challenges to participation in total cost of care models. Many of the current shared savings' approaches in Medicare APMs do not account for these underlying rural payment systems. To address these issues, CMS should:

- Consider a global budget or prospective population-based payment which provides needed stable and predictable payment.

- Lower discounts or minimum savings rate for rural providers in risk-bearing models.
- 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.
- Directing CMS to 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.
- Removing the high-low revenue designation in the MSSP that penalizes certain ACOs, especially safety net providers like RHCs, CAHs, and FQHCs.
- Adapt risk adjustment policies to not disadvantage sicker populations, including providing for considerations for 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.

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

To date, ACOs are built on primary care relationships. Rural providers like FQHCs and RHCs have difficulty gaining patients' plurality of care. Many rural practices lack physicians and rely on non-physician providers like nurse practitioners or physician assistants, which don't drive ACO attribution. Congress should consider the following rural-specific attribution approaches for total cost of care model designs:

- Develop unique attribution steps for certain rural and safety net providers (e.g., FQHCs and CAHs).
- Adopt multi-year alignment approaches as we see in some ACO models in the CMS Innovation Center.
- Allow for NPP attribution or remove the physician-visit requirements in rural communities.
- 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 remove barriers to participation and give additional flexibility and tools to innovate care. The committee should consider the following recommendations 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 rural providers. For example:
    - Waiving the current one-visit, one-service requirement for FQHCs and RHCs that underpay providers for addressing multiple care issues during one visit.
    - Make it easier to provide the Hospital at Home program to expand access to acute care at a lower cost.
    - Removing face-to-face billing requirements for certain services like annual wellness visits to allow providers with an established patient relationship to provide virtual care as needed.
    - Improving 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.

- 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 feedback on this request for information. 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 improving health care access in rural and underserved communities. 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

Appendix.

Federally Qualified Health Centers

Since 2014, FQHCs are paid based on a prospective payment system. Medicare sets a national rate for services, which is adjusted based on where the services are delivered. Medicare pays claims at 80 percent of the lesser of FQHC charges or the FQHC prospective payment rate. There are fundamental challenges for FQHCs to participate in ACOs, including:

Beneficiary attribution

- 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.
- FQHCs employ a disproportionate number of advanced care providers, and seeing those provider types does not satisfy MSSP's one-physician visit rule for attribution.
- Because of facility-based billing, it's hard to know how patients became attributed to ACOs with FQHCs without custom reports.
- Some FQHC-based ACOs 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 FQHCs for chronic care management. They come out of necessity and convenience. Remember FQHCs are by definition safety-net providers.

Reimbursement

- Medicare only reimburses FQHCs for one service per day. This prohibits FQHCs in ACOs from delivering multiple services in a single visit to 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.

Financial benchmarks

- 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, 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.

Critical Access Hospitals

Reimbursement

- CAHs operate under cost-based reimbursement, which means Medicare payments are based on the costs incurred to deliver the services. Such a paradigm makes it inherently difficult to participate in shared savings models because they 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.
- 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 patients would have been normally.

Rural Health Clinics

Beneficiary attribution

- Like other rural providers, RHCs struggle with physician shortages, and a physician visit is required in MSSP, making gaining attributed patients sometimes difficult.

Reimbursement

- As with FQHCs, 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.
- 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.