September 6, 2019

Sens. Tom Daschle and Olympia Snowe
Govs. Ronnie Musgrove and Tommy Thompson
Co-Chairs
Bipartisan Policy Center Rural Health Task Force
1225 Eye Street NW, Suite 1000
Washington, D.C. 20005

Via ruralhealth@bipartisanpolicy.org

Dear co-chairs and members of the Bipartisan Policy Center Rural Health Task Force,

As the largest organization representing accountable care organizations (ACOs), we appreciate the Bipartisan Policy Center's focus on helping rural providers move to new delivery models. Too often, payment and delivery reform overlooks the special needs of rural providers, who face different challenges entering the path to value.

The National Association of ACOs (NAACOS) represents 330 Medicare Shared Savings Program (MSSP), Next Generation Model, and commercial ACOs who provide care to more than 6 million beneficiaries. The number of ACOs in Medicare has grown considerably in recent years and includes nearly 560 ACOs in 2019, covering nearly 13 million beneficiaries. ACOs are leading the way in Medicare's shift to value-based care and represent the dominant option for providers to participate in alternative payment models.

Fixing the ACO "Rural Glitch"

To generate an ACO's benchmark, the financial target CMS sets that determines an ACO's performance for spending, CMS considers the historical costs of the ACO's patients and the costs of patients in the ACO's region. Benchmarks incorporate a regional adjustment to reward ACOs that have lower costs than their regional peers. When ACOs reduce the costs of its patients, they also reduce the region's costs. However, CMS includes all patients in the regional adjustment – including those both in and out of the ACO – which penalizes ACOs for reducing costs relative to its regional competitors. This problem is particularly acute for rural ACOs, who may be the only ACO in the region or the dominant provider in their region.

The "Rural Glitch" refers to this flaw in the MSSP that systematically penalizes rural ACOs when they reduce costs. **Policymakers can correct this my removing ACO patients from the regional reference population.** In other words, the regional adjustment should be the ACO's market minus the ACO's own patients. This change would help rural providers who want to participate in ACOs.

Cover Up-Front Costs of ACO Development

ACOs starting out can be hamstrung by costs. Significant investments are needed in clinical care management, health information technology, population health analytics, reporting, and other administrative costs, which often exceed millions of dollars. Given resource-starved rural providers, this barrier can be too much to overcome.

However, CMS previously offered programs to help fund ACOs' up-front costs, with those payments later recoupled via shared savings. **These programs, such as the ACO Investment Model (AIM), should be reinstated to help ACOs fund activities and transformations to support ACOs' development.**

Researchers from Harvard Medical School studied 41 AIM ACOs and found they collectively reduced Medicare spending by $131 million relative to a comparison group. CMS helped by providing $76.2 million in prepayments, aiding providers in rural and underserved areas in forming ACOs.

Allow All ACOs Freedom to Use Telehealth

Telehealth, including remote monitoring, provides an opportunity to offer vital, cost-effective services to more patients. However, current Medicare regulations limit the use of telehealth to ACOs in two-sided risk tracks. If telehealth were granted to all ACOs, more could be persuaded to enter this voluntary program if they had access to tools to better manage patients. Furthermore, expanding access to telehealth would provide ACOs time to optimize use of the technology before taking on financial risk. Previously, NAACOS has called on Congress to allow the home to satisfy the originating site requirement and waive the geographic limitation for the provision of telehealth services under Section 1834(m) of the Social Security Act for ACOs in one-sided risk tracks.

Remove ACO's "High Revenue" Distinction

Under the Pathways to Success rule, which CMS finalized in December 2018, CMS created a new distinction between "high revenue" and "low revenue" ACOs. CMS calculates the percentage of the total fee-for-service revenue for ACO participants compared to the ACO's benchmark expenditures. CMS tries to distinguish between ACOs who have a greater ability to control spending, giving less time in shared-savings only models to "high revenue" ACOs.

NAACOS believes these distinctions are arbitrary and provide disincentives for rural providers to voluntarily work together in value-based care arrangements. We looked at 2016 Medicare claims data to determine the revenue status of certain ACO types. NAACOS found nearly one in five Federally Qualified Health Center- and Rural Health Clinic-affiliated ACOs would have been designated "high revenue" based on 2016 data. **As written, this policy creates a disincentive for ACOs working in rural and underserved areas. We call on CMS to eliminate high-low revenue distinction and apply the low revenue policies across all ACOs.**

Incentivizing participation in Advanced Alternative Payment Models (APM)

Under the Medicare Access and CHIP Reauthorization Act, eligible clinicians who participate in an Advanced APM and meet certain Qualifying APM Participant criteria will receive a 5 percent annual lump sum bonus from 2019 through 2024. Under the current statute, that bonus expires at the end of 2024. When the Advanced APM bonus expires, healthcare providers have less incentive to participate in these advanced, risk-bearing models. Data so far have shown that Advanced APM participation is lower than what CMS initially projected, which is disappointing because the goal is to move more providers into Advanced APMs. **NAACOS believes all providers, including rural ones, would have more opportunity and incentive to move to models like ACOs if the 5 percent bonus were extended for six additional years.**

Conclusion

Thank you for the opportunity to provide feedback to this important work. Please contact NAACOS staff at advocacy@naacos.com if you have any questions about our comments. We are happy to expound upon these ideas and others.

Sincerely,

Clif Gaus, CEO