April 7, 2023

Physician-Focused Payment Model Technical Advisory Committee (PTAC)
Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services

RE: Specialist integration within total cost of care models

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 how to better integrate specialty care into total cost of care models. 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 PTAC's focus on this issue and its coordination with the Innovation Center's work on specialty engagement in value-based models.

NAACOS and our ACO members share the commitment to the administration's goal of having all Medicare patients and most Medicaid patients in an accountable care relationship responsible for total cost of care and quality by 2030. To achieve this goal, there must be a focus on allowing providers to coordinate care across the continuum of care, working together to achieve optimal patient outcomes. This includes engaging specialists in total cost of care models, like ACOs. After more than ten years of payment model design innovation, we have learned that concurrent episode models and total cost of care models results in a complex set of overlap rules, leading to provider and patient confusion and increased burden. Designing specialty payment approaches within a total cost of care arrangement can create the proper incentives to encourage coordinated care across the care continuum. CMS must first address ACO needs to further this work:

- Share data on cost and quality performance for specialists with ACOs.
- Support total cost of care ACOs with shadow or nested bundled payments for those who elect these arrangements.
- Address policy and program design elements that currently are prohibitive to this work.

Share data on cost and quality performance for specialists with ACOs. ACOs' range in their ability to engage specialists, with some ACOs currently engaging in gainsharing arrangements or sub-contracting

such as shadow bundles, while other ACOs may be in early phases of this work. Regardless of their approach, ACOs need more data on specialist cost and quality performance to identify variations in care, partner with specialists to implement evidence-based protocols to help reduce variation, inform referrals to high-value specialists, and create financial incentives that encourage coordination across the care continuum. Data that would be helpful to provide ACOs to further support this work include episode cost data and quality data along with regional and national benchmarks. While ACOs can develop cost data for specialists, this information is limited to the ACO population and lacks sufficient data to be actionable. Additionally, ACOs do not have access to data on the quality of care provided by specialists. ACOs are eager to obtain quality data on specialty performance, whether it be Merit-Based Incentive Payment System (MIPS) quality data or other sources to support specialist engagement.

While CMS has noted the agency plans to provide data specific to the ACO, it would be more helpful to provide specialist performance data across a broader population. At a minimum, CMS should provide specialist performance data across Medicare. CMS should work to include specialist data across other payers, such as Medicare Advantage, to provide ACOs with a more wholistic and accurate picture of performance in the marketplace. Benchmarks will then allow ACOs to understand how a specialist data compares to the region and nation.

While there is broad interest in gaining access to specialty data across the spectrum, should CMS need to focus on certain specialties to start with, the most logical could include cardiology, gastroenterology, oncology, orthopedics, neurology, endocrinology, retina specialists, dermatology, physical therapy and behavioral health. Data should be timely and actionable so it can be used at the point of care. CMS should also consider:

- Intended use of data. Whether the information is being shared to gain a better understanding of quality and performance information to support referral patterns is different than a use case of designing payment approaches within a total cost of care arrangement. Further, if the data sharing is to help inform patients, there will be very different needs (such as to share performance information with beneficiaries to allow them to make better decisions about their care).
- Ensuring sufficient sample size. ACOs engaging specialists in shadow or nested bundles are often faced with challenges regarding small numbers. Performance data must be based on a sufficient volume of cases so that spending estimates are statistically reliable.

ACOs are very interested and actively engaged in finding ways to further engage specialists in total cost of care models. Providing more data, specifically episode cost data as well as quality data and patient reported outcomes data, will help support this work. Sharing this information with ACOs will allow for enhanced referral management that is based on quality, cost and outcome data for some ACOs, while more sophisticated ACOs may be prepared to engage in sub-contracting within the ACO through financial arrangements such as gainsharing with the ACO.

Support ACOs ready to implement shadow or nested bundled by standardizing definitions. As a secondary priority, CMS could also support ACOs who are more advanced in their work on specialty engagement by creating and sharing target prices as well as quality performance data for episodes and appropriate risk adjustment for ACOs to use in designing their own nested bundles or specialist payment approaches. These increased data transparency efforts will be critical in helping ACOs to facilitate better communication among primary care clinicians and specialists. Efforts to engage specialists should allow for options from a menu set of more standardized approaches while still allowing for flexibility. For example, the Innovation Center should develop industry standard definitions for episodes to be used by

ACOs and others in the way that best suits their particular organization and regional market. Importantly, because ACOs are engaged in arrangements with other Medicare Advantage and other payers, CMS's role to develop standardize definitions should include other payer efforts.

In creating industry standard definitions consideration must also be given to the type of episode. Procedural episodes have been successful in programs like the Bundled Payments for Care Improvement- Advanced (BPCI-A) and the Comprehensive Care for Joint Replacement (CJR) models because the episode can be accurately attributed to a facility and provider. Accordingly, there may be more readiness to implement episodic bundles within ACOs. There has been less success in defining chronic condition episodes because attribution is less clear. It is difficult to assign accountability and more testing and work needs to be done in this area. CMS should work with ACOs to understand opportunities to shift payment for specialists providing chronic care.

It is critical that these types of arrangements remain voluntary, as not all ACOs and markets would be appropriate for such arrangements. There must also be flexibility to allow ACOs, plans and other entities to design approaches that are best for their population. Efforts to engage specialists should allow for options from a menu set of more standardized approaches while still allowing for flexibility. For example, an ACO in a rural area may have very few if any specialist referral options so a program built around enhancing referrals would not meet its patients' needs in that particular market or region.

Address policy and program design elements that currently are prohibitive to the inclusion of specialists. Currently there are several policies that discourage specialist participation in ACOs.

- The MSSP quality requirement to move to electronic clinical quality measures (eCQMs)/MIPS clinical quality measures by 2025 inadvertently penalizes ACOs with specialist participants by requiring reporting and assessment of all-payer and all-patient data rather than focusing on ACO assigned patients. As a result, specialists in the ACO are held accountable for primary care measures that are not clinically appropriate. For example, dermatologists in the ACO would be required to assess and do follow-up on depression screenings, which would not be clinically appropriate. Ultimately this would lead to artificially lowering the ACOs quality score and assessing ACOs based on the case-mix of their population.
- The Qualifying Advanced APM Participant (QP) thresholds, which determine who is eligible for the 5 percent Advanced APMs incentive payment, penalizes ACOs who have a higher proportion of specialists. CMS should consider approaches for reducing the impact of this disincentive.
- The high/low revenue distinction in MSSP discourages ACOs from including specialists. ACOs with more participating specialists are likely to have a larger percent of the ACO's revenue for all expenditures of the assigned beneficiaries. Removing the high/low revenue distinction would remove the disincentive to include specialists in the ACO.
- Participation in MSSP ACOs is predominantly primary care focused because attribution is focused solely on primary care services. To encourage more specialist participation CMS should allow National Provider Identifier (NPI) level participation in the MSSP, which would allow for certain specialists to participate in the model. Currently, specialists who employ advanced practice providers (APPs) may align beneficiaries to the ACO; however, these beneficiaries typically align to the ACO for only one year during a high-cost episode. This discourages ACOs including specialists because they cannot truly manage the cost and care for patients who align for such a brief period. Additionally, specialists who join total cost of care models have only a small proportion of their patient panel in the ACO. CMS should consider attribution approaches that would allow a greater portion of a specialists' patient panel to align to an ACO.

These policies must be addressed to ensure there are strong incentives for collaboration among primary care clinicians and specialists. Importantly there should be no mandatory bundles participation for ACOs or beneficiaries aligned to ACOs. This will create the proper incentives for bundles done within a total cost of care model to ensure there is no incentive for overutilization.

CONCLUSION

NAACOS looks forward to continuing to work with the Innovation Center, CMS and ACOs on this issue to find ways to meaningfully engage specialists in total cost of care models. 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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President and CEO
NAACOS