



November 29, 2019

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Via [Rural\\_Urban@mail.house.gov](mailto:Rural_Urban@mail.house.gov)

Dear co-chairs of the House Ways and Means Committee Rural and Underserved Communities Health Task Force,

The National Association of Accountable Care Organizations (NAACOS) appreciates the Committee's work to address healthcare disparities for rural and underserved urban communities. Nearly 20 percent of Americans live in rural areas. The Health Resources and Services Administration has identified more than 6,700 primary care Health Professional Shortage Areas, creating an unmet primary care need for 55 percent of the country. As such, there's an opportunity for Congress to address these shortcomings.

**To help rural and underserved communities, NAACOS asks that the Committee consider H.R. 5212, the Accountable Care in Rural America Act, cosponsored by Committee members Reps. Jodey Arrington and Suzan DelBene.** This legislation would fix a formula that unfairly penalizes ACOs. Specifically, the bill amends title XVIII of the Social Security Act to improve the benchmarking process for the Medicare Shared Savings Program (MSSP) to ensure that all ACOs have an equal opportunity to share in savings regardless of their geographic location.

NAACOS works to advance population health-focused payment and delivery models and represents 12 million beneficiary lives through hundreds of organizations participating in models in Medicare, Medicaid, and commercial health plans. This includes MSSP, Next Generation ACO Model, Medicare Advantage and alternative payment models supported by a myriad of commercial health plans. Too often, payment and delivery reform, which is needed in health care, overlooks the special needs of providers serving rural and underserved communities, who face different challenges to enter the path to value than their more urban counterparts.

The ACO model is a market-based solution to fragmented and costly care that empowers local physicians, hospitals and other providers to work together and take responsibility for improving quality, enhancing patient experience and reducing waste. Importantly, the ACO model also maintains patient choice of clinicians and other providers. While the origins of Medicare ACOs date back to the George W. Bush

Administration, the number of ACOs in Medicare has grown considerably in recent years and includes nearly 550 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.

According to recent data from the Centers for Medicare & Medicaid Services (CMS), ACOs collectively saved Medicare \$1.7 billion last year alone, and \$739 million after accounting for shared savings bonuses and collecting shared loss payments. The results continue a strong and growing trend of the Medicare ACO program saving money, and ACOs also demonstrate impressive quality. For example, in 2018 ACOs had an average quality score of almost 93 percent. Additional research also confirms positive ACO performance. Researchers at Harvard University, the Medicare Payment Advisory Commission and Dobson DaVanzo & Associates have all done such work. All showed ACOs are lowering Medicare spending by 1 percent to 2 percent, which translates into tens of billions of dollars of reduced Medicare spending when compounded annually. With results like this, it is clear that ACOs are transforming our healthcare system through reduced costs and improved quality.

Our below recommendations represent ways in which the task force can improve care quality, patient safety and overall have a positive impact on health outcomes in rural and underserved urban communities.

### ***Fixing the ACO "Rural Glitch"***

**We strongly urge the Committee to act on H.R. 5212, the Accountable Care in Rural America Act, which would help further alternative payment models in rural America by correcting an unintended flaw in Medicare policy that unfairly penalizes ACOs when they reduce costs.** CMS generates a financial target, or benchmark, that sets an ACO's performance for spending. CMS considers the historic costs of the ACOs' patients and the costs of patients in the ACO's region. Benchmarks incorporate a regional adjustment to reward practices that have lower costs than their regional peers. However, when ACOs reduce the costs of its patients, they also reduce the region's costs. Therefore, counting all patients in the regional adjustment – including those both in and out of the ACO – penalizes ACOs for reducing costs relative to its regional competitors. While also hurting urban or suburban ACOs, this problem is particularly acute for rural ACOs, who may be the only ACO in the region or the dominate provider in their region.

**Congress can correct this "Rural Glitch" by removing ACO patients from the regional reference population, which systematically penalizes rural ACOs when they reduce costs.** This change would help rural providers who want to participate in ACOs. NAACOS and 13 other leading healthcare organizations [have called upon](#) the House to pass [H.R. 5212](#), which would correct this issue.

### ***Cover Up-Front Costs of ACO Development***

ACO formation can be hamstrung by costs. Investments are needed in clinical and care management, health information technology, population health analytics, reporting, and other administrative costs. The average cost of a single ACO [approaches](#) nearly \$2 million. This barrier can be too much to overcome for many providers serving rural and underserved communities.

However, CMS previously offered programs to help fund ACOs' up-front costs, with those payments later recoupled via shared savings. Those ACOs were smaller, mostly rural and primary care-based organizations, according to CMS. **These programs, such as [the ACO Investment Model \(AIM\)](#), should be reinstated to help ACOs fund activities and transformations to support ACOs' development.**

The program was a great success. Overall, AIM participants lowered Medicare spending by 2.3 percent in their first year and 3 percent in their second year, according to [CMS evaluations](#). Hospital readmissions,

emergency room visits, post-acute care visits, among other factors were all decreased. These ACOs have almost entirely repaid CMS those start-up costs, while maintaining quality and leaving established ACOs to help spur Medicare's value-based care movement. Researchers from Harvard Medical School [studied 41 AIM ACOs](#) and found they collectively reduced Medicare spending by \$131 million relative to a comparison group.

### ***Allow All ACOs Freedom to Use Telehealth***

The 115th Congress enacted through the Bipartisan Budget Act (BBA) some parts of the CONNECT (Creating Opportunities Now for Necessary and Effective Care Technologies) for Health Act of 2017. Specifically, Section 50324 of the BBA allows ACOs who use prospective assignment and participate in a two-sided risk track to expand the use of telehealth by lifting certain geographic and site-of-care statutory restrictions. The enactment of BBA Section 50324 will be critical for ACOs as they seek to fulfill their mission of advancing higher quality, lower cost care for Medicare beneficiaries. Telehealth, including remote monitoring, provides an opportunity to offer vital, cost-effective services to more patients.

However, we urge Congress to expand ACOs' use of telehealth to include both those in one-sided risk tracks and those that use retrospective assignment. If telehealth were granted to all ACOs regardless of risk level or assignment methodology, more could be persuaded to enter voluntary ACOs and population-health programs 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 the agency believes 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 Congress 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 (QP) criteria will receive a 5 percent annual lump sum bonus based on performance from 2017 – 2022. Under the current statute, that bonus expires at the end of the 2022 performance year. When the Advanced APM bonus expires, many 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. Just under 100,000 clinicians reached qualifying QP status in 2017, which is less than 10 percent of all eligible clinicians. For performance years 2018 - 2020 CMS estimates an increase in those qualifying, but the numbers remain low and are disappointing because

of our collective goal to move more providers into Advanced APMs. **NAACOS believes all providers, including those serving rural and underserved communities, would have more opportunity and incentive to move to population-health models like ACOs if the 5 percent bonus were extended for six additional years.**

**Additionally, the Committee should cap the QP payment threshold at 50 percent and modify the related partial QP threshold to be 80 percent of the QP threshold set by HHS.** To become a QP, participants must receive at least 50 percent of their Medicare payments or see at least 35 percent of Medicare patients through an Advanced APM; the payment percentage will rise to 75 percent in performance year 2021. These thresholds are too high and are discouraging Advanced APM participation and leading to unintended consequences of APM Entities limiting participation by certain providers. ACOs in rural areas are often referral centers and see a wide range of patients who may not end up being assigned, thus watering down their QP scores.

### **Conclusion**

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

Sincerely,

A handwritten signature in black ink, appearing to read 'Clif Gaus', with a long horizontal flourish extending to the right.

Clif Gaus, CEO