GREATER NEW YORK HOSPITAL ASSOCIATION
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The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS—1767—P
P.O. Box 8016, Baltimore, MD 21244-8016

Subject: [CMS–1770–P] Medicare and Medicaid Programs; Calendar Year 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies; and Implementing Requirements for Manufacturers of Certain Single-Dose Container or Single-Use Package Drugs to Provide Refunds with Respect to Discarded Amounts; Federal Register / Vol. 87, No. 90 / May 10, 2022 / Proposed Rules

Dear Ms. Brooks-LaSure,

On behalf of the more than 160 voluntary and public hospitals and health systems in New York, New Jersey, Connecticut, and Rhode Island that comprise the membership of Greater New York Hospital Association (GNYHA), GNYHA appreciates this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed changes to the Medicare Shared Savings Program (MSSP) included in the proposed rule for the fiscal year (FY) 2023 Physician Fee Schedule. Below you will find our comments regarding the following proposals and requests for information:

- Increasing Participation in Accountable Care Models in Underserved Communities by Providing an Option for Advance Investment Payments (AIPs) to Certain Accountable Care Organizations (ACOs)
- Modifications to the Benchmarking Methodology
- Health Equity Adjustment
- Alternative Quality Performance Standard
- Request for Information (RFI): Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health Measures and Future Measure Development

Increasing Participation in Accountable Care Models in Underserved Communities by Providing an Option for AIPs to Certain ACOs

CMS proposes to allow ACOs that have low revenue and are new to the MSSP to apply for AIPs. CMS defines low-revenue ACOs as ACOs for which total Part A and B revenue of the ACO's participants is less than 35% of the total Part A and B revenue for the ACO's assigned beneficiaries. Under the proposal, eligible providers may receive an upfront payment of $250,000 followed by two years of quarterly payments, the magnitude of which is based on the socioeconomic status of the patient population. Proposed AIPs would be recouped if the ACO generates shared savings within either the current or following agreement period.

GNYHA appreciates CMS's proposed AIP option, which will help some smaller and less financially resourced organizations—particularly those treating vulnerable populations—participate in MSSP. However, GNYHA urges CMS to broaden the eligibility criteria for these payments by removing the low-revenue eligibility criterion and allowing existing ACOs to receive AIPs.

The distinction between low-revenue and high-revenue ACOs was first implemented as a means of distinguishing between ACOs in the 2018 "Pathways to Success" overhaul of the MSSP program. Importantly, the low-revenue designation effectively results in a distinction between ACOs that include a hospital or hospital system and those that do not. According to an analysis conducted by the National Association of ACOs, only 4% of low-revenue ACOs were hospital-affiliated (having at least one hospital as a participant).[1] This distinction thus excludes from the AIP benefit most hospital-affiliated ACOs, many of which are essential providers to underserved populations. **CMS states that AIPs are meant to increase participation in accountable care models among underserved populations. To do so, CMS should make AIPs available to providers regardless of revenue status.**

CMS policies have often promoted participation of low-revenue ACOs based in part on the observation that low-revenue ACOs have generated shared savings at a higher rate than high-revenue ACOs in recent performance years. However, this observation does not account for important differences between high and low-revenue ACOs. For example, a recent Premier, Inc. analysis indicates that low-revenue ACOs tend to cluster in states with higher benchmarks, indicating more opportunity to achieve savings. Premier found that 26% of participating low-revenue ACOs were operating in Florida or Texas while high-revenue ACOs tend to operate in a more diverse set of geographic areas and have higher penetration in states with more moderate benchmarks. The analysis also showed that high-revenue ACOs tend to treat a higher percentage of patients that are attributed through specialists, who tend to be sicker and more costly than those

[1] https://www.naacos.com/naacos-assessment-of-high-low-revenue-designations

attributed through a primary care provider. After accounting for geographic differences and patient complexity, Premier found no statistical difference in the performance of low-revenue and high-revenue ACOs.[2] Therefore, the revenue-based distinction may be denying resources to new ACOs due to differences in the characteristics of the market in which the ACO operates rather than meaningful differences in performance. **CMS should invest in ACOs regardless of revenue status as it is a flawed indicator of ACO performance. The availability of AIPs will enable all new ACOs to invest in innovative techniques to reduce per-capita expenditures for their assigned beneficiaries despite differences in market characteristics.**

In addition to removing the low-revenue requirement for AIPs, CMS should also make AIPs available to existing ACOs. Lack of resources, including revenue, is a major barrier to ACO investment in important interventions. Many ACOs are currently engaged in important work to improve and promote health equity and population health. AIPs would provide an important funding source to either support and scale existing work or to invest in new programs that existing ACOs had determined are not financially feasible. Indeed, independent research indicates that ACOs often struggle with the scalability of their existing population health programs and cites a lack of resources as a common barrier to implementation and scalability.[3] Furthermore, the ability to earn shared savings has been identified as the most important determinant of ACO survival in MSSP.[4] For ACOs that may be struggling to generate shared savings and are considering ceasing operations at the end of their agreement period, the opportunity to earn AIPs may incentivize their continued participation. **Making AIPs available to all ACOs, will promote CMS's goal of promoting access to accountable care for Medicare beneficiaries by supporting continued participation in MSSP and is in line with the Biden Administration's goal to promote health equity.**

Modifications to the Benchmarking Methodology

CMS proposes several modifications to the MSSP benchmarking methodology. These modifications are to encourage long-term participation in the MSSP program and to promote access to ACOs, particularly among underserved populations. CMS proposes to:

- Reduce the impact of the negative regional adjustment by capping its impact and decreasing the adjustment based on the level of dual eligibility and the weighted average hierarchical condition category score

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[2] https://premierinc.com/newsroom/blog/pinc-ai-analysis-hospital-led-acos-perform-as-well-as-physician-led-models

[3] Fraze T, Lewis VA, Rodriguez HP, Fisher ES. Housing, Transportation, And Food: How ACOs Seek To Improve Population Health By Addressing Nonmedical Needs Of Patients. *Health Affairs*. 2016;35(11):2109-2115. doi:10.1377/hlthaff.2016.0727

[4] Bleser WK, Saunders RS, Muhlestein DB, McClellan M. Why Do Accountable Care Organizations Leave The Medicare Shared Savings Program? *Health Affairs*. 2019;38(5):794-803. doi:10.1377/hlthaff.2018.05097

- Incorporate a prior savings adjustment in historical benchmarks for renewing and re-entering ACOs
- Include a prospective external factor in the methodology for updating historical benchmarks

GNYHA supports CMS's proposals to reduce the negative regional adjustment and agrees with CMS that doing so will incentivize participation of ACOs that serve high-cost beneficiaries. GNYHA generally supports CMS's proposal to adjust benchmarks for prior savings, but we suggest that CMS extend its proposal to account for savings generated in Medicare accountable care programs outside of the MSSP. Providers have partnered with Medicare across various initiatives aimed at improving the quality and efficiency of care provided to Medicare beneficiaries. **CMS should consider accounting for the efficiencies generated across accountable care programs when setting MSSP benchmarks to ensure that ACOs are not adversely impacted as benchmarks incorporate efficiencies generated by concurrent accountable care programs within the market.**

Health Equity Adjustment

Beginning with performance year 2023, CMS proposes to implement a health equity adjustment to ACO quality performance scores for ACOs that achieve relatively high-quality performance scores and treat high proportions of dual-eligible beneficiaries or beneficiaries from disadvantaged areas. Eligibility for the health equity adjustment is contingent on the ACO completely reporting all three all-payer electronic clinical quality measures (eCQMs)/Merit-Based Incentive Payment System (MIPS) Clinical Quality Measures (CQMs) of the Alternative Payment Model Performance Pathway (APP) measure set. **GNYHA appreciates that CMS recognizes the efforts of providers that treat significant numbers of underserved beneficiaries but encourages CMS to remove the eCQM/MIPS CQM eligibility requirement**. The health equity adjustment should not be used to incentivize the move to eCQM/CQM reporting. Modifying existing electronic health record systems across ACO participants to support this reporting is burdensome and expensive. The burden is likely more pronounced among providers that treat higher numbers of underserved and disadvantaged patients. Therefore, tying these payments to eCQM/MIPS CQM data submission will significantly impede CMS's ability to reward the provision of high-quality care to those beneficiaries.

Alternative Quality Performance Standard

CMS proposes to revise the MSSP quality performance standard—which determines eligibility for shared savings and shared losses—to allow ACOs that do not meet the defined quality performance standard to be eligible for scaled shared savings and losses. Currently, an ACO that does not meet the performance standard is ineligible for shared savings, and if shared losses are owed, the ACO is fully responsible for those losses. Under CMS's proposal, ACOs that do not meet the quality performance standard but are otherwise eligible for shared savings would be eligible to share in a portion of those savings provided they achieve a quality performance score greater than or equal

to the tenth percentile of the performance benchmark on at least one outcome measure under the APP measure set. Shared savings would be less than the maximum amount and would be reduced as quality performance decreases. Conversely, those that do not meet the quality performance standard would be responsible for scaled shared losses. **GNYHA supports CMS's proposal, as the prior approach represented an artificial threshold in which immaterial differences in quality performance may have resulted in ineligibility for shared savings. The proposal allows ACOs to use shared savings to further increase efficiencies or improve the quality of care while maintaining an incentive to provide care at the highest level.**

Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health Measures and Future Measure Development—RFI

GNYHA generally supports the structural measure on social needs screening for MSSPs and appreciates the alignment with the finalized inpatient quality reporting social needs screening measures. However, GNYHA cautions CMS against the potential "overscreening" of patients whereby patients are screened for social needs several times within a particular timeframe. Should screening requirements increase across settings, "overscreening" can become more prevalent, which can be retraumatizing and confusing for patients. For example, a patient admitted to the hospital could receive a social needs screening as part of discharge, and then receive a screening a few days later at a primary care follow-up appointment. This can lead to increased stressors for the patient, depending on their social needs and concerns, and multiple referrals. GNYHA agrees that social needs screenings are an important component of patient care insofar as they can inform patient care plans and potentially initiate assistance from community-based organizations (CBOs). GNYHA also believes that social needs data standardization and functional data exchange must improve to avoid repeat screens, patient frustration, and duplication of efforts.

As GNYHA commented in response to the Medicare FY 2023 Inpatient Prospective Payment System proposed rule, we do not believe that a screen positive rate for social needs reflects the quality of care provided. It reflects the community served and the factors that impact those communities. Providers should not be held accountable through quality reporting for social and environmental factors in their community that are beyond their control. Furthermore, publicly reporting this measure may result in the community misinterpreting a high screen positive rate as evidence of lower health care quality. This misinterpretation would be particularly detrimental for providers that serve communities with higher rates of homelessness, housing and food insecurity, and other social determinants of health.

Similarly, GNYHA strongly discourages CMS from including future quality measures that would assess how well ACOs address the social needs of Medicare beneficiaries. Such measures would hold health care providers accountable for resolving social needs, which GNYHA believes is inappropriate and also does not measure the quality of care being provided. While health care providers are well-positioned to screen for needs and facilitate CBO

connections, they cannot be held accountable for solving the broader socioeconomic, environmental, and structural drivers of these individual social needs. GNYHA further notes that to develop the CBO program data and referral networks and implement technology that supports efficient social needs referrals requires significant investment.

If you have any questions or would like further information, please contact John Gravina (212-258-5309, jgravina@gnyha.org) or Carla Nelson (201-259-6662, cnelson@gnyha.org)

Thank you for your consideration of our recommendations.

Sincerely,

Elisabeth R. Wynn
Executive Vice President, Health Economics and Finance