

October 14, 2021

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare and Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W.  
Washington, DC 20201

RE: Request to provide MSSP ACOs an option to use pre-pandemic years to set benchmarks

Dear Administrator Brooks-LaSure:

The undersigned organizations are committed to advancing value-based care and the role that Accountable Care Organizations (ACOs) play in that critical transformation of our health care system. We write to express our concern with how existing agency policies to set financial spending targets or benchmarks for ACOs are not fair for many because of the ongoing COVID-19 pandemic. The Centers for Medicare & Medicaid Services (CMS) has worked hard since early last year to give our health system and providers the tools needed to fully combat the ongoing pandemic. We greatly appreciate those efforts which have included modifications to value-based care programs, such as those for Medicare's largest alternative payment model (APM), the Medicare Shared Savings Program (MSSP). However, further policy changes are needed to ensure the shift to value is not derailed by the highly unusual circumstances of the pandemic.

The country has seen and continues to experience tremendous variation in how the pandemic is affecting our healthcare system. Some parts of the country were devastated in 2020 yet have now resumed more in-office preventive visits and elective procedures. For other areas, it was the opposite with 2020 providing little change in utilization from previous years, and doctors and hospitals now being hit hard by the pandemic this year.

The pandemic has also affected which patients are attributed to ACOs. Since attribution is based largely on primary care services, and utilization patterns have been greatly affected by the pandemic, ACO attribution [has been significantly impacted](#) by various aspects of the pandemic, such as patients delaying care. The result for some ACOs has been major differences in ACOs' attributed populations and performance year expenditures. These are out of an ACO's control and not necessarily reflected in the benchmarks for which ACOs are held accountable.

Despite the accommodations CMS has given ACOs during the public health emergency, modifications to ACO benchmarks have not been adequately addressed. **We urge CMS to allow ACOs the opportunity to elect pre-pandemic years for benchmarks for agreements beginning in performance year 2022.** Simply put: The highly unusual circumstances of a global pandemic make it inappropriate to use 2020 as a benchmark year for certain ACOs.

While ACOs recorded a very successful year overall in 2020, some were hurt by the pandemic because of MSSP's benchmarking policies. CMS updates final benchmarks to account for actual spending in a performance year using a blended national-regional adjustment. While nationally Medicare spending [fell](#)

by roughly 7 percent in 2020, some ACOs' local populations continued to have routine office visits and elective procedures as if it were 2019. As a result, many of those ACOs showed losses in 2020.

Analysis conducted by the Institute for Accountable Care earlier this year demonstrated this huge variation in spending between 2019 and 2020. For example, spending in the Boston area fell by more than 12 percent between 2019 and 2020, even when excluding COVID-related costs. Spending fell by more than 11 percent in New York City and Northern New Jersey and by more than 10 percent in Miami. However, spending in places like Idaho and West Texas only fell by a couple of percentage points between 2019 and 2020.

Absent any changes to the methodology, ACOs entering the MSSP in 2022 will have their benchmarks largely based on their historic spending from 2019-2021, which includes two pandemic years. ACOs renewing an agreement in MSSP will also have their benchmarks rebased in 2022 using the same pandemic-stricken years. For some, it would be more appropriate to use pre-pandemic years of 2017-2019 as a baseline and trend those forward, which would provide a more accurate, realistic representation of per patient spending averages than using highly variable, severely impacted pandemic years. Additionally, under current benchmarking policy, CMS's regional adjustments don't adequately reflect regional variations, especially for those ACOs who make up a large portion of their region. This issue has been called the "rural glitch" and diminishes the impact of the regional adjustment on ACOs. While often referred to as the rural glitch, this benchmarking flaw harms ACOs in any geography when they have spending lower than their region. Our organizations have repeatedly called on CMS to fix this benchmarking flaw by removing ACO-assigned beneficiaries from the regional reference population, which should be implemented as soon as possible. Specifically, to do that CMS should remove ACO beneficiaries from calculation of the regional risk-adjusted PMPY spending.

The CMS Innovation Center Global and Professional Direct Contracting Model uses 2017-2019 years for financial benchmarks. CMS has also modified other Medicare payment systems and value-based payment programs to not use data from years affected by the COVID-19 pandemic to set future financial and/or quality benchmarks. For example, the agency has taken the following actions:

- Last spring CMS finalized a modified target pricing methodology to avoid using 2020 data for the Comprehensive Care for Joint Replacement (CJR) model. The revised methodology for performance year six will instead use 2019 data for the target price and performance year seven will use 2021 data.
- CMS finalized policies to use fiscal year (FY) 2019 claims data instead of FY 2020 data for FY 2022 rate setting for the Inpatient, Skilled Nursing Facility, and Long-Term Care Hospital prospective payment systems.
- Similarly, CMS has proposed to use 2019 claims data for Calendar Year 2022 rate setting for the Outpatient and Home Health prospective payment systems.
- The agency is also avoiding use of 2020 data in several pay-for-performance programs including the Hospital Value-Based Purchasing Program, the Hospital Readmissions Reduction Program, and the Hospital-Acquired Condition Reduction Program.

The variety of payment systems and value-based purchasing programs that have been modified to avoid 2020 data illustrates that CMS is concerned about 2020 data being skewed by the pandemic. By allowing an option to use earlier years to set MSSP benchmarks for certain ACOs, CMS will avoid the anomalies in utilization resulting from the COVID-19 pandemic. This provides a more credible baseline for certain ACOs disproportionately harmed by the pandemic. Those such ACOs are currently evaluating whether to

enter new five-year agreement periods. Having a longer agreement period means the effects of pandemic-stricken years will follow ACOs for a significant amount of time. This is particularly problematic as ACOs move to take on greater levels of risk. In a separate [analysis](#) from the Institute for Accountable Care, 45 percent of ACOs set to re-enter a new MSSP contracting in 2022 are harmed under current policy. This includes more than 10 percent of those ACOs that are set to see their benchmarks rise by more than 3 percent because of the inclusion of pandemic-stricken years. As such, CMS should give ACOs the option to use pre-pandemic years of 2017-2019 or to use the current methodology with 2019-2021 as benchmark years for agreements beginning in 2022.

ACOs continue to be the best alternative payment model to control Medicare spending and improve the quality of care. MSSP ACOs in 2020 generated \$4.1 billion in gross savings and \$1.9 billion after accounting for shared savings payments, which are both program highs. MSSP ACOs also received an average quality score of 97.8 percent, a new program best. We are looking forward to similarly positive results in 2020 from the Next Generation ACO Model as well. ACOs, including Next Gen ACOs and the now expired Pioneer ACO Model, have saved Medicare [a combined \\$12.6 billion](#) in gross savings and \$4.4 billion in net savings since 2012.

While the MSSP has shown increasingly positive results, the program has also faced several challenges resulting in a decreasing number of overall ACOs and beneficiaries. Earning shared savings, especially for new ACOs, is challenging and many ACOs have dropped out of the program. Fair benchmarks are needed for ACOs to have a chance at earning savings, which is invested in initiatives that benefit patients, such as in care coordinators and other quality improvement initiatives. Not setting fair benchmarks will exacerbate the trend of declining MSSP participation and stunt the positive effects of the ACO movement.

We urge you to implement our collective recommendation to give ACOs the opportunity to elect pre-pandemic years for benchmarks for 2022. By doing so, CMS can maintain momentum on moving our health system to one that's more accountable for the cost and quality of all traditional Medicare patients.

Sincerely,

American College of Physicians  
American Hospital Association  
American Medical Association  
AMGA  
America's Essential Hospitals  
America's Physician Groups  
Association of American Medical Colleges  
Federation of American Hospitals  
Health Care Transformation Taskforce  
Medical Group Management Association  
National Association of ACOs  
Premier healthcare alliance