

April 29, 2024

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building, Room 445–G  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Administrator Brooks-LaSure:

The undersigned organizations write to request that accountable care organizations (ACOs) are held harmless from anomalous Medicare spending outside their control, such as the aberrant billing for catheters experienced in 2023. We sincerely appreciate the efforts the Centers for Medicare and Medicaid Services (CMS) has taken over the last several years to advance its value-based care strategy. With growth a central part of the strategy, it is critical to ensure that clinicians, hospitals, other healthcare providers and ACOs can remain in the models to best serve patients through accountable care. Including anomalous Medicare spending penalizes ACOs for expenditures outside their control and jeopardizes their continued participation.

Given their focus on promoting high-quality and efficient care, ACOs are well positioned to partner with CMS as good stewards of the Medicare program. ACOs regularly analyze Part A, B and D claims on their assigned patients to find gaps in patients' care, opportunities for clinical interventions, and trends in costs and utilizations in their populations overall. It is through these efforts that ACOs recognize anomalous spending and report suspected fraudulent billing to CMS and the HHS Office of Inspector General (OIG). We appreciate ongoing efforts by CMS and the HHS OIG to look into these reports of fraud.

In 2023, ACOs noticed significantly higher spending for two catheter codes. The Institute for Accountable Care analyzed Medicare claims for these two codes from the CMS Virtual Research Data Center and discovered a nearly 20-fold increase in just two years, with spending increasing from \$153 million in 2021 to \$3.1 billion in 2023. Furthermore, almost all the increase was attributed to just 10 suppliers. The impact to ACOs is serious as this spending is unaccounted for in ACO financial benchmarks. While national trend updates in the ACO programs will account for anomalous spending that occurs nationwide, the impact of the high catheter spending varies greatly from region to region. Accordingly, national trend updates will not help ACOs whose catheter spending on their patients is above national averages. Additionally, data from the Institute for Accountable Care show that nearly half of ACOs in 2023 had catheter spending on their assigned patients that was greater than that of their region. Almost 10% had an average of nearly \$50 per patient per year more than their regional average, and 5% of ACOs would see an impact ranging from \$166 per patient per year to well over \$1,000 per patient per year. Accordingly, these ACOs' spending is affected far more than would be captured by the regional-national spending trends used to update their benchmarks — which would lead to a loss of shared savings.

**We ask that CMS hold ACOs harmless from anomalous spending.** Akin to the COVID-19 Public Health Emergency, this spending is far outside of the control of any clinician, hospital, other provider, or organization engaged in population health management. To hold ACOs harmless from the anomalous

catheter spending in 2023, we ask that CMS take the following actions as part of performance year 2023 reconciliation:

- **Remove catheter expenditures from ACO financial calculations.** ACO benchmarks are meant to be a fair estimate of expected patient spending, based on the historic spending of aligned beneficiaries, adjusting for regional spending and relative risk of patients, then trended forward to reflect national and regional updates in Medicare spending. The recent catheter billing issue is increasing some ACOs' total spending by as much as 2%. Leaving financial calculations unadjusted distorts performance and financial benchmarks, creating an apples-to-oranges comparison for both ACOs and CMS. Moreover, program integrity officials have signaled that this spending is under active investigation, with some of these payments for suspect claims in escrow. Given the ongoing investigation, the fairest way to handle for ACOs and CMS is to remove these questionable claims from all ACO financial calculations, including historic benchmarks, trend updates, and performance year expenditures. At a minimum, we request that CMS remove claims in escrow from ACO financial calculations as these are claims that CMS has already deemed suspicious. Therefore, ACOs should not be held accountable for this spending.
- **Create an outlier policy to account for other similar variation in anomalous spending.** CMS should look at outlying spending patterns and remove those services from ACO financial calculations. For example, CMS could remove services from ACO financial calculations if spending for those services surpasses some pre-determined threshold. CMS has precedent for outlier policies across the Medicare programs and uses a similar policy for ACOs, truncating spending for any individual patient in the 99<sup>th</sup> percentile. But that applies to individual patients, not services. The 2023 catheter spending is not the first, and is unlikely to be the last, instance of ACOs reporting suspected fraudulent billing. For example, ACOs have also reported spikes in spending for diabetic supplies and skin substitutes, which may also fall under a potential outlier spending policy. To prevent similar issues in future years, CMS should consider implementing a permanent outlier policy at the service or billing code level.
- **Provide ACOs an option for a second reconciliation.** We recognize that fraud investigations by CMS and the HHS OIG can take years and may not conclude until well after an ACO's financial reconciliation. In the past, ACOs have reported suspected fraud and then years later learn that fraud was confirmed. This timeline introduces harm for ACOs as they are held accountable for the fraudulent spending. To help, CMS should provide an option for ACOs to elect to have a second reconciliation once the Federal government has concluded if a claim was fraudulent. CMS reserves the right to reopen determinations of ACO shared savings or shared losses in §425.315.

We strongly urge CMS to address these policies for the Medicare Shared Savings Program (MSSP), in the upcoming Medicare Physician Fee Schedule proposed rule, and the ACO Realizing Equity, Access, and Community Health (REACH) Model, which doesn't need formal rulemaking. There is precedence for making such policy changes after a performance year ends. In the [2024 Medicare Physician Fee Schedule](#), CMS finalized a retrospective policy for the MSSP, specifically the underserved multiplier in the health equity adjustment for MSSP starting in performance period 2023. CMS justified the change by saying Section 1871§ (1)(A)(ii) of the Social Security Act authorizes CMS to retroactively apply a substantive change in regulations if it determines that failure to apply the change retroactively would be contrary to the public interest. CMS stated absent a change "current policy may unfairly penalize ACOs for reasons beyond their control." The same logic easily applies to the anomalous 2023 catheter billing situation.

**We also request that CMS continue to work with stakeholders on long-term solutions to address suspected and confirmed fraud.** As stated above, ACOs are well positioned to detect anomalous billing given their in-depth examination of claims data. As the HHS OIG has [previously noted](#), ACOs are excellent sources to uncover potential fraud, waste, and abuse by identifying patterns of unusual billing. The HHS OIG noted that CMS should provide a heightened level of attention to ACO referrals. The undersigned organizations and ACOs are willing partners in promoting program integrity. For example, there are both opportunities to improve how ACOs report fraud, as well as to better educate ACOs on the process CMS and the HHS OIG undertake to investigate fraud. We look forward to discussing opportunities to better leverage ACOs, including these issues and our recommendations.

Thank you for your continued leadership in supporting the movement to value-based care, we appreciate your consideration of our concerns.

Sincerely,

Accountable for Health  
America's Physician Groups  
American Hospital Association  
American Medical Association  
AMGA  
Association of American Medical Colleges  
Federation of American Hospitals  
Health Care Transformation Task Force  
Medical Group Management Association  
National Association of ACOs  
Premier, Inc.