STATEMENT FOR THE RECORD
of
The National Association of ACOs
to the
U.S. House of Representatives Ways & Means Committee
Subcommittee on Health

Hearing on Bridging Health Equity Gaps for People with Disabilities and Chronic Conditions
February 14, 2022

The National Association of ACOs (NAACOS) appreciates the opportunity to express support for value-based payment arrangements and alternative payment models (APMs), such as accountable care organizations (ACOs), as a means to close gaps in health equity and ensure high-quality care for all patients, particularly those with disabilities and chronic conditions. ACOs are groups of doctors, hospitals, and/or other health care providers that work together to improve the quality of patient care while lowering costs. NAACOS represents more than 12 million beneficiary lives through hundreds of organizations participating in population health-focused payment and delivery models in Medicare, Medicaid, and commercial insurance. NAACOS is a member-led and member-owned nonprofit organization that works to improve quality of care, outcomes, and healthcare cost efficiency.

Strengthening the ACO model and other total cost of care models provides an important opportunity to reduce health inequities, as closing these gaps is critical for delivering high-quality care in a cost-effective manner. The upfront investments that ACOs make in health information technology (HIT) and infrastructure to provide coordinated care make them uniquely poised to address health inequities. Because ACOs are held accountable for the total cost and quality of care for their assigned patient populations, they are incentivized to address social factors affecting the health outcomes of their patients and identify and address any gaps in health outcomes.

ACOs also have a strong incentive to provide high-quality, whole-person care for individuals with complex health needs, such as those with disabilities and chronic conditions. To control over-spending by avoiding unnecessary high-cost care such as emergency department visits or preventable hospitalizations, many ACOs identify the highest risk patients, such as those with multiple chronic conditions or co-morbid mental health conditions and provide tailored care coordination services and often additional benefits at no cost to patients. Waivers and other flexibilities allow ACOs to provide these additional benefits and services even though they would not traditionally be covered under Medicare in order to meet patient needs. ACO affiliation has been linked with greater use of care coordination strategies.[1] Leveraging preventive medicine and patient engagement strategies, ACO providers work with patients and their care teams to develop care plans that encompass physical health, behavioral health, and often social needs. Many ACO practices implement a team-based care approach and patient engagement strategies and therefore ACO patients often experience better health

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6417934/

outcomes, more timely access to care, and are more likely to receive appropriate preventive screenings and interventions. Providers in ACOs are also more likely to have care transition management practices in place between primary care and inpatient settings to coordinate patient care.[2] These care management strategies are considered a leading evidence-based approach for treating patients with complex needs.[3]

Many ACOs incorporate health equity initiatives within their care coordination strategies. Studies have shown that ACOs are increasingly working to address patients' nonmedical needs to improve their health outcomes and partner with community-based organizations (CBOs) to meet housing and transportation needs and address food insecurity.[4] However, there are many barriers to implementing such equity-focused initiatives, including the needs for upfront funding to stand up and scale programs, sustainable financing models to coordinate between medical care and social services, and policy flexibilities to deliver tailored care that meets diverse patient needs.

The Centers for Medicare & Medicaid Services (CMS) has stated a goal to have all Medicare fee-for-service beneficiaries in an accountable care relationship by 2030. Today, there are more than 30 million traditional Medicare patients still in unmanaged, uncoordinated care. Recently, CMS released data showing a very modest year-over-year growth in ACO participation, continuing a troubling trend of flat participation in the Medicare Shared Savings Program (MSSP). Greater incentives are needed for providers to participate in total cost of care models, to outweigh the risk, uncertainty, and sizeable upfront and ongoing investments needed to participate. Congress can play a strong role in rebalancing those incentives and encouraging growth in Medicare programs that promote better patient outcomes at lower cost.

We encourage the committee to consider the bipartisan Value in Health Care Act (H.R. 4587),[5] which would go a long way to address incentives for provider participation in these models. The bill would increase shared savings rates for ACOs to restore them to when the MSSP was launched, modify risk adjustment to be more realistic and better reflect factors participants encounter, remove the arbitrary high and low revenue ACO distinction that creates an inequitable path to risk, remove ACO beneficiaries from the regional benchmark to ensure ACOs are not penalized as they achieve savings for their assigned populations, among other changes. Importantly, it would also extend the Advanced APM bonus that Congress created in the Medicare Access and CHIP Reauthorization Act or 2015 (MACRA) for an additional six years and gives the HHS Secretary greater discretion to determine thresholds providers must reach to receive those bonuses. These bonuses have been instrumental in encouraging participation in risk-based APMs but expire at the end of this year. Congress must act to prolong these bonuses and encourage more providers to enter into APMs to extend the benefits we describe above to more Medicare beneficiaries.

We appreciate the opportunity to express our views on the Health Subcommittee, U.S. House of Representatives Ways & Means Committee hearing regarding Bridging Health Equity Gaps for People with Disabilities and Chronic Conditions. We support the efforts of the subcommittee to ensure that high-quality, coordinated and person-centered care is accessible to all Medicare beneficiaries.

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[2] https://journals.sagepub.com/doi/full/10.1177/1355819620913141
[3] https://www.ahrq.gov/sites/default/files/publications/files/caremgmt-brief.pdf
[4] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0727
[5] https://www.congress.gov/bill/117th-congress/house-bill/4587?q=%7B%22search%22%3A%5B%22Value+in+Health+Care+Act%22%2C%22Value%22%2C%22in%22%2C%22Health%22%2C%22Care%22%2C%22Act%22%5D%7D&s=1&r=1