Written Statement for the Record
Of
The National Association of ACOs
For the
House Committee on Energy and Commerce
Subcommittee on Health
Hearing on
"Health Care Spending in the United States: Unsustainable for Patients, Employers, and Taxpayers"

January 31, 2024

The National Association of ACOs (NAACOS) appreciates the opportunity to submit a statement to the House Energy and Commerce Subcommittee on Health in response to the hearing "Health Care Spending in the United States: Unsustainable for Patients, Employers, and Taxpayers." NAACOS represents more than 430 accountable care organizations (ACOs) in Medicare, Medicaid, and commercial insurance working on behalf of health systems and physician provider organizations across the nation to improve quality of care for patients and reduce health care cost. NAACOS members serve over 9 million beneficiaries in Medicare value-based payment models, including the Medicare Shared Savings Program (MSSP) and the ACO Realizing Equity, Access, and Community Health (REACH) Model, among other alternative payment models (APMs). NAACOS appreciates the committee's leadership and commitment to improving access to health care and lowering costs. Our comments reflect the views of our members and our shared goals.

APMS ARE A PLATFORM FOR INNOVATION AND COST SAVINGS

A major pathway for improving access to health care and lowering costs is through advancing APMs. Over the last two decades, APMs have demonstrated that when providers are accountable for costs and quality and provided flexibility from fee-for-service (FFS) constraints, they are able to generate savings for taxpayers and improve beneficiary care. This emphasis on outcomes allows physicians and other clinicians to improve care coordination and prioritize primary and preventive care, keep patients healthy, and coordinate care across the continuum. Last year, NAACOS provided feedback to the House Budget Committee and House Ways and Means Committee on how APMs can help lower costs and increase health care access and quality in rural and underserved communities. [1] [2]

ACOs are the Largest and Most Successful Model Leading Medicare's APM Transformation

In 2024, there are 603 ACOs coordinating care for 13.4 million Medicare beneficiaries. ACOs are a voluntary alternative to the fragmented FFS system that gives doctors, hospitals, and other health care providers the flexibility to innovate care and holds them accountable for the clinical outcomes and cost of treating an entire population of patients.

With primary care as the backbone, ACOs employ a team-based approach that allows clinicians to ensure patients receive high quality care in the right setting at the right time. The ACO model also provides an opportunity for providers to work collaboratively along the continuum while remaining independent. Importantly, ACOs provide shared savings opportunities and enhanced regulatory flexibility that allows clinicians to maintain financial security while practicing medicine more freely.

It's clear these payment system reforms have been a good financial investment for the government. In the last decade, ACOs have generated more than $22.4 billion in savings with $8.8 billion being returned to the Medicare Trust Fund while maintaining high quality scores for their patients. The growth of APMs has also produced a "spill-over" effect on care delivery across the nation, slowing the overall rate of growth of health care spending. Last year, the Congressional Budget Office (CBO) also reported that actual Medicare and Medicaid spending between 2010–2020 was 9 percent lower than original projections.[3] While there are several influences for these changes in spending, improved care management and more efficient use of technology were factors highlighted by CBO. Moreover, providers in APMs help make the Medicare program stronger by reducing improper payments. Using enhanced data and analytics, ACOs regularly identify and report instances of fraud, waste, and abuse.

Regulatory and Statutory Barriers Limiting Growth of APMs

APMs have allowed physicians and other clinicians to change care delivery and improve care coordination while reducing costs. APMs are becoming more rooted in our health care system but growth has been slower than Congress' original goal. It is essential to remove barriers to participation and give additional flexibility and tools to innovate care. Specifically, Congress should:

- **Extend Medicare's advanced APM incentive payments—** MACRA's advanced APM incentive payments encourages providers to move into risk-based payment models while also providing funds that allow them to cover services not reimbursed by traditional Medicare (e.g., meals programs and transportation). These are the types of services that help address patients' social needs, keep patients healthier, and lowers costs. We are encouraged that the Energy and Commerce Committee approved a short-term extension of these incentive payments at the end of 2023. We look forward to working with lawmakers to pass an extension as soon as possible.
- **Develop solutions to improve physician payment—** Stabilizing Medicare's payment system and ensuring payment adequacy is necessary to help physicians and allow them to continue investing in the infrastructure and staffing necessary to transition into value-based models. The current physician payment system does not account for inflation and results in inadequately paying providers as costs rise. We encourage the committee to continue holding hearings on this important issue and consider developing a new payment system that accounts for inflation in payment updates and maintains stronger financial incentives for physicians that move into APMs.
- **Reduce Regulatory Barriers that limit APM adoption—** While APMs have offered numerous benefits to providers and patients, more can be done to attract more providers and meet the unique needs of certain beneficiary populations. It is essential to remove barriers to participation and give additional flexibility and tools to innovate care, including:
    - Delaying implementation of digital quality reporting to address operational issues that will increase costs and burdens on physician practices and ACOs.
    - Improving benchmarks so that APM participants are not penalized for success.
    - Reducing regulatory burdens for providers moving to risk.
    - Addressing unique payment challenges for serving rural and underserved populations.

    - Considering approaches to bring more providers to total cost of care models.
- **Improve approaches to test and scale innovation—** The Centers for Medicare and Medicaid Innovation (CMMI) has been successful in testing innovative payment arrangements and increasing adoption of APMs. The successes of the Innovation Center are not captured within current evaluation approaches. Congress should work with CMS to ensure that promising models have a more predictable pathway for being implemented and becoming permanent and are not cut short due to overly stringent criteria. This includes broadening the criteria by which CMMI models qualify for Phase 2 expansion and directing CMMI to engage stakeholder perspectives during APM development.
- **Establish parity between APMs and Medicare Advantage program requirements—**Recognizing ACOs' and MA's shared goals of improving the quality of care and cost savings to patients, it's imperative to build parity between the two programs. Misaligned incentives are harmful to advancing value as they increase provider burden, create confusion and disincentives for patients, and generate market distortions that favor one entity over another. Parity can be better provided in the programs' benchmark and risk adjustment policies, quality measurement, and marketing requirements. ACOs should be allowed to provide comparable benefits to those offered to MA patients, such as telehealth visits, transportation benefits, home visits, etc. Without parity, providers are forced to spend time managing the various program requirements rather than managing patient care. Congress should direct the Government Accountability Office (GAO) to evaluate how to create more parity between APMs and MA. Additionally, Congress should explore opportunities to incentivize MA plans to enter risk-bearing arrangements with providers.

We thank the committee for this opportunity to provide feedback on this important hearing. NAACOS and its members are committed to providing the highest quality care for patients while advancing population health goals for the communities they serve. We look forward to our continued engagement on improving health care access and lowering costs. If you have any questions, please contact Aisha Pittman, senior vice president, government affairs at aisha_pittman@naacos.com

[1] https://www.naacos.com/assets/docs/pdf/2023/FINAL_NAACOSComments-HealthCareTaskForceRFI_10152023.pdf
[2] https://www.naacos.com/assets/docs/pdf/2023/NAACOSWaysMeansRuralRFI10052023.pdf
[3] https://www.cbo.gov/publication/58997#:~:text=CBO%20overestimated%20mandatory%20spending%20for%20health%20care%20in,9%20percent%20lower%20than%20CBO%20projected%20in%202010