STATEMENT FOR THE RECORD

of

American Medical Association, AMGA, America's Physician Groups, Association of American Medical Colleges, Health Care Transformation Task Force, Medical Group Management Association, National Association of ACOs, and Premier healthcare alliance

to the

U.S. Senate Committee on Finance
Subcommittee on Fiscal Responsibility and Economic Growth

Hearing on the Hospital Insurance Trust Fund and the Future of Medicare Financing

February 2, 2022

The undersigned organizations write to express our collective support for value-based payment arrangements and alternative payment models (APMs) as a means to help prolong the solvency of the Medicare trust fund. According to the most recent Medicare Trustees' Report to Congress, Medicare program assets will be depleted by 2026.[1] This should sound the alarm to Congress and be a reason to update existing law to both encourage new providers to enter into APMs and keep existing providers participating in these models. We offer explanations below as to why Congress should promote value-based care and offer recommendations for how that can be done.

To avoid depleting resources and prolong the Medicare trust fund, Congress in 2010 created the Medicare Shared Savings Program and Center for Medicare and Medicaid Innovation (CMMI) as part of the Patient Protection and Affordable Care Act. In 2015, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA) to promote participation in the Shared Savings Program and other APMs created by CMMI. The overall goals of these two laws were to foster a value-based payment system in health care where providers would be incentivized to provide higher quality care at a lower cost.

So far, value-based care is taking root in our health care system, improving patient care and successfully bending the cost curve. The Centers for Medicare and Medicaid Services (CMS) estimates that Medicare Part A and B spending will grow by approximately 0.7 percent below the rate of inflation between 2021 and 2030.[2] This is a positive sign that recent payment reform efforts have taken hold. Since 2012, accountable care organizations (ACOs) have saved Medicare $13.3 billion in gross savings and $4.7 billion in net savings.[3] While that may sound small in comparison to Medicare's overall spending, data from the Medicare Payment Advisory Commission, researchers at Harvard University, and the analytic firm Dobson DaVanzo and Associates show that ACOs are lowering Medicare spending annually by 1 percent to 2 percent.[4,5,6] Knowing Medicare Parts A and B cost $636 billion in 2018, a 2 percent reduction

[1] https://www.cms.gov/files/document/2021-medicare-trustees-report.pdf
[2] https://www.cms.gov/files/document/2021-medicare-trustees-report.pdf
[3] https://www.naacos.com/highlights-of-the-2020-medicare-aco-program-results
[4] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch6_medpac_reporttocongress_sec.pdf
[5] https://www.nejm.org/doi/full/10.1056/NEJMsa1803388
[6] https://www.naacos.com/studyofmsspsavings2012-2015

in spending would save nearly $200 billion when compounded over a decade, assuming Medicare spending would grow at 4.5 percent per year without ACOs.[7]

Further evidence that ACOs lower spending comes from the impact analysis of the proposed "Pathways to Success" rule in August 2018, in which the CMS Actuary used claims data to look at spending in ACO markets versus non-ACO markets. The agency estimated the overall impact of ACOs, including "spillover effects" on Medicare spending outside of the ACO program, lowered spending by $1.8–$4.2 billion in 2016 alone. [8] When ACOs lower spending across the fee-for-service system, this also lowers payments to Medicare Advantage plans since those payments are based, in part, on fee-for-service spending.

We also know value-based payment models improve quality. In an August 2017 report, the HHS Inspector General reported that in the first three years of MSSP ACOs improved their performance on 82 percent of the individual quality measures compared to their baseline.[9] After the first three years 98 percent of ACOs met or exceeded quality standards. In the same report the Inspector General found that ACOs outperformed fee-for-service providers on 81 percent of quality measures. A study published in the January 2017 issue of Health Affairs found that Medicare ACOs lowered hospital readmissions faster than hospitals not affiliated with an ACO.[10]

APMs, including ACOs, uphold patient rights and regularly evaluate patient satisfaction. Importantly, patients maintain their freedom of choice within traditional Medicare, allowing them to see any willing provider. In ACO models, there are no networks or prior authorization. In fact, patients in many APMs receive more benefits under traditional Medicare such as home visits for care management or post-hospital care, cost sharing support, and chronic disease management rewards. Often, patients must be notified they are being seen by a provider practicing in an APM. Providers in APMs are also held to quality measures to ensure the best patient care and incentive payments can't be received without hitting a threshold for high-quality care.

The committee should be focused on leveraging knowledge gained over the last decade of work in value-based payment to promote a more fiscally sustainable health system. APMs focus on value over volume with a commitment to driving wellness and whole-person care. Providers in APMs place a premium on identifying high-need patients, with an emphasis on delivering proactive, preventive care, chronic disease management, care management, and better transitions of care along with a myriad of other tactics that yield better patient outcomes.

We encourage the Committee to consider the bipartisan Value in Health Care Act (H.R. 4587), which would go a long way to address incentives for APM participation.[11] The bill would increase shared savings rates for ACOs to restore them to the levels 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.

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[7] https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/

[8] https://www.govinfo.gov/content/pkg/FR-2018-08-17/pdf/2018-17101.pdf

[9] https://oig.hhs.gov/oei/reports/oei-02-15-00450.asp

[10] https://www.commonwealthfund.org/publications/journal-article/2017/jan/aco-affiliated-hospitals-reduced-rehospitalizations-skilled

[11] 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

Importantly, it would also extend the Advanced APM bonus that Congress created in 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.

Unfortunately, the pace of APM adoption has not been as fast as Congress desired when MACRA was passed in 2015. Today, there are more than 30 million traditional Medicare patients still in unmanaged, uncoordinated care. Last week, CMS released data showing a very modest year-over-year growth in ACO participation, continuing a troubling trend of flat participation in MSSP. Greater incentives are needed for providers to participate in APMs, 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 appreciate the opportunity to express our views on the Fiscal Responsibility and Economic Growth Subcommittee, U.S. Senate Finance Committee hearing regarding the Hospital Insurance Trust Fund and the Future of Medicare Financing. We support the efforts of the Subcommittee to ensure that the Medicare program remains solvent and look forward to working with the Committee on this important topic.