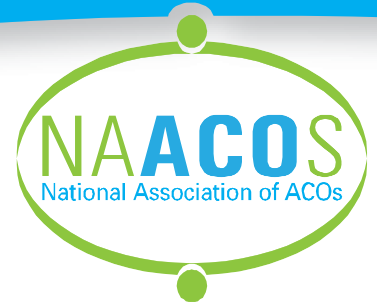

National Association of ACOs

Statement for the Record

Committee on Finance

United States Senate

Re: Medicare Physician Payment Reform After Two Years:

Examining MACRA Implementation and the Road Ahead

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We thank the committee for their work on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and for continuing to ensure the proper implementation of this landmark legislation. We appreciate the opportunity to provide comments on the recent Committee on Finance hearing, "Medicare Physician Payment Reform After Two Years: Examining MACRA Implementation and the Road Ahead."

The National Association of ACOs (NAACOS) is the largest association of accountable care organizations (ACOs), representing more than 5 million beneficiary lives through 330 Medicare Shared Savings Program (MSSP), Next Generation Model, and commercial ACOs. NAACOS is an ACO member-led and member-owned nonprofit working on behalf of ACOs across the nation to improve the quality of Medicare, population health, outcomes, and healthcare cost efficiency. Our members want to see an effective, coordinated, patient-centric care process.

The ACO model is a market-based solution to fragmented and costly care that empowers local physicians, hospitals, and other providers to work together and take responsibility for improving quality, enhancing patient experience, and reducing waste. The number of ACOs in Medicare has grown considerably in recent years and included nearly 650 ACOs in 2018, covering 12.3 million beneficiaries. ACOs have been instrumental in the shift to value-based care and utilize cost-saving tools like telehealth to better reach their patient populations.

Therefore, we feel it is critical that Congress continue to guide the effective implementation of MACRA and the Quality Payment Program (QPP) by strengthening the role of Alternative Payment Models (APMs) as a key piece of the transition to a value-based payment system. As the premier APM, ACOs are focused on population health for the totality of patients they serve. We therefore urge Congress and the Centers for Medicare & Medicaid Services (CMS) take steps to ensure that the ACO program remains a robust, successful participation option for Medicare providers navigating both value-based care and MACRA. Our specific recommendations are as follows:

Quality Payment Program Recommendations

1. Extend the Advanced APM 5% bonus for an additional 6 years

Eligible clinicians who participate in an Advanced APM[1] and meet certain Qualifying APM Participant (QP) criteria will receive a 5% annual lump sum bonus from 2019 – 2024. Under the current statute, after 2024, that bonus expires and QPs will instead only receive a 0.75% increase in Medicare Part B payments.[2]

While CMS projections of the number of eligible clinicians that meet the QP criteria have increased with each year of the program, the number remains low. In fact, the number is lower than Congress envisioned in 2015 when MACRA was passed; in a 2015 CMS Office of the Actuary report, published shortly prior to the passage of MACRA, that office asserted that 60 percent of physician payment would be through Advanced APMs by 2019. The reality has been much slower: in the first year of the QPP, CY2017, CMS predicted between 9-16% of all eligible clinicians to become QPs. For the third year of the QPP, CY2019, CMS estimates that between 17-21% of eligible clinicians will be QPs. Given the slow implementation of

[1] CMS identifies qualifying Advanced APMs annually. In 2019, CMS has identified 13 AAPMs. See CMS "Advanced Alternative Payment Models (APMS)," available here.
[2] The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Pub. L. 114-10(a)(2)(C)(20), enacted April 16, 2015.

Advanced APMs, we urge the extension of the 5 percent Advanced APM bonus for an additional 6 years to encourage adoption.

2. Lower or remove the QP thresholds

To become a QP, an eligible clinician must receive at least 50 percent of their Medicare Part B payments or see at least 35 percent of Medicare patients through an Advanced APM entity at one of three determination snapshots during the year. In addition, 75 percent of practices need to be using certified EHR Technology within the Advanced APM entity. While certain eligible clinicians may also become a QP through the "All-Payer and Other Payer Option," which is a combination of Medicare and non-Medicare payer arrangements such as private payers and Medicaid, this option has not been widely utilized. The current and future QP thresholds are challenging for providers to meet, resulting in less participation in Advanced APMs. Many providers already have difficulty meeting the current percentage threshold, which increased in performance year 2019. The 75 percent threshold that goes into effect for performance year 2021 is far too high for continued widespread and meaningful participation and will undoubtedly preclude many providers from obtaining QP status. To continue to increase participation in Advanced APMs, we urge Congress to modify the statutory QP thresholds such that CMS has discretion to set thresholds OR modify the payment amount threshold to be set at a lower level.

3. Address APM overlap

As more APMs are rolled out, APM overlap within markets and provider organizations has occured more frequently, and we have observed confusion in the marketplace regarding which APMs providers may participate, and when. While some APMs can complement one another when it comes to improved quality and other outcome-based goals, participation in more than one APM can result in conflicting financial incentives that undermine the objectives of those already in existence. APM overlap also adds administrative complexity and dilutes the savings opportunities for those already on the forefront of care redesign.

To address APM overlap, we recommend:

i. An independent review of all CMS APMs and how they overlap with one another, and a subsequent report back to Congress about APM overlap and how the agency is mitigating concerns related to overlap such that APMs support one another rather than conflict.
ii. CMS should be required to address how model overlap will work with each release of a new model. A market-driven approach should be prioritized, establishing methods for APMs to work together.
iii. CMS should be permitted to allow multiple program participants to keep the shared savings they have earned regardless of the existence of program overlap in instances where at least one of the programs is being tested by the Center for Medicare and Medicaid Innovation, under 1115A of the Social Security Act.

4. Modify the All-Payer Combination Option

The All-Payer Combination Option takes into account an eligible clinician's participation in Advanced APMs both with Medicare and other payers (including Medicare Advantage, Medicaid, and other commercial plans) when determining whether the eligible clinician meets the QP threshold. The All-Payer Combination Option allows eligible clinicians to become QPs through participation in a combination of Advanced APMs

and Other Payer Advanced APMs starting in the 2019 QP Performance Period. We recommend modifying the All-Payer Combination Option to be a Multi-Payer Combination Option to allow for increased participation of this option.

As currently structured, CMS requires providers to submit detailed information on all payers with which they have contracts. While there are an increasing number of opportunities to work with payers outside of Medicare on value-based arrangements, many payers do not yet offer APMs that meet CMS's definition of an Advanced APM. Accordingly, providers do not have ample opportunity to receive additional credit for their participation with those payers that do offer Advanced APMs. Effectively, being required to submit information on all payers, regardless of whether they offer Advanced APM opportunities, waters down Advanced APM participation with those that do offer Advanced APMs. We do not believe Congress's intent was to structure the All-Payer Combination Option in this manner, which does not meaningfully reward Advanced APM participation outside of Medicare. CMS has explained that the statutory language does not allow them to provide credit for Advanced APM participation with some payers while not factoring in payers that do not offer Advanced APM arrangements.

To remedy this problem, we urge Congress to modify the statute to base the All-Payer Combination Option on multiple payers without making providers have to meet a more difficult "All-Payer" threshold. This modification would change the All-Payer Combination Option to be additive in a way that it could only help APM entities meet QP thresholds when the entity is unable to do so strictly through Medicare APM participation.

5. Exclude MIPS payment adjustments from ACO expenditures

NAACOS also continues to oppose the unfair policy whereby CMS counts MIPS payment adjustments as ACO expenditures. The current framework CMS has established will punish ACOs for their high performance in MIPS. NAACOS believes CMS should recognize all ACOs, including those in BASIC tracks, as Advanced APMs. However, because CMS continues to subject BASIC track Level A, B, C, and D ACOs to MIPS, these ACOs have no choice but to be evaluated under MIPS while continuing their focus on the ACO program goals. Most ACOs will perform very well under the established MIPS performance criteria and therefore earn bonuses under the program. These bonuses will then count against the ACO when expenditures are calculated for purposes of MSSP calculations. Therefore, the better an ACO and its clinicians perform in MIPS, the more they will be penalized when calculating shared savings for the ACO. This is an unfair and untenable policy, and CMS must modify its position to exempt MIPS payment adjustments as expenditures in the ACO program. CMS does make claim level adjustments by adding sequestration costs back to paid amounts when calculating ACO expenditures, therefore the Administration has the technical ability to make such a change. It was not the intent of Congress to penalize ACOs in MIPS, and therefore CMS must alter this policy to continue encouraging provider participation in the BASIC track of the ACO program. Therefore, we urge Congress to work with CMS to revise this flawed policy.

6. Discontinue delays to MIPS implementation

NAACOS is concerned that Congress and the Administration continue to make changes to MACRA to further dilute accountability for quality and cost performance for Medicare beneficiaries. In the Bipartisan Budget Act (BBA) of 2018, Congress provided CMS with additional flexibility to implement the performance standard for which clinicians were intended to be evaluated against. Additionally, the BBA included a provision allowing for CMS to further delay the incorporation of cost measurement in MIPS. Congress

originally intended for cost to be a component of MIPS scores by 2021. CMS has already delayed incorporating cost in MIPS scores in 2019 and 2020 to provide clinicians with additional time to prepare. Further, for the 2018 performance year, CMS made the decision to exempt an additional 585,560 clinicians from the program, exempting an unprecedented number of clinicians from the performance requirements altogether.

NAACOS fears that continuing to dilute performance requirements and exempting nearly half of providers will discourage those clinicians who have already made a commitment to value-based care and invested time and resources towards making the shift to value-based care. Instead, Congress and CMS should reward high-performing clinicians who have invested heavily in performance improvement and should therefore be rewarded for this investment, time, and effort. While we support providing a phased-in approach to value-based payments for Medicare, it should be noted that the Agency's legacy programs, from which the MIPS program was developed, have been in existence for years and therefore these clinicians have had ample time to prepare for these changes. It is critical that Congress and CMS continue their commitment to transition providers toward value-based payments to improve the experience of care and the health of populations and reduce per capita costs of health care.

Medicare Shared Savings Program Recommendations

7. Increase MSSP BASIC track shared savings rates

Current rates shared savings rates finalized under the Pathways rules are: Basic Levels A and B: 40%; Levels C, D and E: 50%. We urge Congress to focus its efforts on not only making models with downside financial risk more attractive, but also continuing to support shared savings-only models. It is essential that Congress structure the program such that it includes a business model attractive enough to retain current participants while bringing in new ACOs to create a pipeline for ACOs to advance on the path to value-based care.

We urge Congress to provide sufficient shared savings rates to MSSP ACOs to ensure an adequate return on investment and their continued participation in the program. Specifically, increase the shared savings rates to at least the following: Basic Levels A and B: 50%; Levels C and D: 55%; Level E: 60%.

8. Eliminate the MSSP high-low revenue distinction

Under the Pathways to Success Final Rule, CMS created a new distinction between "high revenue" and "low revenue" ACOs. This distinction determines program specifics, including the timing for when an ACO must move to downside risk. Low revenue ACOs are allowed additional time under lower-risk options within the Basic track, while ACOs identified as high revenue are required to transition to the Enhanced track more quickly.

We urge Congress to eliminate this distinction for the following reasons. First, the distinctions are arbitrary- being "high" or "low" revenue does not determine when an ACO is ready to take on risk or how much risk they are able to assume. As previously described, significant investments are needed in population health platforms and care process changes for ACOs to bear risk. The financial position and backing of a particular ACO, as well as the ability to assume risk depends on a variety of factors, including local market dynamics, culture, leadership, financial status, previous program success, and the resources required to address social determinants of health that influence care and outcomes for patients.

Second, the high and low revenue distinctions create unnecessary program complexity. Furthermore, the move creates uncertainty for ACOs who may have a difficult time predicting the category in which they would fall. This distinction may also change over time as ACO participant composition changes, adding more complexity and making long-term planning very difficult. Removing the distinction would minimize some of the complexity and uncertainty.

9. Provide more time in shared savings-only models and keep the Enhanced track voluntary.

Currently, CMS only allows ACOs entering the program on the Basic Track to be in a one-sided risk contract for two to three years. ACOs previously in the program can only be in a one-sided risk model for one year. CMS also expects Basic Track ACOs to eventually transition to the Enhanced Track and therefore take on the most downside risk.

While there should be movement towards risk, ACOs need more time to produce positive financial results and such a movement should be appropriate and reasonable to encourage participation in the MSSP which is a voluntary program. The levels of risk required in two-sided models such as the Enhanced Track are much higher than what many ACOs can bear and are not viable options for most ACOs. The decision to take on risk is critical to an ACO's choice about which model to select and having to potentially pay millions of dollars to Medicare is not feasible for many of these organizations. Requiring ACOs to assume downside risk may result in many ACOs dropping out of the MSSP, which is an unintended consequence and will immediately reduce incentives to help bend the cost curve in Medicare.

We urge Congress to allow MSSP ACOs to remain in a shared savings-only model for at least three years before being required to assume any risk and to not require any ACOs to participate in the Enhanced track. This increased timeline and enhanced flexibility related to risk will help ACOs better prepare to take on downside risk, increase participation, and lead to more successful outcomes.

10. Update the MSSP risk adjustment methodology.

CMS uses the CMS Hierarchical Condition Category (CMS-HCC) prospective risk adjustment models to calculate beneficiary risk scores, adjust the benchmark years used for the historical benchmark, and compute the rebased historical benchmark. Accurate risk adjustment is imperative to assess ACO performance, as risk adjustment should remove or minimize differences in health and other risk factors that impact performance but are outside the ACO's control. The risk adjustment cap finalized in the Pathways to Success rule allows up to a 3 percent increase over five years and should be increased. A risk adjustment methodology that allows risk adjustment scores to increase even more will give ACOs a better ability to meet their financial benchmarks. A downward cap should also be used, thus controlling for outliers on both ends of the spectrum. Further, Congress should require CMS to provide additional transparency on the risk adjustment methodology, which would allow ACOs to better understand the process and provide more certainty.

Specifically, Congress should:

i. Implement a risk adjustment methodology that allows risk adjustment scores to increase at least 5% over 5-year agreement period and apply a cap of up to -5% on downward adjustments.
ii. Require CMS to provide full transparency on the methodology (ex. algorithms) used in risk adjustment.

iii. Provide funding for an independent study comparing Medicare risk adjustment approaches across Medicare programs (including APMs and Medicare Advantage)

11. Modify the MSSP benchmarking methodology

There remain a number of flaws with the MSSP benchmarking methodology which must be addressed. Benchmarking is of the utmost importance to ACOs; it is a fundamental program methodology which determines how ACOs perform individually and is one of the ways CMS evaluates the overall success of the program.

Under the regional benchmarking methodology, CMS uses all "assignable beneficiaries," including ACO-assigned beneficiaries, in determining expenditures for the ACO's region. The determination of which beneficiaries are included in the regional population is very important as this population is the basis for calculating the regional expenditure data that is factored into benchmarks that include a regional component. Rather than comparing ACOs to themselves and other ACOs, CMS should compare ACO performance relative to fee for service (FFS) Medicare by defining the regional reference population as assignable beneficiaries without ACO-assigned beneficiaries for all ACOs in the region. At the very least, Congress should exclude the ACO itself from the region to prevent an otherwise tautological comparison that essentially double counts those ACO-assigned beneficiaries.

12. Allow NPI-level participation in the MSSP

Currently, MSSP ACO participation is limited to participation at the Tax Identification Number (TIN) level (i.e. acute care hospitals, group practice, solo practice, long term care hospitals, skilled nursing facilities, etc.). Participants in MSSP ACOs are identified by their TIN number. Consequently, there is no option for MSSP ACO participation at the National Provider Identifier (NPI) level.

This limitation presents challenges for individuals who wish to participate in an ACO and practice in a group setting that does not participate in an ACO under its TIN. Because providers cannot participate at the TIN level as an individual unless engaged in solo practice, they cannot participate in the program. We recommend Congress allows NPI-level participation in the MSSP to increase opportunities for participation and provide greater flexibility across a wider range of providers.

13. Provide upfront payments to help ACOs get started and assist providers that have difficulty moving to risk

Congress recognized the principle from the ACO authorizing statute that one of the purposes of creating ACOs is to "encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery." ACOs require a significant amount of investment to develop the necessary infrastructure and effectively adjust to a different approach to care. These investments are for clinical and care management, health IT/population analytics/reporting, and ACO management and administration. Not only do such investments require a significant amount of time and money, but they also require organizations to incur a substantial amount of risk apart from any risk associated with strictly providing care. The cost of the necessary infrastructure and operating expenses may deter ACOs from starting up in the first place or continuing on the path to value, as there is no guarantee that the ACOs will earn back the expenses associated with such investments.

We urge Congress to provide greater support to ACOs by providing upfront and ongoing payments to assist with such investments and operating costs. CMS previously offered programs to help fund ACOs up front, with those payments later recouped via shared savings. These programs, such as the ACO Investment Model (AIM), should be reinstated to help ACOs fund activities and transformations early on in ACOs' development.

14. Increase the MSSP BASIC track shared savings rates based on quality performance

Currently, an ACO that achieves CMS's established quality performance levels is not rewarded and is instead merely prevented from forfeiting the shared savings payments it has earned. There is no direct financial reward for improving quality of care and no penalty for poor quality unless the ACO has generated savings. This lack of reward can be a strong disincentive for ACOs to invest in quality improvement. Many efforts to improve the quality of care consume ACO resources and increase spending relative to the ACO's financial benchmark in the short term, even if they decrease Medicare spending over the long term. The more an ACO strives to improve quality performance, the more it often needs to spend. If the services used to improve quality are billable services, they will increase the ACO's spending and reduce the probability of beating its benchmark.

To emphasize and reward above average quality performance or improvement, we urge Congress to provide on a sliding scale up to 10 percentage points of additional shared savings to ACOs scoring in the top half of total ACO quality performance or quality improvement. Additionally, we urge Congress to add a bonus opportunity for ACOs whose quality performance is exceptional, but did not meet criteria for shared savings. Adding this bonus opportunity will more appropriately incentivize quality improvement.

Conclusion

In closing, we appreciate the committee's attention to the important issue of monitoring implementation of MACRA. We hope you will consider these comments as you continue in your efforts to ensure a successful implementation of this critical law which has the power to truly transform Medicare payments to pay for value over volume of services provided to beneficiaries.