June 28, 2022

The Honorable Frank Pallone
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Cathy McMorris Rodgers
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Diana DeGette
Chairwoman
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Morgan Griffith
Ranking Member
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

RE: Medicare Advantage Oversight Hearing

Dear Chairman Pallone, Chairwoman DeGette, Ranking Member McMorris Rodgers, and Ranking Member Griffith:

The National Association of ACOs (NAACOS) writes today to express support for value-based payment arrangements and alternative payment models (APMs) that serve as an alternative to Medicare Advantage (MA) for millions of Medicare beneficiaries. Accountable care organizations (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. These payment models help the Medicare program close gaps in health equity and ensure high-quality care for all patients, particularly those with disabilities and chronic conditions. NAACOS represents more than 13 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.

We urge the Committee to further examine ways to support payment and delivery reform in traditional Medicare to provide better care coordination alternatives to MA. There are numerous efforts underway in traditional Medicare to reward the efficient and cost-effective delivery of healthcare services. For example, the Medicare Shared Savings Program (MSSP) is the largest value-based payment model in the country and an essential tool in moving the health system toward better value by incentivizing higher quality, lower cost care. More than 480 ACOs participate in the MSSP, collectively caring for more than 11 million seniors, making ACOs the largest and fastest growing alternative to private MA plans.[1] Today, ACOs care for roughly a third

of patients not enrolled in MA and about 20 percent of all Medicare patients.

An important difference between ACOs and MA is that ACOs allow seniors to maintain their choice of provider. Since Medicare ACOs operate within traditional Medicare, there are no network restrictions that typically come with MA plans. There is also no use of prior authorization, which is the subject of the Committee's oversight. ACOs place a premium on improving access to care to better manage chronic conditions and avoid unnecessary trips to the costly emergency department.

With Medicare spending estimated to double in the next ten years, and the Medicare Hospital Insurance Trust Fund approaching insolvency, Congress and the Administration must work together now on bipartisan reforms to improve the Medicare program. Data from the Medicare Payment Advisory Commission (MedPAC) shows Medicare spends 4 percent more on MA than it would spend on fee-for-service Medicare.[2] This is unsustainable given Medicare's financial outlook. MedPAC has also recommended reforms for the MA program along with incentivizing APM programs to shift care from high-cost to lower-cost settings. Medicare trustees have also suggested placing more emphasis on APMs as a way to keep Medicare solvent.

While MA plans in the aggregate have never produced savings for Medicare, data from CMS shows ACOs have saved Medicare $13.3 billion in gross savings and $4.7 billion in net savings in the last decade.[3] Data from MedPAC, 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 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] Furthermore, when ACOs lower spending across the fee-for-service system, this also lowers payments to MA plans since those payments are based, in part, on fee-for-service spending. MedPAC also recommended in their June Report to Congress that policymakers may want to reconsider CMS's current practice of including ACO shared savings payments in MA benchmarks since it results in CMS "double paying" for these bonuses and drives up Medicare spending.[8]

Since passage of the Affordable Care Act (ACA) and Medicare Access and Chip Reauthorization Act (MACRA), value-based care has taken root in our healthcare system, improving patient care and successfully bending the cost curve. We also know value-based payment models improve quality. In an August 2017 report, the Health and Human Services (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]

Going forward, 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. ACOs focus on value over volume with a commitment to driving wellness and whole-person care. Providers in ACOs 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.

With value-based payment programs at a critical crossroads, we are calling on the Committee to consider the bipartisan Value in Health Care Act (H.R. 4587), which would go a long way to address incentives for ACO and 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.

Most importantly, it would also extend the 5 percent Advanced APM incentive payment 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 payments. These incentive payments have been instrumental in encouraging participation in risk-based APMs but expire at the end of this year. Congress must act this year to prolong these incentive payments and encourage more providers to participate in 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 around 20 million traditional Medicare patients still in unmanaged, uncoordinated care. Earlier this year, 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 costs.

We appreciate this opportunity to express our views on the Subcommittee's hearing regarding oversight of MA plans. We support the efforts of the Committee to improve the Medicare program and look forward to working together to advance policies that will strengthen Medicare's critical value-based care models.

Sincerely,

Clif Gaus, Sc.D.
President and CEO
NAACOS

[1] https://www.cms.gov/files/document/2022-shared-savings-program-fast-facts.pdf
[2] https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.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
[7] https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/
[8] https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_SEC.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