October 31, 2022

The Honorable Ami Bera, M.D.
172 Cannon House Office Building
Washington, DC 20515

The Honorable Larry Bucshon, M.D.
2313 Rayburn House Office Building
Washington, DC 20515

The Honorable Kim Schrier, M.D.
1123 Longworth House Office Building
Washington, DC 20515

The Honorable Michael Burgess, M.D.
2161 Rayburn House Office Building
Washington, DC 20515

The Honorable Earl Blumenauer
1111 Longworth House Office Building
Washington DC, 20515

The Honorable Brad Wenstrup, M.D.
2419 Rayburn House Office Building
Washington DC, 20515

The Honorable Brad Schneider
300 Cannon House Office Building
Washington DC, 20515

The Honorable Mariannette Miller-Meeks
1716 Longworth House Office Building
Washington, DC 20515

RE: Congressional Request for Information (RFI) on the Medicare Payment System

Dear Representatives Bera, Bucshon, Schrier, Burgess, Blumenauer, Wenstrup, Schneider, and Miller-Meeks:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to the request for information (RFI) on actions Congress should take to stabilize the Medicare payment system. NAACOS represents more than 400 accountable care organizations (ACOs) that serve more than 13 million beneficiaries in a variety of value-based payment and delivery models in Medicare, Medicaid, and commercial insurers. Our ACO members participate in Medicare models including the Medicare Shared Savings Program (MSSP) and the Global and Professional Direct Contracting Model (GPDC), among other alternative payment models. We applaud this important initiative to improve the Medicare Access and CHIP Reauthorization Act (MACRA) and ensure the success of value-base care initiatives. Our comments below reflect our shared goals and policy recommendations for advancing value-based care.

SUMMARY OF KEY RECOMMENTATIONS

- In an end-of-year legislative package Congress should extend MACRA's expiring 5 percent advanced alternative payment model (APM) incentive payments and freeze the qualifying thresholds, which are scheduled for steep increases under current law.
- In the next Congress, lawmakers should work with stakeholders to revise MACRA's incentive structure; making payments more sustainable with stronger financial incentives for advanced APM

participation, decoupling APMs from fee-for-service (FFS), expanding non-financial incentives (e.g., waivers and telehealth), and increasing transparency for Center for Medicare and Medicaid Innovation (CMMI) models.

SUCCESS OF MACRA AND CURRENT CHALLENGES

MACRA's Successes

As you know, a key aim of MACRA was to encourage physicians and other health care providers to transition into advanced APMs. These are payment models rooted in the principles of accountability where financial performance is linked to quality over volume. To help achieve this important goal, MACRA provided 5 percent incentive payments to facilitate participation in advanced APMs. Since MACRA became law in 2015, these incentive payments have helped grow participation in advanced APMs with nearly 300,000 providers projected to participate in 2022.

The incentive payments not only encourage physicians and other health care providers to enter models, but also provide additional resources that can be used to expand services beyond traditional FFS. ACOs, the predominate type of advanced APM, use the 5 percent incentive payments to reinvest in patient care, fund wellness programs, fund patient transportation and meals, and hire patient navigators. MACRA's incentive payments help provide services that are not typically reimbursed through Medicare but improve patient health outcomes and wellbeing.

It's clear these payment system reforms have been a good financial investment for the government, generating cost savings for the Medicare Trust Funds and improving patient outcomes. In the last decade, ACOs have generated more than $16 billion in savings and produced higher quality care for 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.

Challenges of MACRA

While advanced APMs are transforming how patients in traditional Medicare receive care, the ability for clinicians to qualify for the incentive payments is set to expire at end of 2022. If these incentives expire, it will discourage future participation in models that have seen growing uptake in recent years. When MACRA became law, CMS estimated that the share of Medicare physician dollars in APMs would increase to 60 percent in 2019 and to 100 percent by 2038.[1] Unfortunately, uptake of these models has been slower than originally projected. As of 2020, only 24 percent of Medicare payments were tied to APMs incorporating downside risk.[2] Several factors have contributed to slower growth in advanced APMs:

- Incentives favor the Merit-Based Incentive Payment System (MIPS). Total maximum incentives permitted under MIPS (9 percent) are greater than the 5 percent advanced APM incentive payment, therefore incentives are misaligned. This will only become more pronounced if the 5 percent incentive payments for advanced APMs expire and high-performing clinicians can earn a

[1] https://www.cms.gov/research-statistics-data-and-systems/research/actuarialstudies/downloads/2015hr2a.pdf
[2] https://www.cms.gov/files/document/fy2023-cms-congressional-justification-estimates-appropriations-committees.pdf

higher bonus in MIPS. CMS also highlights that MACRA incentives for advanced APMs are not expected to catch up to maximum MIPS bonuses until after 2038.[3]

- Participants in APMs are often still subject to MIPs. Clinicians in non-risk bearing APMs or advanced APMs that do not meet qualifying thresholds for incentive payments remain in MIPS. This creates additional burden as the clinicians must be responsible for MIPS quality and quality in the APM. This creates a disincentive to participate in APMs and holds FFS as the gold standard, rather than value-based payment.
- Insufficient model development for all types of providers. While CMS' population health models have seen sizable growth in the last 10 years, CMS and CMMI have not created enough models for all types of providers. Model overlap has also been an issue since many clinicians, or entities, participate in multiple models. Conflicting incentives and administrative burdens associated with overlap has not been effectively addressed by CMS, causing some entities to forgo or drop participation.
- Inability for some providers to move to risk. Providers vary in their ability to take on downside risk, particularly providers who operate at cost or serve vulnerable populations. Additionally, we know that all providers need time and significant investment to move to risk. Successful transition to advanced APMs has a high cost to providers that can average $1 to 2 million per year.
- Thresholds to qualify for the bonuses are too high under current law. In the 2023 Medicare Physician Fee Schedule proposed rule, CMS estimates that 80,000–100,000 clinicians may no longer qualify as advanced APM participants because of increasing qualification thresholds and expiring incentives. Additionally, the thresholds are calculated in a way that can make including specialists in population health models more difficult.

EXTENSION OF CURRENT INCENTIVES

Overall, MACRA's incentives have driven change in the Medicare payment system, but the incentive structure needs to be revisited for growth to continue. It's clear that advanced APMs are transforming how patients in traditional Medicare receive care but uptake has been slower than originally projected. In the short-term, Congress can maintain MACRA's progress by extending the 5 percent advanced APM incentive payments and freezing qualifying participant (QP) thresholds at current levels.

The 5 percent advanced APM incentive payments help drive growth in risk-based models, which save Medicare money and provide additional services for patients. If the incentives expire this year, and qualifying thresholds increase to unattainable levels, there will be a significant reduction in the move to value. Increasing thresholds and expiring incentives could result in a 32–42 percent drop in participation. A shift back to FFS for these clinicians could possibly increase total Medicare spending annually by $714 to 882 million. As Congress considers priority end-of-year legislation, it's critical that an extension of MACRA's incentives be included.

FUTURE FINANCIAL INCENTIVES

Basis Principles for Revising Incentives

[3] https://www.govinfo.gov/content/pkg/FR-2022-07-29/pdf/2022-14562.pdf

While MACRA's incentive structure was designed to encourage movement to value, we have learned that the current incentive structure is complex and does not always favor value, as noted above. Most notably, Congress should start by revising MACRA's two pathway approach (i.e., MIPS or advanced APMs) and developing a three-tier system that provides increased flexibility and financial incentives for the adoption of value. The three-tier participation tracks should be:

- Fee-for-service—clinicians that are not participating in any alternative payment model. MIPS should be revised so that the program does not incent remaining in FFS. Specifically, Congress should structure MIPS as a penalty only program with positive payment incentives only for those clinicians' taking steps towards value adoption. To remain a budget neutral program, the penalties from MIPS should be used for incentives in the other remaining tracks.
- APMs—clinicians participating in ACOs or other alternative payment models that hold them accountable for cost and quality. Clinicians in this track should be exempt from MIPS and only held to the quality and payment parameters of their model. Financial incentives should recognize the up front and ongoing investments needed to be successful in APMs.
- Advanced APMs—clinicians participating in risk-based models. This track should have the strongest financial incentives and flexibility.

Additionally, new tracks should focus on simplifying the incentive structure to help providers more easily weigh the costs and benefits of the progression to value. Additionally, incentives and payment model structure must also account for providers serving vulnerable populations. Specifically, incentives, payment and model flexibilities should consider the services needed and costs of addressing social determinants of health (SDOH). Ultimately, the incentive structure and payment models should be decoupled from FFS over time. Increasing participation in APMs and Medicare Advantage (MA) will (1) require a new approach for determining payment as FFS will no longer be a sufficient reference population and (2) reduce the need for archaic FFS rules aimed at preventing waste.

Conversion Factor

Beginning in Performance Year 2024, clinicians will be eligible to receive 0.75 percent conversion factor updates for qualifying as an advanced APM. Under MACRA's current incentive structure, this might not be enough of an incentive for providers to move into risk-based models. CMS expressed concern in the 2023 Medicare Physician Fee Schedule that the substantial difference between the QP conversion factor and maximum positive payment adjustment available under MIPS might affect the willingness of eligible clinicians to participate in advanced APMs for several years to come. If this happens it could also impact the availability and distribution of funds in the budget neutral MIPS payment pool as more high performing clinicians choose not to participate, or don't qualify, as advanced APMs. Moreover, the current structure does not account for inflation and could result in inadequately paying providers as costs rise. A three-tiered payment system should account for inflation in payment updates and maintain incentives for moving to value by providing higher updates for APMs and advanced APMs.

It's also critical that Congress includes safeguards to ensure that payment updates for all types of APMs do not negatively impact their financial performance in their models. For example, in the current structure when advanced APMs receive a higher payment update it will be more difficult for the advanced APM to reduce spending below benchmarks. This is because APM benchmarks are based on national and regional spending trends; with most providers still under FFS, the benchmarks will be reflective of the lower payment update. Congress should direct CMS to ensure that benchmarks are not penalizing APMs for an incentive structure designed to encourage value.

Bonuses and Incentive Payments

With only 24 percent of clinicians in value models, robust financial incentives are still needed to grow APM participation. Beyond an initial short-term extension of MACRA's incentives, Congress should still consider a more sustainable longer-term incentive payments system that helps clinicians move away from standard FFS. To successfully transition to value-based care models, clinicians must invest in workflow improvements, digital health tools, care coordinators, data analytics, quality measurement systems, transitional care services, and innovative patient engagement methods. While these advanced care delivery tools help improve patient care and outcomes, it is not without a cost. Incentive payments have been critical in helping clinicians make these initial investments and continue reinvesting in these care transformation initiatives that benefit patients. MACRA's payment system reforms and financial incentives have helped drive this care transformation. Going forward Congress should use incentives as the building blocks to care transformation and consider the following:

- Extend and increase the percentage of incentive payments for new participants and clinicians serving rural and underserved communities. Participation in risk-based models has been well below original projections and more robust incentives will help draw more clinicians into models. Incentive payments could also be slowly phased down or adjusted over time once participation in APMs reaches pre-determined thresholds.
- Align the qualification year with the year in which incentive payment amounts are calculated. The current two-year lag in payments is a disincentive.
- Direct payments to the APM entity that is in the best position to determine the allocation of funds. This would align with how CMS pays ACOs for shared savings under the MSSP rather than directly paying the participant tax identification numbers (TINs) within the ACO. This approach will allow ACOs to allocate incentive payments fairly and accurately in accordance with the shared risk of individual eligible clinicians in an APM entity.
- Establish a permanent high-performance bonus program that is funded using APM savings returned to Medicare. ACOs save Medicare billions of dollars. High performance bonuses could be limited to advanced APMs or expanded to all APMs with a sliding scale for payments.

Qualification Thresholds

MACRA's current qualification thresholds are measured based on the individual providers in the APM. This approach has several limitations that make it difficult for some ACOs to qualify. The current QP thresholds can also make it difficult for some ACOs to include specialists. To qualify, clinicians must receive a certain percentage of Medicare Part B payments, or see a certain percentage of Medicare patients, through an advanced APM entity. These percentages have increased since MACRA became law and will again at the end of 2022. Since specialists see a different patient mix than primary care physicians and providers, their participation in an APM can make it more difficult for the entity to qualify as an advanced APM. Additionally, these thresholds can also increase operational and administrative burdens on APM entities. Under the current system entities need to be experts in both MIPS reporting and APM regulations. This can be difficult for ACOs that are managing hundreds or thousands of clinicians across multiple practices or hospital systems.

Going forward, Congress should consider eliminating QP thresholds altogether, or varying the thresholds based on purpose. For example, thresholds could be eliminated for payment updates, while maintaining thresholds for qualifying for bonuses. Either way, if thresholds are maintained, Congress must give the administration more flexibility to adjust thresholds through rulemaking. This will allow qualifying thresholds to account for model type, provider type, and current APM adoption.

NON-FINANCIAL INCENTIVES AND MODEL FLEXIBILITY

MSSP Enhanced Plus

The MSSP is the largest and most successful value-based care program in Medicare and as such should be utilized as an innovation platform. As CMMI tests new payment models, successful models or key aspects of those models should be embedded as permanent parts of Medicare via the MSSP. The MSSP currently includes various participation options with increasing levels of risk and reward, including Basic Track Levels A–E and the Enhanced Track. However, there is currently no full-risk option for ACOs participating in MSSP, with the highest level of risk at 75 percent of shared savings/losses under the Enhanced Track.

Congress should modify MSSP statute so that CMS can create a separate full-risk option within MSSP to serve as a better bridge between it and ACO REACH. This "Enhanced Plus" track should include greater flexibility in payment design and available waivers. Elements of an "Enhance Plus" option should include:

- Full risk, i.e., 100 percent shared savings and loss rates,
- Participation at the Tax ID Number-National Provider Identifier (TIN-NPI) level to allow the ACO to create a high-performing network, which is critical for such a high-risk model,
- Options for population-based (i.e., capitated) payments ranging from partial to full capitation with the ability to negotiate downstream value-based payment arrangements, and
- Advanced waivers including the Post Discharge Home Visit Waiver, Care Management Home Visit Waiver, and tailored Part B cost sharing support.

As the only permanent total cost of care model in Medicare, the MSSP should be adapted to remain a viable option for more advanced ACOs and further advance value-based care.

Population-based Payments (i.e., capitation)

At a minimum, Congress should direct CMS to create an option for MSSP ACOs to elect partial or full capitated payments for primary care. Hybrid payment systems that include both FFS payments and capitated/population-based payments (PBPs) have gained traction, particularly among the primary care community. Additionally, the National Academies of Sciences, Engineering, and Medicine (NASEM)'s 2021 report recommended a shift to a hybrid payment model to better support robust primary care.[4] Such PBPs would allow ACOs to reallocate resources to advance primary care innovation and transformation. This voluntary payment option should include flexibilities for providers to select capitation levels that meet their needs. Given the critical role of primary care in improving quality and controlling costs, implementing a hybrid payment option within the MSSP could be an effective strategy in furthering the transition to value.

Waivers

Current law allows CMS to waive certain Medicare FFS requirements in MSSP and other APMs. This is a critical component of APMs as it allows providers to operate with fewer restrictions leading to a

[4] https://nap.nationalacademies.org/resource/25983/High%20Quality%20Primary%20Care%20Policy%20Brief%201%20Payment.pdf

reduction in provider burden and care innovation. However, the waivers to date have been limited, are burdensome, and are limited to a few models. For example, MSSP only has two waivers; telehealth and the 3-day rule for skilled nursing facility stays. Yet the ACO Realizing Equity, Access, and Community Health (REACH) model has access to many more waivers. We believe all APMs should have access to all available waivers and that those waivers shouldn't be limited to certain models. Congress should direct CMS to establish a common set of waivers for APMs.

Similar to financial incentives, a standard set of waivers for risk-bearing APMs should decouple ACOs and other APMs from FFS. Specific opportunities include:

- Address SDOH by allowing ACOs to pay for non-Medicare covered services.
- Allow ACOs to test innovations that are being tested outside of the model. For example, Medicare's Hospital at Home waiver should be available to ACOs when the public health emergency (PHE) expires.
- Expand telehealth services for all ACOs. While some ACOs have access to telehealth waivers, the PHE provided a more expansive set of waivers for all providers. Outside of the PHE, telehealth is limited to risk-bearing ACOs. ACOs are accountable for total cost of care and quality and thus incented to ensure patients get the right care in the right setting. This mitigates concerns with overuse of telehealth or stinting care that may be present in FFS. Additionally, Congress should provide protections for ACOs using retrospective assignment, who are acting in good faith and provide telehealth to a beneficiary that does not eventually align to the ACO.
- Improvements to the MSSP Beneficiary Incentive Program (BIP). Congress created a beneficiary incentive program for MSSP in 2018's Bipartisan Budget Act that allows ACOs to provide beneficiaries who receive primary care services up to $20. While well intentioned, this program has not been used because it lacks flexibility to tailor the program. Congress should make technical corrections to the statute to give ACOs flexibility to establish BIPs that are based on the needs of their populations. For example, ACOs could limit the incentive program to certain high-cost or high-need patients and/or for a discrete set of services.

Driving Innovation in Medicare Advantage

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' 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 to the various programs rather than managing patient care. For example, when addressing SDOH, providers must consider the patients' Medicare eligibility. Providers are better equipped to address SDOH for patients in MA because MA provides the opportunity to pay for services not covered by traditional Medicare.

Furthermore, Congress should encourage MA plans to enter risk-bearing arrangements with providers. Unfortunately, most of MA's payments to providers are still rooted in FFS. This doesn't encourage value-based care that we know helps manage chronic illnesses, provides preventive services, and keeps patients healthy. MA should have explicit incentives that will encourage provider-led transformation. Incentives could be tied to the Star Ratings or rebate dollars. Additionally, Congress should require MA plans to share full patient data with providers. In existing risk-bearing arrangements in MA, providers

often have limited data on the services received outside of their care. This hampers ability to coordinate care across the continuum. This is further evidenced by the lack of use of the Other Payer Arrangements designation option to qualify for advanced APM incentive payments.

CMMI TRANSPARENCY

CMMI has tested over 50 models, expanding our understanding of how to shift payment and care processes to improve patient outcomes. However, few models have met the criteria for expansion and lessons learned are not always translated into new models. Unfortunately, little is known about the parameters that must be met for expansion and the model evaluations fail to consider key aspects of innovating care. Congress should direct CMMI to enhance its review of models by:

- Making the criteria for model expansion public and seeking stakeholder input through rulemaking,
- Addressing how a model meets the criteria for expansion as part of the model evaluation,
- Creating a clear roadmap for returning to FFS or transitioning to other models, if a model is to be terminated; CMS should avoid gaps in between model generations, and
- Considering additional elements as part of the evaluation; including but not limited to overlap of models, health equity, and provider burden and satisfaction.

CONCLUSION

Thank you for the opportunity to provide feedback on this RFI on actions Congress should take to stabilize the Medicare payment system. 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 MACRA and value-based care. If you have any questions, please contact Aisha Pittman, senior vice president, government affairs, at aisha_pittman@naacos.com.

Sincerely,

Clif Gaus, Sc.D.
President and CEO
NAACOS