NAACOS
National Association of ACOs

July 30, 2021

The Honorable Frank Pallone
House Committee on Energy and Commerce
publicoption@mail.house.gov
2107 Rayburn House Office Building
Washington, DC 20515

The Honorable Patty Murray
Senate Committee on Health, Education, Labor, and Pensions
publicoption@help.senate.gov
154 Russell Senate Office Building
Washington, DC 20510

Re: **Request for Information on Public Option Legislation**

Dear Mr. Pallone and Ms. Murray:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to the request for information (RFI) regarding the creation of a public option as published on May 26, 2021. 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. NAACOS is the largest association of ACOs and Direct Contracting Entities (DCEs) representing more than 12 million beneficiary lives through hundreds of Medicare Shared Savings Program (MSSP), Next Generation ACO Model, Global and Professional Direct Contracting Model (GPDC), and commercial ACOs. NAACOS is a member-led and member-owned nonprofit that works on behalf of ACOs and DCEs across the nation to improve the quality of Medicare delivery, population health, patient outcomes, and healthcare cost efficiency. NAACOS is committed to advancing the value-based care movement, and our members, more than many other health care organizations, want to see an effective, coordinated, patient-centric healthcare system that focuses on keeping all individuals healthy. Strengthening the ACO model and other total-cost-of-care models provides an important opportunity to reduce health inequities and transition our health system to a culture of value.

NAACOS is supportive of this Congress's goals to ensure coverage and access for all individuals regardless of race, ethnicity, income, age, or zip code. NAACOS has recently responded to other RFIs issued by the Biden administration, including a health equity RFI[i] included in CMS's Hospital Inpatient Prospective Payment System (IPPS) proposed rule and an RFI on advancing equity[ii] through federal agencies issued by the White House Office of Management and Budget (OMB). Our comments in response to these RFIs highlight the ways ACOs and total-cost-of-care models can be leveraged to advance health equity, and in them NAACOS outlines ways that these models can be supported to implement and advance initiatives to address social determinants, improve health equity, and meet social needs. ACOs and other total-cost-of-care models are uniquely positioned to manage population health, improve quality, and control or reduce costs. In order for a public option to successfully ensure coverage and access for individuals equitably, a culture of value should be embedded as a core component and value-based care should be foundational to any federally administered plan.[iii]

Background:
Not only did the Affordable Care Act (ACA) result in significant improvements in reducing the number of uninsured individuals by approximately 20 million,[iv] but it also made important steps toward value-based care by directing the Secretary of the Department of Health and Human Services (HHS) to develop the MSSP,[v] which has embedded the ACO model into the Medicare program, achieving significant savings for taxpayers and improving quality of care for beneficiaries to date.[vi] Medicare ACOs produced their highest annual savings to date in 2019, generating $3.2 billion in gross savings and $1.4 billion in savings after accounting for shared savings payments, shared loss payments, and discounts to CMS. Since 2012, ACOs have saved Medicare $8.5 billion in gross savings and $2.5 billion in net savings, and these savings have been shown to increase over time, with more experienced ACOs generating greater savings.[6]

Additionally, several analyses have been conducted to assess the MSSP's impact on cost and have found significantly greater savings than those estimated through the CMS benchmark approach, which yielded the results described above. CMS estimates ACO savings based on benchmarks constructed in advance to fulfill policy goals, whereas other researchers have used alternative assessments to construct a counterfactual and estimate what spending on the beneficiaries in the ACO would have been in the absence of the ACO.[vii] Using research methods referred to as "as-treated difference-in-differences design," evaluators such as Dobson | DaVanzo & Associates,[viii] the Medicare Payment Advisory Commission (MedPAC),[7] and Harvard University[ix] have consistently found that the MSSP has generated significantly higher net savings than reported by CMS estimates. For example, Dobson | DaVanzo estimated that from Performance Year (PY) 2013 to PY 2017 MSSP ACOs saved CMS approximately $755 million in net savings after accounting for shared savings payments made by CMS, an amount greater than CMS benchmark estimates of $70 million in net losses during this time period.[8] While lowering costs, ACOs have also been found to improve quality, outperforming fee-for-service (FFS) providers on 81 percent of quality measures.[x]

ACOs also exist outside of the MSSP, including through various Center for Medicare and Medicaid Innovation (CMMI) demonstrations, commercial ACOs, and state-based Medicaid ACOs. The state-based Medicaid ACOs, also known as safety net ACOs, have emerged in several states in efforts to serve populations with complex and often unmet social needs by coordinating with other sectors such as social services to meet patients' social needs. It is important to note that many ACOs have multiple contracts across different payers.[xi] Because populations covered in commercial ACOs would likely be similar to those covered under a public option, stakeholders should look to existing ACOs' structures, activities, and outcomes for effective strategies in designing a public option.

Many providers, payers, and policymakers have been testing payment reforms in an attempt to control costs and improve quality of care.[xii] With upfront investments in data infrastructure, health information technology (HIT), and innovative delivery models, ACOs are uniquely positioned to tailor interventions for underserved populations, stratify data to target those with unmet needs and identify gaps in care outcomes, and coordinate with social services to address health inequities. When the COVID-19 pandemic hit in 2020, ACOs were able to leverage the competencies and infrastructure they had in place to redesign their workflows, efficiently transition to telehealth, and meet patients' unique needs.[xiii] Because of their payment structures, ACOs were able to give practices the flexibility needed to pivot quickly in the wake of a public health emergency such as the COVID-19 pandemic.

The cost of health care in this country continues to increase to unsustainable levels. We need more options that offer ways of controlling that cost. Payment and delivery system reform, in the way of ACOs and other accountable care models, offer solid ways to control costs while keeping high quality care at the forefront. NAACOS believes Congress can play an important role in advancing value-based care through the specifics of how a public option is created. Congress should lean on the experience gained over the last decade through the work of the MSSP and the Center for Medicare & Medicaid Innovation (CMMI) to more broadly implement reforms. Similarly, every patient should be in a clinical relationship with a provider who is accountable for their care. More than 460,000 clinicians practice within an MSSP ACO. As such, ACOs are a great place to start building greater clinical accountability into a public option. Beginning a public option with a focus on accountable care will also ensure patients have better coordinated care that will support long-term care management while aiming to improve health outcomes.

NAACOS makes the following recommendations in regard to the design and implementation of a federally administered public option health insurance plan:

Recommendation 1: An emphasis on value should be built in as a core component in the design of a public option health insurance plan.
As described above, ACOs have delivered tremendous value to traditional Medicare over the last decade and that success has had spillover effects to commercially insured patients as well. Through the MSSP, the Next Generation ACO Model, and other similar ACO programs, traditional Medicare beneficiaries have received higher quality care and improved benefits, while providers have delivered care at lower costs. Similar success could be achieved if ACOs are integrated into a public option.

A driving force behind Congress's desire to create a public option for the ACA's marketplaces is to generate competition and lower premiums for consumers shopping for marketplace plans. If the public option were to have similar success through ACOs as has been realized in traditional Medicare, then consumers would receive high value options with lower costs, higher quality, and more benefits.

Therefore, Congress should build upon the success of ACOs and the ACO infrastructure that our healthcare delivery system has spent considerable effort building over the last decade to offer accountable care options for consumers covered under the public option. This could be done by working with existing ACOs and providing new ACO opportunities through the public option.

Recommendations 2: Existing ACO models should be leveraged in the design of a public option.
CMS has been expanding and improving the ACO model and other alternative payment models, and lessons learned from these models provide the opportunity to ensure high quality, cost effective care under a public option. One pathway for this would be to align a public option ACO program with the MSSP, which includes a pathway to downside risk.[9] We also recommend that primary care capitation be incorporated into a public option ACO program, which we also urge CMS to consider for the MSSP.

Additionally, ACOs should be incentivized to assume accountability for patient populations, particularly vulnerable or underserved populations, in a federally administered public option. In order to incentivize providers to assume accountability for these patient populations, the creation of a public option could include upfront funding for infrastructure investments needed to manage population health. A model built on competing at-risk physician groups could lead to a dramatic increase in delivery system reforms.[9] This would further advance the transition to value for our health care system.

Recommendation 3: Keep a public option more like traditional Medicare, rather than Medicare Advantage.
Medicare Advantage (MA) has grown tremendously in size and scope in recent years. More than 40 percent of seniors are enrolled in an MA plan this year, up from just 25 percent a decade ago.[xiv] But there is great concern that the program increasingly disadvantages American taxpayers. According to MedPAC,

the federal government spends $1,000 more on every MA enrollee compared to if they were to stay in traditional Medicare.[xv] In other words, the growth of MA has paralleled CMS's increases in what it pays MA plans. MedPAC has made recommendations to address this serious issue.[xvi]

In crafting a public option, Congress should model the public option based on traditional Medicare rather than MA. Clinicians should be at the core of the public option and should directly receive reimbursement from the federal government while assuming accountability through an ACO contract. ACOs have proven they are a key to cost containment in Medicare and offer great promise to do the same for a public option. As such, we urge policymakers to leverage ACOs and the ACO model when crafting a public option.

Conclusion:
Thank you for the opportunity to provide our comments regarding the creation of a federally administered public option health insurance plan. Should you have any questions about our comments, please contact Allison Brennan, SVP, Government Affairs at abrennan@naacos.com.

Sincerely,

Clif Gaus, Sc.D.
President & CEO
NAACOS

[i] https://www.naacos.com/final-ipps-comments
[ii] https://www.naacos.com/omb-rfi-comments
[iii] https://www.healthaffairs.org/do/10.1377/hblog20210622.426793/full/
[iv] https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/
[v] https://journals.sagepub.com/doi/pdf/10.1177/003335491112600614
[vi] https://www.naacos.com/highlights-of-the-2019-aco-program-results
[vii] http://www.medpac.gov/docs/default-source/reports/jun19_ch6_medpac_reporttocongress_sec.pdf?sfvrsn=0
[viii] https://www.naacos.com/assets/docs/pdf/2019/Final-NAACOS-AsTreatedDID-SavingsEstimateReport2017.pdf
[ix] https://www.nejm.org/doi/full/10.1056/NEJMsa1803388
[x] https://oig.hhs.gov/oei/reports/oei-02-15-00450.pdf
[xi] https://leavittpartners.com/predicting-aco-commitment-accountable-care-one-night-stand-marriage-material/
[xii] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0979
[xiii] https://www.healthaffairs.org/do/10.1377/hblog20200528.402208/full/
[xiv] https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-enrollment-update-and-key-trends/
[xv] http://www.medpac.gov/docs/default-source/meeting-materials/medpac_context_sept_2020.pdf?sfvrsn=0
[xvi] http://www.medpac.gov/docs/default-source/reports/jun21_ch1_medpac_report_to_congress_sec.pdf?sfvrsn=0