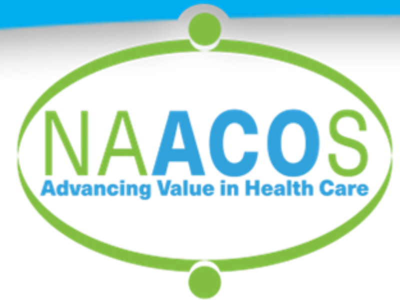


October 15, 2023

The Honorable Michael Burgess
Chair
House Committee on Budget, Health Care Task Force
United States House of Representatives
204 Cannon House Office Building
Washington, DC 20515
Submitted electronically to: hbcr.health@mail.house.gov

RE: Request for Information: Solutions to Improve Outcomes and Reduce Federal Health Care Spending in the Budget

Dear Congressman Burgess:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to the House Budget Committee's Health Care Task Force request for information to examine key drivers of our nation's health care spending and improve health outcomes while bending down the debt curve. NAACOS represents more than 400 accountable care organizations (ACOs) in Medicare, Medicaid, and commercial insurance working on behalf of health systems and physician provider organizations across the nation to improve quality of care for patients and reduce health care cost. NAACOS members serve over 8 million beneficiaries in Medicare value-based payment models, including the Medicare Shared Savings Program (MSSP) and the ACO Realizing Equity, Access, and Community Health (REACH) Model, among other alternative payment models (APMs). NAACOS appreciates the committee's leadership and commitment to improving access to health care and lowering costs. Our comments reflect the views of our members and our shared goals.

APMS ARE A PLATFORM FOR INNOVATION AND COST SAVINGS

A major pathway for improving access to health care and lowering costs is through advancing APMs. Over the last two decades, APMs have demonstrated that when providers are accountable for costs and quality and provided flexibility from fee-for-service (FFS) constraints, they are able to generate savings for taxpayers and improve beneficiary care. This emphasis on outcomes allows physicians and other clinicians to:

- **Improve care coordination and prioritize primary and preventive care.** APMs allow providers to build care teams that include nurses, care managers and social workers. This increases access and support for patients. With ongoing health care shortages, clinicians need to increasingly rely on broader care teams to maintain access. For example, many ACOs utilize care managers that help patients manage their chronic conditions. The care managers help with medication and symptom management, coordination with practitioners to improve care delivery, and educate the patients about how to best manage their conditions.

- **Keeping patients healthy.** APMs allow clinicians to provide services that are not otherwise billable under FFS such as wellness programs, patient transportation, meals programs, and cost sharing reductions. This allows providers to use innovative tools to improve patient outcomes. For example, ACOs often utilize care management visits following an inpatient stay to allow clinicians to better manage the patient's medications, assess their home for safety risks, and coordinate follow up care. This results in reduced readmissions and ensures that patients' needs are met at home.
- **Coordinate care across the continuum.** APMs require providers to align sites of service by ensuring that patients receive the right care in the setting that is best suited for their social and clinical needs. Through coordination, APMs allow providers to share resources while remaining independent.

ACOs are the Largest and Most Successful Model Leading Medicare's APM Transformation

In 2023, there are 588 ACOs coordinating care for 13 million Medicare beneficiaries. ACOs are a voluntary alternative to the fragmented FFS system that gives doctors, hospitals, and other health care providers the flexibility to innovate care and holds them accountable for the clinical outcomes and cost of treating an entire population of patients.

With primary care as the backbone, ACOs employ a team-based approach that allows clinicians to ensure patients receive high quality care in the right setting at the right time. The ACO model also provides an opportunity for providers to work collaboratively along the continuum while remaining independent. Importantly, ACOs provide shared savings opportunities and enhanced regulatory flexibility that allows clinicians to maintain financial security while practicing medicine more freely.

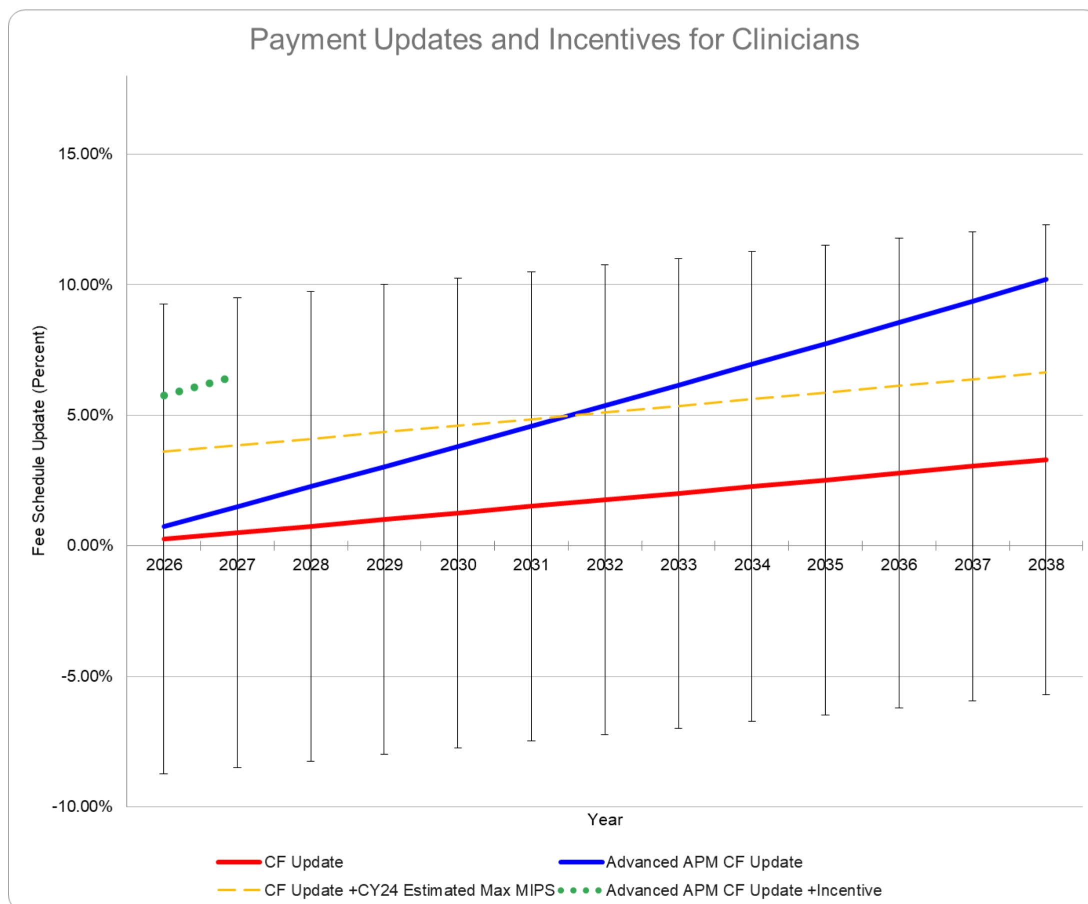
It's clear these payment system reforms have been a good financial investment for the government. In the last decade, ACOs have generated more than $21 billion in savings with $8.2 billion being returned to the Medicare Trust Fund while maintaining high quality scores for their patients. The growth of APMs has also produced a "spill-over" effect on care delivery across the nation, slowing the overall rate of growth of health care spending. Earlier this year, the Congressional Budget Office (CBO) reported that actual Medicare and Medicaid spending between 2010–2020 was 9 percent lower than original projections.[1] While there are several influences for these changes in spending, improved care management and more efficient use of technology were factors highlighted by CBO. Moreover, providers in APMs help make the Medicare program stronger by reducing improper payments. Using enhanced data and analytics, ACOs regularly identify and report instances of fraud, waste, and abuse.

Regulatory and Statutory Barriers Limiting Growth of APMs

APMs have allowed physicians and other clinicians to change care delivery and improve care coordination while reducing costs. APMs are becoming more rooted in our health care system but growth has been slower than Congress' original goal. It is essential to remove barriers to participation and give additional flexibility and tools to innovate care. Specifically, Congress should:

- Ensure incentives promote value-based care.
- Improve existing APMs to encourage adoption and ensure current participants remain in APMs.
- Improve approaches to test and scale innovation.
- Establish parity between APMs and Medicare Advantage.

Ensure Incentives Promote Value-Based Care
Beginning in Payment Year 2026 (Performance Year 2024), incentives will favor clinicians who are not participating in advanced APMs and remain in MIPS. As demonstrated in the chart below, clinicians in MIPS will be provided a 0.25 percent conversion factor update (red line) and can receive an additional positive payment adjustment in MIPS. While maximum potential incentives under MIPS are 9 percent, the maximum MIPS adjustment is estimated to be around 3 percent. Accordingly, the total potential payment adjustment is an estimated 3.25 percent (yellow dashed line). Conversely, clinicians in advanced APMs will only receive a 0.75 percent conversion factor update (blue line). Modeling these changes out several years, 2032 will be the first year in which incentives again favor clinicians in advanced APMs.



Additionally, the thresholds to qualify as an advanced APM are too high under current law. In the 2024 Medicare Physician Fee Schedule proposed rule, CMS estimated that between 30,000-84,000 clinicians may no longer qualify as advanced APM participants because of increasing qualification thresholds and expiring incentives. Additionally, CMS has proposed changes to the determination process that could increase burdens and serve as a disincentive for some specialists to join ACOs.

In the short-term, **Congress should extend APM incentives & adjust qualifying thresholds.** Appropriate financial incentives help attract physicians and other clinicians to participate in advanced APMs and reward those that continue to move forward on their value transitions. While Congress included a 12-month extension of MACRA's advanced APM incentive payment in the Consolidated Appropriations Act of 2023, this short-term extension will expire at the end of 2023. Lawmakers should support the

bipartisan Value in Health Care Act (H.R. 5013), which includes a two-year extension of MACRA's original 5 percent advanced APM incentives and adjusts the one-size-fits-all approach to qualification thresholds to ensure that providers will continue to participate in APMs.

A short-term extension would allow time **for Congress to work with stakeholders to redesign physician payment incentives to promote value**. A three-tier system would provide increased flexibility and financial incentives for the adoption of value. The participation tracks should be:

- **Fee-for-service (MIPS) —** Clinicians that are not participating in any APM. MIPS should be revised so that the program does not incent remaining in FFS. Specifically, Congress should structure MIPS to have adequate payment adjustments for physicians but no additional incentives unless clinicians are taking steps to move to value.
- **APMs —** Currently, clinicians in non-risk bearing APMs or advanced APMs that do not meet qualifying APM participant (QP) thresholds for incentive payments remain in MIPS. This creates an additional burden as the clinicians must be responsible for MIPS quality reporting obligations and quality reporting obligations in the APM as well. This creates a disincentive to participate in APMs and holds FFS as the gold standard, rather than value-based payment. A new approach should exempt clinicians in ACOs, or other APMs, from MIPS quality reporting since they are already being measured on cost and quality in 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.

Improve existing APMs to encourage adoption and ensure current participants remain in APMs
While APMs have offered numerous benefits to providers and patients, more can be done to attract more providers and meet the unique needs of certain beneficiary populations. Congress should work with CMS to address some of the existing challenges in APMs and MSSP, the only permanent APM.

- **Delay implementation of digital quality reporting to address operational issues that will increase costs and burdens.** ACOs will be required to report quality via electronic clinical quality measures (eCQMs) or MIPS CQMs by 2025. While ACOs ultimately want to achieve a more seamless, efficient, and technology-enabled quality reporting system that is highly interoperable and relies on near real-time data to enable improved patient care, the current lack of interoperability means ACOs will face many challenges and increased administrative burden and costs to try and support this work in the near term. Congress must work with CMS to ensure the agency does not move forward with new quality requirements before testing with a pilot.
- **Safeguard ACO benchmarks.** The financial benchmark is an ACO's projected level of spending for its patients. The benchmark is unique to each ACO and is determined by historical spending, patients' relative sickness, and national and regional spending trends. Despite the success of ACOs, CMS has not addressed the "ratchet effect," where ACO benchmarks are lowered with each new agreement period because they continue to lower costs for their assigned populations. Starting next year, CMS is adding a prospective growth rate specific to ACOs called the Accountable Care Prospective Trend (ACPT). This would update MSSP benchmarks annually to account for national spending growth and keep benchmarks realistically attainable. According to CMS analysis, the ACPT will harm nearly one third of ACOs. Congress must work with CMS to establish effective ACO benchmark changes that provide more transparency, address the ratchet effect to ensure long-term participation, and account for regional variations in spending to prevent arbitrary winners and losers.

- **Strengthen nonfinancial incentives within the model**. 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 reduction in provider burden and increased care innovation. However, the waivers to date have been limited. For example, MSSP only has waivers for telehealth and the 3-day rule for skilled nursing facility. The telehealth waiver is far more limited than the flexibilities provided to clinicians during the public health emergency. Moreover, the Innovation Center has tested several waivers in ACO demonstrations, yet those waivers have not expanded to the permanent program, MSSP. Congress should work with CMS to rapidly expand waivers. Congress should direct CMS to establish a common set of waivers for APMs and create a process to accept public nominations for waivers.
- **Address unique payment challenges for providers serving rural and underserved populations.** Rural providers have achieved successes in APMs despite significant barriers and limitations. ACOs and other APMs focus on achieving savings on historical spending. This approach may not be appropriate for rural populations where lower cost settings may not be available or underserved populations who may have historical lower costs due to lack of access. We need a new paradigm where APMs focus on increasing or maintaining access over cost reductions. While cost is an important component of any APM, we should consider approaches for maintaining costs or reducing growth in spending. NAACOS recently provided recommendations to the House Ways and Means Committee on how to improve access to health care in rural and underserved areas.[2]
- **Consider approaches to bring more providers to total cost of care models.** Previous models have been designed to offer APMs to a certain type of provider (e.g., episode payment models for specialists). After more than ten years of payment model design innovation, we have learned that concurrent episode models and total cost of care models results in a complex set of overlapping rules, leading to provider and patient confusion and increased burden. Rather than designing models for specific types of providers, we should focus on total cost of care. With the primary care team as the foundation for coordinating ongoing patient care, the ACO can support patients with referrals to specialists in the community and transitions between hospitalizations, procedures, post-acute care and back to the home. NAACOS has considered approaches for increasing participation of specialists, rural providers, post-acute and long-term care providers in total cost of care arrangements. To do so, changes need to be made to attribution, benchmarks, and data shared with providers. Congress should direct CMS to work with stakeholders to design approaches to meet the needs of various types of providers within total cost of care arrangements.

Improve Approaches to Test and Scale Innovation

The Innovation Center has been successful in testing innovative payment arrangements and increasing adoption of APMs. The successes of the Innovation Center are not captured within current evaluation approaches. For example, CBO estimates that CMMI's activities increased direct spending by $5.4 billion in the first 10 years and another $1.3 billion by 2030. However, CBO's report focuses only on savings achieved and does not account for many aspects of value-based payment models such as provider burden relief, patient experience, clinical transformation, and the spill-over effect that occurs when providers apply value principles across all patient populations. The Innovation Center's evaluation criteria and criteria for model expansion have similar challenges. Congress should work with CMS to ensure that promising models have a more predictable pathway for being implemented and becoming permanent and are not cut short due to overly stringent criteria. Specifically, Congress should:

- **Broadening the criteria by which CMMI models qualify for Phase 2 expansion.** The criteria should consider if the model reduces provider burden, increases patient satisfaction, offers additional benefits and services to patients that are not billed to Medicare, expands participation to more provider types, results in clinical care transformation, or is adopted in private sector value arrangements.
- **Directing CMMI to engage stakeholder perspectives during APM development.** The Innovation Center could leverage the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to provide input on models in development.

Establish parity between APMs and Medicare Advantage program requirements
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' benchmark and 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 the various program requirements rather than managing patient care. Congress should direct the Government Accountability Office (GAO) to evaluate how to create more parity between APMs and MA. Additionally, Congress should explore opportunities to incent MA plans to enter risk-bearing arrangements with providers.

CONCLUSION

Thank you for the opportunity to provide feedback on this request for information. 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 improving health care access and lowering costs. 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

cc:
Chairman Jodey Arrington (TX-19); Rep. Drew Ferguson (GA-03); Rep. Buddy Carter (GA-01); Rep. Lloyd Smucker (PA-11); Rep. Blake Moore (UT-01); and Rep. Rudy Yakym (IN-02)

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[1]https://www.cbo.gov/publication/58997#:~:text=CBO%20overestimated%20mandatory%20spending%20for%20health%20care%20in,9%20percent%20lower%20than%20CBO%20projected%20in%202010.
[2] https://www.naacos.com/assets/docs/pdf/2023/NAACOSWaysMeansRuralRFI10052023.pdf