National Association of ACOs

Statement for the Record

Committee on Ways and Means
Subcommittee on Health
United States House of Representatives

Re: Implementation of MACRA's Physician Payment Policies

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We thank the committee for their work on the Medicare Access and CHIP Reauthorization Act (MACRA) and ensuring a proper implementation of this landmark legislation. We appreciate the opportunity to provide comments on the recent House Ways and Means Committee, Health Subcommittee hearing, "Implementation of MACRA's Physician Payment Policies."

NAACOS represents more than 5 million beneficiary lives through more than 300 Medicare Shared Savings Program (MSSP), Next Generation, and commercial ACOs. NAACOS is an ACO member-led and member-owned non-profit organization that works on behalf of ACOs across the nation to improve the quality of Medicare delivery, population health and outcomes, and health care cost efficiency. Our members, more than many other healthcare organizations, want to see an effective, coordinated patient-centric care process. Therefore, we feel it is critical that Congress ensure an effective implementation of MACRA and we support the notion that Alternative Payment Models (APMs) are 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 are therefore disappointed to see Congress and the Centers for Medicare & Medicaid Services (CMS) take steps to further delay implementation of MACRA's intended performance thresholds and cost accountability measures, as further detailed in our comments below.

Delaying Implementation of Performance Standards and Cost Accountability in the Merit-Based Incentive Payment System (MIPS)

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 recently passed Bipartisan Budget Act (BBA), 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, which the MIPS program was developed from, 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.

Advanced APM Implementation Issues

A key concern NAACOS continues to have with the implementation of MACRA is CMS' lack of strategic direction regarding how to handle the overlap of multiple Advanced APMs. NAACOS fully supports the development of APMs and congratulates Congress and CMS for making the further development of such models a priority. However, as detailed in a previous letter to the agency, we are also deeply

concerned with CMS's lack of strategic planning and direction in addressing APM overlap issues. It appears to date, CMS has attempted to deal with overlap on a per-program basis rather than taking a coordinated and strategic approach. It is essential that the agency develop a more thoughtful approach to program overlap issues, particularly as CMS moves forward with implementation of the MACRA. By the agency's estimates, the number of providers participating in APMs will grow dramatically in the coming years, compounding this problem. For example, CMS estimates the number of providers qualifying for Advanced APM bonuses will roughly double in the second year of the Quality Payment Program (QPP) to total 185,000 to 250,000 for the 2020 payment year corresponding to 2018 performance. Therefore, it is critical that Congress work with CMS and the Innovation Center to address this issue now before the operational challenges grow exponentially and ultimately undermine the progress made to date by APMs currently in existence.

As detailed in previous comments to the Agency, NAACOS also continues to believe that CMS must include MSSP Track 1 as an Advanced APM. Track 1 ACOs have been leaders in the transition to value-based payment models and have significantly invested in their development and early success. Excluding these ACOs undermines this important transition, and we strongly recommend that Congress work with CMS to include Track 1 MSSP as an Advanced APM. CMS currently excludes Track 1 ACOs as qualifying for Advanced APM status due to the agency's refusal to recognize the enormous upfront and ongoing investment costs associated with participating in the ACO program. To address this, NAACOS has consistently urged CMS to develop a process to account for ACO costs and investments to allow those to qualify as meeting risk standards established in MACRA. We urge Congress to encourage these changes for future QPP program years.

Additionally, NAACOS has repeatedly requested that CMS lower the Advanced APM benchmark-based risk threshold and remove Part A revenue from the revenue-based threshold. Specifically, we urge CMS to lower the three percent benchmark-based standard to a more appropriate threshold of one percent. While the agency lowered the benchmark-based threshold from the proposed four percent to three percent in the 2017 final QPP rule, this threshold is still too high for many provider organizations including ACOs. We argue that four percent of total Medicare Parts A and B expenditures is far more than "nominal risk" required in MACRA and therefore is not consistent with congressional intent. Further, the Regulatory Impact Analysis of the 2017 QPP rule notes that CMS has long defined "significant" impact as three percent of physician revenue. We therefore urge CMS to revise the benchmark-based threshold by lowering it to one percent, and we urge Congress to encourage these changes for future QPP program years.

Finally, the Advanced APM bonus provided to clinicians in an Advanced APM is based on payments for covered professional services under the Medicare Physician Fee Schedule, and we strongly recommend CMS revise the revenue-based threshold to focus solely on revenue under the Medicare Physician Fee Schedule. Not doing so creates an asymmetry between the risk level and Advanced APM payments and could create an unintended consequence of ACOs dropping hospitals as ACO participants. This would harm efforts to enhance care coordination across delivery settings and could diminish opportunities to reduce hospital spending, which is one of the greatest areas for potential savings. We urge Congress to work with CMS to continue to make such refinements to these Advanced APM models to ensure they are viable options.

Moving to Risk-Based Payment Models

Given that MACRA intended to encourage clinicians' progression along the value-based care continuum, it is critical that Congress ensure CMS is allowing for appropriate glide paths to risk based payment models. The unintended consequences of forcing risk before clinicians or organizations are ready to assume such risk will significantly undermine the MSSP program in particular and result in diverting valuable investments in care coordination away from Medicare patients and towards other patients under value-based contracts. Further, the disproportionate emphasis on reducing costs often overshadows the equally important goal of quality improvement that the ACO model offers, which benefits patients and the Medicare program generally. While some Track 1 ACOs have not yet been able to experience a return on the investments they have made, they have generated savings to the government while improving patient care, which studies show has a positive downstream impact on spending but may take years to fully materialize.

While Track 1 is a one-sided (upside only) risk model, it is important to note the significant investments ACOs make in start-up and ongoing costs, such as those related to clinical and care management, health IT, population analytics and tracking, and ACO management and administration. NAACOS 2016 survey data show that ACOs invest, on average, $1.6 million annually to operate their ACO. These investments put ACOs at jeopardy of financial losses that have a considerable impact on their organizations, providers and beneficiaries. 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." That investment—the cost of switching to a fundamentally different approach to patient care—constitutes in and of itself a substantial financial risk. ACOs consider and account for their investment costs as risk inherent in MSSP participation and these investments help to fund critical ACO activities designed to achieve the goals of improving beneficiary care and enhancing care coordination to reduce unnecessary spending and hospitalizations.

The MSSP has gained considerable momentum in recent years, and it would be devastating to see a mass exodus of 2012/2013 ACOs in the 2019 performance year if regulations are not changed to allow continued participation in Track 1. In NAACOS' 2016 ACO Cost and MACRA Implementation Survey, when asked how likely they were to participate in the MSSP if CMS required them to share losses, almost half of ACO respondents said they "definitely would not" or "likely would not" participate. Therefore, we strongly urge Congress to instruct CMS to modify regulations to allow ACOs that meet certain criteria related to generating savings or demonstrating quality achievements to continue participating in Track 1 for a third agreement period. Swift action is needed by the agency on this issue so that a revised policy is in place in time for ACO planning for the 2019 performance year. Therefore, we urge Congress to work with CMS to revise this flawed policy.

Other Merit-Based Incentive Payment System (MIPS) Implementation Issues

CMS has struggled to effectively communicate how MIPS policies apply to ACOs specifically. This has created an enormous amount of confusion among ACOs and the clinicians serving in ACOs. In 2018 in the Medicare Shared Savings Program alone there are 561 ACOs serving 10.5 million assigned Medicare beneficiaries. The size of the program is vast and it is therefore critical that CMS is equipped to educate its staff on how MIPS requirements apply to ACOs. Further, ACOs and NAACOS staff have been provided with inconsistent answers from CMS regarding simple MIPS policy questions over the previous two years. NAACOS has worked diligently with CMS to attempt to clarify policy issues and effectively communicate these policies to our ACO members so they can be successful in the QPP.

However, CMS staff continues to provide unclear guidance in a number of policy areas. Additionally, the community supports that are being provided with MACRA funding are often not educated about the nuances to these policies for ACOs. Therefore, the ACO must constantly educate its providers and assure them that there are special circumstances and unique policies that apply to clinicians serving in ACOs. This results in a considerable amount of wasted staff time that would be better spent supporting the ACO's mission. This is unacceptable and must be corrected going forward. We urge Congress to work with CMS to ensure effective, clear and timely communication about how MIPS policies apply to ACOs specifically for future years of the QPP.

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. As stated in our comment letter above, NAACOS believes CMS should recognize Track 1 ACOs as Advanced APMs. However, because CMS continues to subject Track 1 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 greater 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 Track 1 ACO program. Therefore, we urge Congress to work with CMS to revise this flawed policy.

Closing

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.

Sincerely,

Clif Gaus
President and CEO
National Association of ACOs