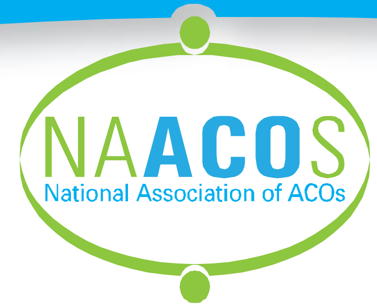

March 1, 2018

The Honorable Lamar Alexander
Chairman
Senate Committee on Health, Education,
Pensions & Labor
428 Senate Dirksen Office Building
Washington, DC 20510

The Honorable Patty Murray
Chairman
Senate Committee on Health, Education,
Pensions & Labor
428 Senate Dirksen Office Building
Washington, DC 20510

Via LowerHealthCareCosts@help.senate.gov

Re: Response to request for information regarding lower health care costs

Dear Chairman Alexander and Ranking Member Murray,

Thank you for the opportunity to respond to your request for recommendations to help address America's rising health care costs. We appreciate the work of the Senate Committee on Health, Education, Labor and Pensions (HELP) has done heretofore to address the cost of health care and the growing burden on taxpayers, employers, and families.

NAACOS is the largest association of ACOs, representing more than 5 million beneficiary lives through 330 Medicare Shared Savings Program (MSSP), Next Generation Model, and commercial ACOs. NAACOS is an ACO member-led and member-owned nonprofit organization that works on behalf of ACOs across the nation to improve the quality of Medicare, population health and outcomes, and healthcare cost efficiency. Our members, more than many other healthcare organizations, want to see an effective, coordinated patient-centric care process.

We address your specific questions below and hope to continue the dialogue with the Committee regarding these important issues.

1. What specific steps can Congress take to lower health care costs, incentivize care that improves the health and outcomes of patients, and increase the ability for patients to access information about their care to make informed decisions?

Congress should continue to ensure that the Medicare Shared Savings Program (MSSP) remains strong and encourages robust provider participation. The MSSP continues to be an important program to promote decreased costs and increased care quality. ACOs are a market-based solution to help lower the cost of health care spending, where groups of doctors, hospitals and other providers take responsibility for the quality and cost of care for a set of patients then work together to provide coordinated care that improves the care delivered. ACOs are incentivized to lower costs by spending less than pre-determined targets and at the same time they must meet quality standards, earning the right to share generated savings. Medicare ACO programs, including the Next Generation ACO Model and the MSSP, are the largest value-based

payment models in the country and an essential tool in moving the health system toward better value. These programs remain voluntary and policymakers need to carefully balance incentivizing an improved health care delivery system with encouraging provider participation because not hitting the proper balance threatens the country's move to a more value-based payment system.

Congress should also consider amendments to 42 C.F.R. Part 2 ("Part 2"), which demands patients must submit written consent prior to the disclosure of their substance use treatment records. Such demands are often challenging, limit whole-person integrated care and care coordination, and are not compatible with the way health care is delivered in the 21st Century. NAACOS is an active member of the Partnership to Amend Part 2, which advocated last year for Congress to pass H.R. 6082 thus aligning Part 2 with the Health Insurance Portability and Accountability Act for the purposes of treatment, payment, and health care operations. Such an alignment would remove the barrier to integrated care for patients with opioid and other substance use disorders.

2. What does Congress or the administration need to do to implement those steps? Operationally, how would these recommendations work?

In December of 2018, the Centers for Medicare & Medicaid Services (CMS) issued a final rule which significantly reorganized the MSSP. While NAACOS was pleased with certain aspects of that rule, we remain extremely concerned that CMS's new ACO regulations, as finalized, will present challenges to providers who want to participate in this important, yet voluntary, Medicare program. NAACOS believes there needs to be movement toward assuming risk, and that movement requires an appropriate and reasonable glide path to encourage participation and success. Specifically, we have serious concerns about CMS's final policies in the following areas:

Shared savings rates. CMS decreased the shared savings rate to 40 percent from 50 percent for certain ACOs. NAACOS is monitoring what impact this decreased rate may have for new ACOs who want to join the program**.** A survey of NAACOS members after the proposed rule was released found reduced shared-savings rates for no- and low-risk ACOs was the most troubling aspect of CMS's proposed changes. According to a 2016 NAACOS survey, ACOs invested an average of $1.6 million into operational costs.

Length of time in shared savings-only models. CMS finalized a two-year limit for certain ACOs, a decrease from the prior duration of six years in a shared savings-only model. Becoming a well-functioning ACO takes time and requires building of IT infrastructure, hiring care coordinators, changing the culture of providers, among many other tasks. There is also a significant operational issue of only allowing two years for certain ACOs to participate as shared-savings only models: under CMS's rules, many ACOs would have just a single year of performance data available to them before evaluating the required move to risk in their third year of the program.

High-low revenue distinction. CMS finalized a "high-low revenue" ACO distinction that will deter providers who want to embark and stay on the path of value-based care. ACOs designated as high revenue are required to assume greater risk at a faster pace than low revenue ACOs. This distinction is problematic and requires too much risk too soon for ACOs deemed to be high revenue. Further, as finalized, this policy will unintentionally harm some physician-led ACOs and rural ACOs, which would be categorized as "high revenue". A NAACOS analysis of how ACOs would be classified under CMS's high-low revenue definitions found that 12 percent of physician-led ACOs would be considered high revenue and 22 percent of ACOs with federally qualified health centers or rural health centers would be high revenue. We believe that there should be an equal playing field for all ACOs and that this distinction is inappropriate and should be eliminated.

Risk adjustment. We were pleased that CMS recognized for the first time the need for modifications on risk adjustment, but the cap of 3 percent should be increased to 5 percent over five years. Further, more research is needed by CMS to ensure the use of valid risk adjustment methodologies for ACOs and also across Medicare alternative payment models.

3. Once implemented, what are the potential shortcomings of those steps, and why are they worthy of consideration despite the shortcomings?

The MSSP is the foundation for value-based care in Medicare and implementing changes to the program will allow it to continue to play a significant role in the move to value-based care, this saving the Medicare Trust Fund billions of dollars. Medicare ACOs have produced tremendous savings. For example, in 2018, NAACOS commissioned Dobson DaVanzo & Associates to conduct an independent evaluation of ACO performance using Medicare claims data from approximately 25 million beneficiaries per year. The largest evaluation to date, this study used rigorous and widely accepted statistical methods to estimate MSSP savings. Since 2013, the first full year of the MSSP, ACOs have generated overall savings of $2.66 billion to Medicare, well above the $1.6 billion calculated by CMS. After accounting for the shared-savings payments earned by ACOs, MSSP net savings were $665.8 million in the program's first four full years — not a loss of as estimated by CMS.

The Next Generation Model, Medicare's more advanced and riskier ACO program, also shows very positive results. For example, in performance year 2017 the 44 ACOs in the Next Gen program generated $337 million in gross savings including discounts to Medicare. After accounting for shared savings paid to ACOs for holding down costs and hitting quality targets as well as shared losses paid back to the government, the Next Gen program netted at least $165 million to Medicare in 2017 alone. Next Gen ACOs saved Medicare $63 million in 2016, the first year of the program, after accounting for incentive payments earned for hitting spending and quality targets, according to an independent evaluation of results. Given the positive results of the Medicare ACO programs, strengthening these programs is critical to staying on the overarching path to value-based care which will reduce Medicare costs and provide high quality patient care.

Thank you for the opportunity to provide feedback to the Committee regarding how the Congress may help lower health care costs. Please contact NAACOS staff at advocacy@naacos.com if you have any questions about our comments.

Sincerely,

Clif Gaus
CEO