Written statement for the Record
of
The National Association of ACOs
for the
Senate Committee on Finance Subcommittee on Health
hearing on
"Improving Health Care Access in Rural Communities: Obstacles and Opportunities"

May 17, 2023

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to the health subcommittee's hearing on "Improving Health Care Access in Rural Communities: Obstacles and Opportunities." 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 in rural communities. Access to health care in rural communities presents many unique challenges with many communities facing shortages of providers. The USDA Economic Research Service published data last year showing that 40 percent of rural areas face primary care shortages and 80 percent have shortages of behavioral health services.[1]

For years doctors, hospitals, and other providers have been paid for each service provided – a system commonly referred to as fee-for-service. In recent years, innovative providers and policymakers have increasingly recognized the need to transition to alternative systems that reward accountability and create incentives for providing care in a coordinated manner focused around placing people at the center of their care, and keeping them healthy, rather than just treating them when they get sick.

The ACO model provides an opportunity for providers to work collaboratively along the continuum while remaining independent. With primary care as the backbone, ACOs can employ a team-based approach that allows clinicians to ensure patients receive high quality care in the

[1] https://www.ers.usda.gov/amber-waves/2022/august/the-most-rural-counties-have-the-fewest-health-care-services-available/

right setting at the right time. Importantly, ACOs provides enhanced flexibilities that allow clinicians to develop interventions targeted to their populations.

Value-based care is the best care model for all patients, and we have seen significant adoption among rural providers. However, adoption of ACOs and value-based care has been stalled by several underlying issues. Specifically, a focus for rural providers is retaining access to care. Approaches that require savings to Medicare through discounts or shared savings may not be appropriate for providers who are paid at cost or are struggling to remain open.

As the committee continues to discuss long-term approaches to improving health care access in rural communities, we urge the committee to consider the following recommendations which would attract more rural providers to participate in value-based care models.

Extend Financial Incentives for Qualifying APMs. 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. These incentive payments also provide financial support that helps rural practices join and remain in risk-based payment models. Many practices also reinvest these payments to help expand services for patients.

In 2022, Congress included a 12-month extension of MACRA's advanced APM incentive payment in the Consolidated Appropriations Act of 2023. While this short-term extension ensures that the nearly 300,000 clinicians working to improve the quality and cost-effectiveness of care continue to have the financial resources to do so, it will expire at the end of 2023. Going forward the committee should consider:

- Providing a multi-year commitment to reforming care delivery by extending MACRA's 5 percent advanced APM incentive payments.
- Ensuring that qualifying thresholds remain attainable to promote program growth by giving the Centers for Medicare & Medicaid Services (CMS) authority to adjust qualifying thresholds through rulemaking and set varying thresholds for models that have difficulty qualifying because of design elements.

Ensure Participants Join and Remain in Existing APMs. Current and past APMs have allowed physicians and other clinicians to change care delivery and improve care coordination. It is essential to remove barriers to participation and give additional flexibility and tools to innovate care. The MSSP is the largest and most successful value-based care program in Medicare and the committee should consider the following recommendations to continue driving innovation:

- Removing the high-low revenue designation in the MSSP that penalizes certain ACOs, especially safety net providers like Rural Health Clinics (RHCs), Critical Access Hospitals, and Federally Qualified Health Centers (FQHCs).
- Developing systems for Medicare to provide technical assistance for APMs that serve rural and underserved populations.
- Directing CMS to establish guardrails to ensure that the process to set financial benchmarks is transparent and appropriately accounts for regional variations in spending to prevent winners and losers.

- Engaging with CMS to encourage the agency to pilot test ACO quality reporting changes to address remaining implementation challenges that exist with the current policy. Otherwise, some ACOs may choose to leave the program because of increased costs and burdens.

Provide a Broader, More Predictable Pathway for More Types of Clinicians to Engage in APMs. Congress established the Center for Medicare and Medicaid Innovation (CMMI) in 2010 to develop and test innovative payment and service delivery models. While CMS's population health models have seen encouraging growth over the last 10 years, there has been insufficient model development for all types of physicians and other clinicians.

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 work with CMMI 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. In February, NAACOS and other stakeholders sent a letter to committee leaders outlining the following recommendations for improving CMMI, including:[2]

- Broadening the criteria by which CMMI models qualify for Phase 2 expansion (e.g., does the model account for retaining access to care in vulnerable regions).
- Directing CMMI to engage stakeholder perspectives during APM development, such as leveraging the Physician-Focused Payment Model Technical Advisory Committee (PTAC).

Evaluate Parity Between Medicare Value Programs. APMs and the Medicare Advantage (MA) program provide opportunity for providers to innovate care and move payments away from fragmented care options to coordinate care that is rewarded for value. As Congress looks for ways to improve access to care for rural communities it is important to understand how the differences between programs like APMs and MA impact care delivery. The committee should work with the Government Accountability Office (GAO) to design a study to evaluate parity between APMs and MA so policymakers can seek greater alignment between the programs to ensure that both models provide attractive, sustainable options for innovating care delivery, and to ensure that APMs do not face a competitive disadvantage.

We appreciate the opportunity to express our views and look forward to working with the committee to ensure that high-quality, coordinated, and person-centered care is accessible to all Medicare beneficiaries.

[2] https://www.naacos.com/assets/docs/pdf/2023/118thCongressValue-BasedCareRecsCoalitionLetter.pdf