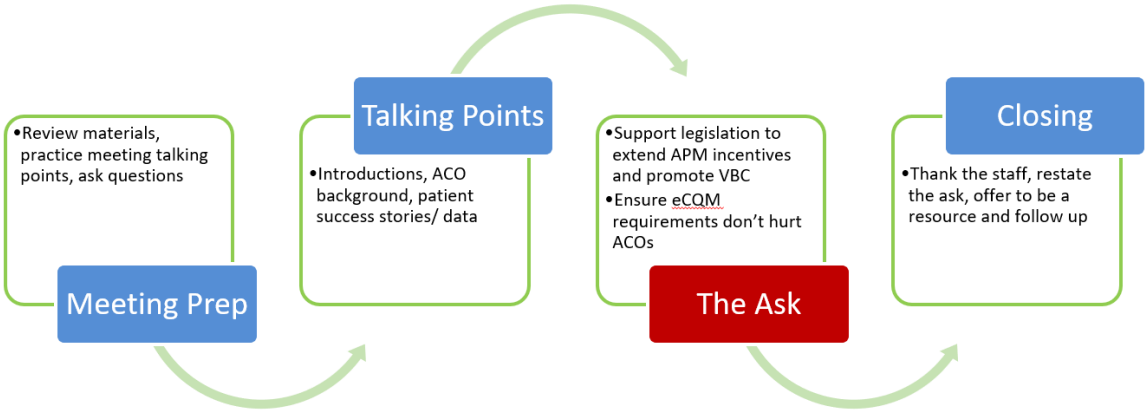
NAACOS Fall Hill Day Talking Points & Hill Staff FAQs

Elements of a Hill Meeting



1) **Support Extension of APM Incentives & Freeze Current QP Thresholds**
2) **Support Legislation to Continue Driving Innovation in Medicare**
    1) **House Offices.** Support the Value in Health Care Act (H.R. 5013), introduced by Reps. Darin LaHood (R-IL); Suzan DelBene (D-WA); Brad Wenstrup (R-OH); Earl Blumenauer (D-OR); Larry Bucshon (R-IN); and Kim Schrier (D-WA).
    2) **Senate Offices.** A Senate version of the Value in Health Care Act is likely to be introduced in the coming weeks. Sens. Whitehouse (D-RI), Barrasso (R-WY) and Welch (D-VT) are likely sponsors. NAACOS is also discussing with Sens. Tillis (R-NC).
        - **Value in Health Care Act.**
            1. Extends value-based care incentives and ensures that qualifying thresholds remain attainable for clinicians.
            2. Removes barriers to participation in value-based care models, such as eliminating regulatory burdens for clinicians and improving financial methodologies.
            3. Evaluates parity between APMs and Medicare Advantage requirements and program flexibility.
            4. Supports continued innovation in the Medicare Shared Savings Program (MSSP) by encouraging CMS to establish a voluntary full risk track.
3) **Ask CMS to Pilot New Quality Requirements Before Implementation**
        - Ensure CMS does a proper pilot program testing eCQM changes before mandatory transition.

FAQs from Congressional Staff

What's changing with the new version of the Value Act?

Maintains	▪ Elimination of high-low revenue distinction; 5% APM incentive extension (2 years); QP threshold freeze and gives CMS authority to set thresholds with cap of 75% and no more than 5% annual increases
Modifies	• Rural glitch to establish overall guardrails re ACO benchmarks
Adds	• Full risk option in MSSP; alternative QP thresholds for outlier models; technical assistance for new APMs in rural and underserved areas; GAO report on MA/APM parity & flexibilities
Removes	• CMS made numerous changes in the 2023 Medicare PFS to improve the MSSP, so we are proposing to remove prior provisions on: ○ Shared Savings Rate Increases; Risk Adjustment; Advanced Investment Payments; APM Model Overlap; & GAO Report on Health Disparities

How much does the Value Act cost?

- Previous versions of the Value Act were estimated to save $280 million over 10 years when factoring in ACO savings to Medicare. Over the last decade ACOs have generated more than **$21 billion** in gross savings, with **$8.2 billion** being returned to Medicare.
- Medicare's advanced APM incentives are a good return on investment as the **$1.8 billion** returned to Medicare by ACOs in 2022 far exceeds the estimated **$644 million** paid in incentives this year.
- **ACOs should share how they reinvest the advanced APM bonus into patient care.**

What organizations support the Value Act?

- (17 national associations) Accountable for Health, American Academy of Family Physicians, American Academy of Orthopaedic Surgeons, American College of Physicians, American Hospital Association, American Medical Association, America's Essential Hospitals, America's Physician Groups, AMGA, Association of American Medical Colleges, Federation of American Hospitals, Healthcare Leadership Council, Health Care Transformation Task Force, Medical Group Management Association, National Association of ACOs, National Rural Health Association, and Premier Inc.

How important is the APM bonus for ACOs and why is another extension needed?

- ACOs account for the vast majority (over 90 percent) of advanced APMs. 84 percent of ACOs surveyed by NAACOS said these incentive payments were "extremely important," with more than 50 percent saying they allowed their ACO to invest in care coordination, data analytics, and to take on more financial risk.
- The incentive payments not only help encourage providers to enter risk-based ACO and Innovation Center models but also provide additional resources that can be used to expand services beyond traditional fee-for-service.
- While Congress passed a one-year, 3.5 percent extension of the advanced APM incentives in 2022, the increase in average MIPS adjustments illustrates that stronger incentives are

needed to continue encouraging growth in risk-based payment models that account for cost and quality of patient care.

- Continuing a 5 percent advanced APM incentive payment for clinicians would ensure that there are stronger incentives for clinicians in advanced APMs.

How would sunsetting APM bonuses for certain clinicians' impact ACOs?

- **Due to cost concerns, there have been discussions amongst Members of Congress regarding sunsetting the bonus after a certain number of years or limiting it to new APM participants only.**
- The best policy solution is to continue incentives for all clinicians in advanced APMs.
- Beginning in 2024 (payment year 26) incentives will favor MIPS.
    - Clinicians with high performance in MIPS will receive a 3.6% payment update (3.35 MIPS update, 0.25 CF update)
    - Clinicians in advanced APMs will only receive a 0.75 percent CF update.
- Continuing a 5% bonus for all clinicians will ensure incentives favor advanced APMs.
    - Limiting the bonus to certain clinicians in advanced APMs will continue incentives to retreat to MIPS and could lead to difficulty recruiting or retaining specialists in ACOs.

How will increasing QP thresholds impact ACOs?

- MACRA established performance thresholds- known as Qualifying APM Participant (QP) thresholds- that APM participants must meet to qualify for incentive payments. These statutory levels, which increase over time, have proven unrealistic relative to the real-life experiences of clinicians.
    - Congress has previously adjusted the QP thresholds in 2020 and 2022.
        - H.R. 5013 ensures that qualifying thresholds remain attainable to promote program growth by giving CMS authority to adjust thresholds through rulemaking and set varying thresholds for more targeted models where participants (i.e., specialists) cannot meet the existing one-size-fits-all thresholds.
- **ACOs should include examples of how increasing thresholds will impact their ability to qualify for APM incentives.**

How will CMS' new benchmark changes impact ACOs?

- According to CMS analysis, the ACPT will **harm nearly 1/3 of ACOs.**
- The ACPT's national spending trend is not reflective of the spending in an ACO's region. When an ACO's regional trend is lower than the United States Per Capita Cost (USPCC), the ACO would be negatively impacted.
- If CMS were to rely purely on the ACPT as proposed it would hurt low-cost, efficient providers.
- Congress must work with CMS to establish effective ACO benchmark policy changes and guardrails to ensure greater participation and innovation in MSSP.

How will CMS' new quality reporting changes impact ACOs?

- To align MSSP quality assessment methods with MIPS methodologies, CMS has created a mandate for ACOs to transition reporting via electronic clinical quality measures (eCQMs) or MIPS clinical quality measures (MIPS CQMs) by 2025.
- eCQMs and MIPS CQMs require reporting and assessment on all patients meeting the measure's criteria, regardless of whether that is an ACO patient, or even a Medicare patient.
- eCQM data must be pulled directly from the Electronic Health Record (EHR). This makes aggregating data across systems and varying EHRs very difficult.
- Lack of interoperability is a key challenge – 2015 CEHRT requirements don't solve this problem.
- In a 2022 poll of NAACOS members, 50% of respondents reported the work to transition to eCQMs or MIPS CQMs for the first year of reporting would cost $100,000 to $499,000. Further, 16% reported a cost of $500,000 to $999,999.
- Although CMS has proposed an interim solution in the Medicare Physician Fee Schedule rule, it does not address these long-term problems for ACOs and does not push back the deadline to transition to electronic clinical quality measures (eCQMs).

How do the MA risk coding changes impact ACOs?

- The HCC model used in MA risk coding is also used for ACOs; however, it's applied differently.
- Ultimately, providers coding practice are agnostic of the provider coverage type (i.e., traditional Medicare, aligned to an ACO, in an MA plan).
- It's positive to see that CMS finalized changes to risk adjustment over a three-year period. ACOs are reviewing the downstream impact on ACO benchmarks.
- That said, there is an opportunity to better align the risk approaches across ACOs and MA.
- The Value in Healthcare Act would require GAO to study parity between APMs and MA, including risk scores, benchmarks, and program flexibilities.

How can Congress reform MACRA?

- NAACOS testified before the House Energy and Commerce Committee re MACRA reform.
- Going forward, Congress must ensure that clinicians receive adequate payment updates with any additional incentives reserved for clinicians who move to APMs. Incentives are the building blocks to care transformation and lawmakers should consider the following:
    - Decouple advanced APMs from the MIPS program and structure MIPS to incentivize participation in APMs.
    - Simplify the incentive structure and account for providers serving rural and underserved populations.
    - Redesign physician payment incentives to promote value by developing a three-tier system that provides 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 incentivize remaining in MIPS. Specifically, Congress should structure MIPS to have adequate payment adjustments for physicians but no additional incentives unless clinicians are taking steps to move to more accountable payment models.

- **APMs—**Clinicians participating in ACOs or other APMs that hold them accountable for cost and quality. Clinicians in this track should be exempt from MIPS quality reporting and only held to the quality and payment parameters of 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.

What impact does the end of the PHE have on ACOs?

- ACOs used telehealth waivers to increase access to care. Only downside risk and prospective assignment ACOs have telehealth waivers. Congress should remove all remaining telehealth restrictions on APMs.

Do ACOs cause consolidation in health care?

- Work in Health Affairs as recently as April 2023 says evidence linking APMs and providers with consolidation is "thin."
- CMS noted in last year's MPFS that payment reforms "have been associated with little acceleration in the consolidation of health care providers."
- ACOs offer an opportunity for clinicians to remain independent working collaboratively along the continuum with other providers.

How do does site-neutrality impact ACOs?

- ACOs are total cost-of-care models that a held accountable for cost and quality of care. ACOs work to provide the right care, in the right setting, at the right time.