July 28, 2023

The Honorable H. Morgan Griffith
Chairman
Subcommittee on Oversight and Investigations
House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Re: MACRA Checkup: Assessing Implementation and Challenges that Remain for Patients and Doctors; Responses to Additional Questions for the Record.

Dear Chairman Griffith,

Thank you for holding last month's hearing to address the Medicare Access and CHIP Reauthorization Act (MACRA). It was an honor to represent the more than 400 NAACOS member organizations that are working to improve quality of care for patients and reduce health care costs. Accountable care organizations (ACOs) bring together clinicians, hospitals, and other providers to innovate care while being held accountable for the clinical outcomes and cost of a population.

In response to your first question regarding expanding the providers included in the Quality Payment Program: It's our understanding that all Part B clinicians not subject to the low-volume threshold (those below $90,000 in Part B billing) are included in the Merit-based Incentive Payment System (MIPS). This includes specialty therapy practitioners such as physical or occupational therapists, speech-language pathologists, and audiologists. While eliminating the low-volume threshold would increase participation in MIPS, it could have unintended consequences where some providers may choose not to accept Medicare patients. Low volume providers can participate in alternative payment models (APMs) and those participating in risk based APMs, who meet the qualifying thresholds, are able to receive the MACRA incentive payments.

We encourage Congress to help ensure that all clinicians have a pathway to APM participation by redesigning Medicare's payment system to promote value adoption and providing appropriate financial and non-financial incentives that help more providers join and succeed in APMs. This includes removing regulatory barriers, increasing flexibility for clinicians to innovate care, and providing more technical assistance.

In response to your second question regarding the Small, Underserved, and Rural Support program (SURS) expiration: While the Centers for Medicare and Medicaid Services' (CMS) population health models have seen encouraging growth over the last 10 years, many practices face challenges transitioning into APMs. NAACOS has consistently encouraged CMS to provide more educational and

technical support for ACOs, small practices, specialists, or providers that serve rural or medically underserved populations as they transition into APMs.

CMS has enacted recent programs to provide additional support to small, underserved, and rural providers. The Advanced Investment Payments (AIP) program within the Medicare Shared Savings Program provides upfront funding to new ACOs. The Making Care Primary model provides additional technical assistance to practices in the model. While these efforts are positive, CMS maintains policies that deter provider participation such as the "high revenue" and "low revenue" designation. Evaluations show that ACOs with Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and other safety net providers are typically designated as high revenue ACOs, requiring them to move to risk faster and be ineligible for AIP. This creates disincentives for including rural and safety net providers in ACOs. We encourage lawmakers to support the Value in Health Care Act (H.R. 5013), which would eliminate the high-low revenue designation for ACOs.

Lastly, while MACRA was a step in the right direction, more needs to be done to drive long-term system transformation. To recap what we outlined during the hearing, Congress should take the following actions to accelerate the adoption of value-based care.

- Extend the MACRA 5 percent advanced APM incentives which are set to expire at the end of this year.
- Redesign physician payment incentives to promote value.
- Improve the non-financial incentives for value by removing barriers to participation and giving additional flexibility to innovate care.
- Work with the CMS Innovation Center to ensure that promising models have a more predictable pathway for becoming permanent.
- Provide parity between APMs and the Medicare Advantage program.

In closing, ACOs and other APMs have demonstrated that when clinicians and other providers come together to innovate care, we lower costs and improve patient care. We should explore all avenues to continue to bolster these arrangements. We look forward to working with the committee to improve the Medicare payment system.

Sincerely,

Aisha Pittman, MPH
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National Association of ACOs