Written Statement for the Record

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For the
House Ways and Means Health Subcommittee

Hearing on
"Improving Value-Based Care for Patients and Providers"

June 26, 2024

Chairman Buchanan, Chairman Smith, Ranking Member Doggett, Ranking Member Neal, and members of the subcommittee, thank you for the opportunity to testify. My name is Stephen Nuckolls, I am the chief executive officer of the independent multispecialty medical practice, Coastal Carolina Health Care and its accountable care organization (ACO), Coastal Carolina Quality Care (CCQC). I'm also a founding member of the National Association of ACOs (NAACOS) and serve on the Executive Committee of its Board of Directors.

My testimony reflects the experience of Coastal Carolina and the broader NAACOS membership. NAACOS represents more than 470 ACOs who provide care for over 9.1 million beneficiary lives through Medicare's population health-focused payment and delivery models, including the Medicare Shared Savings Program (MSSP) and the ACO Realizing Equity, Access, and Community Health (REACH) Model. In addition to the Medicare models, NAACOS' members are engaged in value-based arrangements across Medicare, Medicaid, and commercial insurance. We applaud the subcommittee for holding this hearing to discuss ways to deliver better health outcomes and savings through value-based care (VBC).

Coastal Carolina is a testament to the opportunity for value-based care to reduce costs, improve patient outcomes, and allow providers to remain independent. Coastal Carolina is a physician owned multispecialty medical practice serving Craven, Pamlico, and Jones counties in eastern North Carolina. Our practice was formed in 1997 with the hope that we would be able to manage our patients under a program that provided incentives to keep our patients healthy. That opportunity arrived with the launch of the MSSP in 2012. We were among the 27 to join in the first round of applications in April 2012 and were 1 of 5 to receive advanced investment funding from the Center for Medicare and Medicaid Innovation.

Since that time, our cost of care has been below the established budget or benchmark by $84 million, netting the Medicare program $28 million in savings. For 2023 we project our cost per beneficiary will be 15% below our budget. We have delivered a 900% return to Medicare on the initial $3 million advanced investment payment. In addition to the financial return, our more than 10,000 patients aligned to the ACO have received better care. Since the start of the program, we have reduced hospitalizations 39 percent, from 318 per thousand beneficiaries to 193 per thousand beneficiaries, and reduced emergency department visits by 28 percent, from 620 per thousand beneficiaries to 447 per thousand beneficiaries. Moreover, our colorectal and breast cancer screening rates and blood sugar control for patients with diabetes ranks in the top 1% of the program.

The financial savings have not only accrued to the benefit of the Medicare program but have also benefited patients who have lower out of pocket costs and their supplemental insurance carriers whose claims have declined proportionately. Also, when we work on quality performance, we do it for all populations, not just those assigned to us under the various programs.

Beyond Coastal Carolina's experience, there are proven successes nation-wide. Over the last decade, the MSSP has grown to be the largest and most successful value-based care program in Medicare. As of 2024, there are 602 ACOs coordinating care for 13.4 million Medicare beneficiaries across Medicare's

ACO programs.[1] ACOs have been a good financial investment for the government. In the last decade, ACOs have generated more than $22.4 billion in savings with $8.8 billion being returned to the Medicare Trust Fund while maintaining high quality scores for their patients.[2] Providers in alternative payment models (APMs) also help make the Medicare program stronger by reducing improper payments. Using enhanced data and analytics, ACOs regularly identify and report instances of fraud, waste, and abuse.

Moreover, the growth of APMs has also produced a "spill-over" effect on care delivery across the nation, slowing the overall rate of growth of health care spending. A recent study from the Institute for Accountable Care found that 75% of organizations participating in Medicare ACOs in 2022 also had VBC payment arrangements with Medicare Advantage (MA) or commercial plans and more than 30% had such arrangements in Medicaid.[3] For Coastal Carolina, since entering MSSP we have been able to move other contracts from fee for service (FFS) payments to ones where we have incentives to control the total cost of care. Currently, over 75% of our primary care physician's patients are covered under a total cost of care arrangement.

While VBC is working and more than 400,000 clinicians have made the transition to advanced APMs, misaligned incentives are hampering the movement to VBC. I offer four opportunities to improve Medicare's transition to APMs.

1. **Revise APM benchmarks (or budget) so that providers are not penalized for their prior success.**
2. **Continue financial incentives to join APMs.**
3. **Address incentives across the continuum of care.**
4. **Remove regulatory burden and increase flexibility, providing stronger nonfinancial incentives to adopt value.**

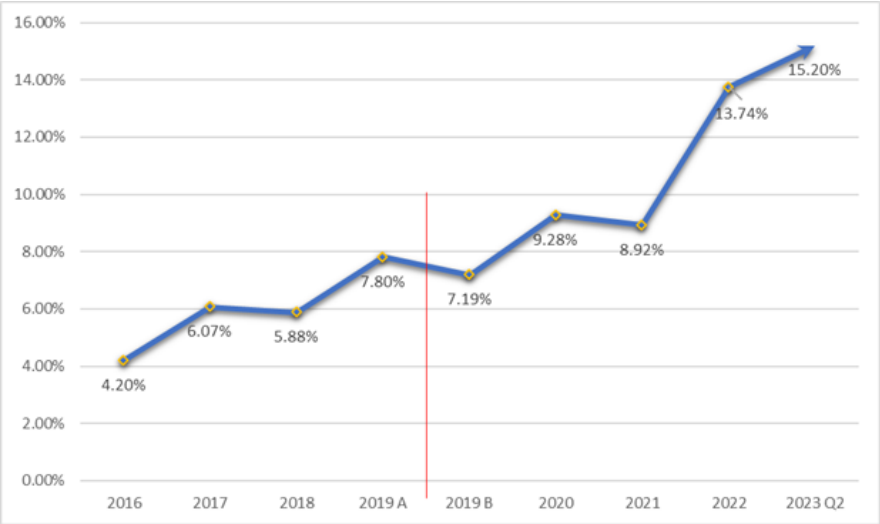
SUSTAINABLE BENCHMARKS

ACO benchmarks are a race to the bottom approach that makes it difficult for clinicians to remain in the program and be successful. Benchmarks in ACOs are set using a combination of historical spending for the aligned beneficiaries and regional and national spending trends. Over the next two years, the majority of MSSP participants will enter new contract agreements and have their benchmarks rebased and lowered due to achieving savings during the current contract cycle. While CMS has adopted policies to reduce the impact of the ratchet (i.e., prior savings adjustment, accountable care prospective trend) these policies do not go far enough and many ACOs may face deep reductions to their benchmarks.

For Coastal Carolina, the impact of the benchmark ratchet is significant. As outlined in the graph below, our ACO, like others, has been successful in lowering costs compared to its benchmarks. Prior to entering the MSSP our assigned patient cost per beneficiary was slightly above the expected cost.[4] Ten

[1] https://www.cms.gov/newsroom/press-releases/participation-continues-grow-cms-accountable-care-organization-initiatives-2024
[2] https://www.naacos.com/wp-content/uploads/2024/01/NAACOS2022ACOSavingsResource.pdf
[3] https://www.ajmc.com/view/allpayer-value-based-contracting-in-organizations-with-medicare-acos.
[4] CCHC Report for 2012 generated by CMS' Physician Quality Reporting System.

years later our cost per patient is 25 percent below the region.[5] Assuming that we maintain our current savings rate of approximately 15 percent and apply the 5 percent cap on the prior savings adjustment or regional efficiency adjustment, our benchmark will be reduced by 10 percentage points or 66% of last year's savings. If you calculate the savings to Medicare using the regional efficiency calculation, excluding our assigned beneficiaries from the calculation, CMS will retain 80% of the cumulative savings.



Ultimately, this policy means that our ACO is unlikely to renew our contract when it ends this year. The CMS policies to partially mitigate the benchmark ratchet (5 percent savings or regional efficiency adjustment) is insufficient to cover the costs of running the programs we operate. While our independent ACO is unlikely to continue, our medical practice is reviewing its options with other organizations.

It is critical that we ensure that ACOs have fair and accurate benchmarks so that providers do not have to face the tough decision to leave a program in which they were previously successful. The savings achieved in these models directly impact patient care by expanding care teams, providing additional beneficiary services that are not billed to Medicare, ensuring provider retention with enhanced provider payment, and investing in technology or other services that enable care coordination and population health management. Lowering benchmarks because of the ratchet effect reduces providers' ability to improve care and reduces the ACO's opportunity to achieve success and reinvest shared savings into beneficiary care. **We need benchmark approaches that do not penalize clinicians for prior success in the model.**

Conversely, in our risk arrangements within Medicare Advantage we do not face ratcheting benchmarks. While our risk arrangements in MA are impacted by MA policy changes, it is far more predictable and stable.

[5] This figure was calculated from data provided to us by CMS in our 4th Quarter and Final Settlement reports for 2022. The regional figure excludes assigned patients from regional per capita costs.

FINANCIAL INCENTIVES TO JOIN APMS

Congress passed MACRA in 2015 to eliminate Medicare's sustainable growth rate (SGR) formula, establish unified quality reporting systems, and provide financial incentives for clinicians to join APMs. MACRA's incentive payments have been effective in facilitating clinicians' transition to advanced APMs. To illustrate the progress that's been made since MACRA became law, as of January 2024, more than 70 percent of the 602 ACOs participating in the MSSP and REACH programs have moved into two-sided risk tracks.[6] MACRA's incentive payments have enabled health care practices to allocate resources towards enhancing care coordination, improving patient outcomes, and reducing unnecessary health care costs. Additionally, they have supported practices in covering services that traditional Medicare does not reimburse.

The advanced APM incentives have been critical for Coastal Carolina. Across our practice we have received $600-700,000 annually in advanced APM incentives. Comparatively, this is 5-10 percent of our shared savings and less than 1% percent of our benchmark. The incentives have been critical in two areas. **First, the incentives provided assurance for the movement towards downside risk**. For a smaller ACO like ours, it was difficult to convince our clinicians to go at risk. The incentives provided financial certainty while becoming comfortable with operating in risk-based arrangements. **In recent years, the advanced APM incentives and shared savings are covering the shortfalls that we lose each year to inflation.** This has allowed Coastal Carolina to maintain clinicians and hire new clinicians, remaining competitive with larger organizations, and help pay for our value-based programs. The absence of permanent solutions for clinician payment updates combined with ratcheting benchmarks in APMs ultimately jeopardizes the adoption of value-based care.

While we have been encouraged that Congress has passed two short-term extensions of MACRA's advanced APM incentive payments, and provided temporary relief from physician payment cuts, more is needed to drive and sustain positive movement to value-based care. With MACRA's incentive payments set to expire at the end of 2024, there will be a stronger financial incentive to remain in FFS. **We support the Value in Health Care Act (H.R. 5013), which extends MACRA's original advanced APM incentive payments along with a freeze of the qualifying thresholds for Performance Years 2025 and 2026.** This approach would ensure that financial incentives to adopt, or remain in advanced APMs, are stronger than the projected incentives in the Merit-based Incentive Payment System (MIPS). At a minimum, the current incentives should be extended to allow additional time for consideration of more extensive payment reforms. While an incentive higher than MIPS is ideal, an extension of current incentives would provide an equivalent incentive to the maximum MIPS performance, based on CMS' current projections.

Beyond a short-term extension of advanced APM incentives, we believe the following principles should be met when designing long-term incentives:

- Provide timely incentives. The current incentive approach is not directly tied to care delivery as there is a two-year lag between the performance year to qualify and the payment year.
- Ensure providers are not penalized for receiving incentives. The higher conversion factor for clinicians in advanced APMs are included in APM expenditures and may make it difficult to meet

[6] https://www.cms.gov/files/document/2024-shared-savings-program-fast-facts.pdf

benchmarks. The advanced APM incentive are excluded from APM expenditures. Similarly, the incentive of a higher conversion factor update should not impact a clinician's ability to meet the financial target in their APM.

- Ensure that incentives are strongest to join an APM. The misaligned incentives are also directly tied to the opportunity to achieve higher financial gain in MIPS. This program needs revision in order to redesign APM incentives that are permanent, stable, and predictable.

ADDRESSING INCENTIVES ACROSS THE CONTINUUM

MACRA established incentives to adopt APMs for clinicians providing services under Medicare Part B. To further the movement to value-based care, we must ensure that there are incentives across the continuum of care. The backbone of the ACO model is primary care, driving beneficiary alignment to the model. However, many ACOs employ a team-based approach that creates incentives for clinicians to work collaboratively to follow evidence-based guidelines to achieve the program's goals. We regularly monitor performance of the providers rendering care to our assigned patients and work to ensure they are receiving the highest quality evidence-based care possible. Similarly, ACOs are incented to encourage beneficiaries to receive clinically appropriate care in the most appropriate setting that is not always the most expensive.

Unfortunately, other parts of the care continuum have minimal incentive to work with the ACO to innovate care when they are continued to be paid by volume. As I note above, the ACO has allowed us to help retain clinicians in our practice, particularly specialists. Cardiologists and many other specialists receive substantial subsidies when working for hospital systems. We use shared savings payments to subsidize their revenue to make it comparable to what they would receive in other settings.

ACOs and other APMs can drive success by only focusing on primary care focused strategies and programs; however, they will not reach their full potential without bringing in specialists and other providers who continue to be paid FFS. **We must reexamine the overall financial incentives that have caused many providers across the continuum to remain outside of value-based care.** This includes examining opportunities to improve benchmarks within APMs. The ratcheting benchmarks described above serve as deterrent for providers with profitable service lines, there is no incentive to invest and implement programs that reduce these profits and penalize success.

REMOVING BURDEN AND INCREASING FLEXIBILITY

MACRA provided both regulatory relief and financial incentives to encourage adoption of APMs. Specifically, MACRA created pathways for reducing provider burden by excluding all clinicians in advanced APMs from MIPS. While this is conceptually the right approach, we have not gone far enough in reducing regulatory burden for providers who are bearing financial risk. Moreover, we're concerned that CMS has restored some of the regulatory burden that was previously removed.

Increased program flexibility and reduced oversight for clinicians in APMs is needed. For example, we remain subject to audits by the Medicare Administrative Contractor for certain spending patterns. At Coastal Carolina, we recently received an audit related to increased ordering of urine drug screens; however, our staff were merely following appropriate guidelines established by our board to help ensure controlled substances were not being diverted. When we're ultimately held to total cost of care and outcomes, we should not be subject to these audits.

Similarly, CMS could increase its use of waivers, allowing providers to operate with fewer restrictions leading to a reduction in provider burden and increased care innovation. To date, the waivers have been limited and can also be burdensome. For example, MSSP only has waivers for telehealth and the 3-day rule for skilled nursing facility stays. Yet the ACO REACH model has access to many additional waivers. We believe all APMs should have access to all available waivers and that those waivers shouldn't be limited to certain models.

One specific opportunity to enhance waivers would be to improve the MSSP Beneficiary Incentive Program (BIP). This program was established in 2018 to help eliminate financial barriers to accessing care. Unfortunately, the current program structure prevents the use of the incentive because an ACO must furnish incentive payments in the same amount to each eligible beneficiary for all qualifying services. As a result, the program is too costly and complex for ACOs to implement.

In fact, HHS reported to Congress that as of October of 2023 no MSSP ACOs have established or operated a BIP.[7] The statute should be modified so that ACOs can (1) select a subset of services or patients to provide cost-sharing incentives and (2) provide a beneficiary incentive for the full amount of coinsurance for the service.

We must ensure APMs and MA are both viable options for innovating care. Providers are engaged in risk-based arrangements across payers; as such they are accountable for cost and outcomes of Medicare beneficiaries in MA and traditional Medicare. Unfortunately, the variation in program rules often means that providers must manage to the model rather than the patient.

We need greater alignment between APMs and the MA program to ensure that both models provide attractive, sustainable options for innovating care delivery and to ensure that APMs do not face a competitive disadvantage. This includes establishing parity between program flexibilities to reduce clinician burdens and improve patient access to care and driving the adoption of value-based arrangements between APMs and MA. Similarly, there is opportunity to reduce burden for providers who are in risk-based arrangements in MA. For example, exemption from prior authorization requirements creates a strong incentive to adopt risk-based arrangements in MA. The Government Accountability Office (GAO) should explore opportunities to improve APM alignment with MA and encourage adoption of risk-based arrangements in MA.

[7] https://www.govinfo.gov/content/pkg/CMR-HE22-00184510/pdf/CMR-HE22-00184510.pdf#:~:text=The%20purpose%20of%20the%20BIP%20is%20to%20allow,be%20no%20more%20than%2023%20dollars%20in%202023

We must reinstate burden reductions established in MACRA. While exemption from MIPS has been a strong non-financial incentive for providers to join APMs, we are concerned that CMS has removed some of this burden reduction. Specifically, CMS has aligned APM reporting requirements with MIPS by requiring clinicians in APMs to report Promoting Interoperability (PI) and requiring ACOs to report electronic clinical quality measures (eCQMs) ahead of industry readiness.

Fundamentally, we believe aligning APM measurement with FFS measurement is a flawed approach, rather FFS measurement should prepare clinicians for adopting APMs. CMS should:

- Develop measures that assess population health, rather than applying FFS measures to APMs.
- Exclude all APMs from MIPS and eliminate MIPS APMs.
- Rescind the recently finalized rule requiring advanced APMs to report PI.
- Delay the planned retirement of the web interface reporting system for at least three years and require CMS to test digital quality changes for a subset of APMs and ACOs to identify key challenges and unintended consequences that need to be resolved before moving forward on a program-wide basis.

CONCLUSION

Thank you for this opportunity to appear before the subcommittee to discuss ways to improve Medicare's transition to value-based care. Coastal Carolina and NAACOS' members are committed to providing the highest quality care for patients while advancing population health goals for the communities we serve. We look forward to your continued engagement to improve the Medicare payment system.