



**Statement**

**of**

**Michael Robertson, MD**

**Chief Medical Officer, Covenant Health Partners**

**on behalf of the**

**National Association of ACOs**

**to the**

**U.S. House of Representatives Committee on Energy and Commerce  
Subcommittee on Health**

**Re: Examining Barriers to Expanding Innovative, Value-Based  
Care in Medicare**

**September 13, 2018**

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Chairman Burgess, Ranking Member Green, and Members of the Subcommittee, thank you for the opportunity to testify on behalf of the National Association of ACOs (NAACOS). NAACOS is the largest association of Accountable Care Organizations (ACOs) representing more than 6 million beneficiary lives through more than 360 ACOs, NAACOS works on behalf of ACOs across the nation, including Medicare Shares Savings Program (MSSP), Next Generation, and commercial ACOs, to improve the quality of Medicare delivery, population health and outcomes, and health care cost efficiency. NAACOS shares the goal of the Committee to accelerate value-based transformation and I appreciate the opportunity to provide my and the Association's views on barriers to expanding innovative, value-based care in Medicare.

I share my perspective as a practicing internal medicine physician since 1986 and, currently, as the Chief Medical Officer of Covenant Health Partners and Covenant ACO in Lubbock, Texas. Covenant Health Partners formed in 2007 and we have had a clinically integrated network for 11 years now. Through our network, we have instituted robust health information technology, contracts for hospital services, and quality metrics for measures like hospital-acquired infections. We then branched out to commercial contracts and, in 2014, made the

quantum leap to a 3 year Track 1 Medicare Shared Savings Program (MSSP) agreement. If we had not already had a clinically integrated network in place, where we had already done much of the work to get ready for MSSP participation, it is unlikely that we would have made the decision to participate in the MSSP. It was also important for us that we didn't have to be concerned about taking downside risk, since we were in a shared savings-only model.

We learned that moving to value-based care is a massive undertaking that requires changing the behavior of multiple providers. We've had to change physician behavior, hospital behavior, skilled nursing facility behavior, home health agency behavior—the list goes on. In looking at our MSSP financial data, we came to understand that much of our cost was coming from post-acute care, namely skilled nursing facilities—whose costs were 180% higher and home health agencies whose costs were 250% higher than national normative data. We had to work closely with those providers to see those costs go down and that took time and effort. By developing and working with providers in our preferred post-acute care network, we eventually got to a place where we have seen quarter by quarter decreases in costs in these areas.

Participation in the MSSP has allowed us to reinvest in technology and infrastructure to manage our patient population. In our first year of participation in the MSSP, we saved Medicare \$5M and our share was \$2.5M. We used the bulk of those funds to reinvest in our IT infrastructure, and developed a physician dashboard where quality data such as adhering to evidence based practices for chronic disease management and preventative care like pneumococcal vaccines and colonoscopies for our patients are displayed. We also invested in analysts to review and manage our quality and financial data. One challenge we had there is that the financial data is only available on a quarterly basis, and then we receive the data about four to six weeks after that, so any change in our process can be delayed. We also hired care coordinators and invested in

software to manage care. We receive real time alerts when our patients arrive at the emergency department (ED) that allow us to push the care plan for a patient to the ED physician so that he or she isn't working blind and can assist us in providing high quality, cost efficient care.

All of these things take time and money; pushing too quickly to achieve results and take on risk, without giving ample time for providers to develop the necessary infrastructure, will mean people don't participate. In year one of our Track 3 agreement, we ended up with a small profit, but based on some earlier actuarial work, at one point we thought that we would have to pay \$1-4M back because the final financial reconciliation for the MSSP is delayed by eight months after the performance year is concluded. Had my physician Board of Directors been told that they would have to pay back \$1M, there is no way that we would have continued participation in the MSSP. From a provider perspective, it doesn't make sense to assume financial risk to take care of Medicare patients as this entails accepting responsibility for costs that physicians cannot control such as the increasing cost of pharmaceuticals such as chemotherapy.

It's important to note that ACOs save Medicare money. In 2017, 472 ACOs caring for 9 million beneficiaries participated in the MSSP, generating gross savings of \$1.1 billion based on the CMS methodology for setting financial benchmarks.<sup>1</sup> According to 2017 CMS performance data, 60 percent of ACOs saved money in 2017 and 34 percent of ACOs earned shared savings, up from 56 percent and 31 percent, respectively, in 2016. After accounting for shared savings earned by ACOs in 2017, net Medicare savings were \$314 million. Notably, the 2017 results also show a continued trend where ACOs that are in the program longer are more likely to earn shared savings and save money overall for Medicare. We also know that ACOs produce better

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<sup>1</sup> Centers for Medicare & Medicaid Services. "2017 Shared Savings Program (SSP) Accountable Care Organization (ACO) public-use file (PUF)," available at <https://data.cms.gov/Special-Programs-Initiatives-Medicare-Shared-Savin/2017-Shared-Savings-Program-SSP-Accountable-Care-O/gk7c-vejx/data>.(August 30, 2018).

quality. For example, a 2017 U.S. Department of Health & Human Services Office of Inspector General (HHS/OIG) report found that ACOs achieved high quality and, in particular, noted progress on important measures such as reduced hospital readmissions and screening beneficiaries for risk of falling and depression.<sup>2</sup>

As the Chief Medical Officer of an ACO that has succeeded over time in the MSSP program, I have observed the work of the Centers for Medicare & Medicaid Services (CMS) to improve and accelerate the program closely. On August 9th of this year, CMS issued a proposed rule that would set a new direction for the MSSP, referred to as the “Pathways to Success” Program.<sup>3</sup> The proposal would improve the existing MSSP in a number of ways, including: lengthening agreement periods from 3 years to 5 years; providing an additional 6-18 months in one-sided risk for 82 current ACOs that would otherwise be required to move to risk on January 1, 2019, if renewing participation; implementing ACO-specific payment rule waivers—such as the expansion of the three-day SNF waiver—and beneficiary incentives; and decreasing burdens related to meeting Electronic Health Record (EHR) requirements. Some of these improvements will lend stability to the program, which is very positive.

The proposed rule also includes three measures which will likely have the unintended impact of discouraging participation of new ACOs. First, the rule shortens the onramp to taking on downside financial risk for new ACOs from 6 to only 2 years. Two years is not enough to take on risk; it took us 11 years and we are still working on it. And, based on a NAACOS survey

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<sup>2</sup> Office of Inspector General, U.S. Department of Health & Human Services. “Medicare Shared Savings Program Accountable Care Organizations Have Shown Potential for Reducing Spending and Improving Quality,” (OEI-02-15-00450) (August 2017).

<sup>3</sup> Centers for Medicare & Medicaid Services. “Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations – Pathways to Success,” 83 FR 41786 (CMS-1701-P) (August 17, 2018).

conducted earlier this year, this will likely result in more than 70 percent of early ACOs leaving the program.

Second, the proposed rule cuts shared savings in half for shared savings-only ACOs, from 50% to 25%, which could severely undermine the business case to join the program and begin the transition to value-based payment for new ACOs. The reduced shared savings amount is going to keep providers out of this program, because it does not allow them to retain enough savings to reinvest in the IT infrastructure and care coordination that is needed to make these programs work.

Third, the limitation of the risk score adjustment of +/-3% over the 5-year contractual period will also be harmful as it penalizes physicians financially for taking care of patients who are sicker. In order to avoid having physicians refusing to accept and provide care to medically complex patients, the risk score adjustment must be reflective of the true risk of the patients under the care of the ACO and it must change, either positively or negatively, as the risk of the patient changes.

I am hopeful that, in light of these significant concerns, the final rule increases the allowed time in upside-only ACOs to at least three years for BASIC Levels A and B (previously Track 1) ACOs—and, for certain ACOs that meet quality and cost standards, allow additional years—and rescinds the proposed decrease in the shared savings rate. Furthermore, I would like for the final rule to be modified to allow for annual adjustments in the risk factor adjustment for patients that is truly reflective of their individual risk and not limited to an arbitrary adjustment which is cumulative over the 5 year contract.

On the topic of barriers to value-based care, I urge the Committee to review barriers which inhibit ACO access to real-time care coordination information. It is widely recognized that

giving timely, actionable data to healthcare providers allows them to work closely with beneficiaries to effectively manage chronic conditions or prevent health conditions from worsening. However, to effectively manage a beneficiary's health, ACOs need more timely and in-depth data. CMS should set standards for timeliness and data set definition to be used across ACOs to effectively manage populations. The data available in the HIPAA Eligibility Transaction System (HETS) is very meaningful and should be provided in real time to ACOs for their beneficiaries. This would allow ACO providers to communicate with treating providers at the hospital and to work with the beneficiary upon his or her release to ensure optimal treatment, medication adherence and follow up care. We urge the Subcommittee to work with CMS to develop a mechanism to share more robust health data, including that from HETS, with ACOs in real time to enhance care coordination, improve outcomes, and reduce costs.

As we look toward the future of value-based care in this country, ACOs should be encouraged to succeed and grow in numbers so that every Medicare beneficiary has the option to join an ACO. Policies which would shrink the pool of ACOs are going in the wrong direction; we should remove barriers to ACO growth, not impose new barriers.

I commend this Committee on its work to examine ways to meaningfully evaluate and responsibly increase the use of value-based models and arrangements in the Medicare program. Thank you for the opportunity to testify.