



STATEMENT
Of
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To the House Energy and Commerce Committee and
Subcommittee on Oversight and Investigations

Re: MACRA Checkup -- Assessing Implementation and Challenges that Remain for Patients and Doctors

June 22, 2023

Chair Rodgers, Ranking Member Pallone, subcommittee Chair Griffith, subcommittee Ranking Member Castor, and other distinguished members of the committee and subcommittee, thank you for the opportunity to provide testimony on the status of the bipartisan Medicare Access and CHIP Reauthorization Act (MACRA, Public Law 114-10).

My name is Anas Daghestani, MD, and I am a practicing primary care physician and a board-certified internal medicine specialist. I serve both as the Chair of the Board of America's Physician Groups, or APG, as well as Chief Executive Officer of the Austin Regional Clinic in Texas.

APG is a national organization representing approximately 360 physician groups in 45 states committed to providing coordinated, integrated, patient-centered care that is accountable for both costs and quality. Our roots go back more than 20 years, when we were founded as an organization representing California-based physician groups determined to transform health care. Today our member groups collectively employ or contract with approximately 195,000 physicians and care for nearly 45 million patients. APG's member groups are committed to the transition to value-based health care and engage in the full spectrum of alternative payment models and Medicare Advantage – for example, caring for an estimated 1.5 million patients in Medicare ACOs and nearly 10 million in Medicare Advantage (MA), or about 33 percent of all MA enrollees nationwide. We work, always in bipartisan fashion, to advocate for policies supportive of all these forms of value-based care.

Austin Regional Clinic (ARC) is a multispecialty medical group with more than 2,500 employees, including 400 physicians providing primary and specialty care for approximately 650,000 patients throughout Austin and Central Texas. In addition, I also serve as chief medical officer for the Seton Health Alliance, an Accountable Care Organization in partnership with the Ascension Seton Healthcare Family. ARC's 400 physicians care for 55,000 Medicare beneficiaries, 24,000 of whom are enrolled in Medicare Advantage plans; another 18,000 are traditional Medicare beneficiaries cared for within a two-sided risk Medicare ACO. We also have 30,000 Medicaid enrollees; 30,000 patients employed by the state of Texas or their dependents; roughly 550,000 patients covered by commercial insurance plans; and approximately 25,000 patients insured through qualified health plans participating in Healthcare.gov. Before joining ARC, I previously practiced medicine at a federally qualified health center in rural Oklahoma, where I cared for many uninsured individuals and U.S. veterans as well.

It is in all these capacities that I appear before the committee to share my experiences with, and observations about, MACRA and to suggest potential improvements to the law. I have three basic points: first, that MACRA constituted a great step forward for Medicare when it was enacted in 2015; second, that while aspects of the law have had many positive effects, others have not lived up to their potential; and third, that substantial opportunities exist now to reengineer the law to improve the care of millions of Medicare beneficiaries and obtain far better value for the dollars expended on health care for both beneficiaries and American taxpayers.

MACRA: An Important Initiative for Its Time

To my first point, MACRA was in many respects the right solution for its time – as evident in the fact that it passed both the House and the Senate by extremely large margins in both parties and was signed into law by President Barack Obama in 2015. As with much major legislation, numerous compromises were made to garner this broad bipartisan support. MACRA repealed the unworkable “sustainable growth rate (SGR)” portion of the Medicare physician payment formula, which was adopted in 1997 out of concern that the Medicare physician fee schedule “by itself would not adequately constrain overall increases in spending for physicians’ services.”¹ However, beginning in 2002, Medicare’s expenditures for physician services exceeded targets, threatening payment cuts for clinicians followed by last-minute actions by Congress to head them off. MACRA wisely replaced the SGR with specified annual fee updates in the short term.

Next, MACRA sought to move beyond fee-for-service payment for clinicians that was, first, unrelated to quality or cost concerns; second, potentially volume-inducing; and third, leading to overprovision of services, substantial low-value care, and outright waste. MACRA thus introduced a new payment track, the Merit-based Incentive Payment System (MIPS), which took effect in 2019. It also built on the alternative payment models introduced under the Affordable Care Act in 2010 by “incentivizing the development of, and participation in, alternative payment models (APMs),” such as the Medicare Shared Savings Program (MSSP), models created by the Center for Medicare and Medicaid

¹ H Hahn, K Blom, The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA); P.L. 114-10). Congressional Research Service, Nov 10, 2015.

Innovation, or new Physician-Focused Payment Models that could be evaluated and adopted by the Secretary of Health and Human Services.²

Under MIPs, which modifies but is still based on fee-for-service payment, physicians and certain other clinicians could receive additional payment under four performance categories: quality, as judged by specific measures; resource use; clinical practice improvement activities; and meaningful use of certified electronic health record technology. Under APMs, clinician payment is based, in part, on the ability to assume accountability for the cost and quality of patient care for clinicians who meet specific thresholds for the receipt of Medicare payments through an eligible APM. In addition, for participation in specific APMs designated as Advanced Alternative Payment Models, eligible professionals could receive through 2024 a 5 percent lump-sum bonus on their previous year's Medicare Part B payments. For the 2025 payment year, the Consolidated Appropriations Act of 2023 (Public Law 117-328) extended the incentive for just one year and reduced it to 3.5 percent.

All these MACRA payment changes were necessary, both in terms of repealing the SGR formula and in creating additional incentives for clinicians to continue improving the quality of care provided to Medicare beneficiaries while being attentive to its costs. As a result, for example, our Medicare ACO has achieved top tier quality measures for 10 consecutive years – meaning that we provide a top-notch quality of care -- and generated shared savings for CMS and the taxpayers for 9 out of 10 years. But – and here I move to my second point – MACRA overall has been a mixed success, and in many respects has not fully lived up to expectations. This reality is in part due to due to the law's fundamental structure and in part because of the challenges of implementing complex legislation through the federal rulemaking process, among other factors.

MACRA: At Best, A Mixed Success, With Multiple Deficiencies

Physician payment under Medicare is complicated and driven by multiple factors, and as the American Medical Association calculates, when adjusted for inflation has fallen 26 percent from 2001 to 2023.³ APG and ARC are grateful that many members of Congress, and even the Medicare Payment Advisory Commission (MedPAC), have recognized the need for a boost in payment.^{4,5} Although some of the incentives available to clinicians under MACRA have been helpful, they have not fundamentally altered the picture of declining real payment to clinicians under Medicare.

² Ibid, pp. 10-11.

³ See <https://www.ama-assn.org/practice-management/medicare-medicaid/fixing-medicare-physician-pay-system-top-priority-ama>

⁴ See MedPAC March 2023 Report to Congress, Recommendation 4-1.

⁵ See H.R. 2474, Strengthening Medicare for Patients and Providers Act, at <https://www.congress.gov/bill/118th-congress/house-bill/2474>

As a result, at a time of increasingly tight health care labor markets, a shortage of primary care providers, and rapid price inflation, the financial pressures on many physician practices are growing. The result is that many practices lack the financial capacity to make the substantial technology and other health care infrastructure investments needed to fundamentally transform health care. This phenomenon is especially true for small independent primary care practices, which must adopt many sophisticated features of advanced primary care that is at the heart of value-based payment models.⁶ Their inability to do so is undoubtedly one key factor in the consolidation of physician practices now seen nationwide.

At the same time, the MIPS program itself is flawed and, for a variety of reasons, has failed to drive sufficient improvement in quality and costs. As MedPAC has noted, the MIPS program is predicated on an unsound principle: That superior outcomes for a patient are the result of actions by a particular clinician, rather than the collective efforts of many clinicians operating within a system incentivized to produce the highest quality of care at an affordable and sustainable cost. Moreover, MIPS is based on “measures that clinicians themselves choose to report,” which means that they end up being “evaluated and compared on dissimilar measures.”⁷ MedPAC further notes that CMS has concluded that more than half of clinicians are exempt altogether from MIPS reporting and payment adjustments.

Other aspects of MACRA have also fallen short of expectations. MACRA created the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to enable the private sector to propose alternate payment models outside the CMMI process. Although more than several dozen such physician-focused models have been proposed to PTAC— and roughly 20 models have in turn been recommended for adoption by PTAC to the Secretary of HHS – none has been adopted. The reasons are complex, but for various reasons, the PTAC mechanism leading to departmental approval clearly has not worked.

Reengineering MACRA for a Dramatic Boost to Value-Based Care

The above analysis leads to my third point: That it is time to reengineer MACRA to fully fuel the transition to value-based health care – a transition that has had broad bipartisan support in Congress for nearly two decades. Although this change has happened far more slowly than many policymakers intended, and produced fewer concrete results, it remains the best option for producing higher-quality health care for Americans at sustainable costs. And with Medicare spending projected at more than \$1 trillion in 2023 – and projected to grow an average of 7.8 percent a year, to nearly \$2 trillion, a decade

⁶ Sharp JP et al, Realizing the vision of advanced primary care: confronting financial barriers to expanding the model nationwide. Health Affairs Forefront, March 30, 2020.

⁷ Moving Beyond the Merit-Based Incentive Payment System. Medicare Payment Advisory Commission Report to the Congress: Medicare Payment Policy, Chapter 15, March 2018.

from now⁸ -- it is essential that policymakers continue to push this program to deliver superior health outcomes for the massive dollars expended.

To this end, APG supports the commitment of the current administration to ensuring that all enrollees in the traditional Medicare program – as well as most Medicaid enrollees – are in “longitudinal, accountable [relationships] with providers that are responsible for the quality and total cost of their care.”⁹ To attain this goal – which by some estimates, would require moving approximately four million Medicare beneficiaries annually into such arrangements over the next six years – the nation needs to drastically reform Medicare payment to drive widespread, holistic change.

Although the magnitude of overall savings to the Medicare program from Accountable Care Organizations (ACOs) has been relatively low, evidence has accumulated that participation in the Medicare Shared Savings Program by physician groups is positively associated with savings.¹⁰ Austin Regional Clinic’s participation in MSSP offers an example.

Since the enactment of the ACA, ARC has participated first, in the Pioneer ACO model (effective 2014); Track 1 of the MSSP one-sided risk model (effective 2017); and in the Pathways to Success two-sided risk model (first the Basic Track and then Track E), in which we are now in the fourth year of a five-year contract. In 2018, the Seton Accountable Care Organization, Inc. (in which ARC was one of three physician groups that participated but contributed 80 percent of the attributed patients) produced more than \$10 million in savings for the government, performing in the top quartile of all ACOs nationally. We also participate in fully delegated, capitated risk in Medicare Advantage, and two-sided risk Medicaid contracts.

We cannot understate the importance of participating in these models, and the power of risk and shared savings in motivating practice change. An episode from my own experience in patient care tells the story.

In ARC’s first year in a Medicare ACO, I had as patients a married couple enrolled in Medicare. The husband had experienced 65 visits to the emergency department in one year, 90 percent of which were preventable and avoidable. I worked with a nurse navigator to establish a weekly call with the patient and monthly clinic visits, and coordinated with community-based organizations to address the patient’s transportation, food security, medication, and other social services needs. One year later, the patient had 20 office visits and only 12 ED visits. We did not change a single aspect of his medical treatment plan, but we invested heavily in holistic care, the costs of which can’t be recouped through

⁸ See National Health Expenditure Projections at <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsprojected>.

⁹ Fowler L et al, The CMS Innovation Center’s Strategy to Support Person-centered, Value-based Specialty Care. Published Nov. 7, 2022, at <https://www.cms.gov/blog/cms-innovation-centers-strategy-support-person-centered-value-based-specialty-care>

¹⁰ McWilliams JM et al, Medicare Spending after 3 years of the Medicare Shared Savings Program. *N Engl J Med* 2018; 379:1139-1149.

Medicare fee-for-service claims. The outcomes were better care and better health for the patient, who received more patient-centric care, as well as lower total costs of care.

We have since continued to improve care by investing in our clinic infrastructure. For example, with the benefit of these new revenue models, we have increased access to patients by expanding our evening and weekend hours across multiple different clinics. Patients now can now see their doctors' schedules and book their own appointments, even for same-day service.

With the benefit of sophisticated IT and analytics, we have focused on quality measures across our various value-based contracts and identified multiple opportunities for improvement. Our rate of screening our Medicare patients for depression and risk of falling has risen from 38 percent two years ago to 80 percent today. As we identify care gaps for patients, we conduct outreach to them to schedule appointments, and thus have boosted rates of everything from colorectal cancer screenings to vaccinations.

We have also invested heavily in population health infrastructure through patient-facing care navigators, pharmacy support, creating connectivity with local hospitals and specialty groups, and building a network of community resources. The \$70 million-dollar-price tag for these investments hasn't been met through the Medicare fee schedule or the generation of Medicare fee-for-service claims, but rather through the shared savings that we have generated in value-based care models. These types of investments are, frankly, unaffordable, and unsustainable without the stability and predictability of MACRA, alternative payment models, and the overall move to value.

Although memories of the COVID-19 pandemic may already be fading, it is worth noting that the shared savings revenue that ARC earned in our one-sided, upside-only MSSP contracts helped us to survive during a time when our fee-for-service revenue was declining. We did not alter our hours or close our clinics, and as a result, we experienced high growth of new patients as we chose to continue that value proposition.

We believe that ARC's experience in value-based care offers proof of improved quality for our patients and savings for both patients and taxpayers. But value-based care models face substantial headwinds, as seen in the fact that the number of Medicare beneficiaries assigned to the Medicare Shared Savings Program ACOs has fallen nearly 3 percent from 2020 to 2023.¹¹ What's more, as enrollment in Medicare Advantage plans have grown substantially, physician practices face a greater burden of contracting with health plans, and have less incentive to participate in value-based models in the traditional Medicare program -- now that more than 50 percent of Medicare enrollees eligible for Medicare Parts A and B are now enrolled in Medicare Advantage, and more than 70 percent in more than a hundred counties.¹²

¹¹ CMS Shared Savings Program Fast Facts – As of January 1, 2023. <https://www.cms.gov/files/document/2023-shared-savings-program-fast-facts.pdf>

¹² APG analysis of CMS MA State/County Penetration 2023-06. At <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenrolldata/ma-state/ma-state/county-penetration-2023-06>

Policymakers now have the opportunity to reverse these headwinds through the five major steps described below.

First, the basic structure of MACRA – MIPS and physician-focused payment models in particular – should be replaced relatively soon with substantially greater incentives, and possibly mandatory requirements, to move to primary care capitation or total risk/global capitation in Medicare. In addition to preserving and extending the ACO Realizing Equity, Access, and Community Health (REACH) program, policymakers should adopt a primary care capitation model into the Medicare Shared Savings Program. Only by boosting primary care and enabling practices to take on greater risk – thus being fully accountable for both costs and quality -- will physician-led organizations achieve the true potential of value-based health care.

Second, both existing and new, partially, or fully capitated ACO arrangements must be multiyear, and must provide stable and sustainable payment for practices over the long haul. CMS and CMMI currently set the financial benchmarks against which the performance of Medicare ACOs is judged on an annual basis, and in such a way that successful participants in these models can see lower benchmarks over time. In effect, we end up competing against ourselves for savings – a true disincentive for continuing in these models. Similar frequent changes in patient attribution formulas and quality measures also create challenging instability and serve as a further disincentive for participation.

Third, for practices that are relatively new to value-based care, policymakers should dramatically increase upfront payments for infrastructure and technology along the lines of the ACO Investment Model (AIM) that CMMI previously tested; the new Advance Investment Payments (AIP) incentive program that will begin next year; and the planned Making Care Primary model.¹³ Small physician practices in rural areas, and/or those serving vulnerable populations, may be unable to survive without such support, let alone to develop the capabilities to participate in risk-based models. The alternative is likely to be the appearance of more primary care deserts, or else ongoing practice consolidation.

Fourth, as a temporary measure amid greater incentives to move to capitation, Congress should restore and extend MACRA’s original 5 percent bonus on top of Part B fee-for-service payment for clinicians participating in Advanced Alternative Payment Models (AAPMs). (As noted above, for performance year 2023, the bonus has been cut to 3.5 percent and limited to one year.) In addition, for the purposes of receiving the bonus, the current qualifying thresholds for participating in AAPMs should be preserved.

As it now stands, beginning in 2024, these current thresholds (“qualifying participants” must receive at least 50 percent of their Part B payments through an Advanced APM over the course of a year or must see at least a 35 percent of their Medicare patients through an Advanced APM entity) will increase to 75 percent of payments or 50 percent of patients, respectively. As a result, CMS itself

¹³ See <https://innovation.cms.gov/innovation-models/making-care-primary>

estimates that as many as 100,000 fewer clinicians will qualify for the bonus under these new thresholds, further undermining incentives to participate in value-based care.

An additional change from current law should be to allow the patients of a given clinician who are enrolled in Medicare Advantage to count toward a preserved 35 percent threshold. (Many of these provisions are likely to be included in a revised version of the Value in Health Care Act that is likely to be introduced in Congress soon.)

Fifth, it is essential to continue to prioritize achieving greater health equity in the adoption of value-based payment. The many equity-oriented features of the ACO REACH model – including the required adoption of specific plans for advancing health equity, and payment incentives to care for patients in underserved areas – are critically important provisions that should be emulated broadly across value-based payment models.

Conclusion

It is likely that there are other ideas beyond the five that I identified above that warrant further exploration as your committee and subcommittee contemplate further updates to MACRA. As always, Congress will have to weigh multiple options, make compromises to garner broad political support, and balance the need to drive further dramatic change against the inevitable political resistance that has dogged the transition to value to date.

However, the longstanding approach of making participation in value-based models entirely voluntary has not achieved the intended results, and perpetuating it further isn't likely to do so. The looming fiscal crunch that will ensue from the ongoing rapid rise in health spending – coupled with the poor and declining health status of many Americans -- create an important “burning platform” for sweeping change.

Once again, I thank the leaders of this Committee and Subcommittee for the opportunity to share these observations and recommendations. We who are member organizations of APG, and who serve at Austin Regional Clinic, look forward to working with you further to advance improvements in U.S. health care, for the benefit of patients, providers, and taxpayers alike.

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