AMERICA'S PHYSICIAN GROUPS

Taking Responsibility for America's Health

October 31, 2022

The Honorable Ami Bera, M.D.
U.S. House of Representatives
172 Cannon House Office Building
Washington, D.C., 20515

The Honorable Larry Bucshon, M.D.
U.S. House of Representatives
2313 Rayburn House Office Building
Washington, D.C., 20515

Re: Request for Information on the Medicare Access and CHIP Reauthorization Act (MACRA)

Dear Rep. Bera and Rep. Bucshon:

America's Physician Groups (APG) appreciates the opportunity to respond to your request for information on the Medicare Access and CHIP Reauthorization Act (MACRA). Since the law was enacted in 2015, APG has worked through legislative and regulatory channels to ensure that MACRA fulfills the congressional intent that it be a driver of value-based care.

The Centers for Medicare & Medicaid Services (CMS) has set a goal to have all eligible Medicare beneficiaries in a care relationship with accountability for quality and spending by 2030. The nation is on its way to meeting that goal. All told, about three-fourths of the 58.6 million seniors enrolled in both Parts A and B of Medicare are in more accountable relationships than previously, through Medicare Advantage, the Medicare Shared Savings Program's Accountable Care Organizations (ACOs), and other ACO models.[1]

However, in the years since MACRA's enactment, key elements of the new Medicare payment regime that it created have not kept pace with rapid changes in health care. Payment and quality provisions produced by MACRA are overly complicated, administratively burdensome, and inconsistently applied. Annual changes to financial benchmarks, patient attribution, and quality measures have created a level of uncertainty for providers that jeopardizes future participation and has slowed the movement into greater risk-sharing arrangements in Advanced Alterative Payment Models (Advanced APMs). If these problems are left uncorrected, the push for value-based care could suffer.

We applaud your view that Congress should now take stock of the MACRA-produced payment regime and evaluate what works and what doesn't. In the following comments, APG will highlight the effectiveness of the program, the regulatory and legislative barriers that need to be addressed, and ways the program can be improved. We also comment on needed changes to other aspects of CMS's

[1] MedPAC Data Book, https://www.medpac.gov/wp-content/uploads/2022/07/July2022_MedPAC_DataBook_SEC_v2.pdf

and the Innovation Center's transformation work that would enhance the transition to value, and that could be incorporated into a broad package of legislation along with revisions to MACRA.

I. About America's Physician Groups

APG is a national association representing more than 330 physician groups committed to the transition to value, and that engage in the full spectrum of alternative payment models and Medicare Advantage (MA). Our motto, "Taking Responsibility for America's Health," underscores our members' preference for being in risk-based, accountable, and responsible relationships with all payers, including MA health plans, rather than being paid by plans on a fee-for-service basis.

Delegation of risk from payers to providers creates the optimal incentives for our groups to provide integrated, coordinated care; make investments in innovations in care delivery; advance health equity; and manage our populations of patients in more constructive ways than if our members were merely compensated for the units of service that they provide. APG members collectively employ or contract with approximately 195,000 physicians (as well as many nurse practitioners, physician assistants, and other clinicians). These professionals in turn provide care for nearly 45 million patients.

II. Summary of APG Comments

- Before Congress considers longer-term MACRA policies, it must first stabilize physician payment for the near-term ***by preventing double-digit cuts in provider payment.*** It should also reinforce the incentives to providers for making the transition to value ***by extending the 5 percent bonus for clinicians participating in Advanced APMs.***

- Congress should ***support, and potentially build on through legislation, recent CMS proposals to speed the transition to Advanced APMs*** and increase participation in shared-savings programs.

- Congress should ***support and defend the ACO REACH program*** and use its patient-centric focus on improving health equity as a model for future APM development.

III. Certainty and Predictability: Stabilizing Medicare Physician Payment

Recommendation No. 1: Congress should prevent a combined 10.4 percent reduction in physician payment rates that is set to go into effect in 2023.

A trio of legislative and regulatory policies are coming together in 2023 that will reduce Medicare physician payment rates by 10.4 percent unless these policies are changed.

First, physicians face an expected 4 percent reduction created under the pay-as-you-go (PAYGO) congressional budgetary provisions of federal law. If PAYGO is enforced, the Congressional Budget Office estimates that providers would face about $36 billion in reduced Medicare payments each year. Second, physicians and other clinicians are also subject to a 2 percent reduction in Medicare reimbursement as part of mandatory federal budget sequestration law. Third, physicians and other clinicians face a 4.5 percent payment reduction under the current Medicare conversion factor that translates relative value

units into actual Medicare payment levels. CMS last year announced an updated 2022 physician fee schedule conversion factor of $34.6062. down 0.82% from the conversion factor set in 2021.

These scheduled cuts would come at a time when COVID-19 cases, as well as hospitalizations due to influenza, are expected to rise, and when health care providers are still rushing to provide needed health care services to Medicare beneficiaries that have been delayed by the pandemic. Providers face very tight labor markets, higher wage and salary demands from workers, and inflationary pressures on costs.

APG supports legislation to head off these expected Medicare payment cuts, in the form of the ***Supporting Medicare Providers Act (H.R. 8800)***, which would extend an existing Medicare payment increase through the physician fee schedule through the end of 2023. However, APG believes that Congress must work on longer-term, more sustainable payment policies that shift physicians away from traditional fee-for-service payments that are not linked to total costs and quality of care.

Recommendation No. 2*:* Congress should advance the ongoing transition to value-based health care by extending Medicare's 5 percent Advanced APM Incentive Payments authorized under MACRA and freezing the current Qualifying Advanced APM Participant thresholds. APG encourages Congress to adopt the bipartisan revisions to MACRA that are included in the **Value in Health Care Act (H.R. 4587)**.

In 2015 and with strong bipartisan support on Capitol Hill, Congress passed MACRA as a replacement to Medicare's sustainable growth rate (SGR) formula, which tied physician payment to a target growth rate that would have triggered lower payments for physicians until Congress regularly stepped in to delay the cuts. Ironically, Congress faces a similar punishing scenario under MACRA today.

To become a Qualifying Participant (QP) in Advanced APM, physicians and other clinicians must receive at least 50 percent of their Medicare 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. QPs are in turn eligible for 5 percent incentive payments that can be used in a variety of ways, including for information technology and other information support to enable the move to value-based care approaches. APG member groups have used these incentive payments to invest in services like disease registries, case management, care coordinators and more. The benefits to Medicare enrollees include wellness programs, transportation to and from clinical visits, meal delivery services, and even reduced cost-sharing.

Under MACRA's original provisions, providers participating in Advanced APMs will only be eligible for the 5 percent incentive payments through the current 2022 performance year, with bonus payments payable in 2024. Although CMS will continue to make determinations about who qualifies as a QP, the thresholds for qualification will change, increasing to having 75 percent of their Medicare payments, and 50 percent of their Medicare patients, come through an Advanced APM entity.

For many clinicians, reaching these new thresholds is likely to prove difficult. CMS itself estimates that in 2023, 144,700 to 186,000 eligible clinicians would become Qualifying Advanced APM Participants—about 80,000 to 100,000 below previous CMS estimates due to these higher patient and payment thresholds.

APG continues to support robust efforts to boost physician participation in Alternative APMs, and believes that the existence of the Merit-Based Incentive Payment System (MIPS) created under

MACRA has done little to produce needed transformation to value in the U.S. health care system, while proving to be overly burdensome for providers engaged in it. In an ideal world, Congress would abandon MIPS altogether and nudge all providers into AAPMs. On that score, allowing the 5 percent Advanced APM bonus to effectively expire, and changing the thresholds for QP eligibility, will only undermine these critical efforts to transform payment and the delivery of care.

IV. Incentivize Providers in Underserved, Rural, and Marginalized Communities to Transition to Value

Recommendation No. 3: Congress should support and improve upon proposed regulatory policies to boost participation in ACOs by physicians in underserved communities.

In its proposed 2023 Physician Fee Schedule rule, CMS offered several policy options designed to increase participation in the Medicare Shared Savings Program, such as extending Advance Investment Payments (AIP) to ACOs that provide care in largely underserved communities. Advanced payments are essential for physicians who want to take on more financial risk but may not immediately be able to do so.

Under CMS's proposal, qualified ACOs that are considered low revenue could receive advanced shared savings payments of $250,000 and quarterly payments for two years. Higher payments would be allotted to those ACOs that treat higher numbers of dual-eligible beneficiaries. CMS would recoup its upfront investment from the shared savings that these ACOs generate.

APG is largely supportive of CMS's proposal and believes it should inspire further legislative measures to boost participation in value-based care models. For example, Congress could extend eligibility for AIPs to ACOs entering the ENHANCED track, and to existing ACOs that have specific health equity initiatives underway. Expanding eligibility to these ACOs would have the larger effect of increasing participation in MSSP while also providing upfront payments for infrastructure costs that come with participating in health equity initiatives. By including ACOs that participate in the ENHANCED track, the agency would extend assistance beyond ACOs that are on the upside-only risk tracks and encourage organizations on the path to accepting downside risk to continue toward that goal. This would also result in savings to the Medicare program.

Recommendation No. 4: Congress should also support regulatory policies, and potentially adopt legislation, that reinforce movement into two-sided risk models through programs such as MSSP and ACO REACH.

To further speed the transition to value, policies must walk a fine line between easing providers' entry into risk-based models and relieving the pressure to move to full accountability for costs and quality. In the proposed 2023 Physician Fee Schedule rule, CMS is examining an option for certain ACOs to stay in upside-only models for as long as 12 years. But not requiring participating MSSP ACOs to cover any losses in an initial six-year track could create a "no-lose" situation for participants, and hurt the program's ability to accrue savings. Additionally, allowing ACOs a longer, more gradual glide path to full risk could attenuate improvements in care quality.

Any delay could have unintended impacts for Medicare Advantage (MA). Allowing a longer glide path to full risk, for instance, could drive additional movement into MA at the expense of MSSP, especially as providers and beneficiaries find the program's stable payments, supplemental benefits and

streamlined administrative features more attractive. While APG are ardent supporters of MA, we nevertheless believe that both MA and traditional Medicare should be strong enough to support to cover as many enrollees as possible.

It remains unclear whether CMS will finalize its proposals for the long "glide paths" toward full risk for some ACO participants as described above. Congress should monitor the process and consider providing legislative direction to ensure that an appropriate balance is struck between attracting new entrants into MSSP and moving providers more quickly into full risk.

Along similar lines, Congress should express in legislative terms its support for the current ACO REACH model, and charge CMS and CMMI with developing a successor model that will build on lessons learned in the initial years of the program. ACO REACH (for Realizing Equity, Access and Community Health) is the retooled version of the Global and Professional Direct Contracting Model created by CMMI in 2020. It is a primary care-based model that provides monthly capitated payments to providers to care for aligned Medicare beneficiaries. It is the first accountable care model to focus on addressing health equity and access to care in underserved communities.

Despite these positive attributes, some in Congress have criticized the program and called for its termination. Lost on many of these critics is the reality that ACO REACH provides an alternative to Medicare Advantage, in that it allows provider groups to offer many of the same supplemental benefits, such as dental care, that currently draw enrollees into MA.

Congress should not only express in legislation its implicit support for ACO REACH, but it should also instruct CMS to create its own "glide path" to a successor direct contracting model once ACO REACH ends in 2026. Past experience has shown that the value-based care transition is slowed when one Innovation Center model ends and there is no immediate path forward for many model participants, as occurred when the Next Generation ACO model ended in 2021.

V. Conclusion

When Congress passed MACRA with overwhelming bipartisan support in 2015, it ushered in new Medicare payment approaches designed to eliminate traditional fee-for-service payments that were not tied to costs and quality, and to replace them with payment structures and care models that would reward clinician accountability for quality and costs. With the passage of time and evolution of these new care models, MACRA must evolve as well. Congress can seize the opportunity to both remove or greatly modify elements of payment created under the law, such as MIPS, and enhance both aspects of the law and institute new policies to accelerate the transition to value and two-sided risk. As always, APG stands ready to assist you in these efforts.

Sincerely,

Susan Dentzer
President and CEO
America's Physician Groups

CC: The Honorable Michael Burgess, M.D.
U.S. House of Representatives

The Honorable Kim Schrier, M.D.
U.S. House of Representatives

The Honorable Brad Wenstrup, D.P.M.
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The Honorable Mariannette Miller-Meeks, M.D.
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