October 31, 2022

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

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

The Honorable Kim Schrier
U.S. House of Representatives
1123 Longworth House Office Building
Washington, D.C. 20515

The Honorable Michael Burgess
U.S. House of Representatives
2161 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Earl Blumenauer
U.S. House of Representatives
1111 Longworth House Office Building
Washington, D.C. 20515

The Honorable Brad Wenstrup
U.S. House of Representatives
2419 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Brad Schneider
U.S. House of Representatives
300 Cannon House Office Building
Washington, D.C. 20515

The Honorable Mariannette Miller-Meeks
U.S. House of Representatives
1716 Longworth House Office Building
Washington, D.C. 20515

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

Dear Representatives Bera, Bucshon, Schrier, Burgess, Blumenauer, Wenstrup, Schneider and Miller-Meeks:

Thank you for the opportunity to comment on **the Request for Information (RFI) on Medicare Access and CHIP Reauthorization Act (MACRA)**. We appreciate your leadership in ensuring that providers are adequately reimbursed for their efforts to improve quality, reduce costs, improve clinical practice, and promote interoperability, and that our regulatory structures create meaningful incentives to adopt and deepen engagement in new payment and delivery system reform initiatives.

The Partnership to Empower Physician-Led Care (PEPC) is a membership organization dedicated to supporting value-based care to reduce costs, improve quality, empower patients and physicians, and increase access to care for millions of Americans through a competitive health care provider market. We believe that it is impossible to achieve truly value-based care without a robust independent practice community. Our members include Aledade, American Academy of Family Physicians (AAFP), California Medical Association, and Medical Group Management Association (MGMA). We also have individual and small medical group supporters across the country, many of whom are independent physicians or practices and wish to remain so.

To help control health care costs, ensure better outcomes for patients, and reduce physician burnout, Congress must prioritize Medicare payment reform. This includes:

- Doubling down on the role of physicians and physician-led practices in leading delivery system transformation initiatives;
- Ensuring robust Medicare fee-for-service (FFS) reimbursement as a platform for value-based care, and advancing policies that support provider competition;
- Aligning the Medicare Quality Payment Program (QPP) to reward physicians and practices that invest in payment and delivery system transformation, including physicians and practices that are just beginning the transition away from free-for-service; and,
- Re-focusing the CMS Innovation Center on transparent model design and development.

Our comments below are focused on these topics, and we look forward to serving as a resource for you on these topics as you consider legislative priorities moving forward.

Role of Physicians in Leading Delivery System Transformation

Our country has been testing various payment and delivery system reform models for decades. Independent physicians have repeatedly demonstrated their superior ability to generate positive results in value-based care arrangements, both in improved health outcomes and reduced costs. For example, through Comprehensive Primary Care+ physicians and physician practices demonstrated their ability to reduce emergency room and acute care visits through advanced primary care medical homes. Independent practices outperformed system-owned practices by 15 percent in PY2017 and 18 percent in PY2019, even though both practice types improved their performance on overall utilization.

Additionally, CMS data shows that physician-led accountable care organizations (ACOs) are creating a better experience for patients while lowering costs across the entire system. Medicare Shared Savings Program (MSSP) results from 2020 show that, across the health care system, ACOs led by physicians, often called "low revenue," typically create more savings than hospital-led ACOs, often known as "high revenue." According to CMS data, in 2020, 90 percent of low revenue ACOs generated savings against the benchmark, compared to only 75 percent of high revenue ACOs. Additionally, low revenue ACOs saved more than 5.3 percent, twice as much as high revenue ACOs, who only saved 2.5 percent. In 2020, low revenue ACOs also generated more than an additional $100 in per beneficiary savings ($241) compared to high revenue ACOs ($137).

Congress and the Administration should ensure that HHS' delivery system reform efforts are oriented around the provider-patient relationship to the greatest extent possible. This trusted relationship has proven to be a cornerstone of successful value-based care efforts.

Robust Medicare Reimbursement and Provider Competition

Because many value-based care models continue to be built on the FFS chassis, Medicare FFS payment rates and policies are integral to the success of CMS' value-based care models. FFS must provide a sustainable platform for providers to deliver care in a way that promotes clinical and financial accountability.

A key part of providing a sustainable platform for accountable care is ensuring that Medicare FFS reimbursement rates keep pace with inflation and rising costs. The services of doctors, nurses and other skilled clinicians have been systematically undervalued by the Medicare program, with the gap between actual costs and reimbursed costs widening over time as costs increase. Failure to update these pricing inputs over time has contributed to the increasingly difficult climate for independent practices to survive. It has led to an imbalance across practice settings with hospitals, skilled nursing facilities and other

facilities receiving annual Medicare payment updates to account for increasing costs while physicians and other clinicians are forced to figure out how to do more with less.

Another key part of providing a sustainable platform for accountable care is ensuring that health care provider consolidation does not jeopardize the future of independent practice. In recent years, there has been a historic pendulum swing between employed physicians and private practice. In 2021, for the first time, the American Medical Association found that less than 50 percent of physicians in the U.S. are in independent practice. Between July 2020 and January 2021, the rate at which hospitals employ physicians increased by 3 percent. Already in 2016, 90 percent of hospital markets were considered highly concentrated by DOJ and FTC guidelines. The situation has only worsened since then, as private equity firms and other players have redefined what consolidation looks like in health care.

Provider consolidation leads to higher costs without measurable improvements in quality. A March 2020 report by the Medicare Payment Advisory Commission (MedPAC) found that in most markets by 2017, a single hospital system accounted for over 50 percent of inpatient admissions. Incentives for physicians to join larger practices include higher commercial prices and increased efficiencies. Recent studies highlighted in the report found that provider consolidation with hospital/health systems led to an increase in commercial prices from 3 percent to 14 percent, however efficiencies aren't increasing with higher total spending as was originally assumed given the potential for improved coordination via consolidated practices.

This report also highlighted the following findings on quality as a result of hospital-physician integration: 1) patients were more likely to choose a high-cost, low-quality hospital when their provider was employed by the hospital; 2) physicians whose practices were acquired by hospitals were more likely to bill for more services in the hospital setting and fewer in the office setting; 3) hospital acquisitions of a physician practice had little effect on improved outcomes on a range of issues, such as mortality, acute circulatory conditions, and diabetes complications; and 4) vertical integration had a limited effect on quality metrics reported by CMS.

Congress and the Administration should take the following action to ensure robust reimbursement in the Medicare program and to implement policies that level the playing the field across practice settings:

- Provide certainty surrounding provider reimbursement to ensure patients continue to have access to the services and care they need. This includes investing in the Medicare physician fee schedule to ensure that Medicare providers are appropriately reimbursed for their services and to ensure that reimbursement accounts for rising overhead costs and inflation.
- Build upon existing site-neutrality rules and create more fairness in the payment system by passing legislation to ensure CMS pays the same Medicare rates for drugs and clinic visits at physician offices and hospitals.
- Conduct congressional oversight of the Federal Trade Commission to ensure it is correctly utilizing its statutory authority to investigate harmful consolidation and promote competition.
- Take steps to improve quality metrics providers are judged by and ensure outdated measures are being eliminated.

<u>Improving MACRA Framework</u>

Re-Thinking the Quality Payment Program

A primary objective of MACRA was to change the way that Medicare rewards clinicians to drive them to value over volume. Under MACRA, physicians and practices have three options: 1) remain in FFS and receive a nominal and/or no annual payment adjustment; 2) participate in the Merit-Based Incentive Payment System (MIPS) and receive a greater payment adjustment based on performance on indicators related to cost, quality, clinical practice improvement, and promoting interoperability; or 3) receive a 5 percent bonus for participating in an advanced alternative payment model (AAPM) that requires taking "more than nominal risk" for the patient panel.

Implementation of the MACRA framework has fallen short of congressional intent, and has become a reporting exercise rather than a true driver of transformation. There is broad consensus across the health care industry that the QPP increased administrative burden and complexity. QPP requirements continue to change year after year. Since there is a dearth of APMs and the MIPS requirements do not closely align with any existing APM, MIPS is primarily a reporting program with arbitrary requirements that do not meaningfully contribute to improved patient outcomes. The significant burden associated with these programs forces practices to direct their time and resources on complying with reporting requirements rather than building the skills and infrastructure that would allow them to succeed in value-based payment.

Further, the vast majority of Medicare providers in APMs get little to no benefit from the framework, as they continue to report through MIPs and are not eligible for the AAPM bonus. Under the current MACRA statute, practices are essentially disincentivized from remaining in an APM that does not qualify as an AAPM, as they are not eligible for the increased conversion factor (beginning in 2026) and are still subject to many of the MIPS requirements. Given that most Medicare providers participate in an APM that does not meet the AAPM criteria, most Medicare providers participating in a value-based care arrangement continue to be stuck in the MIPS track, which has really been designed for providers who continue to practice FFS medicine. MIPS requirements do not incentivize deeper value-based care relationships, and do not push practices to continue to raise the bar with respect to their clinical and financial accountability. Additionally, the incentives associated with high performance on MIPs are not enough to encourage true investment in value-based care infrastructure.

To address these issues and encourage providers to both adopt and deepen their value-based care arrangements across payers, Congress should pass legislation establishing a middle track for providers who are doing more than is required under MIPs and who have adopted value-based care, but who are not yet deriving the majority of their revenue from those models. The incentive offered to these providers should be more than what is available under MIPs, and should reflect the accountability and reporting requirements already present through those models.

Suggestions to Improve Current Framework

While we support a bigger picture approach to re-thinking the MACRA framework, we also recognize that there will need to be a glidepath to implementation of the recommendations above. In the meantime, we believe MIPS Value Pathways (MVPs) should be an optional, voluntary platform to encourage providers to move into value-based care. We encourage CMS to design MVPs to meaningfully reduce burden and align with new and existing APMs. If designed correctly, MVPs may be one pathway that can prepare practices, especially small and independent practices, to transition from FFS to APM participation.

However, we continue to be concerned by the limited number of APMs available to small and independent practices and believe that this is likely to be a limiting factor impacting the goal of using MVPs as a platform to move a wide range of providers into APMs. We strongly urge CMS to develop additional models that

span the risk and participation (e.g., ACO and non-ACO) spectrum. We encourage CMS to design models that provide physicians a glide-path to full risk to make the transition to value-based care more enticing to physicians as physicians who wish to accept full risk may be concerned about accepting full downside risk at the onset. PEPC also urges CMS to ensure MVPs include the measures and activities that will adequately prepare participants for an APM. Increasing alignment between MVPS and APMs will create a clearer on-ramp for practices to move into APMs.

CMS Innovation Center

We support the work of the CMS Innovation Center as a laboratory for testing models and model design components that can be expanded to other programs throughout CMS. With the release of the CMS Innovation Center's Strategic Refresh white paper in October 2021, we were pleased to see that the CMS Innovation Center is committed to making model design choices that ensure its models are accessible to a range of providers, including small providers, independent practices, and physicians practicing in rural and/or underserved areas. We agree that policies that reflect providers' varying abilities to assume risk, programs that provide upfront funds for investment, and metrics that reflect a wider array of transformational policy goals will encourage smaller, independent practices to consider participating in value-based payment innovations.

We encourage Congress to work with the CMS Innovation Center to ensure that their work does the following:

- **CMS should define clear metrics of success that go beyond simply cost savings, taking a holistic approach to the full range of benefits realized by payment and delivery system models.** Other important policy goals include: advancing health equity; addressing racial/ethnic health disparities; increasing access to care in underserved or rural areas; quality improvement; and reduction in ED visits.
- **CMS should create a clear "glidepath" for providers that have invested in value-based care.** The CMS Innovation Center should focus on ensuring that physicians and practices participating in its models clearly understand how to leverage their population health investments into a sustainable, scalable practice change. Practices should understand the options for "leveling up" their participation, for example, by moving from a care management model to a model that requires risk or by deepening the amount of risk taken among other options.
- **CMS should offer physician leaders across specialties a range of different model options, prioritizing multi-payer models and models that are designed to interact or nest within each other to build on existing successes.** Providers should have at least one opportunity to join a value-based care model per year, ideally with more than one opportunity available at various points on the risk-based glidepath.
- **CMS needs a consistent, transparent mechanism for getting feedback from a range of stakeholders, including independent physicians and practices.** The physician-focused payment model technical advisory committee (PTAC) has been a forum for some of this feedback, but as has been well-documented, it is unclear to what extent the CMS Innovation Center has considered PTAC's feedback. If PTAC is not going to be a useful channel of communication with the Innovation Center, there should be another mechanism.
- **Decisions around model design, terms, and conditions should be transparent and communicated to the broader stakeholder industry, including those who are not participating in the model.** Today, many of these communications are made through IT systems used to

implement models, which are behind a firewall for everyone except program participants. Increasing transparency related to program implementation is a way to level the playing field across provider types, and participants and participant partners.

******

Please do not hesitate to reach out to me if the Partnership to Empower Physician-Led Care can be a resource to you. I can be reached at kristen@physiciansforvalue.org.

Sincerely,

Kristen McGovern
Executive Director