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Advancing High Performance Health

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October 31, 2022

The Honorable Ami Bera, M.D.
U.S. House of Representatives
Washington, DC 20515

The Honorable Larry Bucshon, M.D.
U.S. House of Representatives
Washington, DC 20515

The Honorable Kim Schrier, M.D.
U.S. House of Representatives
Washington, DC 20515

The Honorable Michael C. Burgess, M.D.
U.S. House of Representatives
Washington, DC 20515

The Honorable Earl Blumenauer
U.S. House of Representatives
Washington, DC 20515

The Honorable Brad R. Wenstrup, D.P.M.
U.S. House of Representatives
Washington, DC 20515

The Honorable Bradley Scott Schneider
U.S. House of Representatives
Washington, DC 20515

The Honorable Mariannette Miller-Meeks, M.D.
U.S. House of Representatives
Washington, DC 20515

Re: Medicare Access and CHIP Reauthorization Act Request for Information

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

On behalf of AMGA, we appreciate the opportunity to comment on the current state of the Medicare Access and CHIP Reauthorization Act (MACRA) and associated payment mechanisms. This request for information seeks feedback from health care providers, advocacy organizations, health economists, health finance experts and others on the current state of MACRA.

Founded in 1950, AMGA is a trade association leading the transformation of health care in America. Representing multispecialty medical groups and integrated systems of care, we advocate, educate, innovate, and empower our members to deliver the next level of high-performance health. AMGA is the national voice promoting awareness of our members' recognized excellence in the delivery of coordinated, high-quality and high-value care. Over 177,000 physicians practice in our member organizations, delivering care to more than one in three Americans. Our members are also leaders in value-based care delivery, focusing on improving patient outcomes while driving down overall healthcare costs.

In offering recommendation for improving MACRA, it is important to recognize the financial headwinds that providers are facing. For the second year in a row, providers are anticipating unprecedented financial pressure in the new year, as they are facing more than 10% cuts to

Medicare payments that could deeply affect access to care for Medicare patients in communities across the nation. In 2021, these cuts were paused for a year by the passage of the Protecting Medicare and American Farmers from Sequester Cuts Act (S. 610). While AMGA members were grateful for the relief, continued Medicare cuts, workforce shortages, historic inflation, and the ongoing strain due to the COVID-19 pandemic is creating additional burden on providers and patients. Evaluating MACRA and implementing potential reforms to further transition the healthcare system to one based in value presupposes stable and sufficient Medicare reimbursement. Allowing the more than 10% Medicare cuts to take effect would preclude further investments in the transition to value-based care.

AMGA is pleased to offer comments on the prevalent issues affecting our membership: [1]

I. The effectiveness of MACRA;
II. Regulatory, statutory, and implementation barriers that need to be addressed for MACRA to fulfill its purpose of increasing value in the U.S. health care system;
III. How to increase provider participation in value-based payment models;
IV. Recommendations to improve the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Model (APM) programs

The Effectiveness of MACRA

The Centers for Medicare & Medicaid Services' (CMS) regulatory implementation of MACRA to transition Medicare to a value-based payment system was met with many challenges. AMGA is deeply concerned that CMS's regulations do not honor the legislation's original intent. Since the passage of MACRA in 2015, physicians and groups have dedicated significant amounts of time and resources to implement its requirements. However, they have not received the financial incentives Congress authorized in MACRA. MACRA introduced two pathways to clinicians through the Quality Payment Program (QPP): the Merit-based Incentive Payment System (MIPS) and the Alternative Payment Model (APM) program. AMGA has concerns with both options.

APMs have failed to attract the critical mass of physicians and medical groups necessary to ensure the success of the program due to unobtainable requirements. Further, CMS is continually changing these requirements year to year and as providers advance within a particular model. There is great instability within the programs and an ever-moving target that appears to be unachievable, as demonstrated in annual rulemaking and inconsistent sub-regulatory guidance. MIPS has failed to reward providers for superior performance because of its insignificant payment updates, which produced a nominal investment return. AMGA members make significant investments to provide care in value-based models. These systemic improvements require investments not only in technology but all require the investments in care managements, leadership, and analytics. Congress must address the inconsistent thresholds of Advanced APMs and provide incentives in MIPS so that more providers can transition to value as envisioned under MACRA.

MACRA included incentive payments for participation in certain eligible APMs. The legislation included a 5% payment for Qualifying APM Participants (QPs) for payment years 2019 through

[1] Separately, AMGA's comments on the Calendar Year (CY) 2023 Physician Fee Schedule Proposed Rule can be found here: https://www.amga.org/getmedia/1e380afa-de71-489c-93a9-bb2fcd5367e6/AMGA_Comments_on_CY2023_NPRM_9-6-22.pdf.

2024 (2018 through 2022 performance periods). Beginning in CY 2026, there will be two different Medicare physician fee schedule (PFS) conversion factors (CF): one for QPs and a lower one for non-QPs. The 5% incentive payment was intended to foster a value-based payment system in health care and reward physicians who provide high-quality care while taking on a certain level of financial risk. Congress must extend the 5% APM bonus to participating physicians to further incentivize high-quality care, as the QP free-schedule incentive is trivialized by the anticipated Physician Fee Schedule cuts.

These incentive payments were an acknowledgement of the higher level of accountability that eligible clinicians took on by actively participating in certain APMs. Many times, parts of these bonus payments were reinvested back into the care provided to patients to ensure that access to certain technologies, strategies, and patient access to care were maintained at the highest levels. Further, these payments helped to support eligible clinicians and their practices to maintain certain services given the rising inflation and continued cuts to Medicare payments. Without this payment, between 144,700 and 186,000 eligible clinicians will no longer receive MACRA's $600-$750 million payments, compounding concerns we continue to hear from our members. Without congressional intervention, the lack of more favorable financial opportunities in the APMs creates an incentive to remain in fee-for-service (FFS) and not advance as quickly to risk-based models, which counters the goal of shifting toward value-based care.

Evidence has shown that value-based care reduces costs while increasing the quality of care provided.[2] Between 2021 and 2030, CMS estimates that Medicare Part A and B spending will grow by approximately 0.7% below the inflation rate. CMS was able to demonstrate, through analyzing claims data, that Medicare Fee for Service (FFS) expenditures were lower for ACOs compared to the general Medicare FFS non-ACO market. The agency estimated that the overall impact of ACOs, including "spillover effects" on Medicare spending outside of the ACO program, lowered spending by $1.8–$4.2 billion in 2016 alone. This demonstrates that patients who are not assigned to an ACO are able to reap the benefits of coordinated value-based care. Further, these patients also benefit from the improved quality of care provided. After the first three years of the adoption of the largest APM, the Medicare Shared Savings Program, CMS noted that 98% of ACOs met or exceeded quality standards. . In the same report, the Inspector General found that ACOs outperformed fee-for-service providers on 81% of quality measures. In fact, patients in many ACOs received more benefits than those outside on an ACO, such as home visits for care management or post-hospital care, cost sharing support, and chronic disease management rewards.

[2] "Value-Based Care in America: State-by-State." Value-Based Care in America: State-by-State | Delta Center for a Thriving Safety Net, Change Healthcare, http://images.discover.changehealthcare.com/Web/ChangeHealthcare/%7Ba7b8bcb8-0b4c-4c46-b453-2fc58cefb9ba%7D_Change_Healthcare_Value-Based_Care_in_America_State-by-State_Report.pdf.

Regulatory, Statutory, and Implementation Barriers that Need to be Addressed for MACRA to Fulfill its Purpose of Increasing Value in the U.S. Health Care System

Advanced APM Participation

The thresholds to participate in APMs remain steep. For example, the threshold to become a QP is scheduled to increase so that eligible clinicians must receive at least 75% of Medicare Part B payments or see at least 50% of Medicare patients through an Advanced APM. AMGA has concerns that these requirements are unlikely to be met and will not attract the critical mass of physicians and medical groups necessary to ensure the success of the program.

AMGA members report difficulty in meeting the APM thresholds for a variety of reasons. For example:

- Medicare beneficiaries may elect either fee-for-service Medicare or Medicare Advantage. Those who elect fee-for-service Medicare must be notified if their providers participate in a value-based care model, which leads to confusion.
- AMGA members have little control over what other providers a beneficiary may see. For example, patients may see a specialist in an AMGA member group or system. However, the patient's primary care provider may be outside of that group. Such a patient would not count toward the threshold.
- While supportive of the Medicare Advantage (MA) program, patients who are enrolled in MA are potentially otherwise eligible for a value-model.
- The thresholds are hard caps. Those members who fall just short of the required number of beneficiaries are precluded from achieving Advanced APM status. These thresholds, however, do not reflect the value of the care the patients receive.

In addition, AMGA members need regulatory stability to successful deliver care as part of an APM, such as the Medicare Shared Savings Program (MSSP). For example, AMGA is concerned the MSSP has undergone several substantial changes in a very short timeframe. While these changes may be warranted and result in improvements to the program, AMGA is concerned the frequency of the changes may undermine the stability of the model and the ability of providers to effectively model and predict their performance. AMGA recommends CMS trend towards regulatory predictability, and strongly evaluate the needs of providers and the manner in which these providers deliver care before considering further changes, including changes within a model.

MIPS Low-Volume Threshold

Congress created the Merit-based Incentive Payment System (MIPS)—essentially a complex pay-for-performance program—as a way build on efforts to hold providers accountable for the cost and quality of the care they provide and continue the transition to value-based care. Those clinicians who participate in MIPS are eligible for positive, neutral, or negative Medicare payment adjustments. These payment adjustments, according to the MACRA statute, increase over time. The adjustments were intended to be up to 4% 2019, 5% in 2020, 7% in 2021, and 9%

in 2022 and beyond. However, these payment adjustments were not realized and instead were far lower due to the exclusion of clinicians from the program due to a low-volume threshold.

One troubling feature of MIPS is that it disadvantages many physicians and qualified healthcare professionals due to the low-volume threshold criteria. AMGA has long opposed the continuation of the low-volume threshold due to concerns that the number of clinicians excluded from MIPS remains high. For the MIPS 2023 performance period, physicians who bill $90,000 or less in Part B-covered professional services, see 200 or fewer Part B patients, and provide 200 or fewer covered professional services to Part B patients will be excluded from the program. Due to these criteria, CMS estimates that 840,224 physicians and qualified healthcare professionals will not be MIPS eligible in the 2023 performance period.

Due to the budget neutrality requirements of MIPS, the exclusion of such a large number of clinicians will continue to cause MACRA to fail in its original intent to reward providers for their investments in health information technology (IT), enhance care management processes, and improve patient care. Both those who participate in the program and those who do not will experience the consequences of such arbitrary threshold criteria. CMS estimated that two-thirds of MIPS-eligible clinicians will receive a neutral or positive payment adjustment, while approximately 10% will receive a negative one. Such an uneven distribution of scores creates a reimbursement system that is not commensurate with the investments made to transition to value-based care. Additionally, the clinicians who fall within the low volume threshold are unable to participate and thus they are disadvantaged from being able to receive a positive adjustment to their Medicare payment. Instead of the up to 4%, 5%, 7%, and 9% payment adjustment that Congress envisioned, providers received far lower payment adjustments. For example, for the 2023 performance year, rather than the opportunity to earn a payment adjustment of up to 9%, as authorized by Congress, CMS estimates the maximum payment adjustment will be 2.49%. This adjustment is in insufficient incentive to support the long-term investments needed to deliver care in a value-based model.

AMGA does not believe this policy is consistent with congressional intent for the program and is yet another way that CMS policy has hindered the transition to value-based care.

How to Increase Provider Participation in Value-Based Payment Models

We believe that Congress intended to encourage maximum participation by providing greater incentives and facilitating true Medicare transformation while ensuring all Medicare patients receive high-quality care.. As such, AMGA objects to the continuation of the low-volume threshold policy and is concerned that these small payment adjustments do not reflect the considerable investments physicians have made in transitioning to a payment mechanism based on the quality and cost of care provided. Congress should update the MACRA legislation to remove barriers to participating in MIPS, including the prohibition of a low volume threshold.

To address APM participation barriers, AMGA also recommends that Congress consider the bipartisan Value in Health Care Act (H.R. 4587), which provide significant incentives for APM participation. Congress should leverage knowledge gained over the last decade of work in value-based payment to promote a more fiscally sustainable health system. Further, we believe it is important to include improved risk adjustment requirements within Quality Payment Program (QPP). We believe that the Value in Health Care Act (H.R. 4587) would provide the necessary

modifications to the risk adjustment factors to, among other things, better reflect participants' encounters with patients, remove the arbitrary high and low revenue distinction that creates an inequitable path to risk, and remove beneficiaries from the regional benchmark to ensure participants are not penalized as they achieve savings for their assigned populations.

Most importantly, the Value in Healthcare Act would extend the Advanced APM bonus for an additional six years and give the Department of Health and Human Services Secretary greater discretion to determine thresholds providers must reach to receive those bonuses. Unfortunately, the rate of APM adoption has not been as fast as Congress desired when MACRA passed in 2015. Therefore, we believe Congress plays a crucial role in providing more significant incentives for providers to participate in APMs, to better balance the risk, uncertainty, and sizeable upfront and ongoing investments needed.

Recommendations to Improve MIPS and APM Programs

Building on MACRA and Moving to Value-Based Care

AMGA believes there are opportunities to learn from the implementation of MACRA and continue to build on these lessons learned as the system continues to shift to value-based care. AMGA urges Congress to leverage the knowledge gained over the last decade to improve and support the transition to value-based care. We believe a value-based care model is essential to improving healthcare outcomes while lowering the cost of care for Medicare and patients alike. Our members support efforts to reduce unnecessary regulatory and statutory burdens while transitioning to value-based care. We urge Congress to ensure providers are adequately reimbursed for investing in the necessary infrastructure to deliver care in a value-based model. In addition, investments regarding patient engagement, end-of-life care, social determinants of health, and telehealth are essential for Congress to prioritize. Otherwise, providers will need to adjust how they deliver care, which makes it difficult to apply any lessons learned and provides as disincentive to participate in a value-base care model.

We provide the following suggestions on how MACRA can be improved and where Congress can positively influence the transition to value-based care.

A. Capital Investment in Infrastructure

Since the passage of MACRA in 2015, AMGA members have taken on a tremendous payment risk to facilitate Congress's efforts to transition healthcare from volume to value. Integrated systems of care and medical group practices that participated in value-based payment models primarily understood there is financial risk and considerable investments needed. Under value-based care contracts, providers received reimbursement 6 to 8 months after the measurement period. Raising capital to develop an infrastructure has not been easy and came at a substantial cost to providers. Regardless of how a particular model is structured, AMGA members assume significant costs. These upfront investments represent years of planning and significant financial risk. The opportunity costs for AMGA members who are investing in the infrastructure necessary to deliver care in a value-based model is substantial and additional federal support is needed to help continue the transition to value-based care.

AMGA recommends that Congress support funding for programs that provide upfront cost support for the value-based care transition. AMGA believes that payment systems must fully support physicians and health care facilities in offering all patients the ability to receive high

quality care with access to innovative technology, regardless of geographic, racial, ethnic, and socioeconomic demographics.

B. Patient Engagement

Patient engagement in value-based care has been shown to improve patients' overall quality and health outcomes.[3] One of the original intents of MACRA was to modernize Medicare physician payment and reward better healthcare value in several ways, including advancing the role of patient engagement throughout healthcare. MACRA emphasizes the need for incorporating the patient and caregiver experience into the care process. The need for financial incentives for patients to engage in healthcare has become increasingly apparent.

AMGA recommends that Congress develop and implement strategies that encourage and support patients and their ability to be engaged in their healthcare and seek care in value-based models, such as accountable care organizations. As healthcare providers, AMGA members work to have a full understanding of their patients' needs. However, this is most effective when patients are a willing partner and participant, particularly those patients in a value-based care model. AMGA members are willing to assume financial risk for the cost and quality of care they provide through properly constructed value-based model. However, clinicians only see or interact with patients for a fraction of their daily lives. Over the course of a year, clinicians may see a patient for 2% of the year. What happens with the 98% of the time the patient is not interacting with the healthcare system is vital to their health and wellbeing. Providing incentives so patients are engaged in their own health outside of the healthcare system will help providers most effectively spend what limited time they do have with their patients.

Financial incentives provide additional reasons for the patient to actively participate in their care. Traditionally, patient engagement focuses on the relationship between patients and providers in making care decisions or how to improve patient efforts to manage their own care. However, research has shown incentives that invest in further health improvement have the potential to decrease health care costs in the long-term. Furthermore, implementing rewards programs, with the appropriate safe harbors in place to allay concerns over patient inducements, encourages providers to place emphasis on the value aspect of their service to keep patients motivated in achieving their health goals.

C. End-of-life Care

End-of-life care is an important aspect of any value-based care model. The development of appropriate quality measures for patients and their families as it relates to end of life care services is critical. Data suggest that making quality end-of-life care available to all who could benefit from it will require a better-prepared workforce and financial incentives to encourage more clinicians to enter the field.[4] End-of-life care also is hampered by the shortcomings in the design and implementation of MIPS. Because the MIPS program was conceived with only the

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[3] Bombard, Y., Baker, G.R., Orlando, E. et al. Engaging patients to improve quality of care: a systematic review. Implementation Sci 13, 98 (2018). https://doi.org/10.1186/s13012-018-0784-z

[4] Rowe, J. W., L. Berkman, L. Fried, T. Fulmer, J. Jackson, M. Naylor, W. Novelli, J. Olshansky, and R. Stone. 2016. Preparing for Better Health and Health Care for an Aging Population: A Vital Direction for Health and Health Care. *NAM Perspectives.* Discussion Paper, National Academy of Medicine, Washington, DC. https://doi.org/10.31478/201609n.

traditional office-based practice in mind, the quality indicators are not optimally geared towards many portions of end-of-life care, which involves a home-based care aspect.

AMGA recommends that Congress implement provisions that will increase and provide adequate payment so providers can have end-of-life discussions with patients and their families; otherwise, Americans could lose access to necessary care at the end of life. Congress has an opportunity to implement changes to improve the quality of end-of-life care significantly. Therefore, AMGA supports the principles of the Improving Access to Advanced Care Planning Act (H.R. 8840/S.4873). The legislation creates new tools for measuring the quality- of- care that end-of-life beneficiaries receive. Such tools will help providers measure the concordance between the individual's stated goals, values, and preferences with documented care plans, counseling, and pain management. This bill also establishes grants for state-based advance care planning programs. It has been shown that advanced care planning conversations significantly improve outcomes for patients, including an increased likelihood that their care will be consistent with their wishes, fewer hospitalizations, and an increased chance of the patient passing in their preferred location.[5]

D. Social Determinants of Health

According to the U.S. Department of Health and Human Services, social determinants of health (SDOH) are the "conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes."[6] Cumulative efforts to improve patients' health outcomes would be ineffective without Congress enacting legislation that addresses SDOH, such as economic stability, access to healthcare, environmental harm, and other types of systemic disadvantage. AMGA strongly believes that SDOH plays a vital role in achieving health equity, which is essential for providing high-quality care. However, if these concerns are not accurately discovered, measured, recorded, and reported, they cannot be addressed. It is imperative for Congress to address the total cost of treatment to meet these social demands, lessen health inequities frequently caused by certain aspects of poor SDOH, and in turn, move our healthcare system toward a value-based culture.

Providers are responsible for the overall cost and quality of treatment provided to their assigned patient populations, and therefore, are motivated to address social issues affecting the health outcomes of their patients to enhance quality ratings and control costs. However, our existing healthcare system is not designed to support this kind of work, and numerous barriers prevent providers from properly addressing SDOH.

AMGA members are increasingly working to address patients' nonmedical needs to improve their health because they understand the role that these elements play in serving the entire patient. Our members are actively partnering with other organizations in the community to meet housing and transportation needs and address food insecurity. However, we believe it is important to actively test innovative approaches to improving health equity and addressing SDOH through additional flexibility within Medicare legislation, allowing providers to deliver supplemental benefits to patients as necessary. Therefore, AMGA recommends that Congress

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[5] Jimenez G, Tan WS, Virk AK, et al. Overview of Systematic Reviews of Advance Care Planning: Summary of Evidence and Global Lessons. J Pain Symptom Manage 2018; 56:436.

[6] https://health.gov/healthypeople/priority-areas/social-determinants-health.

consider passing the Social Determinants Accelerator Act (H.R. 2503/S. 3039), which would provide a more significant investment in social determinants of health.

E. Telehealth

To promote patient access to healthcare services, we believe that MACRA must establish a pathway by which Medicare can reimburse physicians for services provided remotely. The COVID-19 pandemic served as a catalyst for the widespread integration of telehealth services that redefined care delivery and payment. As stay-at-home orders drove down in person office and hospital visits across the country, many health care providers and health systems worked to ramp up their ability to deliver quality telehealth services. Telehealth quickly became an essential tool for families to continue accessing needed health care services during the public health emergency (PHE) and enabled practices to keep their doors open in the wake of reduced in-person volume. AMGA believes this is a critical moment for Congress to extend the current telehealth flexibilities beyond the PHE, ensuring telehealth becomes integrated into our physician payment and delivery system. These telehealth services should be woven into the fabric of the American healthcare system. Many AMGA members have leveraged telehealth to increase patient engagement and focus on prevention and chronic care management outside the traditional physician office visit.

Congress should permanently extend Medicare telehealth waivers and allow providers to care for patients without geographic limitations. Specifically, AMGA recommends the following:

- Medicare geographic and originating site of service limits need to be eliminated.
- Medicare payment parity between in-office and telehealth should be continued permanently. Audio-only services should be protected by ensuring pay parity between audio-only and telehealth visits. In addition, audio-only diagnoses that are made via telehealth should be factored into risk adjustments.
- Federal licensing and credentialing standards for telehealth services should be established.

The Future of MACRA and Value-Based Care

The changes enacted by MACRA will shape health care and value- based care payment policy for the years to come. AMGA is prepared to work with Congress on developing innovative reforms to the Medicare program so it can help providers continue the transition to value-based care. To do so, AMGA recommends that Congress address several key areas.

- Eliminate the low-volume threshold in MIPS so that providers have an opportunity to earn meaningful payment adjustments
- Reform the APM thresholds so providers have a realistic opportunity to earn Qualified Practitioner status. In addition, Congress should extend the availability of the 5% bonus for participating in an APM.
- Congress should ensure the Centers for Medicare & Medicaid Services recognizes the importance of regulatory stability in MIPS and APMs. While providers expect these programs to evolve, consistent reforms undermine the willingness of providers to participate.

We thank you for your consideration of our comments. Should you have questions, please do not hesitate to contact AMGA's Darryl M. Drevna, senior director of regulatory affairs, at 703.838.0033 ext. 339 or at ddrevna@amga.org.

Sincerely,

Jerry Penso, M.D., M.B.A.
President and Chief Executive Officer, AMGA