October 31, 2022

To: Representatives Ami Bera, M.D.; Larry Buschon, M.D.; Schrier, M.D.; Michael Burgess, M.D.; Earl Blumenauer; Brad Wenstrup, D.P.M.; Bradley Scott Schneider; and Mariannette Miller-Meeks, M.D.

Re: Medicare Access and CHIP Reauthorization Act Request for Information

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

The Health Care Transformation Task Force (HCTTF or Task Force) appreciates the opportunity to comment on your request for information on approaches to improve the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Task Force is a consortium of private sector stakeholders that support accelerating the pace of transformation in the delivery system to one that better pays for value. Representing a diverse set of organizations from various segments of the industry – including providers, payers, purchasers, and patient advocacy organizations – we share a common commitment to transform our respective businesses and clinical models to deliver better health and better care at reduced costs.

We strive to provide a critical mass of policy, operational, and technical support from the private sector that, when combined with the work being done by Congress, CMS and other public and private stakeholders, can increase the momentum of delivery system transformation. We appreciate the opportunity to provide input on the following topic areas outlined in the RFI:

1. the effectiveness of MACRA;
2. 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;
3. how to increase provider participation in value-based payment models; and
4. recommendations to improve MIPs and APM programs

We look forward to continuing to work with Congress and CMS to refine and promote the adoption of Alternative Payment Models that advance health system transformation.

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I. Intended Goals of MACRA

When the Medicare Access and Chip Reauthorization Act (MACRA) passed in 2015, many supporters of health care reform welcomed the effort by Congress to encourage participation in value-based health care models that link physician payments to the value – rather than volume – of services provided. The Quality Payment Program (QPP) created under MACRA offered providers two tracks: the Merit Based Incentive Payment System (MIPs) track and the Advanced Alternative Payment Models (Advanced APM) track. The MIPs track was built upon the traditional fee-for-service (FEE-FOR-SERVICE) Medicare payment system and aligned earlier CMS quality reporting systems to create a new performance criterion for providers. The Advanced APM track encouraged providers to transition away from fee-for-service by offering participants a five percent incentive payment for participating in a qualifying Advanced APM. By participating in an Advanced APM, providers also exempted themselves from MIPs reporting requirements while accepting greater accountability for the cost and quality of care.

In 2015, Congress intended for MACRA to achieve three main goals:

1. **Eliminate the Sustainable Growth Rate Formula**: The Sustainable Growth Rate (SGR) was a formula used to determine how much Medicare paid physicians for the services they provided. However, the formula was flawed and would have resulted in steep cuts to physician payment rates without annual Congressional intervention. In 2015, MACRA repealed the SGR, and replaced it with the QPP. The QPP fundamentally changed the methodology for how physicians are paid by Medicare for their services and was itended to provide greater system stability and move providers into value-based care arrangements.
2. **Simplify the Range of CMS Reporting Programs**: The MIPs track in MACRA simplified Medicare quality reporting requirements by streamlining three reporting programs - the Physician Quality Reporting System, the Value-Based Payment Modifier Program, and the Medicare Electronic Health Record Incentive Program - into a single payment program. The original programs now correspond to the four performance categories included in MIPs: Quality, Advancing Care Information, Improvement Activities, and Cost.
3. **Encourage Greater Alternative Payment Model Adoption**: Through the MIPs pathway, Advanced APM option, and differential fee schedule updates, MACRA encourages greater adoption of Alternative Payment Models (APMs) by Medicare providers.
    - MIPs Reporting Requirements: MIPs is based off traditional fee-for-service Medicare payments, with adjustments to Medicare Part B payments based on clinician-reported data in the four performance categories. Each category is weighted to calculate a final score, with the weightings changing over time to increase the emphasis on quality and cost. The final score is used to determine payment calculations.
    - Advanced APM Incentive Payment: To incent physicians to participate in the Advanced APM track, MACRA administers a 5 percent payment to qualifying Advanced APM clinicians. The incentive is equal to 5 percent of the qualifying physicians (QP) prior year aggregate Medicare Part B payments for certain services. While this incentive has driven higher net per beneficiary savings for Advanced APM-level ACOs vs non Advanced APM-level ACOs in the

Medicare Shared Savings Program (MSSP), the incentive is slated to end. PY 2022 is the last year to qualify for the incentive, payable in 2024.

- Differential Fee Schedule Updates: Beginning in 2026, the MIPs and Advanced APM pathways offer slight upward adjustments to physician payments to move providers along in their risk arrangements. MIPs participants will receive a 0.25% upward adjustment to their payments, and Advanced APM participants will receive a 0.75% upward adjustment.

Congress expected to see wide APM uptake in response to the policy changes made by MACRA. However, as detailed in the following sections, MACRA has not met initial expectations in regard to moving more organizations to value. The Task Force appreciates the opportunity to offer our perspectives on the issues.

II. MACRA Problems and Proposed Solutions:

Since the passage of MACRA there has been progress in regard to Advanced APM adoption, however, the rate of uptake among providers remains far below what Congress expected to see. Furthermore, while MACRA was intended to address the instability caused by the SGR, physicians are once again facing financial pressures and Congress is again tasked with making annual fixes. In short, MACRA was a step in the right direction but more needs to be done to stabilize our health care system in the short term and drive health system transformation and in the intermediate and long term. To this end we encourage Congress to pursue two primary goals in revisiting MACRA:

Goal #1: Stabilizing the primary care environment to enable system transformation

While the QPP addressed several problems with health care payment, it did not resolve some other key longstanding issues. Specifically, the QPP failed to rebalance the nation's spending across hospitals, specialists, and primary care providers, and has not addressed the financial instability that was the core issue with the SGR.

1. Underinvestment in Physician Services Relative to Other Specialties/Services: MACRA did not address the underpayment by Medicare for physician services (especially primary care) in relation to other Medicare providers and services. MACRA's annual updates to Medicare payment rates for physicians are paltry compared to the methodologies used for other providers. The Medicare Economic Index has not been updated since 2006, such that the underlying factors being used to determine payment rates does not reflect current circumstances faced by physicians.
2. Inability to Adapt to Changing Market Forces: MACRA requires budget neutrality and lacks a mechanism to account for inflation, two facts that make it difficult to respond to changing market dynamics. The budget neutrality requirements in MACRA create a disincentive for broad adoption of value-added services like team-based care and behavioral health integration. This is due to the fact that introducing more eligible billing provider/supplier types to Medicare Part B has the effect of shrinking the per-provider/supplier pool of funds (i.e., more people competing for the same pot of money). This zero-sum game does not represent a sustainable investment in primary care. Further compounding these issues is the fact that MACRA has no mechanism to respond to the effects on inflation on care delivery outside of the 0.25 percent and 0.75 percent fee schedule adjustments set to take effect in 2026. This issue has escalated from an inconvenience during the period of historically low-inflation over the last decade to a

crisis for primary care providers in the current high-inflation environment as the cost of supplies, staffing, real estate, and other resources required to operate clinics increase.

Robust primary care is the backbone of most effective value-based payment models and, given the importance of team-based care and care coordination to improving quality and controlling costs, adequate funding is needed to support physicians in the short-term to allow them to invest in the infrastructure and staffing necessary to transition into value-based models. **We strongly encourage Congress to implement appropriate updates to overall Medicare payment rates for physicians to stabilize the existing primary care workforce while continuing to drive a long-term shift to greater uptake of value-based care.** A short-term strategy for supporting providers is vital for the system overall and critical to attracting and retaining physicians in value-based payment models that operate on a fee-for-service chassis (like the Medicare Shared Savings Program).

Goal #2: Establish a clear national strategy for transitioning the majority of Medicare providers and beneficiaries into health care delivery models that promote high quality, equitable, and patient centered care.

The Task Force has long held that the best way to meet these goals is by advancing the adoption of value-based care models that create provider accountability for the cost and quality of care. The Centers for Medicare and Medicaid Services (CMS) has set out to achieve the goal of having all original Medicare beneficiaries in one of these accountable care arrangements by 2030. While APM adoption has increased since the passage of MACRA, the rate of growth has been lower than expected. In 2015, CMS estimated that 60 percent of clinicians would be in an Advanced APM by 2019. Unfortunately, actual participation has fallen far short of that projection with only 26 percent of clinicians expected to qualify for the Advanced APM Incentive Payments in 2022.

Consequently, Advanced APM Incentive payments are also significantly lower than initially projected. When MACRA was enacted, the Administration estimated incentive payments would total almost $2.7 billion in 2024. The most recent CMS estimates have downgraded expected incentive payment spending to between $600-750 million in 2024. Advanced APM adoption is likely to fall further with the loss of the Advanced APM incentive payment at the end of PY 2022. An estimated 225,000-290,000 eligible providers will no longer receive the bonus, therefore impacting their ability to invest in the practice redesign and technology needed to succeed in an Advanced APM.

The slower than expected rate of APM adoption is a symptom of several underlying issues with the design and implementation of MACRA. While some of these issues can be addressed by CMS many of the biggest challenges require Congressional action. We urge Congress to use the policy levers at its disposal to help achieve this goal and drive positive health system change. To do this, our national health care policies must be designed to make remaining in traditional fee-for-service less appealing than transitioning to value-based payments over the intermediate and long term. We recommend Congress addressing the following areas:

Advanced APM Incentive Payment Expiration and Insufficient Incentives from Fee Schedule Updates

Currently, the Task Force's main legislative priority is to extend the five percent APM Incentive Payment for at least two years. If that goal is achieved, this change would offer a much-needed incentive to address the 2025 gap year in Advanced APM payment incentives during the transition to differential fee schedule updates. We believe it is appropriate to extend

the five percent incentive payment because the uptake of advance value models has not gone as fast as Congress anticipated. This strong financial incentive should remain in place to attract new providers to participate in Advanced APMs and reward those that continue to move forward in their journeys. MIPS quality incentives should not be allowed to exceed the incentives for participation in Advanced APMs. CMS lacks the ability to provide financial incentives akin to the Advanced APM incentive payments without a Congressionally authorized extension. **We urge Congress to take action to extend the Advanced APM incentive payments, especially given the fact that the program has spent only a fraction of what was originally anticipated when MACRA was passed in 2015.**

Another major headwind for continued growth in APM adoption is the lack of clear drivers for the transition from fee-for-service under MACRA as currently structured. Through performance year 2022, qualifying providers are eligible to receive a five percent Advanced APM incentive payment, which will be paid in the 2024 payment year. Beginning in 2026, Qualifying APM participants will receive a 0.75 percent increase to their MPFS annual payment update while MIPs providers will be limited to a 0.25 percent increase. Under current law, there is no financial incentive for Qualifying APM Participants in Advanced APMs in CY 2025 and there is essentially no incentive for CY 2023 or 2024 due to the fact that 2022 is the last performance year to qualify for payment of the Advanced APM incentive payment in 2024.

Additionally, beginning in CY 2024, MIPS providers not in Advanced APMs will be eligible to earn an estimated 6.9% maximum quality bonus. This will mean that under MACRA the incentive to NOT participate in an Advanced APM will be higher than participating in one. CMS expressed their concern about this in the CY 2023 Medicare Physician Fee Schedule Proposed Rule, particularly given that despite the conversion factor differential beginning in payment year 2026, the maximum MIPS incentive is estimated to remain higher than that for Advanced APM participants until 2038. Congress should correct these misaligned incentives. Below is an excerpt from the proposed rule:

> *"Beginning in payment year 2025, the statutory incentive structure under the Quality Payment Program for eligible clinicians who participate in Advanced APMs stands in contrast to the incentives for MIPS eligible clinicians. Specifically, as described in section VI.E.16.d.(4) of this proposed rule, we anticipate that the maximum potential positive payment adjustment that could be applied under MIPS for payment years beginning in 2025 will be at or above 6.9 percent, and the corresponding maximum negative payment adjustment will be 9 percent. While only some MIPS eligible clinicians could earn the maximum positive payment adjustment, there is nonetheless a significant range of potential positive payment adjustments under MIPS that would exceed the differentially higher QP conversion factor beginning in payment year 2026 and for many years to come. […] [T]he QP conversion factor, with the compounded differentially higher 0.75 percent update in each year, is not expected to equate to the anticipated maximum available positive payment adjustment under MIPS until after CY 2038."*

Qualifying Physician Thresholds

Clinicians participating in an Advanced APM must meet increasingly strict participation thresholds – determined by the percent of Medicare Part B payments or patients seen through an Advanced APM entity – to become Qualifying APM Participants (QPs) and receive the Advanced APM incentive payments. The current statutory thresholds are based on the percentage of Part B payments or attributable patients and are set at 50 percent and 35 percent

respectively. Furthermore, the method by which CMS factors in a model's or program's attribution methodology when calculating the thresholds can result in some unintended consequences. For example – in the Medicare Shared Savings Program, the formula uses attributed beneficiaries divided by attribution-eligible beneficiaries. Since attribution is based on patients receiving primary care services in the ACO, specialists in the ACO are more likely to contribute attribution-eligible, but not attributed patients, which increases the attribution-eligible denominator thereby decreasing the QP score. This may lead ACOs to avoid engaging specialists in the ACO, which in turn suppresses Advanced APM participation and opportunities to drive value across the care continuum.

These thresholds have proven to be a barrier to QP qualification for many providers. In recognition of these challenges, Congress passed a legislative freeze on the QP threshold in PY 2021 and PY 2022; both will remain frozen at PY 2020 levels. While this was a positive step, more action is required to redesign more realistic QP threshold targets given the current APM environment. The health care marketplace is dynamic making it hard to predict the optimal methodology and QP thresholds necessary to drive APM adoption in statute. **We urge Congress to grant CMS the authority to set these thresholds and make clear that they will allow for more realistic thresholds that can be differentiated depending on the characteristics of particular value-based payment models.**

Insufficient Opportunities to Participate in Advanced APMs

As mentioned in the background section, the QPP operates on two tracks: the MIPs and track and the Advanced APM track. As originally designed, the QPP increased focus and scrutiny on the quality-of-care physicians provide to Medicare beneficiaries, with the Advanced APM track affording greater financial reward for operating under advanced risk payment arrangements designed to reduce program cost in addition to improving quality. For providers ready to take the next step into an Advanced APM, this track offered the opportunity to earn greater shared savings, and to be exempt from MIPs reporting requirements.

However, few APMs qualify as Advanced APMs – only 12 APMs qualified as Advanced APMs for the PY 2022 year. This is a significant drop from 2021, when 21 APMs qualified for Advanced APM status. Many of these models were time limited tests run out of the Center for Medicare and Medicaid Innovation (CMMI). CMMI models offer important opportunities to test new ideas, but their temporary status significantly impacts the number of models available for providers to participate in to qualify as an Advanced APM. This leaves experienced providers interested in continuing to refine concepts like full-risk APMs with no permanent participation options.

Given the success of APMs, and especially Advanced APMs with greater accountability for quality and cost outcomes for a population of patients, the primary goal of the next phase of physician payment reform should be to expand access to these models and move as many physicians as possible into them. **We encourage Congress to consider ways to support, and CMS should begin testing, alternative payment mechanisms such as 100 percent risk fully capitated payment models and primary care capitation within Medicare Shared Savings Program ACOs.** Upfront payments that support strong primary care and team-based care provide enhance predictability for physicians and greater flexibility to meet patients' health care and health-related needs.

Congress should also address the fact that providers who are not ready for the risk involved with an Advanced APM have little incentive to move out of MIPs. **To address this Congress should consider revised the QPP to have three tracks: (1) a modified MIPs (based on**

recommendations to improve the existing system); (2) an APM track; and (3) and an Advanced APM track. The payment rates for each track should be gradually higher to create an incentive for physicians to move through the continuum to a level of value-based payment that is right for them. Given that an Advanced APM may be initially, if not permanently a bridge-too-far for some physicians, a new payment incentive should be created to entice physicians to move past MIPs (and antiquated fee-for-service) into other models that focus on reducing total cost of care, improving quality, and moving away from the volume driven incentives of fee-for-service medicine**.**

Under this approach, the three tracks would create a natural glidepath with clear incentives to move out of fee-for-service over the long-term.

1. **Advanced APM Track:** Advanced APM participants would be eligible to receive the highest Medicare payment incentives. We urge Congress to grant CMS the authority set the patient count and payment amount thresholds for determining Qualifying APM Participants. We also recommend that Congress include guidance to CMS to set thresholds in a manner that incentivizes specialist engagement in models, supports primary care, and accounts for impacts on health equity by emphasizing model adoption in underserved communities and among safety net providers.
2. **APM Track:** Participants in lower risk APMs that fail to meet the Advanced APM criteria would be eligible for the second highest Medicare payment incentives. As with the Advanced APM track, we urge Congress to grant CMS the authority to define the APMs that fit into this track as the market needs may evolve over time. Within this track Congress and CMS could consider a combination of monetary and non-monetary incentives for APM participation. This could include a smaller APM bonus opportunity, access to grant funding to support successful APM transitions (similar to the Advanced Investment Payments proposal in the 2023 MSSP proposed rule), and simplified reporting requirements that exempt providers from MIPS reporting.
3. **MIPs/Fee-for-service Track**: Providers that remain in fee-for-service outside of the APM and Advanced APM tracks would receive the lowest payment adjustments and would continue to be required to comply with the MIPS reporting requirements.

Unrealized Opportunities to Improve Provider Experience

Finally, the Task Force would like to highlight the potential benefits of participating in APMs that go beyond the financial incentives. Administrative simplification and increased flexibility in care delivery have been marketed to providers as a benefit of moving away from fee-for-service. While these promises have sounded good in theory, they have too often failed to fully materialize in practice. APMs do have the potential to greatly reduce administrative tasks (e.g., coding, billing, and managing authorizations) and to free providers from a volume driven practice model that only values what can be billed. Yet, to fully realize this potential, APM financial methodologies and reporting requirements should be aligned across service areas and payers.

Congress included an All-Payer combination option in MACRA that allowed for the HHS to establish options for providers to count participation in non-Medicare APMs towards achieving the QP threshold. This was intended to incentivize the adoption of APMs across other payer types including commercial payers. The All-Payer combination option was an important recognition on the part of the legislation drafters that multi-payer alignment is key to advancing broad APM adoption as Medicare only represents a portion of most providers payment

arrangements. Both payers and providers may submit information to CMS to have an APM certified as an Other Payer Advanced APM.

Unfortunately, few payers or providers have taken up this option. Some HCTTF members have noted that the complexity of the submission process and perceptions that Other Payer Advanced APM are unlikely to make a material difference in a providers QP determination have discouraged investments in submitting APMs for consideration. **We urge Congress to create an All-Payer APM option within the APM track described above, allow for a simplified determination process, and explore mechanisms for encouraging broad payer participation in pursuit of cross-payer APM alignment.**

The Task Force appreciates the opportunity to advise Congress on opportunities to improve MACRA and advance our shared goals of creating a high quality, equitable, and efficient health care system for all. Please contact HCTTF Senior Director Joshua Traylor (Joshua.Traylor@hcttf.org) with questions or follow up regarding these comments.

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Sincerely,

The Health Care Transformation Task Force

ABOUT THE HEALTH CARE TRANSFORMATION TASK FORCE
Health Care Transformation Task Force is a unique collaboration of patients, payers, providers and purchasers working to lead a sweeping transformation of the health care system. By transitioning to value-based models that support the Triple Aim of better health, better care and lower costs, the Task Force is committed to accelerating the transformation to value in health care. To learn more, visit **WWW.HCTTF.ORG**.

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