AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

October 28, 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

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

On behalf of the American Academy of Family Physicians (AAFP), which represents more than 127,600 family physicians and medical students across the country, I thank you for your bipartisan leadership in examining and addressing ongoing Medicare challenges affecting our members and the patients they care for. I am writing in response to your request for information on the current state of the payment reforms introduced by the Medicare Access and CHIP Reauthorization Act (MACRA) and to offer our policy recommendations.

The Quality Payment Program (QPP) provided two pathways to pay physicians based on quality, value, and the results of care provided rather than on the number of services delivered. The stated goals of QPP include the following:

- To repeal the Sustainable Growth Rate (PDF) formula
- To change the way that Medicare rewards clinicians for value over volume
- To streamline multiple quality programs under the new Merit Based Incentive Payments System (MIPS)
- To provide bonus payments for participation in eligible alternative payment models (APMs).

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The QPP does not adequately pay for Medicare physician services
While the elimination of the sustainable growth rate was lauded by the physician community at the time, MACRA has left the majority of Part B clinicians in a similar state of financial insecurity.

The authors of MACRA intended for physicians to receive an annual 0.5% increase in the Medicare conversion factor (CF) for five years (2015–2019) followed by no change in the CF until 2026, during which time all payment adjustments were to be determined by physicians' performance under one of two pathways of the Medicare Quality Payment Program. However, that is not the payment reality that Medicare Part B clinicians have been faced with. The 2022 Medicare physician fee schedule CF ($34.6062) is less than it was in 2014 ($35.8228), before MACRA was implemented. Between 2015 and 2019, the CF decreased twice, and all the increases (other than the one for July 1-December 31, 2015) were less than the 0.5% prescribed by MACRA.

Not only have physicians endured lower than expected increases to the CF, they would have faced significant reductions in recent years if not for legislative interventions providing a temporary increase to the CF in 2021 and 2022. Because Medicare budget neutrality rules require that any significant increases to Medicare payments for part B services be offset by reductions elsewhere in the fee schedule, positive changes such as the recent revaluation of evaluation and management codes– a critical step toward appropriately valuing primary care – are partially negated by reductions to the CF. **Without legislative intervention, budget neutrality adjustments will continue to erode clinician payment. The AAFP urges Congress to pass the Supporting Medicare Providers Act of 2022 (H.R. 8800) to avert a 4.42% reduction to the CF in 2023, which threatens practices' ability to remain financially viable and continue serving Medicare beneficiaries.**

On top of budget neutrality limitations, Medicare physician payments have failed to keep pace with inflation. According to the American Medical Association's analysis of Medicare Trustees report data, Medicare physician payment has been reduced by 20% when adjusted for inflation over the past 20 years. Practically speaking, this means that physicians are struggling to cover the rising costs of employing their staff, leasing space, and purchasing supplies and equipment -let alone make investments to transition into new payment models. Even the nominal positive updates to the CF eventually envisioned by MACRA are well below the inflation in costs to run a medical practice as measured by the Medicare Economic Index (MEI). This is why **the AAFP and hundreds of other medical groups urge Congress to end the statutory freeze on annual updates to the fee schedule and enact a positive annual update to the CF based on MEI.** Many independent physician practices grappling with inadequate payment are forced to sell their practices to hospitals or large health systems in order to keep their doors open. This is happening at the same time that hospitals, skilled nursing facilities, ambulatory surgery centers and other Medicare providers receive annual payment increases to account for rising costs. **Subjecting physicians to passive payment cuts by failing to provide any inflationary update undervalues the foundational and important role that physicians play in helping their patients navigate the broader health care system.**

MACRA has fallen short of supporting physicians moving into alternative payment models
While MACRA was designed to shift financial incentives away from fee-for-services (FFS) payment into alternative payment models, the aforementioned decreases in FFS payments under the Medicare physician fee schedule have inhibited most physician practices from making the necessary investments that would allow them to successfully move into alternative payment models

MACRA requires CMS to apply payment adjustments to Medicare Part B fee-for-service payments based on an eligible clinician's (EC) performance in the Merit-based Incentive Payment System (MIPS). ECs with a MIPS final score above the performance threshold receive a positive adjustment while those below the threshold receive a negative adjustment. The adjustments must be budget neutral – meaning the positive adjustments are equal to the negative adjustments. As such, both the positive and negative adjustments are made on a sliding scale with the exception that those in the bottom quartile automatically receive the maximum negative adjustment for the year. The statute also included $500 million to provide an additional positive adjustment to those who meet a higher threshold, referred to as the exceptional performance threshold. The funding for the exceptional performer adjustment will end after the 2022 performance year.

The maximum adjustment gradually increased over the first few years of the program before reaching ±9 percent in 2022, where it will remain for all subsequent years. The payment adjustments to date have not supported or outweighed the burden of participating in MIPS. The scoring policies combined with the necessary exceptions to account for the COVID-19 pandemic allowed most physicians to avoid a negative adjustment. As a result, the positive adjustments have been minimal. The maximum positive adjustment for payment year 2022 was 1.88%, which is well below the potential maximum adjustment of 9%. The majority of the adjustment came from the exceptional performance funds. Since the exceptional performance funds are expiring, the positive payment adjustments are likely to decrease. However, it is important to note that, while most physicians have met or exceeded the MIPS performance threshold, physicians in small and rural practices consistently have lower than average MIPS scores. As the performance threshold increases, it will become more difficult for small and rural practices to avoid a negative adjustment.

MACRA may also negatively impact health equity by undervaluing the care delivered by those physicians caring for the most complex and challenging patient populations. Research has shown that physicians who participated in the Merit-based Incentive Payment System (MIPS) and serve a higher proportion of dual-eligible patients have significantly lower MIPS scores compared to other physicians. As a result, physicians caring for larger proportions of patients with higher social risk receive greater negative payment adjustments. Penalizing practices caring for patients at higher social risk means practices have fewer resources to meet their patients' needs or make the investments that would allow them to transition to an alternative payment model (APM). Furthermore, the budget neutral requirement for MIPS requires the negative adjustments to fund the positive adjustments and creates a "reverse Robinhood effect," where resources from those caring for less affluent patients is transferred to those caring for more affluent patients.[i] This gap will only become more pronounced as the program progresses and the MIPS performance threshold continues to increase. Ultimately, MIPS merely perpetuates the flaws of the value-based modifier program and exacerbates resource disparities rather than helping practices transition to payment models that more adequately support equitable, high-quality care.

MACRA has not successfully moved physicians into alternative payment models that prioritize quality and value over volume. The structure and incentives in MACRA were intended to move physicians and clinicians to advanced alternative payment models (AAPMs). However, MACRA fails to recognize that AAPMs with significant downside financial risk may not be the goal nor feasible for many practices. **The AAFP strongly supports APMs that shift away from fee-for-service models to value-based payment arrangements that provide prospective and risk-adjusted payments to better support comprehensive, longitudinal primary care. Unfortunately, MACRA's definition of success forces practices to drastically accelerate from fee-for-service to AAPMs, without**

regard to the level of risk that is most appropriate for the practice or the degree to which those APMs provide the kind of prospective payment that primary care requires. 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. This creates additional problems in MIPS as MIPS APM participants outperform MIPS eligible clinicians (ECs) who are not part of an APM and often have fewer resources to meet the MIPS requirements. Thus, MIPS is reduced to a compliance program for both MIPS APM participants and traditional MIPS ECs. To better support the transition to value-based payment, there need to be incentives for practices to move to the APM that offers a level of risk that is commiserate with their ability and resources. Furthermore, there needs to be a suite of models across the risk spectrum (including both accountable care organization [ACO] and non-ACO programs) that are available nationwide.

MACRA has not achieved its original goal to streamline Medicare's existing quality programs and simplify reporting requirements. It may have had the alternative effect as there is broad consensus that the Quality Payment Program increased administrative burden and complexity. The Program's requirements have continued to change year after year. While all programs should be flexible and make improvements, the QPP has primarily changed the requirements without making improvements or reducing burden. For example, the scoring policies for MIPS have changed each year and only become more and more complex. A recent qualitative study found that the average per-physician cost to participate in MIPS was $12,811, and physicians and staff together spent 201.7 hours annually per physician on MIPS activities.[ii] The costs were higher for small and medium primary care practices ($18,466 and $13,631, respectively). Importantly, this study only analyzed the time and financial costs for participating in MIPS. Previous studies have found that practices spend an average of 785.2 hours $40,069 per physician per year on quality reporting requirements.[iii] 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.

MACRA's overly prescriptive and complex approach to implementation has created unnecessary burdens for participants. The inflexibility of the MACRA statute has created significant barriers to implementation of reforms aimed at moving physicians from payment on volume to value. Health care markets, value-based care models, and other factors can change quickly (COVID has exemplified this) and additional flexibility is needed to ensure programs keep pace with these changes without awaiting congressional intervention.

The MACRA statute was overly prescriptive in several ways:

- Dictating that MIPS eligible clinicians receive a final score based on performance in four separate categories continues the burdensome, siloed approach of the legacy programs. Furthermore, CMS has cited the statute as restricting its ability to provide multi-category credit – something called for repeatedly by stakeholders. The MIPS Value Pathways (MVPs), which are intended to be an additional reporting pathway to APMs, simply continue this approach. While CMS has attempted to reduce the reporting burden with MVPs, it still approaches MIPS with a siloed lens. Connecting quality and cost are key components of any value-based payment program. However, the disjointed structure of MIPS forces practices to focus on four

separate sets of reporting requirements rather than developing strategies and skillsets that will prepare them for participation in an alternative payment model and improve patient outcomes and reduce costs in a holistic way.

- MACRA also requires measurement of resource use using "per patient total allowed charges for all services under part A and this part (and, if the Secretary determines appropriate, part D) for the analysis of patient resource use, by care episodes and by patient condition codes…" Unfortunately, the statute does not consider whether measuring total per capita costs is appropriate for all clinicians or whether a clinician can be reasonably expected to impact total costs. The AAFP has consistently opposed the use of the Total Per Capita Cost (TPCC) measure. This and other cost-based measures such as the Medicare Spending Performance Benchmark (MSPB) hold primary care physicians accountable for costs they cannot control, penalize physicians for increasing utilization of recommended preventive health measures, and fail to capture long-term cost savings generated by high-quality, longitudinal primary care. Notably, physicians are being held accountable for total cost of care without being comprehensively paid for providing person-centered primary care services that are proven to reduce health care spending over time.

MACRA has created unnecessarily high barriers to receiving bonus payment for advanced APM (AAPM) participation and fails to appropriately recognize adoption of other payer APMs. These barriers include both the complexity and level of participation established for an individual physician to be considered a qualifying participant (QP), as well as the APM to be considered eligible as an AAPM.

MACRA allows an AAPM participant to become a qualifying participant (QP) if they receive a certain percentage of their payments or see a certain percentage of their patients through the AAPM. A participant can become a QP through participation in a Medicare model or through a combination of participation in a Medicare model and an Other Payer model (called the All-Payer Option). However, there are several design issues with the All-Payer Option that make it difficult to achieve QP status through the All-Payer Option.

To be considered an Other Payer AAPM, the payer or the clinician must submit a request to CMS. Practices participating in different models with different payers (or even lines of business) may not receive appropriate credit toward the All-Payer QP threshold if the payer or the clinician has not completed the complicated determination process for each arrangement. Family physicians are contracted with an average of seven to 10 different payers, which makes the Other Payer AAPM process even more complicated and burdensome. CMS has not released information on how many physicians have earned QP status through the All-Payer Option, and the number of models considered an Other Payer AAPM is limited.

Another issue is that criteria to be considered an Other Payer AAPM mirrors the AAPM criteria. As noted above, this fails to recognize or reward participation in an APM, which may be the most appropriate option for some practices. Additionally, not all payers offer models that meet the AAPM criteria, or they have their own participation criteria that may limit a practice's ability to participate in an arrangement that may qualify as an AAPM.

Finally, there are insufficient Medicare AAPMs or participation options available in all regions of the country. With a limited availability of models, practices that have significant participation in an Other

Payer AAPM but do not have a Medicare AAPM available or cannot participate in a Medicare AAPM (e.g., because they do not meet the beneficiary minimums) are unable to achieve QP status. Even practices that can participate in both a Medicare AAPM and an Other Payer AAPM may not reach QP status if they do not have a significant (and increasing) portion of their patients participating in the Medicare model. In all instances, the practice does not receive any credit (even though they have meaningful AAPM participation) and is still subject to the burdensome MIPS reporting requirements.

Any federal incentive program designed to reward clinicians for high levels of participation in APMs needs to appropriately recognize and provide adequate credit for participation in APMs with all federal programs (e.g. Medicare Advantage, Medicaid) and commercial payers). This is a crucial step toward supporting model alignment across payers and in many cases is necessary to for practices to justify the expense of APM participation.

The increasing payment and patient thresholds are a barrier to physicians attaining QP status. The limited participation options are outside a practice's control. With the expiration of the five percent AAPM bonus, the main incentive to participate in an AAPM is to become exempt from MIPS reporting requirements. If a practice cannot achieve QP or partial QP status, they will be required to report to MIPS. This not only adds burden to the AAPM entities, but it also further disrupts MIPS scoring. As noted, MIPS APM participants have been the highest MIPS performers. Requiring AAPM participants to also report under MIPS will skew the performance thresholds even higher and make it more difficult for non-APM ECs to succeed in MIPS.

Increasing the investment in primary care through prospective payment approaches that adequately and sustainably support physician-led, team-based primary care is essential to the long-term success of the U.S. health care system. As noted in the National Academies of Science, Engineering, and Medicine report, Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care, "…*primary care is the only health care component where an increased supply is associated with better population health and more equitable outcomes. For this reason, primary care is a common good, making the strength and quality of the country's primary care services a public concern."*

The AAFP agrees that fee-for-service is not well-suited to accomplish these lofty aims and there is a dearth of APMs that have moved beyond a strong reliance on FFS. We believe strongly that there is a need for a stable suite of multi-payer APMs that are appropriate for practices with varying levels of experience with value-based care that requires a fundamentally different skill set in population health capabilities compared to the visit-centered approach incentivized by fee-for-service. As practices acquire these new capabilities, they are being asked to take on increasing levels of financial risk and practices require assistance and time to transition to more advanced APMs. Models should be available across all regions and support a variety of participation options, including both non-ACO and ACO. APMs can address this by incorporating features such as upfront access to capital, prospective payment, risk adjustment for clinical and social factors, and targeted technical assistance enhance patients' access to high-quality, continuous primary care and strengthen practice capabilities that improve quality and reduce health care spending. We further encourage coordination across Medicare, Medicaid, CHIP, marketplace plans, and commercial payers to harmonize APM requirements and quality measures. Aligning models across payers and embedding equity as a shared aim regardless of the patient population will foster greater physician participation and

resource practices more efficiently to ensure all patients receive high quality, affordable, patient-centered care.

The AAFP urges HHS to increase Medicare APM participation opportunities, align models across payers, and ensure physicians caring for rural and underserved populations can successfully participate in APMs.

Because most APMs are designed based on FFS payment rates, modernizing FFS payment for primary care is one essential strategy for support physicians' transition into value-based care. To be successful, alternative payment models (APMs) need to provide primary care practices with additional flexibility and financial stability, which practices leverage to hire additional staff (e.g., social workers, behavioral health professionals) and provide advanced primary care services not paid for under FFS. These models have reduced utilization of emergency department and acute care services and improved patients' health outcomes. Unfortunately, a dearth of APMs that provide a prospective payment approach that is more conducive to supporting team-based primary care and the inadequacy of FFS payment rates are undermining the transition to value-based care.

CMS' Medicare Value Pathways (MVPs) are not a bridge to APM participation. Beginning in 2023, MIPS ECs will have the option to report via an alternative mechanism: an MVP.CMS believes MVPs will reduce burden and ease the transition from FFS to value-based payment (VBP) models. However, MVPs do not reduce burden, nor do they provide a significantly different reporting structure that would be more akin to reporting under an APM. If MVPs move forward, CMS should ensure MVPs include the measures and activities that will adequately prepare participants for an APM. Increasing alignment between MIPS and APMs will create a clearer on-ramp for practices to move into APMs. Further, models need to be able to accommodate physicians across the financial risk spectrum. Physicians will be reluctant to transition to APMs if the only models available require a jump to significant downside risk. Without addressing the underlying problems with MACRA and the QPP, MVPs will only serve as a different reporting option that continues to lack a destination. CMS has noted the current statute prevents them from providing additional flexibilities under MVPs, such as multi-category credit. There are also no incentives to report MVPs. Further, the negative payment adjustments for failing to participate in MIPS or meet the performance threshold have significant financial consequences. Significant negative consequences could be an incentive to move out of MIPS, but the financial harm they cause forces practices to find ways to make up the lost revenue. By doing so, practices must continue to focus on the volume of services provided rather than developing the skill sets they need to advance to APMs.

A sustainable FFS Medicare payment system is needed to help advance transitions to and participation in APMs. Absent sustainable FFS payment rates, practices cannot invest in transformation or invest in the tools and resources they need to be successful in APMs. Most APMs are designed on or around a FFS chassis – inadequate FFS payment rates undermine successful APM participation.

The AAFP recommends the following methods to improve MIPS and APM programs:

- **Increase the availability of APMs that rely heavily on prospective payments to meet the unique needs and flexibilities required for the sustainable delivery of physician-led, team-based comprehensive primary care.** The existing volume-based payment system typically does not pay for or support robust activities, such as community health workers or care coordination services that support family physicians' efforts to provide whole-person care within a patient's community. Family physicians cite expanded capabilities to address patients'

HRSNs as a primary reason for transitioning to alternative payment models (APMs): they are looking for a payment model that will provide adequate, stable financial support and flexibility to deliver innovative whole-person care to meet patients clinical, behavioral, and social needs.

- **Provide technical assistance, shared learning collaboratives, and data infrastructure to support all primary care practices to transition to APMs.** Primary care's information needs are particularly complex which requires technical capabilities and a reliance on others to fill information gaps, including payers and other provider organizations.

  Often, IT departments may be non-existent or staffed by non-IT personnel, posing challenges when implementing new or updated hardware or software, connecting to regional health information exchanges (HIEs), and setting up registries. Additionally, building and understanding reports from an EHR is time-consuming, burdensome, and can be costly if there is a need for custom reports. Safety nets also face additional reporting burden on top of payer reports due to other reporting requirements based on their funding streams (grants, Uniform Data System, etc.).

- **Fund ongoing technical assistance programs to support overall adoption of APMs by all practices in all settings.** MACRA provided funding to assist practices in small practices, with priority given to small practices in rural and health professional shortage areas. The purpose of the funding was to support practices in MIPS and how to transition to APMs. CMS created the QPP Small, Underserved, and Rural Support (QPP SURS) program. Unfortunately funding for the QPP SURS expired in February 2022 and has not been renewed.

The AAFP appreciates the opportunity to offer feedback on MACRA and the QPP, and we are eager to work with you and your colleagues in Congress to establish a more equitable and sustainable Medicare physician payment system.

Sincerely,

Sterling N. Ransone, Jr., MD, FAAFP
Board Chair, American Academy of Family Physicians

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[i] Khullar D, Schpero WL, Bond AM, Qian Y, Casalino LP. Association Between Patient Social Risk and Physician Performance Scores in the First Year of the Merit-based Incentive Payment System. *JAMA*. 2020;324(10):975–983. doi:10.1001/jama.2020.13129

[ii] Khullar D, Bond AM, O'Donnell EM, Qian Y, Gans DN, Casalino LP. Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System: A Qualitative Study. *JAMA Health Forum.* 2021;2(5):e210527. doi:10.1001/jamahealthforum.2021.0527

[iii] Casalino LP, Gans D, Weber R, Cea M, Tuchovsky A, Bishop TF, Miranda Y, Frankel BA, Ziehler KB, Wong MM, Evenson TB. US Physician Practices Spend More Than $15.4 Billion Annually To Report Quality Measures. Health Affairs. 2016;35(3). https://doi.org/10.1377/hlthaff.2015.1258