June 14, 2024

The Honorable Ron Wyden
Chair
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Re: Senate Finance Committee White Paper on Medicare Physician Payment and Chronic Care

Dear Chairman Wyden and Ranking Member Crapo:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit a response to the Senate Finance Committee's White Paper, "Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B." NAACOS represents more than 470 accountable care organizations (ACOs) in Medicare, Medicaid, and commercial insurance working on behalf of health systems and physician provider organizations across the nation to improve quality of care for patients and reduce health care cost. NAACOS members serve over 9.1 million beneficiaries in Medicare value-based payment models, including the Medicare Shared Savings Program (MSSP) and the ACO Realizing Equity, Access, and Community Health (REACH) Model, among other alternative payment models (APMs).

NAACOS appreciates the committee's leadership and commitment to improving the Medicare payment system. We encourage the committee to prioritize policies that incentivize health care providers to deliver high-quality, well-coordinated care that keeps patients healthy by getting them the right services, at the right time, in the right care setting. Our comments and recommendations reflect the shared goal of our members to advance value-based care.

ADDRESSING PAYMENT UPDATE ADEQUACY AND SUSTAINABILITY

Medicare Physician Payment

As outlined in the committee's white paper, it's clear that Medicare's existing payment system does not adequately adjust physician payments to account for rising costs. Medicare also underinvests in primary care which results in physician practices having limited funding or tools to proactively manage patient care, leading to fragmentation of patient care with higher costs. To improve patient outcomes and make the best use of taxpayer dollars, it's imperative to stabilize Medicare's payment system, ensure payment

adequacy, and provide robust financial and non-financial incentives for payment arrangements that reward on outcomes and costs.

The Medicare Access and CHIP Reauthorization Act (MACRA) included financial incentive payments and regulatory relief to encourage participation in advanced APMs that take on down-side risk. MACRA's advanced APM incentive payments have proven successful in supporting the transition to new payment models. Since MACRA became law nearly 10 years ago, we have seen a nearly 290 percent increase in the number of clinicians qualifying as advanced APM participants. These financial and non-financial incentives have provided clinicians with the ability to expand care teams, develop new programs, and invest in population health infrastructure that has undoubtedly benefited both clinicians and patients alike. However, the looming expiration of MACRA's incentives and CMS' recent alignment of APM policies towards the Merit-based Incentive Payment System (MIPS) underscores the need to reform Medicare's payment system.

A well-designed payment system can promote efficiency and lead to better outcomes for patients. It is essential for Congress to ensure that the progress made in recent years is not lost and that clinicians can continue to innovate and improve patient care well into the future.

We support approaches that will stabilize Medicare's physician payment system to account for inflation. Specifically, the committee should support the Strengthening Medicare for Patients and Providers Act (H.R. 2474), which replaces MACRA's differential conversion factor with a permanent annual update equal to the increase in the Medicare Economic Index (MEI). NAACOS remains concerned that annual cuts to physician payment jeopardizes beneficiary access to care and prevents clinicians from investing in resources to support patient care. When clinicians are not adequately paid in fee-for-service (FFS), there is not a runway for clinicians to make the needed investments to innovate care. Stabilizing and ensuring payment adequacy is necessary to support the infrastructure and staffing necessary to transition to value-based payment.

INCENTIVIZING PARTICIPATION IN ALTERNATIVE PAYMENT MODELS

Financial Incentives

MACRA's incentive payments have proven successful in helping clinicians transition into advanced APMs. As of January 2024, more than 70 percent of the 602 ACOs in the MSSP and REACH programs are in two-sided risk tracks.[1] These payments have allowed practices to invest in people and technology to coordinate care, improve patient outcomes, and reduce unnecessary spending. They have also provided resources for practices to help cover services not reimbursed by traditional Medicare.

While NAACOS is pleased that Congress has passed two short-term extensions of MACRA's advanced APM incentive payments, and provided temporary relief from physician payment cuts, Congress has not gone far enough to drive and sustain positive movement to value-based care. We believe all approaches

[1] https://www.cms.gov/files/document/2024-shared-savings-program-fast-facts.pdf

to stabilize physician payment should also support transition to value by adopting the following principles:

1. **Prepare clinicians for a transition to APMs.**
2. **Ensure stronger financial incentives for clinicians in APMs compared to traditional FFS.**
3. **Ensure that financial incentives for adopting APMs do not impact a clinician's ability to meet financial targets in APMs.**

Currently, the financial incentives have shifted from advanced APM adoption to remaining in FFS. For clinicians in advanced APMs, the 1.88 percent advanced APM incentive for 2024 and higher conversion factor update (0.75 percent) is a lower incentive than the maximum potential MIPS adjustment estimated to be around 3 percent and the lower conversion factor update (0.25 percent). The next year when financial incentives favor clinicians that participate in advanced APMs over those who remain in traditional FFS will be 2032. The current approach presents several challenges:

- The conversion factor updates do not adequately address inflationary concerns in the immediate years.
- In later years the compounding conversion factor updates will create more complexity for clinicians and will make it harder for clinicians in APMs to meet financial targets.
- Some clinicians may choose to voluntarily shift back to MIPS because the program will continue to offer opportunities for high performing APMs to qualify for greater financial incentives.

Designing adequate incentives for clinicians in APMs depends on what payment reform approaches Congress considers. Below we offer options for incentives in the short-term under the current physician payment approaches and considerations for long-term reform that is tied to more significant changes in clinician payment.

Continuation of Existing Incentives

Under the current physician payment approaches**, we encourage the committee to support an extension of MACRA's original advanced APM incentive payments along with a freeze of the qualifying thresholds for Performance Years 2025 and 2026.** This approach would ensure that financial incentives to adopt, or remain in advanced APMs, are stronger than the projected incentives in MIPS. At a minimum, **Congress should extend the current incentives to allow additional time for consideration of more extensive payment reforms. While an incentive higher than MIPS is ideal, an extension of current incentives would provide an equivalent incentive to the maximum MIPS performance**, based on CMS' current projections. Along with a short-term extension of bonuses, Congress should address existing challenges with the incentive structure.

- **Improving timeliness of incentive payments**. The current incentive approach is not directly tied to care delivery as there is a two-year lag between the performance year to qualify and the payment year. Congress should ensure that incentive payments are timelier and work with CMS to explore options for providing incentives during the performance year. At a minimum, incentive payments should be paid the year following a performance year (in Q2 after claims runout).
- **Safeguarding performance in APMs.** The current advanced APM incentive payments are not included in calculations for the purposes of rebasing ACO benchmarks nor are they counted as

expenditures for the ACO. ACOs are concerned that under current law when qualifying APM participants (QPs) receive the higher 0.75 percent conversion factor update beginning in Payment Year 2026, it will become more difficult for ACOs to reduce spending below benchmarks. This is because ACO benchmarks are based on national and regional spending trends. Since most providers are still participating in MIPS, benchmarks will be reflective of the lower 0.25 percent payment updates. With participation in APMs already lagging behind original projections, it's important to ensure that payment updates for clinicians do not negatively impact their financial performance in their models. Congress should ensure that the fee schedule differential conversion factor does not impact clinicians' ability to meet APM benchmarks by removing the higher conversion factor from expenditure calculations or directing CMS to develop an approach to mitigate the impact of the higher conversion factor on APM reconciliation.

- **Benchmark considerations.** The committee's paper highlighted how advanced APM incentive payments may prove more targeted and less costly if excluded from Medicare Advantage (MA) benchmark calculations. The MACRA statute excluded incentive payments from APM benchmarks but had no corresponding exemption for MA. NAACOS supports the removal of advanced APM incentive payments from MA benchmarks. As an alternative to removing the incentive payments from MA benchmarks, the committee could evaluate options to ensure that the incentive payment dollars included in MA benchmarks are used to encourage, or reward, plans that participate in value-based payment arrangements with providers. Additionally, we ask that Congress direct CMS to collect more information from MA plans on the adoption and structure of value-based payment arrangements with providers.

Approaches for Continuing Incentives as Part of Physician Payment Reform

As we note above, the current physician payment system presents several challenges, which include misaligned incentives, unsustainable and complex conversion factor updates that do not address inflation, and significant regulatory burdens associated with MIPS reporting that does not adequately prepare clinicians to transition to APMs.

Currently, MIPS is an overly complex system. Clinicians are required to participate in four performance categories, each with its own set of rules that vary by clinician. Many of the measures used are not meaningful to the clinicians being assessed and are seen as a check-box approach to measuring performance. Additionally, this is very costly as MIPS compliance costs upwards of $12,800 per physician annually.[2] This burden detracts from actual performance improvement work and does not truly assess quality of care being provided to patients in a way that is meaningful to patients or clinicians' performance improvement activities. For clinicians in APMs that are not considered advanced APMs, MIPS creates additional burden as clinicians must track performance in their APM and MIPS.

This complexity leads to MIPS creating arbitrary winners and losers in the program. MIPS utilizes a tournament style approach, with "losers" creating the potential bonus pool for "winners." Additionally, the potential for significant financial reward in MIPS creates a dynamic where clinicians in APMs evaluate whether MIPS or the APM present the strongest financial incentive. **NAACOS encourages the**

[2] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2779947

committee to advance the American Medical Association's (AMA) proposal to eliminate the current MIPS bonus system and replace it with payment updates based on performance. Under the AMA's proposal, clinicians in MIPS would receive a range of payment updates from half of the payment update to one and one-quarter of the payment update; eliminating the misaligned payment incentives that exist today. This approach would allow lawmakers to design a new incentive payment system that rewards value adoption and maintains stronger incentives than MIPS. Specifically, Congress should explore:

- **Maintaining higher payment updates for clinicians in APMs.** This would ensure that incentives are permanent, stable, and predictable, like the existing higher conversion factor update for clinicians in advanced APMs**.** For examples, clinicians in advanced APMs could receive a payment of one and three-quarters of the update; clinicians in other APMs could receive a payment update of one and one-half of the update, or at a minimum, automatically receive the highest payment update under MIPS. As previously mentioned, lawmakers must ensure that these payment adjustments would not impact a clinician's ability to meet APM benchmarks.
- **Redesigning incentive payments to better encourage clinicians to join and meaningfully participate in APMs.** As previously noted, the incentive payment has been successful in encouraging clinicians to adopt APMs; however, misaligned incentives have hindered growth. It would be important to maintain incentives to encourage continued growth. The committee expressed interest in restructuring the current incentive payments to better align them to clinicians with meaningful participation in advanced APMs. MACRA currently restricts incentives to clinicians in APM entities who have a certain percentage of revenue or patients through the advanced APM. The threshold is arbitrary and does not reflect realistic opportunities for APMs to increase the amount of revenue or patients in the APM. For example, clinicians participating in bundled payment models are unable to meet current thresholds due to model design. The original intent of this policy was to incent clinicians to increase participation in advanced APMs. Congress could meet this intent while recognizing the limitations of various APMs. Below, we provide considerations for redesigning incentive payments.

Incentive Payments Based on Revenue

The committee expressed interest in exploring ways to move away from paying advanced APM incentives on the full amount of a clinician's Part B revenue. The simplest option would be to design an incentive that would be paid based on a percentage of the clinician's revenue through the APM, rather than all Part B services. This approach, which is discussed in MedPAC's June 2024 Report to Congress, would give higher rewards to clinicians who have more significant participation across APMs and incent clinicians to participate in multiple APMs to increase their rewards.[3] A criticism of the current incentive structure is that it may encourage clinicians to increase revenue to receive a higher incentive. This concern is mitigated when limiting the incentive payment to revenue through the APM as the incentive in the APM is to reduce costs.

We believe this approach also improves specialist opportunities to receive advanced APM incentive payments. To date, specialists have historically had few pathways to receive advanced APM incentives

[3] https://www.medpac.gov/wp-content/uploads/2024/06/Jun24_MedPAC_Report_To_Congress_SEC.pdf

because they may not drive patient attribution in the model. Rewarding clinicians on revenue through an APM presents an opportunity to incent specialists to work with numerous APM entities. For example, a specialist could participate in a specialty-driven model (e.g., bundled payments) and work with several ACOs in total cost of care arrangements. Their revenue through the bundled payment model and the multiple ACO models would count toward incentive payments. Implementing this approach would require exploring how specialist participation is considered in ACO models. For example, the current preferred provider designation in ACO REACH is participants who do not drive alignment but that work with the ACO to achieve its overall financial goals and clinical outcomes.

Incentive Payments Based on Beneficiaries
Another approach that has been recommended by stakeholders is providing incentive payments based on the number of patients attributed to an APM. Under this approach, clinicians in APMs would receive a fixed payment based on the number of patients aligned to a given APM. While this approach would reward clinicians that drive alignment in value models (i.e. primary care), this approach has challenges.

- Clinicians serving medically complex patients will be disadvantaged. Under a fixed dollar per-beneficiary incentive payment system, high-needs patients will effectively have a lower incentive payment unless the incentive is risk-adjusted.
- This will be administratively complex as attribution varies across programs. For example, attribution in some models is at the TIN level (MSSP) while for others it is at an NPI level (ACO REACH), creating separate rules for how incentive payments are applied.
- This would not create a pathway for incentives for specialists that participate in APMs but do not drive alignment. These specialists would not be eligible to receive incentive payments which is counter to the goal of integrating more specialists into value models. The current approach has created an incentive for specialists to seek out partnerships with ACOs; however, qualifying thresholds and other programmatic policies have hampered this incentive in recent years.

Should the committee choose to pursue a per-beneficiary incentive payment, the best approach would be to pay the incentive payment directly to the APM entity. This would eliminate the administrative complexity associated with varying attribution models and allow APM entities to distribute incentives to all participating clinicians in an equitable fashion based on a clinician's contributions and performance within the model. This would give ACOs and other APM entities more financial resources to recruit specialists to engage and join total cost of care models.

Nonfinancial Incentives

MACRA created non-financial incentives for clinicians in APMs by exempting them from regulatory burdens associated with the FFS payment system through exemption from MIPS and waivers to payment rules. Unfortunately, nonfinancial incentives have not been strong enough and some have been scaled back in recent years. Going forward lawmakers should:

Exempt clinicians in APMs from MIPS reporting requirements
MACRA created pathways for reducing provider burden by excluding all clinicians in advanced APMs from MIPS. Similarly, other clinicians in APMs (i.e., those who do not meet qualifying thresholds or do not bear risk) were exempt from all MIPS categories except quality. While this has been a strong non-

financial incentive for providers to join APMs, we are concerned that CMS has removed some of this burden reduction. Specifically, CMS has aligned APM reporting requirements with MIPS by requiring clinicians in APMs to report Promoting Interoperability (PI) and requiring ACOs to report electronic clinical quality measures (eCQMs) ahead of industry readiness. Fundamentally, we believe aligning APM measurement with FFS measurement is a flawed approach, rather FFS measurement should prepare clinicians for adopting APMs. The committee should direct CMS to:

- Develop measures that assess population health, rather than applying FFS measures to APMs.
- Exclude all APMs from MIPS and eliminate MIPS APMs.
- Rescind the recently finalized rule requiring advanced APMs to report PI.
- Delay CMS' planned retirement of the web interface reporting system for at least three years and require CMS to test digital quality changes for a subset of APMs and ACOs to identify key challenges and unintended consequences that need to be resolved before moving forward on a program-wide basis.

Increase program flexibility in APMs

Current law allows CMS to waive certain Medicare FFS requirements in MSSP and other APMs. This is a critical component of APMs as it allows providers to operate with fewer restrictions leading to a reduction in provider burden and increased care innovation. However, the waivers to date have been limited and can also be burdensome for providers. For example, MSSP only has waivers for telehealth and the 3-day rule for skilled nursing facility stays. Yet the ACO REACH model has access to many additional waivers. We believe all APMs should have access to all available waivers and that those waivers shouldn't be limited to certain models. Congress should direct CMS to establish a common set of waivers for APMs.

One specific opportunity to enhance waivers would be to improve the MSSP Beneficiary Incentive Program (BIP). This program was established in 2018 to help eliminate financial barriers to accessing care. Unfortunately, the current program structure prevents the use of the incentive because an ACO must furnish incentive payments in the same amount to each eligible beneficiary for all qualifying services. As a result, the program is too costly and complex for ACOs to implement. In fact, HHS reported to Congress that as of October of 2023 no MSSP ACOs have established or operated a BIP.[4] A primary limitation is that the program requires ACOs to provide incentive payments equally to all beneficiaries for all qualifying services, regardless of financial need or condition. The committee should modify the statute so that ACOs can (1) select a subset of services or patients to provide cost-sharing incentives and (2) provide a beneficiary incentive for the full amount of coinsurance for the service.

Provide additional technical assistance

Transitioning into APMs can be difficult for small practices and rural providers. Lawmakers should direct CMS to establish more technical assistance programs and data options for new APMs with a focus on small practices and rural providers. The committee should also restructure MIPS to prepare clinicians for adopting APMs.

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[4] https://www.govinfo.gov/content/pkg/CMR-HE22-00184510/pdf/CMR-HE22-00184510.pdf#:~:text=The%20purpose%20of%20the%20BIP%20is%20to%20allow,be%20no%20more%20than%2023%20dollars%20in%202023.

Improving primary care payments
It's clear that more flexible payment mechanisms are needed to support care delivery transformation, strengthen primary care, and increase participation in value models like ACOs. Shifting to prospective payments provides primary care practices with stable and predictable cash flow needed to transform care delivery and provide comprehensive, team-based care. As the largest APM in Medicare, the MSSP is well-positioned to drive primary care payment innovation. Unfortunately, the recently announced ACO Primary Care Flex Model is a time-limited model that will be restricted to a narrow subset of MSSP ACOs for a single application window. Given the wealth of evidence supporting hybrid primary care payment approaches tied to several of the Center for Medicare and Medicaid Innovation's (CMMI) value models, this option should be made available to all MSSP ACOs as a permanent feature of the program to serve as another incentive to encourage more provider participation in value models.

Eliminate arbitrary distinctions that place certain providers at a disadvantage
CMS has a policy that differentiates between "high revenue" and "low revenue" ACOs. CMS participation data show that ACOs with Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and other safety-net providers are typically designated as high revenue ACOs. As a result of this arbitrary policy, ACOs with these types of provider groups are required to move to risk faster. They are also ineligible for advance investment payments that support new ACOs and the new primary care hybrid payments in the PC Flex model. This policy creates disincentives for including rural and safety net providers in ACOs. We encourage the committee to remove this arbitrary designation by supporting Section 2 of the Value in Health Care Act (S. 3503).

Identify opportunities to ensure APMs and MA are viable options for innovating care
Providers are engaged in risk-based arrangements across payers; as such they are accountable for cost and outcomes of Medicare beneficiaries in MA and traditional Medicare. Unfortunately, the variation in program rules often means that providers must manage to the model rather than the patient. Congress should seek greater alignment between APMs and the MA program to ensure that both models provide attractive, sustainable options for innovating care delivery and to ensure that APMs do not face a competitive disadvantage. This includes establishing parity between program flexibilities to reduce clinician burdens and improve patient access to care and driving the adoption of value-based arrangements between APMs and MA. Congress should Direct the Government Accountability Office (GAO) to explore opportunities to improve APM alignment with MA.

ENSURE MORE TRANSPARENCY AND PREDICTABILITY IN CMMI MODELS

Over the past decade, CMMI has advanced multiple successful models focused on improving care for patients, while addressing Medicare costs. While population health models have seen encouraging growth and positive results, only a few of the models tested have subsequently been expanded or extended, a reality that can create significant uncertainty for participants and make them hesitant to invest in new payment models. To date, there has also been insufficient model development for all types of providers.

We believe there are opportunities to provide a broader, more predictable pathway for more types of providers to engage in APMs. As CMMI tests new payment models, successful models or key aspects of those models should be embedded as permanent parts of Medicare via the MSSP. As the only permanent total cost of care model in Medicare, the MSSP should be adapted to remain a viable option to further advance participation in value-based care.

Congress should work with CMMI to ensure that promising models have a more predictable pathway – both for initial implementation and for permanent adoption into Medicare – rather than being cut short due to overly stringent criteria. To accomplish these goals, Congress should do the following:

- Direct CMS and CMMI to focus on filling the current gaps in APM opportunities for medical specialties, safety net, rural, small, and other practices that, to date, have struggled to join APMs due to high entry barriers or simply because there is no clinically relevant model available.
- Broaden the criteria by which CMMI models qualify for expansion based on enhancing the quality of patient care or access to care, rather than making expansion contingent on achieving the short-term cost savings. For example, CMMI should be instructed to consider whether a model effectively expands participation to more physician and other health care provider types or offers enhanced benefits and services to beneficiaries.
- Direct CMMI to engage stakeholder perspectives during APM development. For example, CMMI could ask the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to review models under development by the Center and set priorities for model development. Additionally, CMMI should make more data available so that stakeholders can develop models that have a higher likelihood of producing actuarial savings. CMS should also engage stakeholders early on and throughout its own development of models. This will improve the clinical relevance of models and cut down on the near constant churn of model re-designs, which hinders participation.
- Direct CMS to improve its evaluation strategies by providing more data on the effectiveness of specific innovations and waivers and better controlling for other variables such as complications due to model overlap.

CONCLUSION

Thank you for the opportunity to provide feedback on "Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B." NAACOS and its members are committed to providing the highest quality care for patients while advancing population health goals for the communities they serve. We look forward to our continued engagement on bolstering chronic care management through payment system reforms. If you have any questions, please contact Aisha Pittman, senior vice president, government affairs at aisha_pittman@naacos.com.

Sincerely,

Clif Gaus, Sc.D.
President and CEO
NAACOS