



June xx, 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: Response to Senate Finance Committee 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 towards 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 has undoubtedly benefited both clinicians and patients alike. However, the looming expiration of MACRA's incentives and CMS' recent alignment of APM policies towards 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. 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, 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, 70 percent of the 602 ACOs in the MSSP and REACH programs are in two-sided risk tracks.<sup>1</sup> 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, it does not go far enough to drive and sustain positive movement to value-based care. We believe all approaches 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.**

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<sup>1</sup> <https://www.cms.gov/files/document/2024-shared-savings-program-fast-facts.pdf>

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%) 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 another short-term extension of MACRA's 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 at least comparable to the highest potential incentives in MIPS while allowing additional time for Congress to consider more extensive payment reforms. Based on current CMS projections for MIPS adjustments, a continuation of the current incentive payment for performance year 2025 (payment year 2027) would result in a total incentive for advanced APM clinicians that is 0.9 percent weaker than the estimated max adjustment in MIPS. In the second year of advanced APM incentives extension, the total incentive for advanced APMs would shift to 0.42 percent higher than MIPS.

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 payment year. At a minimum, incentive payments should be paid the year following a performance year (in Q2 after claims runout).
- **Safeguarding Performance in APM Models.** 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 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 payment updates. With participation in

APMs already lagging 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 fee schedule differential CF does not impact clinicians' ability to meet APM benchmarks by removing the higher CF from expenditure calculation or directing CMS to develop an approach to mitigate the impact of the higher CF on APM reconciliation.

- **Cost Reductions.** The committee's paper highlighted how advanced APM incentive payments may prove more targeted and less costly if excluded from 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.

### ***Other Considerations for Incenting Value***

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.

**We recommend that the committee should explore paying incentives based on a percentage of the clinicians' revenue through the APMs, rather than all Part B services.** This approach 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. 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 model is to reduce costs.

We believe this approach also improves specialist opportunities to receive advanced APMs. To date, specialists have historically had few pathways to receive advanced APM incentives 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 such as 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. The preferred provide approach in ACO REACH is a designation for participants who do not drive alignment but may work with the ACO to achieve its overall financial goals. Preferred providers have the option to work with numerous ACOs.

### ***Approaches for Continuing Incentives as Part of Physician Payment Reform***

As we note above, the current physician payment system presents several challenges, which includes misaligned incentives, unsustainable and complex conversion factor updates that do not address inflation, and significant regulatory burdens associated with MIPS quality reporting.

Currently, MIPS is an overly complex reporting approach across four performance categories. The rules and opportunities for success are highly variable across clinician types, yet clinicians are rewarded and penalized based on the success or failure of other clinicians. That is, clinicians can only “win” in the program if other clinicians “lose.” This tournament style approach creates arbitrary winners and losers. Additionally, the potential for significant reward in MIPS creates a dynamic where clinicians in APMs evaluate whether MIPS or the APM present the strongest financial incentive.

**The committee should explore approaches for eliminating MIPS bonuses and adjusting clinician payment based on MIPS performance and APM participation.** For example, clinicians in MIPS would receive a range of payment updates based on performance, clinicians and APMs would receive higher payment updates, and clinicians in advanced APMs would receive the highest updates. As previously mentioned, lawmakers must ensure that these payments adjustments would not impact a clinician’s ability to meet APM benchmarks. This approach is similar to the current differential conversion factor but would eliminate the potential for high rewards in MIPS and incent initial participation in APMs that do not bear risk. Moreover, this would ensure that incentives are permanent, stable, and predictable.

Under this approach Congress should also consider retaining a separate incentive payment that’s targeted towards encouraging new clinicians to join and meaningfully participate in APMs.

### **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. 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 by requiring clinicians in APMs to report Promoting Interoperability, aligning APM requirements with MIPS, 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. The committee should direct CMS to:

- Develop measures that assess population health, rather than applying FFS measures to APMs.
- Excluded all APMs from MIPS and eliminate MIPS APMs.
- Rescind the recently finalized rule requiring advanced APMs to report PI. Instead, CMS could require advanced APMs to attest to additional needed elements such as information blocking.

***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 Improving 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.<sup>2</sup> 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.

***Eliminate arbitrary distinctions that place certain providers at a disadvantage***

CMS has a policy that differentiates between "high revenue" and "low revenue" ACOs. Evaluations 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. This creates disincentives for including rural and safety net providers in ACOs. In fact, most primary care providers currently participating in MSSP are in "high revenue" ACOs, including 67 percent of primary care physicians, 68 percent of NPs, 72 percent of PAs, 87 percent of RHCs, and 25 percent of FQHCs. 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

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<sup>2</sup> <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.>

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 in. Congress should Direct the Government Accountability Office (GAO) to explore opportunities to improve APM alignment with MA.

## **ENSURE MORE TRANSPARENCY AND PREDICABILITY IN CMMI MODELS**

As the Center for Medicare and Medicaid Innovation (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. Policymakers should ensure that promising models have a more predictable pathway for being implemented and becoming permanent and are not cut short due to overly stringent criteria. Lawmakers should look at opportunities to improve the development of APMs, including:

- **Evaluations & Expansion of Models.** Direct CMS to redesign its evaluation strategies to better isolate specific innovations while controlling for other variables. Lawmakers should also broaden the criteria by which CMMI models qualify for Phase 2 expansion (e.g., does the model positively address health equity or effectively expand participation to more provider types).
- **Stakeholder Engagement.** Direct CMMI to engage stakeholder perspectives during APM development, such as leveraging the Physician-Focused Payment Model Technical Advisory Committee (PTAC) throughout the model development process. CMS should make more data available so that stakeholders who take models to PTAC are informed by actuarial concerns. Lastly, Congress could direct CMMI to use a portion of their existing funding to test PTAC approved models.

## **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 CCM through payment system reforms. If you have any questions, please contact Aisha Pittman, senior vice president, government affairs at [aisha\\_pittman@naacos.com](mailto:aisha_pittman@naacos.com).

Sincerely,

Clif Gaus, Sc.D.  
President and CEO  
NAACOS