June 18, 2024

Re: Response to Senate Committee on Finance’s White Paper, “Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B”

Dear Chairman Wyden, Ranking Member Crapo, and Members of the Committee:

Arnold Ventures welcomes the opportunity to respond to the Committee’s recent paper, “Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B” that was published on May 17, 2024.

Arnold Ventures is a philanthropy dedicated to investing in evidence-based policy solutions that maximize opportunity and minimize injustice. Our work on provider payment reform aims to re-orient the health care system toward delivering higher quality, less costly care that improves health outcomes. A primary focus is accelerating the adoption of population-based payment models such as capitated payments for primary care and accountable care organizations (ACOs), which give providers greater flexibility to deliver the care their patients need while holding them accountable for quality and total cost of care. These models are a promising alternative to fee-for-service (FFS) payment, which often results in inefficient and inequitable care.

We also recognize the importance of improving the physician fee schedule both for its accuracy and because it is the platform for alternative payment models like ACOs. This includes addressing the longstanding misvaluation of certain services, which has resulted in underinvesting in cognitive services and primary care and overpaying for certain procedural services over time. In addition, it is important that physician payment updates are determined based on what is necessary to ensure beneficiary access to high-quality care and to maintain adequate clinician participation in the program while limiting unnecessary Medicare spending increases borne by beneficiaries and taxpayers.

We want to thank the Committee for its important work to improve Medicare physician payment policy, given your many competing priorities, and for the opportunity to provide input. The table below summarizes our key recommendations, and more details are below.
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| I. Addressing Payment Update Adequacy and Sustainability (pg. 3)    | • Congress should not make payment updates equal to full Medicare Economic Index (MEI) growth and should increase payment updates over time only to the level needed to maintain beneficiary access to high-quality care, which experience suggests is below MEI growth. Payment updates should strike a balance between protecting against clinicians’ rising input costs and guarding taxpayers and beneficiaries against higher Medicare spending.  
• Maintain a positive payment differential or “wedge” between fee-for-service (FFS) and advanced alternative payment models (AAPMs), including a higher payment update for AAPM participants or extension of the AAPM bonus.  
• Consider the following policy options proposed and vetted by experts to offset the costs associated with Medicare Part B payment reforms: expanding site-neutral payments, eliminating incident to-billing, addressing overvaluation of global surgical codes and other pricing distortions in the fee schedule, reducing overpayments to Medicare Advantage (MA) plans, and excluding the AAPM bonus from MA payment benchmark calculations. |
| II. Incentivizing Participation in Alternative Payment Models (pg. 10)| • Extend the AAPM bonus at an amount closer to the original 5 percent bonus stipulated in MACRA and restructure the bonus to be more effective and aligned with the goals of AAPMs.  
• Restructure the AAPM bonus to be a consistent amount per-beneficiary assigned under an AAPM rather than based on a percentage of Part B revenue as it is currently designed.  
• Give CMS the authority to adjust AAPM thresholds upwards over time with appropriate guardrails to prevent backsliding. |
| III. Reducing Physician Reporting Burden Related to MIPS (pg. 13)   | • Eliminate MIPS rather than work to improve it.  
• Instead of improving MIPS, prioritize moving clinicians into AAPMs, particularly ACOs, which hold clinicians accountable for the cost and quality of care. |
| IV. Supporting Chronic Care in the Primary Care Setting (pg. 14)     | • Shift primary care payment in the Medicare fee schedule to a hybrid capitated payment model (that is, prospective, per-beneficiary, per-month (PBPM) payments).  
• Give CMS flexibility to design and implement the payment structure and risk adjustment processes for the hybrid payment for primary care.  
• A new population-based payment should cover high-volume, lost-cost services, care management and care coordination, and telehealth services. |
V. Ensuring Integrity of the PFS (pg. 17)

- Require CMS to implement accurate and ongoing data collection so that the agency can independently validate relative value units (RVUs).
- Direct CMS to establish an empirical source of information on the time and intensity associated with services.
- Establish an advisory body within CMS (e.g., a technical advisory committee) to balance the RUC process.
- Direct CMS to improve transparency and better facilitate information around how the RUC reaches its valuation decisions.
- Consider ways to direct CMS to better address currently misvalued services such as global surgery codes.

I. Addressing Payment Update Adequacy and Sustainability

Despite the repeal of the sustainable growth rate with the introduction of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Congress is regularly called on to intervene and modify annual payment updates for physicians. Furthermore, MACRA was intended to catalyze physician movement away from FFS and into advanced alternative payment models (AAPMs), yet over half of Medicare physicians remain in FFS.¹ In reforming Medicare physician payment policy, Congress should aim to create sustainable, accurate payment updates that establish certainty for physicians, do not require regular congressional action, and further incentivize movement away from FFS.

Payment updates should be determined with a few key goals in mind:
- Ensuring access to high-quality care for beneficiaries;
- Maintaining adequate clinician participation in the Medicare program; and
- Limiting unnecessary Medicare program spending increases, which create additional financial burdens for taxpayers who finance a substantial portion of the program and beneficiaries who pay higher premiums and cost-sharing when Part B spending increases.

We recommend higher payment updates over time to the extent they are needed to maintain access while limiting unnecessary program spending increases. Experience suggests payment updates do not need to keep pace with growth in the Medicare Economic Index (MEI) to achieve this. The data on beneficiary access, physician compensation, and spending per beneficiary suggest that physician payment updates that keep pace with the growth in physicians’ input costs are not needed to maintain beneficiary

¹ Health Care Payment Learning and Action Network. 2023. 2023 APM Measurement Effort.
access to high-quality care, and that a lower across-the-board update would be more appropriate. Congress could also consider targeting higher reimbursements to certain providers (e.g., primary care physicians and physicians caring for a disproportionately large number of low-income beneficiaries).

In addition, the physician payment system should provide incentives for clinicians to participate in effective population-based payment models, which can be accomplished by creating a payment differential or “wedge” between potential revenue for physicians in FFS versus AAPMs. Stronger incentives for AAPM participation would also allow the Centers for Medicare and Medicaid (CMS) to design more effective AAPMs with strong incentives to reduce costs and transform care delivery. There are several policy options that Congress should consider for creating and maintaining the wedge including having higher annual payment updates for AAPM participants, which will go into effect in 2026 under MACRA. Another mechanism for creating the wedge is to extend bonus payments for AAPM participation originally established under MACRA. **We recommend creating a wedge between FFS and AAPMs to incentivize more participation in AAPMs. This could be achieved via higher payment updates for AAPM participants or extending the AAPM bonus,** which, if extended, should be restructured to be more effective (discussed further below). Eliminating the Merit-Based Incentive Payment System (MIPS) would also help. MIPS has not been effective at improving quality, creates significant administrative burden and costs for clinicians, and undermines the incentive to participate in AAPMs. MIPS is discussed further in sections II and III.

**Balancing Clinician Payment, Access to High-Quality Care, and Affordability for Beneficiaries and Taxpayers**

Rather than a blanket goal for payment rates to keep pace with the growth in physicians’ input costs, conversion factor updates should balance limiting unnecessary increases to Medicare program spending with ensuring beneficiary access to high-quality care and adequate physician participation in the Medicare program. Evidence on beneficiary access to high-quality care, physician participation in the Medicare program, and Medicare physician fee schedule spending per beneficiary does not support increasing fee schedule rates by the growth in the MEI, which measures the growth in clinician input costs. Furthermore, implementing unnecessarily high payment rate updates exposes taxpayers and Medicare beneficiaries to higher Medicare spending and is not fiscally sustainable.

The payment rate represents one piece of physician payments which are determined by the volume and intensity of services in addition to the prices of services. While updates to fee schedule payments have grown at a slower rate than physicians’ input costs and have not kept up with this inflation, the volume and intensity of services have increased, resulting in higher Medicare physician fee schedule spending per
beneficiary over time.\(^2\) In other words, despite payment updates below inflation, spending per beneficiary has increased over time and kept pace with inflation.\(^3\)

In addition, physician compensation has also increased faster than Medicare payment rate updates, likely due in part to the increase in the volume and intensity of services noted above in addition to other factors. All-payer physician compensation has increased at rates similar to general inflation. From 2021 to 2022, median compensation for physicians grew by 9 percent - a little faster than inflation, which was 8 percent.\(^4\) In 2022, the median compensation for physicians was $344,000 (however compensation varies substantially by specialty, with radiologists’ median earnings exceeding $500,000).\(^5\)

Medicare beneficiaries report having access to care that is similar, or better than the commercial market.\(^6\) Approximately 87 percent of Medicare beneficiaries ages 65 and older report being “very” or “somewhat” satisfied with their ability to find providers with appointments when needed.\(^7\) Furthermore, the overwhelming majority of clinicians (96 percent of non-pediatric physicians) accept Medicare and acceptance rates are similar to those observed in the commercial market, indicating sufficient clinician demand to participate in the Medicare program despite lagging Medicare payment rate updates.\(^8\) Beneficiary access and physician participation in Medicare has been relatively stable over time despite payment updates that have been lower than the growth in clinician input costs.

To date, increasing fee schedule rates based on MEI has not been necessary to ensure beneficiary access to care or ongoing participation of clinicians. Future payment updates likely need to be higher and more stable than the status quo, but the experience of the past couple decades does not support updating payment rates based on the total growth in input costs. Given the evidence, and future projections of stabilizing and lower MEI growth compared to pandemic years\(^9\), Congress should not make payment updates equal to full MEI growth and should consider payment updates that strike a balance between adjusting for clinicians’ rising input costs and guarding taxpayers and beneficiaries against higher Medicare spending in the form of unnecessarily high-rate updates that do not appear needed to maintain access. This approach recognizes the strain of rising practice costs and the interest to at least

\(^2\) Medicare Payment Advisory Commission. \textit{March 2024 Report to the Congress: Medicare Payment Policy – Chapter 4.} March 15, 2024.
\(^3\) Ibid.
\(^4\) Ibid.
\(^5\) Ibid.
\(^6\) Ibid.
\(^7\) Ibid.
\(^8\) Medicare Payment Advisory Commission meeting. \textit{Considering approaches for updating the Medicare physician fee schedule.} April 11, 2024.
\(^9\) Medicare Payment Advisory Commission. \textit{March 2024 Report to the Congress: Medicare Payment Policy – Chapter 4.} March 15, 2024.
partially insulate clinicians from inflation effects while considering the level of payment needed to ensure access to care.

Aligned with this view, the Medicare Payment Advisory Commission (MedPAC) has previously recommended increasing physician payment rates based on some portion of practice input cost inflation and has said that updates tied to full MEI growth are not warranted.\(^{10}\) Similarly, experts have highlighted that making annual updates equal to MEI growth is likely not necessary to maintain beneficiary access and would result in large fiscal costs, which are borne by both taxpayers and beneficiaries since higher Medicare Part B spending increases premiums and cost sharing for beneficiaries.\(^{11}\) Instead, they suggest that updates could be based on MEI growth minus a fixed percentage, which would ensure payment reflects changes in economy-wide inflation but in a more sustainable way.\(^{12}\) In 2023 and 2024, MedPAC recommended payment updates equal to 50 percent of MEI growth.\(^{13,14}\) Practice expenses make up about half of the MEI measurement, so an update reflecting 50 percent of MEI growth would address concerns about higher input costs associated with running a practice. These approaches would allow for more appropriate payment increases over time relative to making payment updates equal to full MEI growth, and they reflect the current evidence on how payment rates impact beneficiary access to care.

**Targeting Higher Reimbursements at Select Providers**

While aggregate access metrics are positive for Medicare beneficiaries, there are select providers, like primary care physicians and physicians caring for a disproportionate share of low-income beneficiaries, that may merit targeted, higher payment updates or add-on payments. While surveys show that beneficiaries on a whole have not seen declining access over time, low-income beneficiaries have reported worse access to care. For example, in 2023, low-income beneficiaries were more likely to not receive care for a health problem that they thought warranted treatment compared to other beneficiaries.\(^{15}\) In addition, beneficiaries under age 65, who typically require more health care services and are lower income, reported having more trouble getting health care.

Higher payments for targeted providers can be accomplished through a mix of policies – conversion factor updates, add-on payments, or changes to the valuation process that affect payment rates – although there may be reasons to prefer one approach over another. Payment updates tied to full MEI growth are likely

\(^{10}\) Medicare Payment Advisory Commission meeting. [Considering Current Law Updates to Medicare’s Payment Rates for Clinician Services](https://www.medpac.gov/content/download?downloadId=55935), October 5, 2023.


\(^{12}\) Ibid.

\(^{13}\) Medicare Payment Advisory Commission. [March 2023 Report to the Congress: Medicare Payment Policy](https://www.medpac.gov/content/download?downloadId=55935), March 13, 2023

\(^{14}\) Medicare Payment Advisory Commission. [March 2024 Report to the Congress: Medicare Payment Policy – Chapter 4](https://www.medpac.gov/content/download?downloadId=55948), March 15, 2024.

\(^{15}\) Medicare Payment Advisory Commission. [March 2024 Report to the Congress: Medicare Payment Policy – Chapter 4](https://www.medpac.gov/content/download?downloadId=55948), March 15, 2024.
not warranted; however, Congress should consider addressing underlying misvaluation in the fee schedule that has resulted in underpaying for primary care services and overpaying for certain procedural services (discussed below). In addition, targeted approaches such as add-on payments may be appropriate.

**Building Incentives for AAPM Participation into Payment Updates**

Physician payments should also incentivize movement away from FFS payment and towards population-based payment models. Evidence suggests that population-based payment models like ACOs and select models in the AAPM track represent promising approaches to improve the efficiency of the health care system and promote personalized, high-quality care, resulting in modest savings and similar or improved quality of care. Additionally, population-based payment models offering prospective payment give clinicians greater revenue certainty and insulate them from financial shocks. For example, Pennsylvania’s hospital global budget program helped keep rural hospitals open during the COVID-19 pandemic, ensuring patients could access needed care. Similarly, primary care providers in Hawaii that receive prospective, population-based payments were financially protected from the shocks of the pandemic and were well-equipped to care for patients remotely due to previous investments in practice infrastructure enabled by prospective payments not linked to patient visits.

While MACRA aimed to incentivize clinician movement into AAPMs, it has not worked as well in practice. A key problem is that incentives to join AAPMs have been weak and are eroding. Weak participation incentives also limit CMS’ ability to design effective AAPMs that would be more likely to result in care delivery changes and generate savings for the Medicare program. Incentives for clinicians to join AAPMs can be created through policies that establish a positive payment differential or “wedge” between potential earnings in FFS versus AAPMs. Under MACRA, AAPM participants are set to see higher payment updates beginning in 2026 compared to non-participants in FFS (0.75 vs. 0.25 percent). A payment differential can play an important role in incentivizing clinicians to move into AAPMs, but there are several complementary policies that could also be used to create a wedge. **Congress should maintain a payment wedge that is favorable to AAPM participants and can do so through several approaches, including by maintaining a positive payment differential, extending and restructuring the AAPM participation bonus set to expire at the end of this year, and eliminating MIPS** (discussed further below).

**Offsetting Costs and Strengthening Medicare’s Fiscal Sustainability**

Even nominal annual payment rate updates would increase Medicare spending at a time when the Medicare program is facing significant fiscal challenges, underscoring the critical need for Congress to

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18 U.S. Senate Committee on Finance Hearing on “Bolstering Chronic Care through Medicare Physician Payment.” April 11, 2024. *Testimony of Amol Navathe*. 

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consider other policy proposals to offset the cost and strengthen Medicare’s fiscal health. According to the 2024 Medicare Trustees Report, spending across the Medicare program is expected to rise from 3.8 percent of GDP in 2024 to 5.3 percent in 2035.\textsuperscript{19} Medicare Part B, which funds physician services, accounts for most of this growth with spending expected to grow by 8.2 percent over the next ten years, far outpacing GDP growth of 4.2 percent over the same period.\textsuperscript{20} Note that Part B spending growth is also driven by factors other than physician fee schedule spending, such as spending growth for physician-administered drugs. However, it underscores the challenges that higher Part B spending growth due to increased physician payment updates could create. Because Medicare Part B is deficit-financed, this growth places an increasingly large burden on taxpayers and Medicare beneficiaries who pay higher premiums as a result of spending increases. Given these fiscal pressures, it is crucial that reforms to improve Medicare Part B payment do not increase overall program costs and that Congress implements additional reforms to strengthen Medicare’s fiscal sustainability. AV recommends that Congress consider the following policy options proposed and vetted by experts to offset the costs associated with Medicare Part B payment reforms:

- **Expand site-neutral payments.** Many medical services are provided safely and effectively in a physician’s office, yet when these same services are provided in a hospital-owned facility, Medicare pays significantly more. We urge Congress to expand site-neutral payment, which would ensure Medicare pays the same price for the same service regardless of where the service is delivered and produce significant cost savings for taxpayers and Medicare beneficiaries. Comprehensive site-neutral payment reform would reduce Medicare spending and save taxpayers by more than $150 billion and lower health care costs for Medicare beneficiaries by more than $90 billion.\textsuperscript{21} Site-neutral payments in Medicare would also have beneficial spillover effects in the private market that would save employers and consumers more than $140 billion and is an important policy to help discourage further consolidation in the health care market that drives up health care costs.\textsuperscript{22} Incremental site-neutral reform such as the bipartisan, House-passed Lower Costs, More Transparency Act, which would apply site neutral payment to drug administration services and enact site-of-service billing transparency, would save about $6 billion over 10 years.\textsuperscript{23}

- **Eliminate incident-to billing.** Rather than billing Medicare directly at 85 percent of the physician rate, visits conducted by advanced practice clinicians (APCs) such as nurse practitioners (NPs) and physician assistants (PAs) can alternatively be billed by a supervising physician at the full Medicare physician rate, a practice known as “incident to” billing. This indirect billing practice adds costs to

\textsuperscript{19} The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. The 2024 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. May 6, 2024.

\textsuperscript{20} Ibid.


\textsuperscript{22} Ibid.

the Medicare program and limits the ability to evaluate the cost and quality of care delivered by APCs because Medicare claims do not specify whether an APC or physician provided the service. The lack of specificity in the Medicare claims also contributes to fraud as Medicare’s recovery audit program cannot detect when incident-to billing is being used inappropriately. **We encourage Congress to eliminate incident-to billing and instead require APCs to bill directly.** Published estimates suggest that eliminating indirect billing of APC-provided evaluation and management services would have generated $194 million in savings to the Medicare program in 2018.  

Forthcoming research finds that indirect billing is a common practice across many specialties and services, suggesting considerably larger savings.

- **Address overvaluation of global surgical codes.** Medicare’s global surgical codes provide a single payment for all services associated with a surgical procedure. The global surgical codes – which include a 0-day, 10-day, and 90-day code – reimburse for the procedure as well as pre- and post-operative care. While the services included in the global surgical codes reflected clinical practice at the time of their introduction decades ago, it is now common for providers other than the surgeon to provide follow-up care. As a result, surgeons may receive payments for post-operative care that they do not provide.  

  To address this pricing distortion, Congress should direct CMS to unbundle the global surgical codes, which would better reflect clinical practice and generate savings to the Medicare program. There are a number of other pricing distortions in the fee schedule that have been described in the literature and that Congress should address to improve valuation in the fee schedule and drive efficiency.  

- **Reduce overpayments to Medicare Advantage (MA) plans.** Numerous studies, investigations, and audits have consistently shown that MA plans are overpaid. MedPAC estimates that payments to MA plans are 22 percent higher than FFS Medicare. Annual overpayments to MA plans are largely driven by plans intensively coding enrollee diagnoses to make them appear less

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27 Ibid.
healthy and increase plan payments. MA plans’ upcoding accounts for $50 billion in excess Medicare spending in 2024 alone. Total excess payments to MA plans are even higher due to other factors including the quality bonus program, which increases payments to plans despite evidence that it does not meaningfully measure or improve quality, and favorable selection of healthier beneficiaries into the program. Annual overpayments to MA plans are a significant driver of overall Medicare spending, and they increase Medicare Part B premiums for all beneficiaries (whether in an MA plan or in FFS Medicare). MedPAC estimates that premiums will be about $13 billion higher in 2024 because of excess payments in MA. \(^{34}\) Reforms to reduce overpayments in MA are urgently needed. Congress should follow the recommendation of MedPAC and other experts by directing CMS to fully account for coding differences between MA and FFS Medicare, which could be done in a way that accounts for coding variation across plans. \(^{35}\) This policy proposal was included in bipartisan legislation introduced by Senators Cassidy and Merkley last year.\(^{36}\)

- **Exclude the AAPM bonus from MA payment benchmark calculations.** MA plan payment rates are based on MA plan bids (a plan’s estimate of the costs for providing Medicare Part A and Part B benefits) and a predetermined benchmark based on average spending in FFS Medicare. Because payments in MA are tied to FFS spending, increases in FFS spending factor into MA benchmark calculations. Increasing and maintaining incentives for physicians in FFS Medicare to participate in AAPMs would also increase MA benchmarks. As the Committee notes, the AAPM bonus would be more targeted and less costly if it was excluded from MA benchmark calculations. In addition, building this small increase into the MA benchmark is not needed to reflect the cost of providing the Medicare benefit to MA enrollees and would not meaningfully impact the provision of supplemental benefits, given the evidence. **We recommend excluding the AAPM bonus from the MA payment benchmark.**

### II. Incentivizing Participation in Alternative Payment Models

Given evidence on the potential for AAPMs to improve efficiency and promote personalized, high-quality care, efforts to reform physician payment should prioritize creating incentives for clinicians to join AAPMs. MACRA created two tracks that clinicians can choose from – the AAPM track and the MIPS track. Congress plays an important role in supporting greater clinician uptake of AAPMs by creating a larger wedge or positive payment differential between payments clinicians receive in the AAPM track versus in MIPS. The AAPM bonus is another potential tool to create this wedge and support clinicians’ movement away from FFS. **AV recommends extending the bonus at an amount closer to the original 5 percent bonus stipulated in MACRA and restructuring the bonus to be more effective and aligned with the goals of AAPMs. We also recommend eliminating MIPS, which further erodes the incentives to join AAPMs while creating**

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\(^{34}\) Ibid.

\(^{35}\) Ibid.

\(^{36}\) No UPCODE Act, S.1002, 118th Congress. 2023.
additional costs for physicians and failing to meaningfully improve quality (discussed further in section III).

**Restructuring the AAPM Bonus**

To delink AAPM incentives from FFS payment and equally reward clinicians for taking financial risk, AV supports restructuring the AAPM bonus to be based on a fixed amount per beneficiary associated with an AAPM rather than based on a percentage of Part B revenue as it is currently designed. Relative to the current structure, using a flat amount per beneficiary would remove an incentive to increase utilization and further delink physician reimbursement from FFS, which is more aligned with the goals of the AAPM track.³⁷ Tying the AAPM bonus to a per-beneficiary amount could also create incentives for increasing patient attribution to AAPMs. Physicians would be incentivized to increase the share of their patients under AAPMs rather than remaining stagnant once passing the minimum AAPM participation threshold. This would help mitigate the existing AAPM participation cliff effects (discussed further below).

Under the current structure, the bonus is inconsistently proportional to the financial risk providers face, which is more similar across providers regardless of revenue level.³⁸ The size of the bonus is much smaller for low-revenue providers, like primary care clinicians, although they may incur the same costs from efforts to manage care and face similar levels of risk as high-revenue providers.³⁹ A per-beneficiary bonus amount would equally reward low- and high-revenue providers for their efforts to manage care and take on financial risk. Restructuring the bonus would benefit low-revenue providers like primary care clinicians and independent physician practices and could incentivize more of these types of providers to participate in the AAPM track and potentially as ACOs in the Medicare Shared Savings Program.⁴⁰ Low-revenue ACOs tend to be made up of physicians from smaller, independent practices, including those in rural areas and have historically demonstrated greater savings.⁴¹

In addition to direct financial rewards for participation in AAPMs, Congress should consider additional mechanisms to incent participation in AAPMs. For example, waivers allowing greater flexibilities for telehealth in the context of AAPMs (versus a more restrictive policy in FFS) may help encourage clinician movement into AAPMs.

**Adjusting AAPM Track Participation Thresholds**

The AAPM track could be further strengthened by modifying or adjusting the participation thresholds mandated in MACRA. For a clinician to qualify for the AAPM track, they must receive at least 50 percent

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³⁸ Ibid.
³⁹ Ibid.
⁴⁰ Congressional Budget Office. Medicare Accountable Care Organizations: Past Performance and Future Directions. April 2024.
⁴¹ Ibid.
of Part B payments or see at least 35 percent of Medicare patients through an AAPM during the performance period.\textsuperscript{42,43} To create a glidepath to widespread AAPM adoption, MACRA sought to increase the level of participation needed to qualify for the AAPM track and bonus over time. Thresholds were set to increase to 75 percent of Part B revenue or at least 50 percent of Medicare patients beginning in performance year 2024, but the existing, lower thresholds were extended in the Consolidated Appropriations Act of 2024.\textsuperscript{44} There are multiple priorities to consider with the AAPM participation thresholds and adjusting the thresholds requires balancing several goals:

- **Incentivizing continuous improvement and increasing movement from FFS to AAPMs.** Maintaining a low participation threshold can hamper movement away from FFS and allow clinicians that may be successful with more AAPM participation to remain at lower levels. Raising thresholds over time can push further uptake of population-based payment models. Restructuring the bonus to a per-beneficiary amount would also support continuous improvement rather than giving clinicians the same bonus regardless of whether they just meet or far exceed the required thresholds.

- **Creating opportunities for rural and safety net providers to join the AAPM track.** Given the smaller patient panels and lower operating margins of many small and rural providers, it can be difficult for these clinicians to meet higher participation thresholds. Raising thresholds over time can reduce participation of these groups, so it is important to consider additional policies that support their participation in AAPMs (e.g., upfront investments for rural providers to participate in ACOs).

- **Creating stability for current AAPM participants.** Increasing the overall uptake of population-based payment requires ensuring current participants are successful and remain engaged in AAPMs. Sudden or sharp eligibility shifts could threaten the success and viability of current participants.

Given the balance needed across these different priorities, **AV supports giving CMS the authority to adjust AAPM thresholds upwards over time with appropriate guardrails to prevent backsliding**, like what has been proposed in the Value in Health Care Act.\textsuperscript{45} Creating clear parameters around potential threshold changes will ensure stability for providers in the AAPM track while still creating steady pressure to increase AAPM participation.

The current design of the participation thresholds also creates cliff effects on clinician eligibility for the AAPM track. In other words, clinicians that exceed the threshold are eligible for the full bonus, while clinicians that fall short, even by a very small amount, are not eligible for any bonus payments.\textsuperscript{46} This “all or nothing” structure means clinicians are not incentivized to increase engagement with AAPMs over time. Moving to a bonus structure that is based on an amount per-beneficiary in an AAPM rather than on a

\textsuperscript{43} Advanced APM Criteria. \textit{42 C.F.R § 414.1415}, June 2024.
\textsuperscript{44} Consolidated Appropriations Act, 2024, \textit{H.R.4366}, 118\textsuperscript{th} Congress. 2024.
\textsuperscript{45} Value in Health Care Act of 2023, \textit{H.R. 5013/S. 3503}, 118\textsuperscript{th} Congress. 2023.
\textsuperscript{46} United States Senate Committee on Finance Hearing on “Medicare Physician Payment Reform After Two Years: Examining MACRA Implementation and the Road Ahead”. May 8. 2019. \textit{Testimony of Matthew Fiedler}. 

percentage of Part B revenue would help mitigate this issue for clinicians above the minimum threshold (as noted above).

III. Reducing Physician Reporting Burden Related to MIPS

The MIPS track has fundamental design flaws that prevent it from meaningfully improving patient care. In addition, it adds administrative costs and burden on physicians and weakens the incentives to participate in an AAPM. **AV urges Congress to eliminate MIPS rather than work to improve it**, a recommendation supported by evidence and consistent with recommendations from MedPAC and other experts.47,48 MIPS has the following problems that inhibit its effectiveness:

- MIPS and predecessor “pay-for-performance” programs have not improved quality, decreased spending, or reduced use of low-value care, suggesting it is unlikely that MIPS will bring about a better outcome in the future.49,50 In addition, clinicians in MIPS can choose which measures to report on, a major flaw that incentivizes clinicians to select the measures on which they are already performing well which hampers the incentives to improve care and prevents comparisons across clinicians.51
- MIPS places significant administrative and cost burdens on clinicians. CMS projected that for 2018, clinicians would spend nearly $700 million to comply with MIPS.52 Clinicians have raised concerns that efforts needed to comply with the program are not worth the benefit of a small upward adjustment.53
- The availability of the MIPS track discourages movement into AAPMs, which should be prioritized over FFS because of their potential to improve care delivery and increase efficiency using a population health framework with less administrative burden for clinicians.54,55 Clinicians in MIPS receive FFS payments that are adjusted upwards or downwards based on their performance on cost, quality, improvement activities, and promoting interoperability. For performance years 2017

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48 United States Senate Committee on Finance Hearing on “Medicare Physician Payment Reform After Two Years: Examining MACRA Implementation and the Road Ahead.” May 8, 2019. Testimony of Matthew Fiedler.
54 U.S. Senate Committee on Finance Hearing on “Bolstering Chronic Care through Medicare Physician Payment.” April 11, 2024. Testimony of Amol Navathe.
through 2021 (which affected payment in 2019 through 2023), the maximum upward adjustments have been fairly small and hovered around 2 percent.\textsuperscript{56} However, recent data shows that the maximum upward payment adjustment in MIPS for performance year 2022 is 8.26 percent, significantly higher than previous maximum upward adjustments.\textsuperscript{57} While it is difficult to predict the likely magnitude of MIPS adjustments over time, the potential for future, higher maximum payment adjustments in MIPS further erodes and weakens incentives to join AAPMs, particularly considering if the AAPM bonus is allowed to expire or extended at a low level past 2024.

IV. Supporting Chronic Care in the Primary Care Setting

Primary care plays a vital role in an efficient, high-performing health care system. Continuity in primary care is associated with reduced mortality, health care expenditures, and hospitalizations.\textsuperscript{58,59} However, the status quo FFS system pays according to the amount of care delivered rather than the health of the patient. AV encourages Congress to shift primary care payment in the Medicare fee schedule away from FFS and instead pay primary care clinicians partially through prospective, per-beneficiary, per-month (PBPM) payments that reflect the patient population they care for (this model is also referred to as a hybrid capitated payment model).

In a landmark 2021 report on implementing high-quality primary care, the National Academy for Science Engineering and Medicine highlighted the shortcomings of FFS and recommended that a hybrid capitated, per-patient per-month payment, rather than FFS, be the default for primary care.\textsuperscript{60} In a hybrid capitated payment model, providers receive two kinds of payments: (1) PBPM payments for a core set of services and care management and (2) FFS payments for select additional services provided at visits. This payment structure can result in more patient-centered care, greater use of technology like telehealth when appropriate and cost-effective, and stronger team-based staffing that enables high-quality primary care.\textsuperscript{61} Hybrid capitated payments’ flexibility and focus on outcomes can also better position primary care providers to deliver more comprehensive, personalized, and equitable care.\textsuperscript{62}

\textsuperscript{56} Centers for Medicare & Medicaid Services. \textit{Quality Payment Program Experience Data}. Data.cms.gov.


\textsuperscript{60} The National Academies of Sciences, Engineering, and Medicine (NASEM). \textit{Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care}. 2021.

\textsuperscript{61} Ibid.

In addition, evaluations of CMMI models that tested different forms of prospective payments report positive physician experiences.\textsuperscript{63} Practices highlighted that reliable, predictable funding allowed for better budgeting, resources and staffing dedicated to care coordination, and integration of other health care professionals like behavioral health providers.\textsuperscript{64} Practices with prospective payment models also highlighted the value of consistent revenue during shocks like the COVID-19 pandemic.

\textit{Payment Structure for Hybrid Payment}

Hybrid capitated payments for primary care have been widely studied by health services researchers and tested by CMMI and select private payers. Tested models vary in design but provide some insights on how to best structure a hybrid capitated payment within the Medicare physician fee schedule. However, \textit{iteration and updates over time will likely be needed, meaning Congress should give some flexibility to CMS to design and implement hybrid payment for primary care most effectively.} One of the key questions is determining which services should be included in a PBPM payment and which services should continue to be paid on a FFS basis. FFS payment drives higher utilization while population-based payment is well-suited for wrap-around services that may not be associated with a specific visit and are not as easily reimbursable in FFS. PBPM is most appropriate to cover the following types of services:

- **High-volume, low-cost services** like minor office procedures. With these services, capitated payments would reduce volume-based incentives and give clinicians greater flexibility to deliver services in the time and format that’s most efficient and appropriate.\textsuperscript{65}
- **Care management and coordination** as these types of services are not often linked to a specific visit between a patient and a clinician. Capitated payment can provide more flexible resources for clinicians to offer care coordination without burdensome coding and documentation.\textsuperscript{66}
- **Telehealth** services because population-based payments can reduce restrictions or burdensome documentation requirements often placed on clinicians with use of telehealth while creating incentives to avoid duplicative or unnecessary telehealth use. For example, providers could elect to offer audio-only or video-based telehealth services based on what is most effective for patients and efficient for clinicians.

In contrast, high-value, high-cost services like immunizations should be reimbursed through FFS. These types of services are important to deliver to patients and may include high delivery costs so incentivizing greater utilization is appropriate. Additionally, evaluation and management services, which are the platform for most diagnoses and counseling in primary care, could be paid partially by capitated

\textsuperscript{63} Corinne Lewis et al. The Commonwealth Fund. \textit{How Upfront, Predictable Payments Can Improve Primary Care}. May 13, 2024.
\textsuperscript{64} Ibid.
\textsuperscript{65} Berenson RA, Shartzer A, Pham HH. \textit{Beyond Demonstrations: Implementing A Primary Care Hybrid Payment Model in Medicare}. Health Affairs Scholar. August 1, 2023.
\textsuperscript{66} Ibid.
payments, and partially by FFS. Blending FFS and capitated payment for evaluation and management services will offer providers more flexibility while still ensuring strong access to care for patients.\textsuperscript{67}

Based on these recommendations, \textbf{60 to 70 percent of payment for most primary care clinicians would be covered by a new population-based payment while the remaining 30 to 40 percent would be reimbursed through FFS payments}. These estimates align with the model proposed in the bipartisan \textit{Pay PCPs Act} which would give HHS the authority to establish prospective, PBPM payments that represent 40 to 70 percent of expected charges and may cover care management, patient communication, behavioral health integration, and office-based evaluation and management visits.\textsuperscript{68} The suggested structure is also supported by simulations of capitated payments for primary care which find that practice transformation, specifically shifting to more team-based and non-visit-based care, would be incentivized when 63 percent of a practice’s patients had capitated payments in place.\textsuperscript{69} Importantly, stipulating a range for the population-based payment proportion is likely appropriate to give CMS the ability to fine tune the payment structure and to adjust over time depending on practice behavior.

\textbf{Risk Adjustment & Payment Accuracy}
Risk adjustment, which can be used to adjust the level of payment to providers based on their patients’ health status and expected utilization, plays an important role in population-based payment models. For hybrid capitated payments for primary care, risk adjustment helps ensure that PBPM payments match the expected intensity of primary care that is likely needed, which varies based on the makeup of clinicians’ patient panels. In addition, risk-adjusted payments help ensure providers have sufficient resources to invest in practice transformations to enable high-quality care.

A reasonable starting place for risk adjustment for a hybrid capitated model is to base the payment on historic utilization while considering moving to an approach that bases payment on population needs over time. This approach would enable a smooth transition from FFS by minimizing the potential for financial shocks to practices and enable them to ease into care delivery changes (i.e., decreasing visit volume and increasing use of other resources over time). While historic utilization is a reasonable starting place for risk adjustment in a hybrid capitated payment model, the longer-term goal should be to adjust for risk using an approach that moves payments away from utilization patterns observed in FFS. Historic utilization does not capture the care delivery patterns that hybrid capitated payments aim to incentivize, and an alternative risk adjustment approach would better align financial incentives under a value-based framework. This is also important for advancing equity as a model based on historic utilization may not

\textsuperscript{67} United States Senate Committee on the Budget Hearing on “Achieving Health Efficiency through Primary Care.” March 6, 2024. \textit{Testimony of Amol Navathe}.
\textsuperscript{68} Pay PCPs Act, S.4338, 118th Congress. Introduced May 15, 2024.
\textsuperscript{69} Basu S, Phillips RS, Song Z, Bitton A, Landon BE. \textit{High Levels Of Capitation Payments Needed To Shift Primary Care Toward Proactive Team And Nonvisit Care}. \textit{Health Affairs}. September 1, 2017.
provide sufficient resources for clinicians to care for patient populations who have been historically underserved such as racial and ethnic minorities.

The risk adjustment system for hybrid capitated payments for primary care physicians must be constructed with appropriate guardrails that prevent intensive risk score coding to increase risk-adjusted payments, a major problem in MA that drives significant overpayments to plans. In the context of ACOs, CMS caps risk score growth, which has helped limit the impact of payment increases due to coding incentives. A similar approach could be incorporated into a risk adjustment system for hybrid capitated payments in primary care to protect against greater coding intensity and unwarranted spending increases.

Congress should require risk adjustment for hybrid capitated payments to primary care physicians and give CMS the authority to design and implement a risk adjustment approach for hybrid capitated payments in primary care. CMS has extensive experience with risk-adjusted prospective payments in primary care from several CMMI models including Comprehensive Primary Care, Comprehensive Primary Care Plus, Primary Care First, Making Care Primary, and, most recently, ACO Primary Care Flex. They also have authority over risk adjustment in MA and experience making changes to improve the CMS-Hierarchical Condition Category (CMS-HCC) model over time. CMS is well-positioned to develop a risk adjustment approach for hybrid capitated payments for primary care that is informed by the evidence from CMMI’s models and that gradually moves away from historic utilization.

V. Ensuring the Integrity of the PFS

The valuation of services in the fee schedule is based on recommendations to CMS from the American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee (RUC), an expert panel with substantial influence on value determinations, the rate-setting process, and, subsequently, physician payment. Structural flaws with the RUC, including inherent conflicts of interest and a reliance on survey data from medical societies, undermine the accuracy of its recommendations and point to an urgent need for reforms. As a result, payment in FFS is not always well aligned with the value of services, meaning reimbursement levels do not always reflect the actual time and resources needed to deliver a service, and the fee schedule overvalues procedural services and undervalues cognitive services.

Needed Structural Improvements

Given the baseline issues with the data that the RUC uses to determine valuation, Congress should require CMS to implement accurate and ongoing data collection so that CMS has information to independently validate relative value units (RVUs) and supplement the existing survey information with empirical

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71 Centers for Medicare & Medicaid Services. Making Care Primary (MCP) Model. CMS.gov.
72 Centers for Medicare & Medicaid Services. ACO Primary Care Flex Model. CMS.gov.
information on time and intensity associated with services. The RUC relies on surveys of specialty medical society members to assess the time and intensity of a specific service and to produce a recommendation for the service’s total work RVU. These surveys tend to lead to inaccurate, distorted RVUs because they are subjective and may not accurately account for the time and effort of most physicians performing the service. Physician respondents also have an inherent conflict of interest to inflate work values. One study comparing data from operative logs with RUC survey data found that the RUC survey data overestimated procedural times by an average of 31 minutes across 60 procedures. In addition, specialties other than primary care have greater representation on the RUC.

In most cases, CMS accepts the RUC’s recommended RVUs given that other data sources for CMS to validate RUC recommendations do not exist. As a result, value determinations, and therefore payment rates, are based on flawed data. Congress should direct CMS to establish an empirical source of information on the time and intensity associated with services and consider their implications for RVUs. Data could include code-specific time data from practices and reflect differences in cost structures in various practice environments. This would reduce reliance on self-reported specialty estimates of codespecific work that clinicians perform.

We recognize that using more accurate, ongoing data collection to validate RVUs will take time to implement, but there are steps that Congress can take now to enable CMS to improve accuracy. One such step is for Congress to establish an advisory body within CMS (e.g., a technical advisory committee) to balance the RUC process. This aligns with recommendations from experts as well as a proposal in the bipartisan Pay PCPs Act. The committee should be made up of individuals with no conflicts of interest, and the committee could review empirical data, consider updates to nonprocedural codes, and recommend additional changes to payment amounts. They could also advise on additional information that should be collected to supplement the current survey-based approach. Creating a technical advisory committee could ultimately mitigate biased decision-making and promote more stakeholder engagement.

At a minimum, Congress should direct CMS to improve transparency and better facilitate information around how the RUC reaches its valuation decisions. The secrecy around voting within the RUC may contribute to the RUC’s recommendations being biased in favor of certain specialty societies, which

78 Pay PCPs Act, S.4338, 118th Congress. Introduced May 15, 2024.
highlights the need for greater transparency. CMS should make a public, central repository of guidelines and standards, including information on physician work data and methods, that the RUC follows to generate recommendations.

There is a need to address currently misvalued services like the global surgical codes (discussed above). CMS initially led the misvalued services agenda by analyzing data and providing the RUC with lists of codes to review but has recently deferred this review to the RUC. Congress should direct CMS to again lead the misvalued code review and set expectations for changes they would like to see as a result of review. Congress should direct CMS to identify services with notable growth in allowed charges, which can flag high expenditure services that need more timely reviews and ensure reviews are done on a rolling basis.

VI. Conclusion

We appreciate the Committee’s interest in the important issue of improving Medicare physician payment and the opportunity to provide input. Please contact Erica Socker at esocker@arnoldventures.org or Mark Miller, Ph.D., Arnold Ventures’ Executive Vice President of Health Care, at mmiller@arnoldventures.org with any questions.

Erica Socker, Ph.D.
Vice President, Health Care
Arnold Ventures

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84 Ibid.