



Representative Ami Bera  
172 Cannon House Office Building  
Washington, DC 20515

Representative Larry Bucshon  
2313 Rayburn House Office Building  
Washington, DC 20515

October 28, 2022

RE: Request for Information on the current state of MACRA and associated payment mechanisms

Dear Representatives Bera and Buschon,

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 reorient 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, patient-focused payment models, such as 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.

First, we recognize you have many competing priorities and thank you for making this important commitment to improve the Medicare payment system and shift clinicians into value-based payment models. We at Arnold Ventures share a commitment to working toward a more affordable, sustainable, and patient-centered health care system. The fee-for-service (FFS) payment system – the predominant way we pay for health care services – often results in unaffordable, low-quality care for patients. Population-based payment models are a promising alternative for increasing value in our health care system because they incentivize providers to keep people healthy and deliver care efficiently. Population-based models like ACOs have demonstrated the ability to generate modest net savings and have enabled providers to maintain or improve quality.<sup>1</sup> Payment reforms like ACOs also have the potential to play a role in containing overall Medicare spending.

In 2015, Congress substantially changed how the federal government pays physicians when it passed the bipartisan Medicare Access and CHIP Reauthorization Act (MACRA). The new law aimed to create more stability in physician payments and incentivize clinicians to participate in advanced alternative payment models (AAPMs)—alternatives to the status quo FFS system such as ACOs and similar models. Unlike FFS, AAPMs hold clinicians accountable for the quality and cost of care. Moving clinicians into these models is critical for improving the affordability of health care and patient outcomes. MACRA also incorporated a value-based payment adjustment in FFS for clinicians remaining outside of AAPMs.

While one goal of MACRA was to catalyze clinician movement into value-based care, it has not worked well. A key problem is that the incentives to join AAPMs have been weak and are eroding at a critical time when the focus must be on accelerating the shift to effective alternative payment models. In addition, the quality program for clinicians outside of AAPMs has design flaws that make it unlikely to improve the care delivered by providers who remain in FFS. The Centers for Medicare and Medicaid Services (CMS) has a role in designing alternative payment models that encourage providers to participate and deliver affordable, high-quality care, and recently proposed changes to the largest ACO program intended to achieve that objective.<sup>2</sup> However, given the challenges that arise directly from the MACRA statute, Congress must also do its part to support the shift to a health care system that delivers more value to

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<sup>1</sup> Medicare Payment Advisory Commission (MedPAC). June 2021. Report to Congress. *Chapter 2: Streamlining CMS's Portfolio of Alternative Payment Models*. <https://www.medpac.gov/recommendation/streamlining-cmss-portfolio-of-alternative-payment-models-june-2021/>

<sup>2</sup> CMS. 2022. [Calendar Year 2023 Medicare Physician Fee Schedule Proposed Rule -Medicare Shared Savings Program Proposals](#).



Medicare beneficiaries and taxpayers. This includes creating more certainty and a clearer signal to clinicians that the path to achieving greater value requires participation in AAPMs.

In this response, we explain the importance of shifting clinicians into AAPMs. A subset of AAPMs—namely, population-based payment models such as ACOs in which clinicians are accountable for the total cost and quality of care—have the greatest potential to be effective and should be prioritized over other alternative models; however, for sake of simplicity, we refer to these models as AAPMs throughout our response. We discuss how MACRA intended to shift clinicians into AAPMs and the challenges with its approach. We then provide recommendations for Congress to increase value in our health care system. Our recommendations focus on the need for three kinds of policy solutions:

- Strengthening incentives for AAPM participation,
- Addressing design flaws of the quality program for clinicians in FFS, and
- Implementing other changes to FFS to increase value and make the status quo less attractive relative to AAPM participation.

### **Moving clinicians into advanced alternative payment models (AAPMs) is important to improve health outcomes and affordability**

Shifting clinicians from FFS into AAPMs is important for increasing value in our health care system. AAPMs hold clinicians accountable for the quality and cost of care. By contrast, FFS reimburses clinicians based on the number and type of services they provide, incentivizing them to deliver more and higher priced care even if services have no clinical benefit or could harm patients. FFS has contributed to our health system's poor performance by failing to hold clinicians accountable for keeping patients healthy, reducing health inequities, and improving the affordability of care.

ACOs are the most promising type of AAPM based on the performance of the payment models tested by CMS to date.<sup>3</sup> If clinicians in ACOs reduce the cost of care for their patient population and hit quality targets, they can share in the savings with the payer, and in more advanced ACOs, clinicians are responsible for a portion of the costs if they exceed the spending target. ACOs and similar AAPMs are a promising solution for addressing the misaligned incentives in the status quo FFS payment system because they give clinicians greater flexibility and incentives to deliver the mix of services that will improve patient health outcomes and reduce wasteful spending. Another advantage of ACOs' population focus is that payments can be designed to direct resources to underserved populations and the payment structure enables clinicians to direct their time and practice resources to where they are most needed such as to higher risk patients and those with complex medical needs.<sup>4</sup>

### **The design of MACRA was intended to shift clinicians from FFS into AAPMs**

MACRA repealed the sustainable growth rate (SGR)—a flawed formula that mandated cuts to Medicare physician payments which Congress perennially averted via short-term legislation—and replaced it with a new schedule for annual payment rate updates. It also consolidated three pre-existing performance programs into a new Quality Payment Program (QPP) and created two tracks clinicians can choose from:

- Advanced Alternative Payment Model (AAPM) track. To qualify, clinicians in this track must achieve a certain level of AAPM participation (e.g., participation in the Medicare Shared Savings Program and select demonstrations administered by the CMS Innovation Center including ACO models) based on

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<sup>3</sup> MedPAC. June 2021. Report to Congress. *Chapter 2: Streamlining CMS's Portfolio of Alternative Payment Models.* <https://www.medpac.gov/recommendation/streamlining-cmss-portfolio-of-alternative-payment-models-june-2021/>

<sup>4</sup> Michael E. Chernew and J. Michael McWilliams. January 2022. [The Case For ACOs: Why Payment Reform Remains Necessary.](#) *Health Affairs Forefront.*



payment amount or patient count thresholds. Clinicians get a five percent lump sum bonus payment for participating in an AAPM, additional incentives/risks from the model itself (i.e., ACO shared savings/losses), and, starting in 2026, a 0.75 percent annual update to their payment rates. This year, however, is the last performance year in which clinicians in the AAPM track can earn the five percent bonus for AAPM participation, which is to be paid out in 2024.

- Merit-Based Incentive Payment System (MIPS) track. Clinicians in this track receive FFS payments that are adjusted upward or downward based on performance on cost, quality, improvement activities, and promoting interoperability (i.e., activities related to use of electronic health records). Clinicians have a zero percent annual payment update until 2025. Starting in 2026, these clinicians receive annual updates to their payment rates, but the update is 0.25 percent, which is lower than the update for clinicians participating in AAPMs.

The goal of the QPP was to encourage clinicians to participate in AAPMs (through a bonus and higher annual payment rate updates) while also encouraging clinicians who choose not to participate in AAPMs to improve quality (through performance-based adjustments to their FFS payments). The QPP creates a payment differential between clinicians in and out of AAPMs that will start in 2026 and grow indefinitely, making it increasingly less attractive for clinicians to remain outside of AAPMs. MACRA highlights the crucial role that Congress can play in enabling CMS to realize a value-based health care system that generates savings to Medicare. By influencing AAPM participation incentives, Congress has the potential to enable CMS to implement effective payment models *and* attract clinicians to participate in them.

#### **Reforms to MACRA's AAPM track are needed to strengthen incentives for AAPM participation going forward**

While MACRA aimed to incentivize greater clinician participation in AAPMs, its effectiveness in shifting our health care system toward a value-based model has been limited. CMS envisions that eventually all clinicians will deliver value-based care via AAPMs and has focused on designing AAPMs that clinicians find attractive. However, to realize the vision of value-based care, Congress must support CMS by strengthening the incentives that draw clinicians into AAPMs and making it less attractive for them to remain in FFS. This will bolster CMS's recent regulatory actions intended to increase participation while also enabling CMS to design more effective models.

#### **Issue 1: Incentives for AAPM participation have not been strong enough and are eroding at a critical time**

Achieving widespread adoption of *effective* AAPMs requires balancing between two goals: increasing participation in alternative payment models and designing models with strong incentives to improve performance and contain costs. Balancing these two goals is difficult given the voluntary nature of provider participation in AAPMs. Financial incentives that make participation more attractive to providers (e.g., changes CMS makes to the financial benchmarks that make it easier for providers to achieve savings) can also reduce the likelihood the models reduce Medicare spending. Congress plays an important role in supporting greater clinician uptake of AAPMs, including models with higher financial risk, by creating a larger wedge between the payments clinicians receive in the FFS and AAPM tracks through a combination of incentives to join AAPMs and disincentives to remain in FFS.

Indeed MACRA created a payment differential between the AAPM track and the MIPS track as well as a bonus for AAPM participation to support CMS's efforts to increase participation in AAPMs. However, one key problem with MACRA's design is that the payment differential between the AAPM track and the MIPS track is not large enough to motivate clinicians to join AAPMs, particularly since clinicians are uncertain about how they will perform and whether they will earn gains or experience losses in AAPMs. This



problem will be made worse when the AAPM participation bonus expires in 2022, as the bonus has played a role in increasing participation in AAPMs.

Despite the initial success of MACRA in moving more clinicians into AAPMs, the pace of AAPM uptake has been underwhelming in recent years. For example, the Medicare Shared Savings Program, Medicare's largest and only permanent ACO program, has seen a leveling off after several years of rising participation.<sup>5</sup> In the recent Medicare Physician Fee Schedule proposed rule, CMS proposed several changes to the Medicare Shared Savings Program intended to increase participation. Now is a crucial time for Congress to also play its part in structuring payments to support greater adoption of ACOs with strong incentives to reduce spending.

Pure FFS and FFS with links to quality and value (including MIPS) still account for the majority of Medicare physician payments.<sup>6</sup> The predominance of FFS underscores several factors that have contributed to MACRA's limited success. FFS is still relatively attractive and familiar to clinicians, and the presence of the MIPS track detracts from participation in AAPMs. The opportunity to receive an upward payment adjustment based on performance in MIPS has led the majority of clinicians to choose MIPS over an AAPM where they face uncertainty with respect to gains/losses. Furthermore, the decision to participate in an AAPM is complex due to the number of AAPMs available, many of which are time-limited CMS Innovation Center demonstrations rather than permanent programs like the Medicare Shared Savings Program, and the variety of factors that determine clinician performance in these models.

These challenges will continue to undermine the effectiveness of MACRA in shifting clinicians into AAPMs, and with the upcoming expiration of the AAPM participation bonus, we are at serious risk of backsliding. The expiration of the bonus may deter clinicians from joining AAPMs as they may be able to get a higher payment by staying in MIPS. At best, sunseting of the AAPM bonus will stagnate the transition to value-based payment. At worst, it will reverse the progress made to date.

#### Issue 2: Thresholds for AAPM participation have cliff effects that should be smoothed out and simplified

For a clinician to qualify for the AAPM track, they must deliver a sufficient proportion of their care through an AAPM, measured by the percentage of payments or patients linked to an AAPM. The flaw of this approach is that it creates an eligibility cliff. Clinicians with AAPM participation below the minimum threshold for a partially qualifying clinician, which is fairly high, do not receive a bonus or any other reward for participating. Another limitation is that once clinicians meet the minimum threshold for AAPM participation, they do not have any incentives to increase participation beyond the threshold.

#### Recommendations to increase MACRA's effectiveness in shifting clinicians into AAPMs

Given these challenges, we recommend that Congress take the following steps:

- **Strengthen incentives for clinicians to participate in AAPMs by extending the AAPM participation bonus and increasing the size of the current five percent bonus.** This will increase adoption of AAPMs and give CMS greater opportunity to design models with powerful incentives to contain costs. Congress could do this in a budget neutral way by pairing a larger bonus for AAPM participation with penalties for non-participating clinicians, similar to the approach used in MIPS and other quality

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<sup>5</sup> Sherrie Wang et al. Oct 2022. [Performance Results of the Medicare Shared Savings Program in 2021: Continued Uncertainty with Positive Movement](#). *Health Affairs Forefront*.

<sup>6</sup> Health Care Payment Learning and Action Network. 2021. [APM Measurement Effort](#).



programs.<sup>7, 8</sup> Another option is to use other changes to Medicare payments to offset the costs of extending the bonus. For example, Congress could lower payment rate updates for post-acute care providers to better align payments with the costs of treatment or reduce overpayments in Medicare Advantage, such as by increasing the coding intensity adjustment, which have been recommended by numerous policy experts and the Medicare Payment Advisory Commission (MedPAC).<sup>9, 10, 11</sup>

- **Smooth out and simplify thresholds for clinicians to qualify for the AAPM track so that there are incentives along the continuum of AAPM participation levels.** This would reward clinicians for current participation levels *and* incentivize them to increase participation. This could be done in a way that does not increase Medicare spending by lowering the threshold for a bonus and then gradually increasing the size of the bonus as participation increases.
- **Tighten the definition of AAPM to focus on models that are most effective at reducing costs and maintaining or improving care.** By limiting the definition of AAPMs to the most effective models, such as ACOs, and excluding models that have not been effective at reducing costs, Congress can drive clinicians into more effective models.

**Issues with MACRA’s MIPS track include challenges with the measures as well as fundamental design flaws which underscore the need for Congress to consider eliminating MIPS or make major changes**

Outside of AAPM participation, MIPS links clinicians’ payments to their performance with the goal of increasing value. Several challenges undermine MIPS’ effectiveness in achieving this goal. Moreover, fundamental design flaws combined with lackluster evidence from similar programs strongly suggest incremental changes to MIPS will not substantially improve it, and that Congress should eliminate it. In this section, we describe challenges with MIPS. We then outline policy options that would partially address these challenges if Congress is committed to maintaining the MIPS track, as well as our preferred recommendation to eliminate MIPS.

**Issue 1: Problems due to clinician selection of measures to report**

A major design flaw with the performance metrics in MIPS is that clinicians can choose which measures to report for most domains, which creates several problems. First, it does not meaningfully advance improvements in patient care as clinicians are incentivized to select measures on which they are already performing well. Indeed, nearly 800,000 clinicians had an upward performance-based payment adjustment in 2021 and just 3,000 received downward adjustments, mostly for failing to report data.<sup>12</sup> These numbers show that MIPS has not differentiated performance among clinicians. Second, the ability of clinicians to perform well in MIPS and receive an upward payment adjustment without having to change their behavior undermines incentives for clinicians to join AAPMs. Third, clinician choice of measures contributes to MIPS scores clustered around a high average with a very restricted range in performance such that small fluctuations in measure scores—that could be due to variation that is not reflective of a meaningful change in clinician performance—can lead to payment adjustments that vary substantially

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<sup>7</sup> Tim Gronniger et al. July 2021. [The \(SGR\) Fix Is In: How MACRA Short-Circuited Incentives for Joining Two-Sided Models](#). *Health Affairs Forefront*.

<sup>8</sup> 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](#).

<sup>9</sup> MedPAC. March 2020. Report to Congress. *Chapter 7: Improving Medicare Payment for Post-Acute Care*. [https://www.medpac.gov/wp-content/uploads/import\\_data/scrape\\_files/docs/default-source/reports/mar20\\_medpac\\_ch7\\_sec.pdf](https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar20_medpac_ch7_sec.pdf)

<sup>10</sup> Committee for a Responsible Federal Budget. Feb. 2021. [Reducing Medicare Advantage Overpayments](#).

<sup>11</sup> Arnold Ventures. 2022. [Comment Letter on 2023 Medicare Advantage Advance Notice](#).

<sup>12</sup> MedPAC. March 2022 Report to Congress. *Chapter 4: Physician and Other Health Professional Services*. [https://www.medpac.gov/wp-content/uploads/2022/03/Mar22\\_MedPAC\\_ReportToCongress\\_Ch4\\_v2\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch4_v2_SEC.pdf)



from one year to the next.<sup>13</sup> Fourth, patients cannot compare across clinicians because they report on different measures and as noted above, changes in a clinician's scores may not reflect meaningful changes in performance. These design issues undermine patients' ability to use publicly reported quality data to make informed decisions when selecting clinicians and make it unlikely that MIPS achieves policymakers' goal of driving quality improvements in FFS.

#### Issue 2: Problems due to small numbers

Another problem is that several hundred thousand clinicians (nearly 50 percent) do not meet threshold patient volumes to be in MIPS or are excluded for other reasons, and few perform a sufficient volume of services to enable accurate, reliable, and equitable measurement.<sup>14,15</sup> As a result, incentives do not apply to many clinicians, and measures are based on a relatively small number of patients, enabling chance to influence scores and decreasing incentives to deliver care more efficiently.

#### Issue 3: MIPS places significant administrative burden on clinicians

Administrative burden related to MIPS is particularly salient given the aforementioned challenges that make the program unlikely to increase value. CMS projected that for 2018, clinicians would spend nearly \$700 million to comply with MIPS.<sup>16</sup> Clinicians have reported that annual programmatic changes further increase burden, and have raised the concern that efforts needed to comply with the program (including tracking performance on measures they may not end up reporting) are not worth the benefit of a small upward adjustment.<sup>17</sup> While AAPMs also impose administrative burden on clinicians, the potential added value of AAPMs is higher and the use of measures based on administrative claims or data embedded in electronic health records have streamlined reporting and reduced burden relative to MIPS.

#### Issue 4: Fundamental flaws with the basic design of MIPS

A major conceptual problem with MIPS is that it is oriented around individual clinicians, which does not reflect that other providers and settings are involved in patient care and influence quality. This creates a misalignment between the outcomes that MIPS aims to achieve and the target of incentives, and it is a poor substitute for shifting clinicians into AAPMs. In AAPMs, there are incentives for clinicians to adopt a population health perspective, which may lead to care delivery changes and team-based approaches to manage population health. Increasing value in our health care system involves creating incentives for clinicians to coordinate care. A more holistic approach targeting groups of clinicians could also help address fragmentation in our system by creating alignment across clinicians working toward (and held accountable to) a shared goal of better population health.

Another flaw of MIPS is that it is modeled after predecessor programs that have not been successful, making it unlikely to bring about a different result. One such program was the Value-Based Payment Modifier, which, like MIPS, tied clinicians' payments to performance on quality and spending. A study on

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<sup>13</sup> 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](#).

<sup>14</sup> 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. Statement of James E. Mathews. [https://www.medpac.gov/wp-content/uploads/import\\_data/scrape\\_files/docs/default-source/congressional-testimony/05082019\\_medpac\\_statementforthecord\\_macra\\_senate\\_finance\\_sec.pdf](https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/congressional-testimony/05082019_medpac_statementforthecord_macra_senate_finance_sec.pdf)

<sup>15</sup> CMS. 2021. [CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies](#).

<sup>16</sup> CMS. 2017. [CY 2018 Updates to the Quality Payment Program](#).

<sup>17</sup> Dhruv Khullar et al. 2021. [Physician Practice Leaders' Perceptions of Medicare's Merit-Based Incentive Payment System \(MIPS\)](#). *Journal of General Internal Medicine*, 36(12).





the program's effectiveness found no impacts on avoidable hospitalizations or readmissions, Medicare spending, or mortality.<sup>18</sup>

#### Recommendations to address MIPS' ineffectiveness in creating value in FFS

Given these challenges, we recommend Congress consider the following options:

- **Eliminate MIPS rather than work to improve it.** Given its fundamental design flaws, incremental changes are unlikely to improve the program, so we recommend eliminating the MIPS track for clinicians in FFS. MIPS is unlikely to result in quality improvements in FFS and plays a role in discouraging movement into AAPMs. Our recommendation is consistent with those from MedPAC and other experts to repeal MIPS.<sup>19, 20</sup>
- **Revamp the performance measures in MIPS by streamlining and standardizing the measures on which clinicians must report.** Given flaws in the basic structure of MIPS, changes are unlikely to yield substantial improvements. Although we would eliminate MIPS, if Congress is committed to retaining MIPS, revamping the performance measures could improve them. Such changes could hold clinicians to a consistent and better standard for receipt of upward payment adjustments and may help make MIPS less attractive relative to AAPMs to facilitate a greater shift into AAPMs.

#### Beyond MIPS, additional FFS changes are needed to increase value in our health care system

One of the goals of MIPS was to introduce value into the fee schedule using measure-based payment modifiers; however, the adjustments are relatively small. Additional reforms to the fee schedule are needed to increase value. The majority of health care spending remains through FFS and most AAPMs are built on a FFS chassis.<sup>21</sup> Because FFS payments are not aligned with the value of a service, they create financial incentives that run counter to the objectives of value-based care.

There are several flaws with the current FFS system. First, the fee schedule's overvaluation of certain services and types of specialty care drives unnecessary care that can harm patients clinically and financially, because clinicians have incentives to deliver more high-margin services.<sup>22</sup> Second, FFS payments undervalue primary care services and are not structured to support a comprehensive primary care system. It incentivizes primary care clinicians to focus on patient visits, which they are reimbursed for, and fails to adequately reimburse them or provide them with sufficient flexibility for other kinds of services that are important for maintaining population health such as coordinating with other providers and engaging patients to help them manage their health. Lastly, there are additional distortions in the FFS system that result in higher spending for patients and taxpayers. One notable issue is that the Medicare program pays higher rates for services provided in hospital outpatient departments than when the same services are provided at physician offices, which adds unnecessary costs to the system.<sup>23</sup> Congress must harmonize incentives in FFS with the objectives of value-based care through the following steps:

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<sup>18</sup> Eric T Roberts, Alan M Zaslavsky, and J Michael McWilliams. 2018. [The Value-Based Payment Modifier: Program Outcomes and Implications for Disparities](#). *Annals of Internal Medicine*, 168(4).

<sup>19</sup> MedPAC. March 2018. Report to Congress. *Chapter 15: Moving beyond the Merit-based Incentive Payment System*. [https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-mar18\\_medpac\\_ch15\\_sec-pdf/](https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-mar18_medpac_ch15_sec-pdf/)

<sup>20</sup> Matthew Fiedler et al. Feb. 2018. [Congress Should Replace Medicare's Merit-Based Incentive Payment System](#). *Health Affairs Forefront*.

<sup>21</sup> Rachel O. Reid et al. 2022. [Physician Compensation Arrangements and Financial Performance Incentives in US Health Systems](#). *JAMA Health Forum*, 3(1).

<sup>22</sup> MedPAC. March 2022. Report to Congress. *Chapter 4: Physician and Other Health Professional Services*. [https://www.medpac.gov/wp-content/uploads/2022/03/Mar22\\_MedPAC\\_ReportToCongress\\_Ch4\\_v2\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch4_v2_SEC.pdf)

<sup>23</sup> Committee for a Responsible Federal Budget. Feb. 2021. [Equalizing Medicare Payments Regardless of Site-of-Care](#).



- **Reassess the Medicare Physician Fee Schedule** so that payments better reflect the value of services. In addition, if Congress decides to increase physician payments, they should not enact across-the-board increases in payments. Instead, they should target payment increases to clinicians who are underresourced such as safety net providers or those whose services are currently undervalued. The current specialty bias in the fee schedule is a result of using one approach to determine the value of a diverse set of services. This bias could be addressed in a budget neutral way by increasing rates for primary care and other nonprocedural services and lowering rates for other services. In addition, using empirical data to measure time spent on services could help improve value in the fee schedule.<sup>24</sup>
- **Implement a hybrid capitated payment model for primary care.** Shifting primary care payments to a hybrid reimbursement model that includes a capitated, per-beneficiary per-month payment would address shortcomings in our current model. It would enable predictable, prospective payments to primary care providers and give them greater flexibility to deliver the services that are essential to keeping patients healthy such as preventive care and chronic disease management. Furthermore, it could help drive payment transformation across the system, and it aligns with recommendations from the National Academy for Science Engineering and Medicine's recent report on high quality primary care.<sup>25</sup>
- **Promote and expand site-neutral payments.** In 2015, Congress established site-neutral payments for services received at off-campus hospital outpatient departments but excluded existing off-campus departments. Congress should expand site-neutral payments by eliminating grandfathering for existing off-campus departments and by applying site-neutral payment for all evaluation and management visits to all on-campus departments. Such policies have bipartisan support and were included in both President Obama's and President Trump's Presidential budgets.<sup>26</sup>

### Conclusion

We appreciate Congress's commitment to improving Medicare payment and shifting clinicians into value-based payment models. Again, we thank you for the opportunity to provide responses to this request for information. Please contact Mark Miller, Ph.D., Arnold Ventures' Executive Vice President of Health Care, at [mmiller@arnoldventures.org](mailto:mmiller@arnoldventures.org) or Erica Socker at [esocker@arnoldventures.org](mailto:esocker@arnoldventures.org) with any questions.

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

CC: Representatives Earl Blumenauer, Michael C. Burgess, Mariannette Miller-Meeks, Bradley Scott Schneider, Kim Schrier, and Brad R. Wenstrup

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<sup>24</sup> Maura Calsyn and Madeline Twomey. July 2018. [Rethinking the RUC: Reforming How Medicare Pays for Doctors' Services](#).

<sup>25</sup> National Academies of Sciences, Engineering, and Medicine. 2021. [Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care](#).

<sup>26</sup> Committee for a Responsible Federal Budget. Feb 2021 [Equalizing Medicare Payments Regardless of Site-of-Care](#).