



Medicare Payment
Advisory Commission

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October 28, 2022

Representative Ami Bera, M.D.
Representative Larry Bucshon, M.D.
Representative Kim Schrier, M.D.
Representative Michael Burgess, M.D.
Representative Earl Blumenauer

Representative Brad Wenstrup, D.P.M.
Representative Bradley Schneider
Representative Mariannette Miller-Meeks, M.D.
macra.rfi@mail.house.gov

RE: Congressional Request for Information on the Medicare Access and CHIP Reauthorization Act (MACRA)

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

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to respond to the Request for Information (RFI) regarding the implementation of Pub.L.114-10, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), and associated payment mechanisms. Each year, as required by law, the Commission makes recommendations about appropriate payment levels under Medicare's physician fee schedule (PFS) in the upcoming year (e.g., 2023). Such recommendations are based on an evaluation of the adequacy of payments made to physicians and other health professionals under the PFS for care provided to beneficiaries enrolled in traditional fee-for-service (FFS) Medicare. Our evaluation uses an established framework that includes an examination of beneficiaries' access to care (measured by service use, the supply of providers, and Medicare beneficiaries' experiences accessing care), the quality of care they receive, and Medicare payments and providers' costs. These recommendations are based on our review of the latest available data and attempt to balance the need for payments that are high enough to ensure beneficiaries' access to high-quality care with the need to be a responsible steward of the Medicare program.

Beyond the Commission's work on payment adequacy, the Commission examines other issues related to the physician fee schedule and makes recommendations, as needed, to support efficient use of Medicare program resources while maintaining beneficiaries' access to high-quality services.

Our response to this RFI focuses on the Commission's most recent recommendations related to payment adequacy for physicians and other health professionals, the Merit-based Incentive Payment System, and advanced alternative payment models (A-APMs).

Summary of the current payment system for physicians and other health professionals

Prior to the enactment of MACRA, the sustainable growth rate (SGR) system governed payment updates under Medicare's PFS from 1999 to 2015. The SGR system determined annual payment updates using a formula that ensured that total spending would not increase faster than a target—a function of input costs, FFS enrollment, gross domestic product (GDP), and changes in law and regulation. Because annual spending generally exceeded these SGR parameters, payments to clinicians were scheduled to be reduced by ever-growing amounts starting in 2002. However, the Congress overrode these cuts in all but the first year they were scheduled.

MACRA repealed the SGR system, eliminating the negative updates, and established new statutory updates to the PFS's conversion factor (which determines payment rates). MACRA also established: (1) bonuses for clinicians who participate in A-APMs, such as accountable care organization models, through 2024, and (2) a Merit-based Incentive Payment System (MIPS) to make payment adjustments based on quality measure performance for clinicians who do not participate in A-APMs. Though we discuss these payments as if they go to clinicians, increasingly they go to the medical groups or health systems where the clinicians work. In 2021, payments for (or on behalf of) about 800,000 clinicians reflected a positive MIPS adjustment, and for about 200,000 clinicians Medicare paid the 5 percent A-APM bonus. In addition, hundreds of thousands of clinicians received no payment adjustment because they were exempt from MIPS (e.g., due to a low volume of Medicare patients), while about 3,000 clinicians (or their organizations on their behalf) received negative MIPS adjustments of up to -7 percent, primarily because they failed to report MIPS measures.¹

For 2023, MACRA specifies a 0 percent update to the PFS's conversion factor. Clinicians qualifying for the A-APM bonus under MACRA will receive a lump-sum payment equal to 5 percent of their annual Medicare payments under the PFS. For clinicians who do not qualify for the A-APM bonus under MACRA, CMS has some discretion in the design of the MIPS program, which has allowed CMS to maximize the number of clinicians who can qualify for positive MIPS adjustments (but has reduced the size of the maximum positive adjustments they can receive). For 2023, MACRA allows CMS to provide MIPS payment adjustments of between -9 percent and +9 percent (or higher) based on clinicians' performance on quality measures, but historically CMS has opted to impose small negative adjustments on a limited number of providers resulting in positive adjustments of less than 2 percent.² For example, in 2021, top performance on MIPS measures yielded a positive 1.79 percent MIPS adjustment, which is comparable to prior years' top MIPS adjustments.³ MACRA's annual 5 percent bonus for clinicians participating in A-APMs expires after 2024 but, beginning in 2026, MACRA specifies a 0.75 percent annual update to the PFS's conversion factor for clinicians in A-APMs and a 0.25 percent annual update to the conversion factor for clinicians in MIPS. Over time, the difference between payment rates for clinicians in

¹ Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

² Under MACRA, positive adjustments are allowed to exceed negative adjustments by \$500 million per year through 2024. Beginning in 2025, MIPS adjustments must be budget neutral, so any positive adjustments to payments for high performing clinicians will need to be fully offset by negative adjustments for poor performing ones.

³ Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

A-APMs and MIPS will grow. Since the PFS is used to pay clinicians who practice in a wide variety of clinical settings, using differential conversion factors to incentivize participation in A-APMs has the potential to encourage a variety of provider types to participate in A-APMs.⁴

The Commission's position on payment adequacy for clinicians

In our most recent analysis, using data from 2019, 2020, and 2021, we found that access to clinician services for Medicare beneficiaries appeared stable and comparable to (or better than) that for privately insured individuals. Beneficiary surveys and focus groups found that the vast majority of beneficiaries were satisfied with their care and did not experience difficulty accessing care. Over 90 percent of beneficiaries in our survey reported that they had a primary care provider. From 2015 to 2019, the number of clinicians billing the PFS grew relative to the size of the overall Medicare population, which suggests that clinicians had sufficient incentive to serve Medicare beneficiaries. However, in 2020, while the number of clinicians held steady, the ratio of clinicians to beneficiaries dipped slightly because of enrollment growth. Nevertheless, the share of clinicians billing Medicare who are enrolled in Medicare's participating provider program—meaning they accept PFS amounts as payment in full—remains very high, and the share of beneficiaries who report encountering a clinician who does not accept Medicare is extremely low.⁵

While we were unable to assess the quality of care due to both temporary changes in the delivery of care and data limitations unique to the coronavirus pandemic, analyses prior to 2020 have shown wide geographic variation in the rates of ambulatory care-sensitive hospitalizations and emergency department visits—hospital use that could have been avoided with appropriate, high-quality, and timely care in ambulatory settings—signaling opportunities to improve the quality of care that clinicians provide to beneficiaries.⁶

In terms of Medicare payments and providers' costs, after growing at an average annual rate of 2 percent from 2015 to 2019, FFS Medicare's allowed charges for clinician services per FFS beneficiary fell by 10.6 percent in 2020, due to care being postponed or forgone during the pandemic. As a result, Medicare spending on clinician services in 2020 was \$8.7 billion lower than it was in 2019. However, the Congress provided clinicians with tens of billions of dollars to offset pandemic-related revenue losses. This support contributed to an acceleration in national spending on clinician services across all payers, which climbed 5.4 percent in 2020 (up from 4.2 percent in 2019).

On the basis of our assessment of payment adequacy indicators, the Commission concluded that aggregate payments made under the PFS appeared adequate and recommended a 2023 payment update consistent with current law (0 percent).⁷ In December of this year, we will reassess indicators of the adequacy of Medicare payments to clinicians using the most currently available

⁴ Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

⁵ Medicare Payment Advisory Commission (2022). *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

⁶ Medicare Payment Advisory Commission (2022). *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

⁷ Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

data in the context of the recent acceleration in inflation (which is not automatically reflected in PFS updates, unlike in other fee schedules). Based on this assessment, in January 2023 we will make a recommendation regarding a payment update for PFS services for 2024. The recommendation will be published in our March 2023 report to the Congress.

Moreover, although we concluded last year that aggregate payments made under the PFS appeared adequate, the Commission has long been concerned about Medicare payments for primary care services such as ambulatory evaluation and management (E&M) visits. Our analyses indicate that these services have historically been underpriced in the PFS relative to other services. At the same time, the nature of PFS payment allows certain specialties to increase the volume of services they provide—and the payments they receive—more easily than primary care clinicians. These issues have contributed to substantial compensation disparities between primary care physicians and certain other specialists. Our analyses indicate that, from 2015 through 2020, the number of primary care physicians treating Medicare beneficiaries dropped from 141,000 to 135,000 (or from 2.8 to 2.4 physicians per 1,000 beneficiaries). Although the vast majority of Medicare beneficiaries we surveyed in 2021 reported having a primary care provider, about 3 percent of our survey respondents had looked for a new primary care provider in the past year and had trouble finding one.⁸

To help maintain an adequate supply of primary care clinicians, in our June 2018 report to the Congress, the Commission described a budget-neutral approach to rebalance the PFS by increasing payment rates for ambulatory E&M services while reducing payment rates for other services (e.g., procedures, imaging, and tests).⁹ Under this approach, the higher payment rates would apply to ambulatory E&M services provided by all clinicians, regardless of specialty, but primary care specialties would receive a substantial increase in their total PFS payments (on net). Subsequently, the Commission strongly supported CMS's proposal to raise the payment rates for E&M office/outpatient visits because this action is an important first step in addressing the long-term devaluation of these services.¹⁰ We also supported the implementation of this change in a budget-neutral manner, as specified by law, because doing so helps to rebalance the PFS from services that have become overvalued (e.g., procedures, imaging, and tests) to services that have become undervalued—thus improving payment accuracy.

Finally, in addition to supporting delivery of primary care, the Commission is concerned about the financial stability of clinicians who deliver a high proportion of care to beneficiaries with lower incomes, many of whom are dually enrolled in Medicaid. Our ongoing analyses have examined how Medicare might provide support to clinicians who serve this population because they often receive lower total payments due to state Medicaid policies, and potentially face higher costs to deliver care to these beneficiaries. While still under development, our approach to supporting safety-net clinicians could include targeting additional Medicare funds to support safety-net clinicians.

⁸ Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

⁹ Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

¹⁰ Medicare Payment Advisory Commission. 2020. Comment letter to CMS on the proposed rule on the physician fee schedule and other changes to Part B payment policies, October 2.

The Commission's position on MIPS

In March of 2018, the Commission concluded that for several reasons MIPS would not fulfill the goal of adjusting payment to clinicians based on the quality of care they provide, nor would it succeed as an incentive program designed to improve clinician practice patterns. We thus recommended that MIPS be eliminated.¹¹ The Commission did not reach this conclusion hastily. We examined options for improving MIPS as it was implemented, and we provided constructive feedback as CMS established rules for the first two years of the program. However, we maintain that the basic design of MIPS is fundamentally incompatible with the goals of a beneficiary-focused approach to quality measurement.¹² Indeed, many clinicians are not evaluated at all because, as individuals, they do not have a sufficient patient volume for statistically reliable scores under MIPS.

In lieu of MIPS, the Commission recommended creating a new clinician value-based purchasing program—a voluntary value program, or VVP—to take its place.¹³ The VVP is based on the premise that patient outcomes rely on the combined contributions of multiple clinicians involved in a patient's care, and emphasizes that quality improvement is a collective effort. A VVP would reorient incentives so that all clinicians (of all specialties) would face an incentive to improve population-based outcomes and would be measured based on the same set of measures: clinical quality, patient experience, and value. Since these measures assess the health care of a population, the program would encourage clinicians to address care across time and across settings. Three important features distinguish the Commission's VVP from MIPS including:

- Clinicians would be eligible to receive a payment adjustment at a voluntary group level. A VVP would require only minimal administrative structure (clinicians would elect to be measured as a voluntary group).
- These voluntary groups would be assessed on a uniform set of population-based measures that align with the Commission's quality principles.
- Clinicians would no longer need to report quality data to Medicare because all measures would be calculated by CMS from claims and surveys.¹⁴

Using claims-calculated and centrally administered survey information to calculate performance would be much less administratively burdensome than the current MIPS program is today. Under a VVP, CMS could (through annual rulemaking) modify the measures, scoring, or payment adjustment calculation without requiring clinicians to change their reporting process. Thus, this approach would be flexible, allowing Medicare to react in a timely way to changes in clinical

¹¹ Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

¹² Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

¹³ Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

¹⁴ Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

practice, input from stakeholders, and the needs of the Medicare population. Relying on claims-based measures would remove a significant, demonstrable cost and time burden of clinician reporting. Further, using a uniform set of measures would remove the incentive for clinicians to measure (and report on) things they do well, instead of areas of quality needing improvement. Infrastructure requirements for a VVP are minimal; that is, clinicians would only need to elect to be measured as a voluntary group. However, if groups then wished to substantively improve performance, they would likely need to make additional investments to achieve that goal. The program could be designed to emphasize the role of all clinicians in quality improvement and to align incentives for providers across the Medicare FFS delivery system as well as with A-APMs.

The Commission's position on A-APMs

The Commission has been interested in the development of A-APMs as an alternative to FFS payments. Research has found that many A-APMs generated gross savings for the Medicare program before model payments (e.g., performance bonuses) were taken into account, suggesting they have the potential to change provider practice patterns.¹⁵ The actual effects of these models are hard to measure because providers can participate in multiple A-APMs simultaneously, and Medicare beneficiaries can be treated by providers participating in multiple models at the same time. In addition, providers participating in multiple models may face conflicting incentives. As a result, the Commission recommended that the Secretary implement a smaller, more harmonized portfolio of A-APMs that are designed to work together to support the strategic objectives of reducing spending and improving quality.¹⁶ Operating a smaller portfolio of more harmonized models, with more consistent parameters and clearer and more aligned incentives, should more successfully encourage providers to furnish care efficiently across the continuum of care, which could, in turn, decrease Medicare spending.

In 2022, the Commission continued to discuss options that CMS should consider when implementing A-APMs, including implementing a simplified population-based payment model that reduces the number of accountable care organization (ACO) model tracks and implementing a mandatory national episode-based payment model for certain types of proven clinical episodes.¹⁷ For beneficiaries concurrently attributed to the episode-based payment model and the population-based payment model, the Commission suggested that CMS allocate episode bonus payments so that (1) episode-based providers have an incentive to furnish efficient, high-quality care, (2) providers in ACOs have an incentive to refer their attributed patients to low-cost, high-quality episode-based providers, and (3) when combined, these incentives are not so large that they increase total Medicare spending.

The Commission also discussed ways to strengthen incentives for providers to participate in this simplified population-based payment model. The Commission proposed that ACOs' spending targets ("benchmarks") not be rebased every few years based on actual spending; instead, benchmarks could be updated using exogenous administrative growth factors that would be known

¹⁵ Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

¹⁶ Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

¹⁷ Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

to ACOs in advance.¹⁸ Moving away from rebasing would ensure that ACOs that succeed in lowering their spending are not penalized in subsequent years by having their benchmark “ratcheted” down based on their recent actual spending. Ideally, a growth factor would be chosen to produce benchmarks that increase fast enough to give participating providers a reasonable chance to earn shared savings payments, but slow enough to give the Medicare program a high probability of realizing net savings (relative to what Medicare would have spent in the absence of this model), while avoiding significant forecasting errors. Recently, CMS requested input for an approach to updating benchmarks for ACOs participating in the Medicare Shared Savings Program in a manner not dissimilar from the approach outlined by the Commission.¹⁹

We appreciate the opportunity to provide feedback on these very important issues facing clinicians participating in the Medicare program. Please consider us a resource for any issue related to the Medicare program. If you have any questions regarding our comments or wish to discuss the Commission’s work on Medicare physician payment policies in greater detail, please contact James E. Mathews, MedPAC’s Executive Director, at 202-220-3700.

Sincerely,

A handwritten signature in black ink, appearing to read "m. chernew", with a long horizontal line extending to the right from the end of the signature.

Michael E. Chernew, Ph.D.
Chair

¹⁸ Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

¹⁹ Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2022. Medicare and Medicaid programs; CY 2023 payment policies under the physician fee schedule and other changes to Part B payment policies; Medicare Shared Savings Program requirements; Medicare and Medicaid provider enrollment policies, including for skilled nursing facilities; conditions of payment for suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS); and implementing requirements for manufacturers of certain single-dose Container or single-use package drugs to provide refunds with respect to discarded amounts. Proposed rule. *Federal Register* 87, no. 145 (July 29): 45860–46843.