June 27, 2024

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

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

The Honorable Jason Smith
Chair
House Committee on Ways and Means
1139 Longworth House Office Building
Washington, DC 20515

The Honorable Richard Neal
Ranking Member
House Committee on Ways and Means
1129 Longworth House Office Building
Washington, DC 20515

The Honorable Cathy McMorris Rodgers
Chair
House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
House Committee on Energy and Commerce
2322A Rayburn House Office Building
Washington, DC 20515

Re: Value-Based Care Stakeholder Recommendations to Improve Physician Payment

Dear Chairman Wyden, Chairman Smith, Chairman McMorris Rodgers, Ranking Member Crapo, Ranking Member Neal, and Ranking Member Pallone:

The undersigned organizations thank you for your leadership in seeking solutions to bolster patient care through physician payment reforms. As the committee works to meet the needs of Medicare enrollees, we ask that you prioritize measures to advance value-based care.

Value-based payment enables physicians and other health care providers to deliver high-quality, well-coordinated, cost-effective care. These payment reforms have generated more than $22 billion in gross savings for Medicare over the past decade and improved the quality of care for millions of patients. However, ongoing support is needed to help physicians and other health care providers transition to, remain in, and succeed in value-based payment models.

The advanced alternative payment models (AAPMs) incentive payments provision of the Medicare Access and CHIP Reauthorization Act of 2015 have helped physicians and other health care providers cover the investment costs of moving to new payment models, provided the financial resources to expand care teams, enabled adoption of population health infrastructure, and aided clinicians in providing services beyond those typically covered by traditional Medicare. These incentives, however, are currently scheduled to end with the 2024 Performance Year. Unless the bonuses are extended – and in tandem with the downward pressures on Medicare physician fees – practices will have less in financial resources to manage complex patients and innovate in the provision of care.

We appreciate that Congress passed legislation that mitigated severe Medicare payment cuts and extended the AAPM incentives. However, it is critical to avoid annual stop-gap measures that create uncertainty for physicians and other health care providers. We ask that you consider the following recommendations:

Extend AAPM Incentives.
We urge the committee to provide a multi-year commitment to reforming care delivery by supporting the Value in Health Care Act (S. 3503/ H.R. 5013), which would extend the AAPM incentives for two years and freeze qualifying thresholds. Doing so would provide more certainty for physicians and other health care providers in AAPMs and recruit new participants into them. The committee should also consider solutions to reduce the current two-year lag between each performance year and the subsequent payment year and develop safeguards to ensure that the fee schedule's differential conversion factor updates do not adversely affect the ability of AAPM participants to meet their annual benchmarks. The current AAPM incentive payments are not included in calculations for the purposes of rebasing APM benchmarks nor are they counted as expenditures. AAPM participants are concerned that, under current law, AAPM qualifying participants (QPs) who receive the higher 0.75 percent conversion factor update beginning in Payment Year 2026 may be unable to reduce spending below benchmarks.

Sustaining Physician Payment.
Medicare's existing physician payment system has resulted in payment cuts in recent years. Failing to adequately adjust payments in line with rising costs results in fewer resources to manage complex patient needs. To ensure that patients continue to have adequate access to care and that clinicians have the resources to continue investing in value-based care initiatives, the committee should pursue long-term reform options. One example is the Strengthening Medicare for Patients and Providers Act (H.R. 2474), which provides a permanent annual update equal to the increase in the Medicare Economic Index (MEI). This critical adjustment would allow practices to invest in new strategies to advance high-value, patient-centered care.

Provide More Opportunities for Physicians and Other Health Care Providers to Engage in APMs.
Over the past decade, the Centers for Medicare and Medicaid Innovation (CMMI) has advanced multiple successful models focused on improving care for patients, while addressing Medicare costs. While population health models have seen encouraging growth and positive results, only a few of the models tested have subsequently been expanded or extended, a reality that can create significant uncertainty for participants and make them hesitant to invest in new payment models. To date, there has also been insufficient model development for all types of physicians and other health care providers.

We believe there are opportunities to provide a broader, more predictable pathway for more types of physicians and other health care providers to engage in APMs. Congress should work with CMMI to ensure that promising models have a more predictable pathway – both for initial implementation and for permanent adoption into Medicare – rather than being cut short due to overly stringent criteria. To accomplish these goals, Congress should do the following:

- Direct CMS and CMMI to focus on filling the current gaps in APM opportunities for medical specialties, safety net, rural, small, and other practices that, to date, have struggled to join APMs due to high entry barriers or simply because there is no clinically relevant model available.
- Broaden the criteria by which CMMI models qualify for expansion based on enhancing the quality of patient care or access to care, rather than making expansion contingent on achieving the short-term cost savings. For example, CMMI should be instructed to consider whether a model effectively expands participation to more physician and other health care provider types or offers enhanced benefits and services to beneficiaries.
- Direct CMMI to engage stakeholder perspectives during APM development. For example, CMMI could ask the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to review models under development by the Center and set priorities for model development.

Additionally, CMMI should make more data available so that stakeholders can develop models that have a higher likelihood of producing actuarial savings. CMS should also engage stakeholders early on and throughout its own development of models. This will improve the clinical relevance of models and cut down on the near constant churn of model re-designs, which hinders participation.

- Direct CMS to improve its evaluation strategies by providing more data on the effectiveness of specific innovations and waivers and better controlling for other variables such as complications due to model overlap.

We thank you for your leadership on these important issues. Our organizations look forward to working with the committee to develop legislative solutions that will improve Medicare's payment system.

Sincerely,

America's Physician Groups
American Medical Association
Health Care Transformation Task Force
National Association of ACOs
Premier Inc.
Accountable for Health
American College of Physicians
AMGA
Association for Clinical Oncology
Association of American Medical Colleges
Medical Group Management Association
National Rural Health Association
Partnership to Empower Physician-Led Care