AMA
AMERICAN MEDICAL ASSOCIATION

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June 21, 2023

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 Energy and Commerce Committee
2322 Rayburn House Office Building
Washington, DC 20515

The Honorable Morgan Griffith
Chair
House Committee on Energy and Commerce
Subcommittee on Oversight and Investigation
2202 Longworth House Office Building
Washington, DC 20515

The Honorable Kathy Castor
Ranking Member
House Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
2322 Rayburn House Office Building
Washington, DC 20515

Dear Chair McMorris Rodgers, Chair Griffith, Ranking Member Pallone, and Ranking Member Castor:

On behalf of the physician and medical student members of the American Medical Association (AMA), I commend the Committee on Energy and Commerce Subcommittee on Oversight and Investigations for holding a hearing on the Medicare Access and CHIP Reauthorization Act (MACRA) entitled, "MACRA Checkup: Assessing Implementation and the Challenges that Remain for Patients and Doctors." The AMA recognizes the importance of evaluating the implementation of MACRA and understanding the challenges faced by patients and physicians. Reforming the Medicare Physician Payment System (MPS) continues to be one of the AMA's top advocacy priorities as physicians from every state and specialty have expressed intense frustration with the current MPS and its lack of positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs. Without systemic reforms, the current physician payment system will continue to drive private practices out of business.

The AMA is deeply alarmed about the growing financial instability of the MPS due to a confluence of fiscal uncertainties physician practices face related to statutory payment cuts, lack of inflationary updates, the ongoing negative impact of the pandemic, and significant administrative barriers. The MPS is on an unsustainable path that is jeopardizing Medicare patient access to physicians.

The AMA is working with our national specialty and state medical association Federation partners to determine the best path forward to lead the MPS to a more sustainable track. The AMA, along with our Federation partners, also developed the Characteristics of a Rational Medicare Physician Payment System, endorsed by over 120 state medical and national specialty societies, including those representing primary care, surgical care, and other medical specialties. This core set of principles serves as the basis for reforming the broken physician payment system.

From these principles, the AMA has implemented a comprehensive strategy to address the challenges in Medicare physician payment. This strategy involves a series of key recommendations aimed at improving

the system and reflects the AMA's commitment to improving Medicare physician payment and ensuring sustainable, high-quality health care delivery for our patients.

The AMA's specific recommendations for Medicare physician payment reform are as follows:

- End the MACRA mandated six-year freeze on physician payment updates and pass H.R. 2474 to establish a stable, annual Medicare physician payment update that keeps pace with inflation and the cost of practicing medicine.
- Modify statutory budget neutrality requirements by establishing a look-back period to remedy overestimates and underestimates of spending based on actual claims data, refining which services are subject to budget neutrality, and increasing the trigger for budget neutrality adjustments;
- Improve Merit-based Incentive Payment System (MIPS) by allowing greater flexibility to set MIPS criteria, ensuring physicians have access to actionable data, and streamlining and fine-tuning measures and methodologies; and
- Extend the five percent APM participation incentive payments for at least two years, as well as halt the revenue threshold increase, which will have a chilling effect on participation, to encourage more physicians to transition into APMs.

We address each of these in greater detail below in the following order: 1) Need for Medicare Physician Payment Reform; 2) Status of MIPS: statutory refinements are necessary; and 3) How to increase provider participation in value-based payment models.

## Need for Medicare Physician Payment Reform

### 1. Establish a permanent, annual inflationary based update to physician payment

MACRA repealed the Sustainable Growth Rate (SGR) and instituted significant reforms to Medicare by shifting the program's approach to physician payment—paying physicians and other health professionals based on quality and value. Unfortunately, MACRA froze physician payment rates for six years, from 2019 through 2025, at which point updates resume at a rate of only 0.25 percent a year indefinitely, a rate well below the medical or consumer price index and the rising costs facing physician practices.

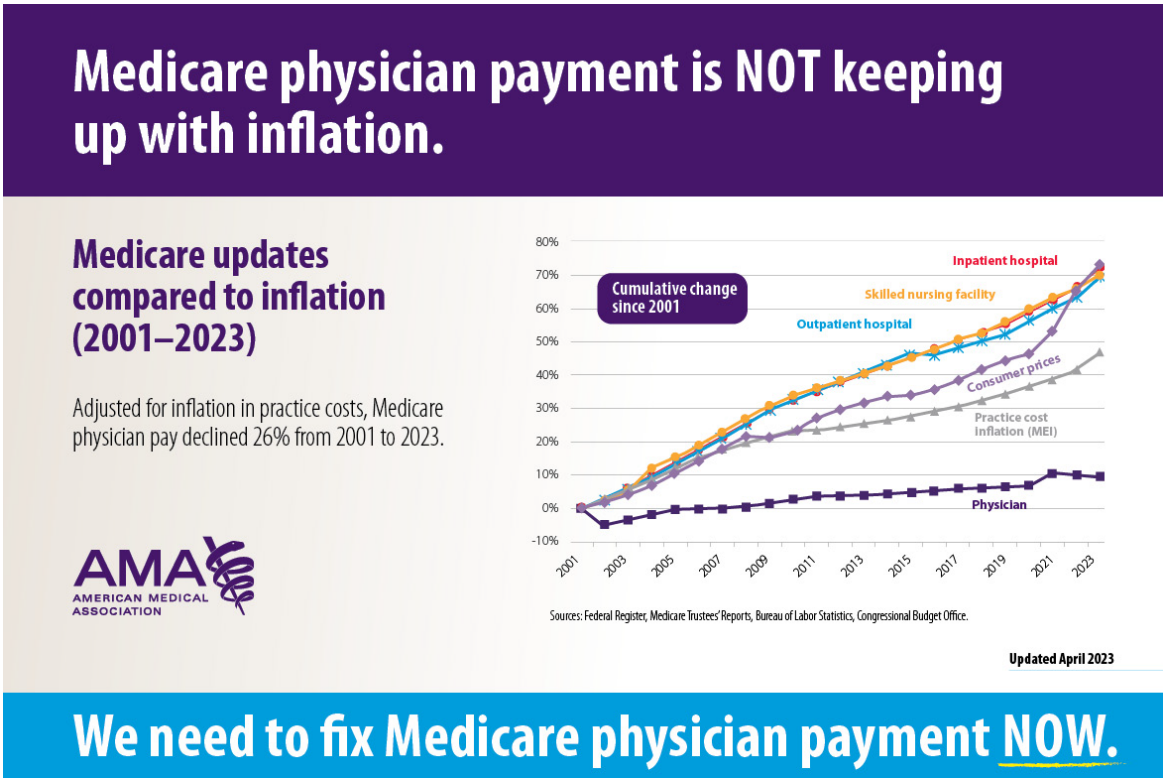
The physician community stands ready to work with Congress to develop long-term solutions to the systemic problems with the MPS in order to preserve patient access to care. The AMA commends Representatives Ruiz, Bucshon, Bera and Miller-Meeks for introducing H.R. 2474, the Strengthening Medicare for Patients and Providers Act. The legislation applies a permanent inflation-based update to the MPS conversion factor, which will provide much-needed stability to the Medicare payment system as our members contend with an increasingly challenging environment providing Medicare beneficiaries with access to timely and quality care. Passing H.R. 2474 is essential to enable physician practices to better absorb payment distributions triggered by budget neutrality rules and periods of high inflation.

We also appreciate that Congress, in the Consolidated Appropriations Act, 2023, mitigated a 4.5 percent cut to Medicare physician payment in 2023, but physicians still faced a two percent pay cut in 2023 and at

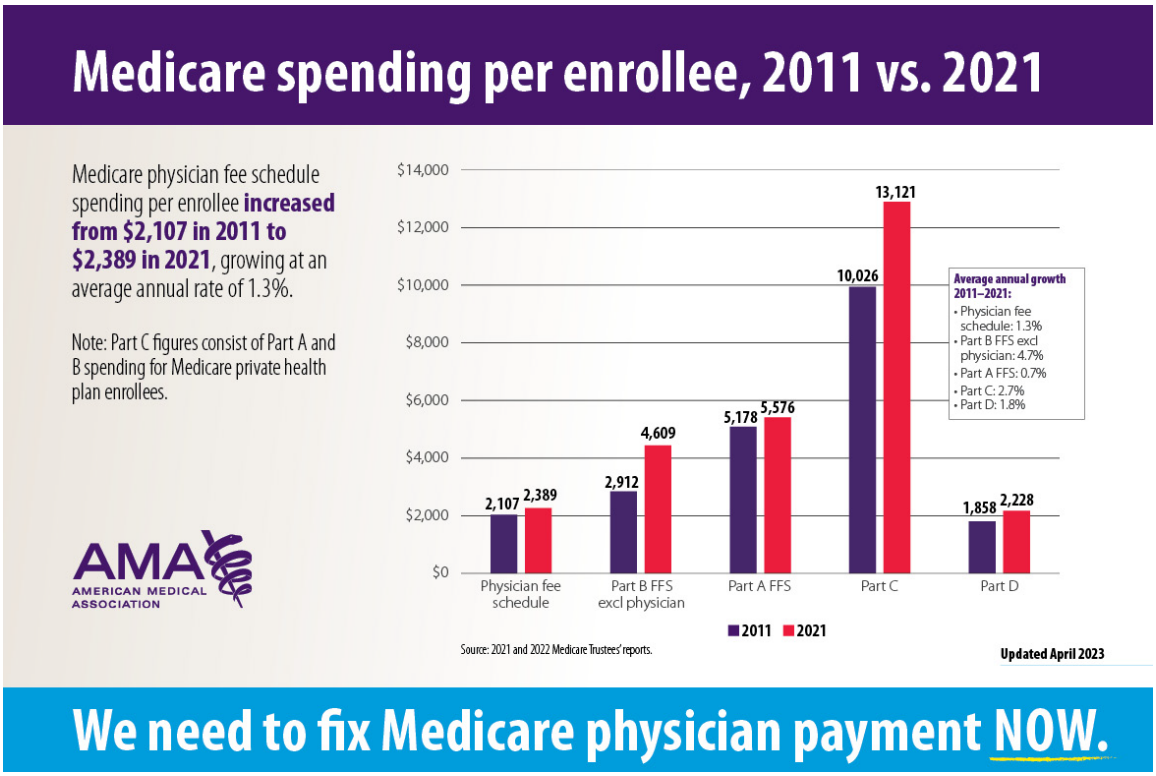
least 1.25 percent in 2024. Although Congress has taken action to mitigate some of the recent MPS cuts on a temporary basis, payment rates will continue to decline.

In the 2023 Medicare Trustees Report, the trustees warned that they expect access to Medicare-participating physicians to become a significant issue in the "long term" unless Congress takes steps to bolster the payment system. "In addition, the law specifies the physician payment updates for all years in the future, and these updates do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases," the report said. The Medicare Trustees report followed a Medicare Payment Advisory Commission (MedPAC) recommendation that Congress increase 2024 Medicare physician payments above current law by linking the payment update to the MEI, something the AMA has long supported.

Adjusted for inflation in practice costs, Medicare physician payment declined 26 percent from 2001 to 2023. This is particularly destabilizing as physicians, many of whom are small business owners, contend with a wide range of shifting economic factors when determining their ability to provide care to Medicare beneficiaries. Additionally, Medicare payment rates for nearly all Medicare services except those on the physician payment schedule, such as inpatient and outpatient hospital services and skilled nursing facility services, have updates tied to inflation. Physician payment rates have been further eroded by the manner in which rates are adjusted to meet budget neutrality requirements, as well as Medicare sequestration.

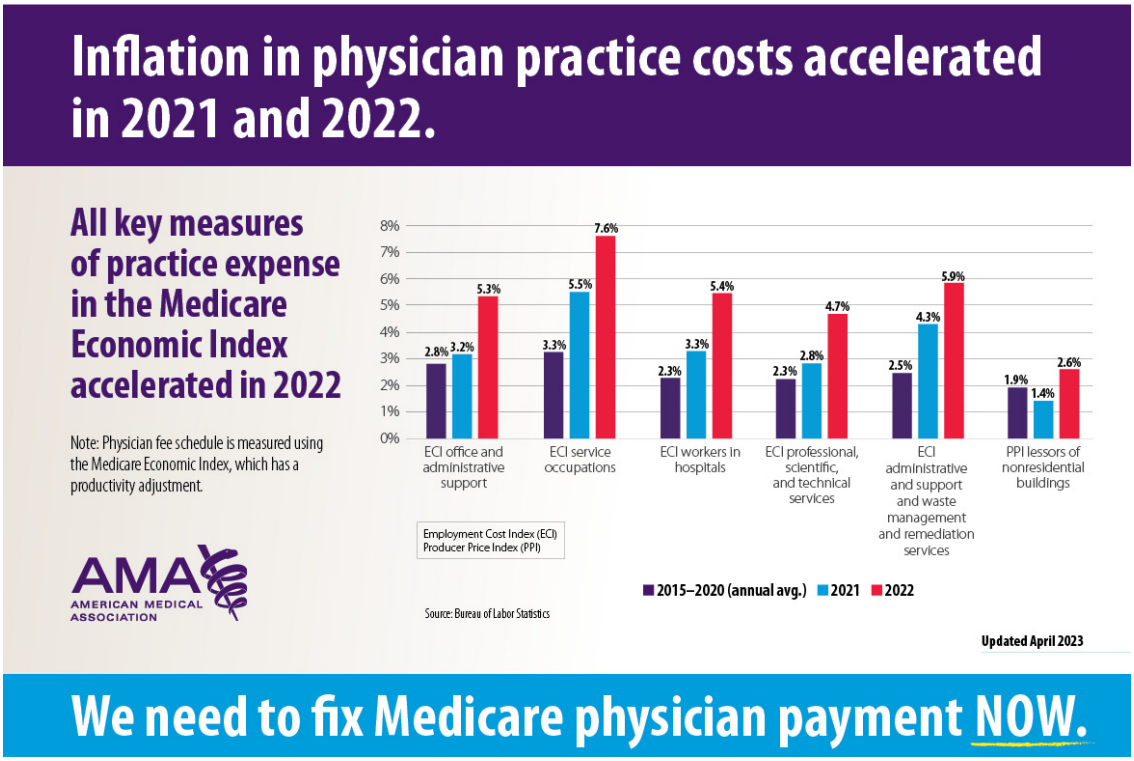


In addition, Medicare spending per enrollee has been nearly flat for a decade for physician payment schedule services even as it has risen steeply for other Medicare benefits.




Current government data on key elements of the MEI make it clear that, without an inflation-based update, the gap between frozen physician payment rates and rising inflation in medical practice costs will widen considerably.

Employment Cost Index (ECI) and Producer Price Index (PPI) data from the U.S. Bureau of Labor Statistics indicate that growth in key contributors to the MEI is much higher now than in previous years, which threatens to significantly widen this gap.




**Recommendation: Congress must pass H.R. 2474 to establish a stable, annual Medicare physician payment update that keeps pace with inflation and practice costs and allows for innovation to ensure Medicare patients continue to have access to physician practice-based care.** We look forward to working with Congress to ensure passage of H.R. 2474 and continue conversations around further payment reform to ensure America's seniors continue to receive access to the high-quality care they deserve.

2. **Address Budget Neutrality**

CMS actuaries have on occasion grossly overestimated the impact of Relative Value Units (RVUs) changes in the fee schedule, resulting in permanent removal of billions of dollars from the payment pool. For example, a previous administration based the 2013 budget neutrality offset for Transitional Care Management (TCM) on a significantly greater estimate of initial utilization of the service than what actually occurred. At that time, CMS estimated there would be 5.6 million claims for TCM when actual utilization was just under 300,000 the first year and still less than one million after three years of implementation. Unfortunately, the damage was already done. For 2013, CMS reduced Medicare physician fee schedule spending by more than $700 million based on its overestimate of TCM utilization, and by 2021, Medicare physician payments had been reduced by $5.2 billion more than they should have been as a direct result of overestimation of this code alone. Similarly, CMS overestimated Chronic Care Management (CCM) utilization when adopting that code one year later (4.7 million estimated claims versus 954,000 in the first year). The overestimates of the utilization for TCM and CCM and the budget neutrality adjustments resulted in permanent reductions in MPS payments, disadvantaging physicians.

**Recommendation: Congress should require a look-back period (as has been implemented in other payment systems) that would allow CMS to correct for overestimates and return inappropriately reduced funding back to the payment pool.**

Importantly, the $20 million threshold that establishes whether RVU changes trigger budget neutrality adjustments was also established in 1989—three years before the MPS took effect. Since then, there have been no adjustments for inflation.

**Recommendation: Congress should increase the budget neutrality threshold to $100 million to better account for past and future inflation.**

Finally, the physician community is concerned that budget neutrality adjustments could be applied based on changes in the MPS that directly result from changes in law or regulations or updates to elements of direct practice costs used in the determination of relative values and practice expense components. These categories of potential changes to spending under the MPS should be exempt from future budget neutrality adjustments:

- Newly covered Medicare services (e.g., A&B scores from the United States Preventive Services Task Force related to preventive services, new types of facilities or health professional services added to the MPS);
- Services that are being incentivized (e.g., physician bonuses, or no patient copay to encourage uptake of preventive services);
- Services specifically designed to be used within an APM that are already intended to lower Medicare expenditures;
- Benefit or access expansions;
- New technology; and
- Updates to direct practice costs used in the determination of relative values and practice expense components.

Many of these benefit categories are high value services designed to improve patient care but adding them to the fee schedule negatively impacts payment for all Medicare services due to current budget neutrality requirements.

**Recommendation: Congress should exempt from budget neutrality requirements certain high-value benefits or services for which utilization is expected to increase due to direct changes in law or regulations, including (but not limited to) those listed above.**

**<u>Status of the Merit-based Incentive Payment System (MIPS): Statutory Refinements are Necessary</u>**

Since the enactment of MACRA, the AMA has worked closely with Congress and CMS to promote a smooth implementation of MIPS. We supported MACRA's goals to harmonize the separate, burdensome, and punitive Meaningful Use, Physician Quality Payment System, and Value-Based Payment Modifier programs. However, eight years after passage of MACRA, there is a growing body of literature finding that MIPS has resulted in adverse outcomes, including harming small, rural, independent practices and exacerbating health inequities. Worse, a new study found MIPS is no better than chance at distinguishing between high- and low-quality care. We have serious concerns that this flawed program will increasingly

penalize physicians up to -9 percent of Medicare payments, particularly on the heels of the COVID-19 pandemic and when physicians must absorb the highest costs in recent history despite the lack of an inflationary update. For these reasons, statutory refinements to MACRA are urgently needed to achieve the goals of MIPS to improve quality care, reduce costs, and harness health information technology to these aims, while reducing undue administrative burden that contributes to physician burnout and waste in the health care ecosystem.

The AMA is working closely with national specialty and state medical societies to finalize a short list of recommendations to remove statutory impediments to get closer to achieving the goals of MACRA to move toward value-based care while reducing administrative burden on physicians. Foremost among these changes must be greater flexibility for the Secretary to set MIPS requirements based on current data and circumstances, an enforcement mechanism to ensure implementation of MACRA's data sharing requirements, and technical refinements to improve MIPS measures and methodologies with a focus on improving patient outcomes while reducing burden.

1. **The COVID Impact**

To mitigate the impact of COVID-19, CMS has implemented significant flexibilities and hold harmless policies in MIPS from 2019 through 2023. The AMA strongly advocated for and supported policies to hold physician practices harmless from penalties as physicians cared for patients with COVID-19 during multiple surges, postponed non-essential procedures, and transitioned to telehealth when feasible. While we supported these much-needed flexibilities, it means that MIPS was disrupted for five years and there is currently no flexibility in statute to allow for a glide path to reengaging in the program as physicians recover from the pandemic, face staffing shortages, and try to absorb the rising costs of practicing medicine. These extraordinary headwinds could not have been foreseen when MACRA passed in 2015. The AMA greatly appreciates that CMS extended the hardship exception policy due to COVID-19 in 2023. However, during this five-year freeze, the statutory and regulatory requirements to comply with MIPS have continued to increase. As a result, the performance threshold to avoid a penalty has more than doubled and the MIPS penalty also increased from four percent to as much as -9 percent of total Medicare physician payment. When the MIPS requirements were originally set to resume in 2023, CMS estimated one-third of all MIPS eligible clinicians would receive a penalty. When the COVID-19 flexibilities end in 2024, we can expect an even greater number of MIPS eligible clinicians will be penalized because the performance thresholds, data completeness requirements, and measure benchmarks will be even higher. We know from the research that MIPS penalties are disproportionately likely to impact small, rural, independent, and safety net practices.

How will these practices continue to see Medicare beneficiaries and keep their lights on when they have only begun to recover from the financial hardships of COVID-19 and face rising costs, due to substantial staffing problems and higher supply costs while facing a nearly 10 percent cut to their Medicare payments?

**Recommendation: Congress must afford the Secretary more flexibility to set MIPS performance thresholds based on current data and circumstances, rather than a rigid, preset formula.**

2. **Lack of Timely, Meaningful Data**

Physicians and specialty societies need timely access to their claims data analysis to identify patterns or variations in quality outcomes and spending. Moreover, the MACRA statute requires CMS to provide physicians with timely feedback about their MIPS performance, as well as access to their raw claims data. Despite this, CMS currently provides physicians with a single annual MIPS Feedback Report that includes information about their performance on MIPS metrics from six to 18 months after they have provided a service to a Medicare patient. For example, the first MIPS Feedback Report that physicians received for services they provided anytime in 2021 was August 2022. CMS has also made no attempt to grant physicians access to their claims data.

Taking cost measures as another example, CMS calculates up to 25 cost measures for each physician using Medicare claims data. Physicians do not know either at the time they provide services or at any point during the performance year how they are performing on any of these measures that collectively account for 30 percent of their total MIPS score, including which cost measures they will be measured on, which patients are attributed to them, and for what costs or services provided by other health professionals or facilities outside of their own practices they will be held accountable.

Without this critical information, physicians have no way to monitor their performance, identify opportunities for efficiencies in care delivery, and avoid unnecessary costs. This is not due to a lack of interest in the information. Physicians have repeatedly urged CMS to share more frequent and actionable data.

Physicians who do not receive timely information, which is used to improve care for their patients, identify and reduce avoidable costs, and monitor their performance in MIPS, should not be subject to a penalty of up to -9 percent of their Medicare payment. Congress in MACRA established a MIPS program in which data flows bi-directionally between physicians and CMS. Physicians would share their quality, cost, health IT, and practice improvement data with CMS, while CMS would share comparisons of their performance against benchmarks and claims data to inform physicians about the types of care that their patients receive outside of their practice, such as in emergency departments or other specialty practices. Yet, this is not how the program functions today. Physicians receive stale MIPS feedback that cannot be used to improve their performance and never receive claims data to better inform their quality and cost decision-making. Congress can solve this problem by enforcing the data sharing provisions in MACRA.

**Recommendation: To improve the timeliness and usability of MIPS data, we urge Congress to exempt from MIPS penalties any physician who does not receive at least three quarterly MIPS feedback reports during the performance period.**

### 3. MIPS Technical Refinements Needed

There is mounting evidence that the MIPS program, as implemented, is causing significant burden; raising costs for physician practices; further disadvantaging small, independent, and rural practices; and exacerbating health inequities. Worse, new research finds that MIPS may be totally divorced from clinical outcomes. Below is a summary of some of the key problems with the program that have been uncovered since MACRA's 2015 implementation:

- **MIPS is about as effective as chance at identifying high- and low-quality care.** A 2022 study in *JAMA* found that MIPS scores are inconsistently related to performance.

- **MIPS is administratively burdensome and costly.** Researchers found it costs $12,811 and 201 hours per physician, per year to comply with the complex and ever-changing MIPS requirements, and, on average, physicians themselves spent more than 53 hours per year on MIPS-related tasks. These 53 hours are equivalent to a full week of patient visits.

- **MIPS disadvantages small and independent practices.** According to a study in *JAMA*, MIPS eligible clinicians affiliated with a health system were associated with significantly better 2019 MIPS performance scores.

- **MIPS exacerbates health inequities.** According to a study in *JAMA* that looked at the first year of MIPS, physicians with the highest proportion of patients dually eligible for Medicare and Medicaid had significantly lower MIPS scores compared with other physicians. Another 2022 *JAMA* study found that physicians caring for more medically and socially vulnerable patients were more likely to receive low scores despite providing high-quality care. These studies suggest that MIPS may penalize physicians for social factors outside of their control and, due to budget neutrality requirements, transfer resources from those caring for poorer patients to those caring for more affluent patients. This is called the reverse Robin Hood effect.

- **Rural and medically underserved practices participating in MIPS.** According to a Government Accountability Office (GAO) report, physicians in rural and medically underserved areas face several barriers to participating in MIPS, including lack of technology; lack of vendor support and high costs of ongoing investments needed for participation, staffing shortages, and challenges staying abreast of program requirements. According to another GAO report, similar challenges limit rural practices' ability to transition to APMs, meaning they are largely stuck in MIPS.

Since the passage of MACRA, the AMA has made numerous recommendations to CMS to make MIPS more clinically relevant and less burdensome, including in letters, town halls, and meetings with CMS staff. We have made progress where CMS has statutory authority and flexibility, such as increasing the low-volume threshold or reducing the total number of required measures in the forthcoming MIPS Value Pathways (MVPs), which aim to hold physicians accountable for the quality and cost during an episode of care, around a specific condition, or for a public health priority, once represented an opportunity for improvement. Unfortunately, due to statutory barriers, MVPs are repeating many of the same mistakes as the traditional MIPS program.

However, we have run into statutory roadblocks when we have recommended more impactful improvements to MIPS. Several of these statutory constraints in MACRA stem from the statute's hyper specificity and lack of flexibility for CMS to respond to ongoing circumstances, such as the COVID-19 pandemic. Physicians agree that Congress must amend MIPS to allow a more flexible approach to achieve the program's original aim of incentivizing quality improvements and reducing unnecessary costs, while addressing the clear inequities the program has created and reducing the unnecessary burden that has

evolved due to the siloed nature of the program's design. **The check-the-box requirements and zero-sum nature of the existing MIPS program doom it to failure.**

Accordingly, the AMA recommends the following statutory changes to give CMS greater flexibility to incentivize movement away from a check-the-box compliance program toward one that supports changes in care delivery to improve patient outcomes and reduce unnecessary costs and creates a more effective glidepath to widespread participation in APMs and to help MACRA fulfill its goal of increasing value in the U.S. health care system:

- **Recommendation: Alleviate the tournament model in MIPS by reducing penalties and using those funds to incentivize investments in value-based care.** MIPS' current design pits practices against one another, putting practices with fewer resources such as small, rural, independent, and safety net practices at a disadvantage, and limits CMS' ability to incentivize practices to test new measures or participation options that could help improve the program, such as a new payment pathway that could serve as a bridge to alternative payment model participation.

- **Recommendation: Remove overly prescriptive requirements in the Cost Performance Category,** including holding physicians accountable for costs outside of their control and requiring CMS to capture half of all Medicare Parts A and B costs, which results in measures that meet this requirement without regard to whether they result in adverse consequences, such as patient access problems, or align with high-quality care.

- **Recommendation: Recognize the value of clinical data registries and other promising new technologies** by allowing physicians to meet the Promoting Interoperability requirements via attestation of using certified electronic health record technology (CEHRT) or technology that interacts with CEHRT, participation in a clinical data registry, or other less burdensome means.

- **Recommendation: Streamline and align the four performance categories together as appropriate and award cross-category credit for measures activities that are applicable to multiple categories** (e.g., participation in a clinical data registry), rather than requiring separate reporting and using separate scoring methods in four siloed components of MIPS, which adds burden and inhibits practices' abilities to achieve progress towards aligned value-based performance goals.

- **Recommendation: Create scoring flexibility for new or significantly refined measures, benchmarking approaches, or participation options**, such as MVPs, to facilitate continued improvement of the MIPS Program.

**How to increase physician participation in value-based payment models**

1. **Need for Expanded Opportunities for APM Participation**

CMS adoption of new nationwide voluntary alternative payment models to date has been slow. While the AMA is encouraged by the recent announcement of the Making Care Primary (MCP) Model, there are still limited details available, and a new model in eight states is not enough to solve the problem. This dearth of models to date means there are no APMs available for many of the conditions, episodes of care,

or patient populations that many physicians manage. There is also still no nationwide Medicare primary care medical home model.

Like the MIPS program, too often APMs are designed in ways that only allow practices that are part of large health systems to participate and succeed. Financial risk requirements are too steep and administrative requirements are difficult for small and medium size practices to fulfill. The AMA has long emphasized the importance of an onramp to risk and upfront payments to practices with fewer resources to support the up-front costs of transitioning to an APM, such as building out the necessary personnel infrastructure and investing in health information technology. We have also emphasized the importance of model payment structures that allow for greater flexibility in the way services are delivered by supporting hybrid models that blend in-person and virtual services. MCP, which takes effect in July 2024, will be a step in the right direction but there is still a long way to go.

Another specific void to date has been the lack of specialty-focused models. The AMA has developed a method for incorporating specialty care coordination within an Accountable Care Organization (ACO) model called the Payments for Accountable Specialty Care (PASC) Model. Under PASC, a specialist would receive an enhanced payment for delivering specific types of services to patients who are referred by primary care physicians participating in the ACO. Agreements between specialists and ACOs would describe how the specialist would use these enhanced payments to improve outcomes and/or reduce avoidable spending. Health equity would also be improved by providing higher payments to help support care for patients who have complex conditions or who are at higher risk for poor outcomes due to health-related social needs or other factors.

In addition, the APMs that have been implemented often do not really address the barriers in the current payment system. One of the most promising reasons for physicians to participate in an APM is because APMs can give them the ability to deliver higher-quality care to their patients than is possible under current payment systems by paying for the kinds of high-value services that improve outcomes and reduce unnecessary spending. Unfortunately, many existing models fail to fully recognize this potential because they are too narrowly focused on scope or timeframe. For example, certain episode-focused models begin after a patient has been admitted to the hospital or started chemotherapy but do not include support for physicians to prevent hospitalizations in the first place by better managing chronic conditions in outpatient settings. Medicare APMs should include payments for currently non-reimbursed care coordination and patient support services and funding for transitional care costs so that physicians can implement better approaches to care delivery. For example, many patients who come to an emergency department with symptoms, such as chest pain or syncope, could return home instead of being admitted to the hospital if the emergency physician could be sure the patient would receive the necessary assistance to return home safely, and that the patient would receive prompt follow-up care from a primary care physician. Medicare does not pay emergency physicians for the time needed to: locate the patient's primary care physician and develop a coordinated discharge plan; help identify community-based health and social services for the patient; or hire a nurse or community health worker to help the patient return home safely. As a result, the only safe option may be for the emergency physician to admit the patient to the hospital.

The American College of Emergency Physicians developed an APM proposal to fix this problem by paying for these discharge planning and transitional care services. Although the proposal was unanimously endorsed by the Physician-Focused Payment Model Technical Advisory Committee

(PTAC), which was created by MACRA, the model has not been implemented. As a result, patients continue to be admitted to the hospital who might otherwise have been safely discharged to their home. In addition to undermining efforts by physicians to be good stewards of scarce Medicare resources, failure to implement this policy proposal will likely disproportionately affect patients with health-related social needs and contributes to health inequities. This emergency medicine model is just one of 19 APM proposals that the PTAC recommended for further development, testing or implementation, which brings us to another important point. CMS, unfortunately, to date, has elected not to pursue a single APM proposal ultimately endorsed by the PTAC. Congress and the Administration should work together to develop a viable pathway for physician practices to voluntarily participate in pilot programs of APM proposals developed by stakeholders, such as those recommended by the PTAC.

**Recommendation: Congress should work with the Administration to increase opportunities for physicians in all specialties and types of practice to voluntarily participate in well-designed, patient-centered APMs, including development of a pathway to permit people with Medicare to access health care through stakeholder-developed APMs such as those recommended by the PTAC.**

**2. Advanced APM Incentive Payments Need to Be Continued**

The five percent incentive payments for participants in Advanced APMs have been a key factor in physicians' interest and even in their ability to participate in APMs. Without these incentive payments, many physicians could not otherwise cover the costs of APM participation, cover the costs of providing services that are necessary for APMs to meet their care improvement goals, handle the downside financial risk, or deal with the revenue reductions that can occur from reducing avoidable services.

Physicians also face significant transition costs participating in APMs. For example, even if an APM pays for delivery of enhanced services to patients that the payment schedule alone does not adequately support, the physician practice will still have to recruit, hire, and train staff to perform those functions, which requires incurring significant costs before services and payments can begin. APM participants also make investments in data analytics, technology, and other improvements that allow them to effectively participate in the APM that the incentive payments help to offset.

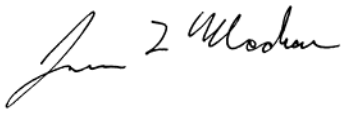
The AMA has significant concerns with regards to the negative consequence of allowing the APM incentive payments created under MACRA to expire at the end of the year. It is important for Congress to pass the soon-to-be-reintroduced Value in Health Care Act, which would extend the incentives for an additional two years.

The Value in Health Care Act would also authorize CMS more flexibility to set the APM revenue percentages that participants in Advanced APMs must meet to be eligible for the incentive payments. The most recent report from CMS on these thresholds shows that the MACRA mandate to generate at least 75 percent of their revenue from their APM, which takes effect in 2024 under current law, would be unattainable for many Advanced APM participants. Even participants in the largest Advanced APM model, Medicare Shared Savings Program accountable care organizations (ACOs), had an average revenue score of 63 percent. For the Bundled Payments for Care Initiative Advanced model, the average score was just five percent, and for the Comprehensive Care for Joint Replacement Model, just three percent.

**Recommendation: Congress should pass the Value in Health Care Act of 2023, which would extend the Advanced APM incentive payments created under MACRA and authorize the Secretary increased flexibility to set the revenue threshold for physicians to be eligible for these incentive payments.** Absent Congressional intervention, 2023 marks the last year physicians are eligible to qualify for an APM incentive payment and the associated revenue thresholds jump from 50 percent to 75 percent on January 1, 2024.

Reforming the MPS is an urgent matter for the AMA, our physician members, and their patients, and we are ready to work with Congress to achieve a sustainable solution for this vital issue. Without needed reforms, we are on a collision course with a payment system that threatens to destabilize the Medicare program and patient access to care. We thank you for considering our recommendations.

Sincerely,



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