Association of
American Medical Colleges
655 K Street, NW, Suite 100, Washington, DC 20001-2399
T 202 828 0400
aamc.org

October 26, 2022

The Honorable Ami Bera, MD
U.S. House of Representatives
170 Cannon House Office Building
Washington, DC 20515

The Honorable Larry Bucshon, MD
U.S. House of Representatives
2313 Rayburn House Office Building
Washington, DC, 20515

Dear Drs. Bera and Bucshon:

The Association of American Medical Colleges (AAMC) appreciates your demonstrated commitment to supporting health care providers and strong interest in ensuring the financial security of our nation's health care system. We welcome the opportunity to respond to your request for information on actions Congress can take to stabilize the Medicare physician payment system and quality payment program, without dramatic increases in spending, while also ensuring value-based incentives are in place.

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members comprise all 156 accredited U.S. medical schools; 14 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and nearly 80 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and the millions of individuals across academic medicine, including more than 191,000 full-time faculty members, 95,000 medical students, 149,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened the AAMC's U.S. membership and expanded its reach to international academic health centers.

Through their mission of providing the highest quality patient care, teaching physicians who work at academic medical centers (AMCs) provide care in what are among the largest physician group practices in the country, often described as "faculty practice plans" because many of these physicians teach and supervise medical residents and students as part of their daily work. They are typically organized into large multi-specialty group practices that deliver care to the most complex and vulnerable patient populations, many of whom require highly specialized care. Often, care is multidisciplinary and team based. These practices are frequently organized under a single tax identification number (TIN) that includes many specialties and subspecialties. Recent data shows that faculty practice plans range in size from a low of 115 individual national

provider identifiers (NPI)s to a high of 3,694 NPIs, with a mean of 1,258 and a median of 1,088.[1] These practices support the educational development of residents and physicians who will become tomorrow's physicians.

Teaching physicians are vital resources to their local and regional communities, providing significant primary care services and other critical services, including a large percentage of tertiary, quaternary, and specialty referral care in the community. Their patient base may span regions, states and even the nation. They also treat a disproportionate share of patients for whom issues associated with social determinants of health, such as housing, nutrition, and transportation, contribute significantly to additional health challenges, adding greater complexity to their care.

The AAMC and our member institutions are committed to working with Congress to ensure that Medicare payment policies promote access to high quality care for patients, accurately reflect the resources involved in treating patients, are not overly burdensome to clinicians, and reduce health care disparities, while incentivizing value-based models of care. We stand ready to work with Congress to develop long-term strategies to achieve these goals, and propose that Congress:

- Prevent nearly 8.5 percent in statutory payment reductions by passing the Supporting Medicare Providers Act of 2022 (H.R. 8800) and legislation to waive the pending 4 percent statutory pay-as-you-go (PAYGO) cut.
- Pass the Value in Health Care Act (H.R. 4587), which would extend the Advanced Alternative Payment Model (AAPM) 5 percent bonus for an additional 6 years.
- Give the Centers for Medicare and Medicaid Services (CMS) the authority to set thresholds in the future at a level that will incentivize participation in AAPMs.
- Incentivize participation in AAPMs through additional policy changes.
- Make additional improvements under the Merit-Based Incentive Payment System (MIPS) such as:
    - Extending the $500 million exceptional performance bonus to reward exceptional performers participating in MIPS for their investment in quality performance;
    - Making reporting and performance measurement more meaningful by appropriately adjusting all measures in the Quality Performance Program (QPP) to account for the clinical and social complexity of patients; and
    - Exploring better data sources and analytic techniques to support attribution.

Additional details on these proposals can be found below.

Preventing Statutory Payment Reductions

As currently structured, the Medicare physician payment system is on a path that jeopardizes Medicare patients' access to physicians. The Medicare Access and CHIP Reauthorization of 2015 (MACRA) established a six-year freeze on updates to physician payment from 2019

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[1] Data derived from The Clinical Practice Solutions Center (CPSC), developed by the Association of American Medical Colleges (AAMC) and Vizient.

through 2025; in other words, during this period there would be no updates to Medicare payments to physicians. Beginning in 2026, the law specifies that clinicians participating in AAPMs who also meet certain thresholds would receive an update of 0.75 percent and those who are not in AAPMs would receive a 0.25 percent update. These updates are well below the rate of inflation. According to an American Medical Association (AMA) analysis of Medicare Trustees data, when adjusted for inflation Medicare physician payment has been reduced 20 percent from 2001–2021.[2]

In this year's Physician Fee Schedule (PFS) rule, CMS proposes the dollar conversion factor (CF) of $33.08 that would be used to update the payment rates in 2023. This represents approximately a 4.42 percent reduction from the 2022 conversion factor. The 2023 CF reflects the expiration of the one-year 3 percent increase for services furnished in 2022 under provisions included in the Protecting Medicare and American Farmers from Sequester Cuts Act and budget neutrality adjustments**.** In addition to this 4.42 percent CF reduction, on January 1, 2023, physician practices are facing additional Medicare payment cuts from the imposition of a 4 percent PAYGO sequester reduction. Taken together, these cuts would result in approximately an 8.5 percent reduction in payment. These cuts are further compounded by the termination of the 2 percent sequestration moratorium in July 2022.

We are deeply concerned about the impact of these significant cuts and the minimal updates in future years. Payment reductions of this magnitude would pose a major problem at any time, but to impose them when teaching physicians and other health care professionals are continuing to respond to multiple public health emergencies and associated longer-term challenges, such as historic workforce shortages, will be extremely harmful. The COVID-19 pandemic has caused significant disruption to physician practices, and physician practices are still recovering from the financial impacts of the ongoing pandemic. For example, continued implementation of infection control protocols has also increased the cost of providing care as practices continue to comply with state and federal workplace safety requirements. Practices have had to purchase additional personal protective equipment (PPE), update cleaning protocols, maintain adequate social distancing, create physical barriers, and undertake other costly measures with increased costs due to inflation.

Even prior to the pandemic there were major concerns about physician well-being, which the pandemic only exacerbated. Physician well-being is low due to many factors, including concerns regarding their health and safety and that of their staff and family, increased hours of care, workforce shortages, and challenges with providing care during a pandemic that requires additional procedures and protocols. Payment for services should be commensurate with services provided. An 8.5 percent cut in physician payment will add to the stress and is likely to trigger further retirement or reduction in physician services during a time when physicians are needed the most in their communities.

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[2] American Medical Association, Economic and Health Policy Research, October 2021 (https://www.ama-assn.org/system/files/medicare-pay-chart-2021.pdf)

We are concerned that the additional reductions in revenue from the budget neutrality adjustments and sequester could result in significant access problems for patients. **Given these unprecedented challenges and the critical importance of patient access to health care services, we urge Congress to pass the Supporting Medicare Providers Act of 2022 (H.R. 8800), which would provide a 4.42 percent CF adjustment for 2023, and legislation that would waive the 4 percent statutory PAYGO requirement.** This would help to ensure that physicians and other health care providers can continue to provide high quality care to their patients by giving them crucial short-term financial stability and allowing time for long-term payment reform.

Looking ahead, we believe that there are ongoing structural problems with the Medicare PFS that must be addressed by Congress. Medicare provider payments have been constrained for many years by the budget neutrality system. The updates to the CF have not kept up with inflation, while the cost of running a medical practice has increased significantly. The budget neutrality requirement has led to arbitrary reductions in reimbursement.

The AAMC recommends that Congress ensure that any payment system provides financial stability through a baseline positive annual update that reflects inflation in practice costs and eliminates or replaces budget neutrality requirements to allow for appropriate changes in spending growth. The payment system should also recognize physicians' contributions in providing high-value care and the associated savings and quality improvements across all parts of Medicare and the health care system (e.g., preventing hospitalizations that would increase Part A costs). We would welcome an opportunity to work collaboratively with Congress, CMS, and other interested groups on efforts to make changes to the payment system.

Changes to MACRA for Advanced Alternative Payment Models

Extend the Advanced APM Bonus

One goal of MACRA was to provide physicians with a glide path to transition from fee for service (FFS) to alternative payment models (APMs). To encourage this transition, Congress established a 5 percent bonus payment for clinicians who participate in AAPMs from 2019-2024. Unfortunately, in performance year 2023, which correlates with calendar year (CY) 2025 payment, there is no further statutory authority for a 5 percent APM incentive payment for eligible clinicians who become qualified participants in advanced APMs. However, beginning with performance year 2024, which correlates with CY 2026 payment, there will be two different PFS conversion factors depending on whether the services are furnished by an eligible clinician who is a qualifying participant (QP) for the year. In the 2023 PFS proposed rule, CMS noted that the updates for QPs in AAPMs are not expected to match the anticipated maximum available positive payment adjustment potentially available under the Merit-based Incentive Payment System (MIPS) until after CY 2038.

We are concerned that the end of the 5 percent bonus payment will discourage participation in advanced APMs in the future. Value-based care is improving patient care and successfully reducing costs in the health care system. These payment system reforms have been a good

investment for the government. For example, Shared Savings Program accountable care organizations (ACOs) have saved Medicare $13.3 billion in gross savings since 2012 and, according to a Department of Health and Human Services (HHS) Inspector General Study, ACO clinicians have outperformed FFS providers on 81 percent of quality measures.[3] APMs give providers tools to innovate and coordinate care, resulting in improved outcomes for beneficiaries.

Under AAPMs, participating clinicians bear financial risk for the cost and quality of care. The 5 percent bonus payments have been critical to clinicians in covering the investment costs of moving to new payment models and reinvesting the 5 percent bonus payment into practice redesign to better manage care. This includes investing in new electronic health records (EHRs), additional staff, telehealth managers, telehealth platforms, and other areas that will enable them to better manage care when they bear the financial risk. For example, ACOs have used these incentives to fund wellness programs, pay for patient transportation and meals programs, and hire care coordinators. Although these services are not typically reimbursed under the Medicare program, they have been shown to improve health outcomes.[4,5]

The AAMC is concerned that the lack of the 5 percent financial incentive under the QPP for APMs for the CY 2025 payment will discourage participation in AAPMs in performance year 2023. For CY 2025 payment, clinicians in MIPS have the opportunity for a payment adjustment of +/-9% while those in AAPMs have no incentives. While there will be a higher update to the conversion factor beginning in 2026 payment year for QPs in an AAPM as compared to non-QPs, we do not believe that this higher update will be sufficient to incentivize participation. As CMS showed in the 2023 physician fee proposed rule, the QP conversion factor is not expected to equate to the anticipated maximum positive payment adjustment under MIPS until after CY 2038. **Therefore, we urge Congress to pass the Value in Health Care Act (H.R. 4587), which would extend the AAPM 5 percent bonus for an additional 6 years.**

Modify Thresholds to Achieve Qualifying Participants (QPs) Status in AAPMs

To be classified as a QP or partial QP in an AAPM, providers need to meet or exceed thresholds based on the number of patients seen or payment received for services provided through AAPMs. These thresholds, which were established by Congress in 2015, have been progressively increased per statute since the start of the program. Originally, the Medicare statute set higher thresholds for CY 2023 payment. Beyond that, the law increased the requirements so that a QP must have at least 75 percent of their revenue in the Medicare FFS program received through a Medicare APM, or 50 percent of their Medicare FFS patients would need to receive services through the APM. These thresholds are very high and would have made it much more

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[3] US Department of Health and Human Services Office of the Inspector General, "Medicare Shared Savings Program Accountable Care Organizations Have Shown Potential for Reducing Spending and Improving Quality," Report (OEI-02-15-00450) (August 2017)
[4] Shier et. al., Strong Social Supports, Such as Transportation and Help for Caregivers, Can Lead to Lower Health care use and Costs, Health Affairs Vol. 32, No. 3 (March 2013).
[5] Williams et. al., Sustainable care coordination: a qualitative study of primary care provider, administrator, and insurer perspectives, BMC Health Serv Res. (February 2019).

difficult for an eligible clinician to be considered a QP and to receive the 5 percent bonus payment in 2023. Congress recognized this problem and addressed it in the Consolidated Appropriations Act of 2021 which froze the thresholds for CYs 2023 and 2024 at the CYs 2021 and 2022 levels. The thresholds for 2022 performance year remained at 50 percent of the revenue received through the APM and 35 percent of their Medicare patients receiving services through the APM. We supported the change to these thresholds.

We remain deeply concerned about the increase to the thresholds that will occur for CY 2025 payment (2023 performance). The increasing thresholds that must be met to be considered qualified participants in an advanced APM will discourage participation, thereby limiting beneficiary access to high quality and better coordinated care. It is very difficult for APMs to increase the volume of payments received through the APM or the number of Medicare FFS patients who receive services through the APM. It is especially difficult for ACOs in rural areas and those that include specialists since primary care services are used to determine ACO assignment. **We urge Congress to give CMS the authority to set thresholds in the future at a level that will incentivize participation in advanced alternative payment models.**

Improve AAPM Participation Through Additional Policy Changes

While the 5 percent bonus payment is very important, there are other factors that affect an eligible clinician's decision about whether to participate in an AAPM. Providers consider whether the APM model aligns with care goals for their patient populations, especially whether the APM will enable them to be reimbursed for providing more coordinated high-quality care than the current system. In addition, providers assess the overall financial opportunity of participation in the APM, including: 1) the availability of shared savings; 2) whether the benchmark methodology sets financial targets that adequately risk adjust for factors beyond clinician control; 3) whether there is sufficient volume of patients so that a small number of outliers do not impact success; 4) administrative burden associated with data submission requirements; and 5) whether there is enough time for implementation before downside risk applies.

Making changes to the program that address these factors can make it more attractive for providers to participate in AAPMs and improve health outcomes. Specific actions that would encourage participation in AAPMs include changing the benchmarking methodology, increasing shared savings opportunities, reducing administrative burden, allowing more flexibility, and allowing longer transitions to downside risk.

Specifically, for the Medicare Shared Savings Program we recommend:

- ***Removal of ACO beneficiaries from regional benchmarks*** to ensure ACOs are not penalized as they achieve savings for their assigned populations.
- ***Eliminating high/low revenue distinctions*** for ACOs and base distinctions on patient characteristics instead.
- ***Considering approaches to health equity,*** such as incorporating social determinants of health in risk adjustment to ensure that APM participants are not disadvantaged for

serving medically and socially complex beneficiaries. Consider paying for services that address social determinants of health.
- ***Allowing advance payments*** for all new, inexperienced ACOs to assist in the upfront costs needed to become an ACO.
- ***Slowing the Path to Risk*** for all new ACOs to encourage participation in the program.

Additional Improvements Under MIPS

The AAMC urges Congress to make additional changes to the QPP to make reporting and performance more meaningful for physicians and consumers and to encourage participation by increasing the pool of dollars available for payment incentives.

The MIPS incentives are budget neutral so that any positive payment adjustments are funded by penalties. The only exception to budget neutrality has been a separate $500 million pool of funding established under MACRA for eligible clinicians who exceed the exceptional performance threshold. Under the MACRA statute, the $500 million funding allocation will expire at the end of the 2022 performance year (2024 payment). Due to budget neutrality, this exceptional performance funding pool has made up the bulk of positive payment adjustments received by clinicians. Even while this funding has been available, the annual MIPS maximum payment adjustments have been very low relative to the maximum percentages that were allowed under MACRA. Eligible clinicians who achieve the MIPS performance threshold have had positive adjustments around zero, and those who have achieved the exceptional performance threshold have had positive adjustments below 2 percent. When this funding ends, the amount of positive payment adjustments that high performing eligible clinicians receive will be even lower than 2%. The A**AMC urges Congress to extend the $500 million exceptional performance bonus to reward exceptional performers participating in MIPS for their investment in quality performance.**

To make reporting and performance more meaningful for physicians and patients, the **AAMC recommends that all measures used in the QPP, both in MIPS and APMs, be appropriately adjusted to account for the clinical and social complexity of patients.** Differences in patient clinical complexity and health-related social needs can drive differences in average episode costs and performance on other measures. The COVID-19 pandemic has demonstrated the importance of accurate risk adjustment. The pandemic has had a disproportionate impact on racial and ethnic minorities, those with housing instability, individuals in long-term care facilities, the elderly, and those with underlying conditions. Without accurately accounting for clinical complexity and health-related social needs, the scores of physicians who treat vulnerable patients will be negatively and unfairly impacted, and their performance will not be adequately reflected in their MIPS score. Physicians at academic medical centers care for a vulnerable population of patients who are sicker, poorer, and more complex than many patients treated elsewhere.

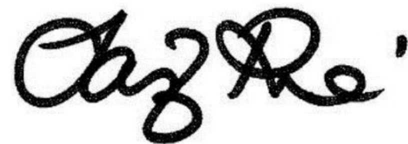
It is critical that when measuring performance under MIPS, there is an accurate determination of the relationship between a patient and a clinician to ensure that the correct clinician is held responsible for the patient's outcomes and costs. This is complicated given that patients often

receive care from multiple clinicians across several facilities and teams within a single practice or facility. The attribution method should be clear and transparent to clinicians. **We suggest that better data sources and analytic techniques should be explored in the future to support attribution.**

The AAMC also recommends that Congress and CMS explore ways to reduce administrative burden under MIPS so that eligible clinicians can focus on providing high quality care to their patients.

Thank you for the opportunity to share the AAMC's thoughts on stabilizing the Medicare payment system to ensure that patients are able to continue accessing high quality health care. We look forward to continuing to work with you on this and other clinical and patient care issues. If you have any further questions, feel free to contact me at trasouli@aamc.org, or my colleague Leonard Marquez, Senior Director of Government Relations & Legislative Advocacy (lmarquez@aamc.org).

Sincerely,



Tannaz Rasouli, MPH
Acting Chief Public Policy Officer
Association of American Medical Colleges

CC:

David Skorton, MD
President and CEO
Association of American Medical Colleges

The Hon. Kim Schrier, MD
U.S. House of Representatives

The Hon. Earl Blumenauer
U.S. House of Representatives

The Hon. Brad Schneider
U.S. House of Representatives

The Hon. Michael Burgess, MD
U.S. House of Representatives

The Hon. Brad Wenstrup, DPM
U.S. House of Representatives

The Hon. Mariannette Miller-Meeks
U.S. House of Representatives