



**Statement of the
American College of Physicians
to the U.S. House Ways and Means Health Subcommittee Hearing
on
Improving Value-Based Care for Patients and Providers
June 26, 2024**

The American College of Physicians (ACP) is pleased to provide comments in response to the House Ways and Means Health Subcommittee hearing on “Improving Value-Based Care for Patients and Providers.” We thank Chairman Buchanan and Ranking Member Doggett for holding this hearing to examine ways to improve patient access to value-based care and to make it a more sustainable practice model for physicians. Our recommendations, outlined below, are consistent with established ACP policy to improve Medicare by aligning physician payment with the value of care provided and supporting the transition to value-based payments through alternative payment models (APMs) that can accommodate a wide range of specialties, practice sizes, and unique patient populations.

There are a number of incentives to encourage physicians and other clinicians to adopt value-based care. These include: reforming the Medicare physician payment system and budget neutrality; extending the APM incentive payment by passing the bipartisan Value in Health Care Act; providing physicians with flexibility to participate in payment models and APMs that best suit their practices’ unique needs and reporting on meaningful quality metrics; and recognition of the transition to value-based payment and the role that the Center for Medicare and Medicaid Innovation (CMMI) plays in designing, testing, and implementing new payment models that move health care towards this goal.

ACP members include 161,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge, clinical expertise, and compassion to the preventive, diagnostic, and therapeutic care of adults across the spectrum from health to complex illness.

Payment Reforms Are Needed to Ensure a Viable Transition to Value-Based Care

The Physician Fee Schedule (PFS) does not have an annual update based on inflation. As a result, when accounting for inflation, Medicare physician payments have declined 29 percent from 2001 to 2024. The Medicare Access and CHIP Reauthorization Act (MACRA) must be viewed within the broader context of the physician payment system. While physician services represent a very modest portion of the overall growth in health care costs, they are primary targets for cuts when policymakers seek to

tackle spending. For years physicians have struggled with a broken Medicare payment system that does not allow them to keep up with practice expenses and rising inflation. That has made it much harder for physician practices to manage sharp increases in practice expenses or navigate staffing and supply shortages.

The modest statutory updates previously included in MACRA have ended and physicians are in a six-year period with no updates. The result is real reductions to payments when accounting for inflation and budget neutrality requirements. ACP [urges](#) Congress to pass H.R. 2474, the Strengthening Medicare for Patients and Providers Act, to provide an annual Medicare physician payment update tied to inflation, as measured by the Medicare Economic Index (MEI). An MEI update for the PFS would allow physicians to make needed investments in their practices to help ensure that they are able to deliver high quality care to their patients.

Medicare Physician Fee Schedule Cuts

The current structure of the PFS does not provide sustainable, reliable and consistent payment rates for physicians who see Medicare beneficiaries. Patients and their physicians are left to deal with the uncertainty of cuts to Medicare payment rates each year. These cuts, especially when practice expense costs have markedly increased, further strain our nation's doctors, limiting patient access to care. Each year, physicians routinely face harmful payment cuts making it increasingly difficult to remain in practice and accept Medicare patients.

Unless Congress acts, a continuing statutory freeze on annual physician payments is scheduled to last until 2026, when updates would resume at a rate of .25 percent per year, well below inflation rates. Some physician services in the fee schedule, such as evaluation and management services, have been increased. The problem is that any increases in the fee schedule must be paid for by across the board payment cuts to all services in the PFS. This policy, known as budget neutrality (BN), has caused annual cuts to physician payments over the past several years. Although Congress has passed legislation to mitigate the impact of these cuts – patchwork measures by Congress do not provide a stable, predictable payment structure for physicians in Medicare.

We urge Congress to act this year to pass the Provider Reimbursement Stability Act, H.R. 6371, which would give CMS more flexibility in setting payment rates, updating average costs doctors incur in calculating reimbursement and making payments more predictable. The bill would require CMS to conduct a look-back period, to reconcile overestimates and underestimates in utilizations. We support this approach as it would allow for a more accurate calculation of the Medicare conversion factor based on actual utilization data and claims. Further, it would raise the BN utilization estimate threshold from \$20 million to \$53 million and would use cumulative increases in the MEI to update the threshold every five years afterwards. The \$20 million threshold was established in 1992 and has not been updated since. Raising the budget-neutrality threshold would allow for greater flexibility in

determining pricing adjustments for services without triggering across-the-board cuts in Medicare physician pay. We believe that this is a practical approach, which would help account for inflation. An alternative bill ACP also supports is H.R. 6475, the Physician Update and Improvements Act. This bill would also raise the threshold for implementing budget neutral payment cuts from \$20 million to \$53 million and would provide an increased update to the threshold every five years afterwards based on the MEI.

Pass the Value in Health Care Act to Extend APM Incentive Payments

ACP [supports](#) extending incentive payments for participation in eligible alternative payment models through 2026. Congress should pass the Value in Health Care Act of 2023, H.R. 5013, to extend the five percent bonus for physician participation in advanced APMs. This bipartisan legislation makes several important reforms to ensure that APMs continue to produce high quality care for the Medicare program and its beneficiaries. The [Value in Health Care Act](#) makes a number of important reforms to strengthen Medicare's value-based care models and Accountable Care Organizations (ACOs) to ensure that these models continue to produce high quality care for the Medicare program and its beneficiaries as well as to generate savings for taxpayers. The bill extends MACRA's five percent advanced APM incentives that are scheduled to expire at the end of the year. It also gives the Centers for Medicare and Medicaid Services (CMS) authority to adjust APM qualifying thresholds so that the current one-size-fits-all approach does not serve as a disincentive to including rural, underserved, primary care or specialty practices in APMs. This approach would help to maintain incentives that support physicians' transition from a volume-based fee-for-service health care system to one that is based on the value and quality outcomes of health care delivered to the patient. Another bill we support, H.R. 6369, also extends incentive payments for participation in eligible alternative payment models.

Meaningful and Cost-Effective Quality Metrics

ACP supports policy that provides physicians the flexibility to report on meaningful quality metrics and participate in payment models that best suit their practices' unique needs. We support legislation that aligns with ACP's [New Vision](#) for U.S. healthcare, in which ACP recommends moving toward a limited set of patient-centered, actionable, appropriately attributed, and evidence-based measures for public reporting and payment purposes, while supporting the use of additional clinically meaningful measures for internal quality improvement purposes.

We are supportive of legislation which would exempt practitioners who participate in certain Medicare Advantage (MA) payment arrangements from Merit-Based Incentive Payment System (MIPS) reporting requirements and adjustments. ACP [supports](#) this approach as it would reward clinicians for their participation in innovative new payment models, as well as reduce administrative burdens by not requiring clinicians who have demonstrated substantial involvement in innovative payment models that already hold them accountable for cost and quality to be forced to comply with an entirely different set of quality and cost metrics through MIPS. We ask that Congress also consider examining policies to improve reporting flexibility for traditional Medicare. ACP supports [equitable access to](#)

[payment arrangements](#) across Medicare to better support patients and the physicians who serve them. The quality measurement systems for both MA plans and traditional Medicare should align to promote high-quality care for all beneficiaries, streamline quality reporting across Medicare programs, encourage administrative simplification, and provide beneficiaries with a clear and understandable means to compare benefits and options across Medicare programs.

We support legislation that would allow MIPS reporting flexibility for physicians who perform much of their work in a facility-based setting, allowing physicians to choose to use quality or value-based program measures used under their respective sites of care. We have [longstanding policy](#) in support of increasing MIPS reporting flexibility, which would provide clinicians with more options to choose measures that are most appropriate for their practices and patients, reducing the burden of clinician participation and thereby giving clinicians more time to focus on patient-centered care and subsequently improve health outcomes.

ACP supports H.R. 5395, the SURS Extension Act, which would extend the Quality Payment Program-Small Practice, Underserved, and Rural Support (QPP-SURS) program for fiscal years 2024-2029. This program was established under MACRA and has provided direct assistance to eligible clinicians required to participate in MIPS. This assistance was critical in ensuring that small practices in rural and underserved areas received the support resources necessary to succeed in the MIPS program. However, after five years of support, QPP-SURS ended on February 15, 2022, leaving clinicians without a direct technical assistance program to help them navigate continuously changing regulations in the remaining years and increasing performance thresholds of the QPP.

Increasing Access to APMs

ACP believes streamlined prospective payment models that adequately support and sustain comprehensive, longitudinal patient-physician relationships and address the whole person, including health-related social needs, are essential. This payment infrastructure enhances patients' access to high-quality, continuous primary care and strengthens practice capabilities that improve quality and reduce health care spending. This is especially important for independent practices that care for a large share of underserved patient populations in marginalized and rural areas. Advanced risk models provide experienced practices with additional flexibility to improve quality and reduce health care spending.

CMMI Plays a Critical Role in the Transition to Value-based Health Care

Physician practices, whether operating on their own or within the context of a broader accountable care organization, need a stable suite of multi-payer models, that provide predictable, prospective revenue streams adequate to meet patient and practice needs. This suite of models should include participation options for practices that are prepared to assume varying degrees of financial risk. CMMI's recent [Strategy Refresh](#) laid out several goals to accelerate adoption of value-based care, including having 100 percent of Medicare beneficiaries in an accountable care relationship by 2030. CMMI notes in its Strategy Refresh that advanced primary care and accountable care models are central to achieving this goal.

Since its inception in 2010, CMMI has tested over 50 advanced APMs aimed at rewarding physicians and other health care clinicians for delivering high-quality and cost-effective care. CMMI, together with Medicare's QPP, are making meaningful improvements to value-based care. ACP has written several [letters](#) to Congress in support of CMMI where we highlighted that any decrease in funding for CMMI would severely affect the ability for CMS to test new models of care and would undermine MACRA's goal to improve care for Medicare beneficiaries. Further, under current law, Congress did intend for CMMI's funding to be available until expended so that it could be deliberate in how to allocate resources without the pressure of expiring funding. We urge against any legislative action that could limit or restrict the range and length of possible CMMI models and/or add required congressional approval to expand actuarially proven innovation models. These restrictions would greatly hinder—if not defeat—CMMI's ability to quickly and effectively implement successfully developed innovation models into the Medicare and Medicaid programs to advance value-based care.

ACP continues to advocate for increased investment in primary care to ensure that patients have access to preventative and continuous comprehensive care. As internal medicine physicians who make up 24 percent of the physician workforce in this country, we play a [role](#) in preventive health by helping to reduce the prevalence of chronic diseases, which improves health outcomes. Not only are our members uniquely qualified and positioned to manage chronic illnesses, but they are also trained to identify risk-factors that can lead to such illnesses. Primary care physicians can effectively encourage patients towards preventive measures, such as increasing their physical activity and eating healthier. Their role can be supported by innovative payment models that would provide primary care clinicians with the financial support, tools, and resources to meet our patients' health goals and social needs – helping to improve population health outcomes.

Despite the lack of APMs, we support the "[Making Care Primary Model](#)" being implemented through CMMI in eight states. This model for primary care is structured to facilitate and promote care coordination between [primary care physicians](#) and other specialists. The model aligns with recommendations in ACP's [paper](#), "Beyond the Referral: Principles of Effective, Ongoing Primary and Specialty Care Collaboration."

The Making Care Primary Model is designed to provide primary care clinicians with enhanced payments, tools, and support to improve the health outcomes of their patients. It incorporates key elements that ACP proposed in the [Medical Home Neighborhood Model](#). That model will provide a great number of opportunities for subspecialists and other specialists to more effectively coordinate care with their internal medicine colleagues and other physicians providing primary care, which will open up access and allow those specialists to see more urgent cases sooner. The model encourages more meaningful engagement between primary care specialists and other specialists. The aim is to address concerns by specialists about referrals that are sometimes inappropriate or misdirected. One of the key components of our recommended model is the prescreening of patients by the internal medicine subspecialists and other specialists as to whether or not they believe the referral is appropriate.

ACP appreciates CMMI's focus on advancing primary care through the testing and implementation of several additional primary care focused APMs. The Primary Care First (PCF) Model was launched in 2021 and is a voluntary, multi-payer, five-year model that is operating in 26 regions across the country. The model offers enhanced payments to support advanced primary care services. PCF is designed to help primary care practices support their patients by prioritizing the clinician-patient relationship. ACP appreciates that the model provides a variety of payment approaches to support internal medicine and primary care practices, from smaller and independent practices to larger integrated ones; it includes a range of risk options available to practices, and it could potentially reduce administrative burdens that would allow physicians to spend more time with their patients.

The Comprehensive Primary Care Plus (CPC+) program was launched in 2017 and supported the advancement of the primary care medical home model of health care delivery. CPC+ strengthened the ability of internists and other primary care clinicians, in thousands of practices nationwide, allowing them to deliver high value, high performing, effective, and accessible primary care to millions of patients. The success of the model has allowed for several [iterations](#) of it to be used across many states, providing quality primary care to beneficiaries in Medicaid, Medicare Advantage, and private insurance.

Conclusion

We commend you for working in a bipartisan fashion to identify ways to improve the provision of value-based care to patients. If you have any further questions or if you need additional information from ACP, please contact George Lyons at (202) 261-4531 or glyons@acponline.org.