October 27, 2023

Michael Chernew, PhD
Chairman
Medicare Payment Advisory Commission
425 I Street, NW, Suite 701
Washington, DC 20001

Dear Dr. Chernew:

At its October 5, 2023, public meeting, the Medicare Payment Advisory Commission (MedPAC) discussed Medicare's payment rates for clinician services. A key question raised by MedPAC staff was whether to recommend restructuring or eliminating the bonus to clinicians participating in advanced alternative payment models (APMs), as well as the differential payment updates for them from 2026 onward. We are writing to offer our analysis that these payment policies are not working as intended.

Medicare's framework for value-based care is deeply flawed and needs reform. It does not seem that the current APM bonuses encourage higher quality and less costly care in Medicare. Furthermore, the track record of Medicare APMs has been worse than expected. The current evidence does not justify subsidizing advanced APM participation.

Paragon Health Institute is a nonprofit, nonpartisan health care policy think tank dedicated to empowering patients and reforming government programs. Our analysis draws on the experience of a diverse range of experts, including former federal officials and academic researchers. Most recently, our staff has published research and delivered congressional testimony on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).[1]

I. Financial Incentives for Alternative Payment Model Participation

Under MACRA, Medicare APM participation was generally considered a more effective mechanism for encouraging value-based care than the Merit-Based Incentive Payment System (MIPS). The bonuses and increased payment updates offered to participants reflected this belief. Since 2018, MedPAC has concluded that MIPS should be eliminated. Additional evidence reaffirms that MIPS will not succeed in improving value in Medicare.[2] Repeal would reduce the need for financial incentives to participate in advanced APMs, as there would be no alternative value-based pathway.

There are a few major flaws with the advanced APM bonuses themselves as well. First, the availability of such bonuses is unequal. Medicare APMs by design often apply to discrete types of providers, services and health conditions, or geographic areas, which leaves some clinicians unable to become advanced APM participants due to these characteristics, even if they would otherwise be

[1] Joe Albanese, "MACRA: Medicare's Fitful Quest for Value-Based Care," Paragon Health Institute, May 2023, https://paragoninstitute.org/research-paper-joe-albanese-macra-medicare-value-based-care-page/; Joe Albanese, testimony before the House Committee on Energy and Commerce Subcommittee on Oversight and Investigations, "MACRA Checkup: Assessing Implementation and Challenges That Remain for Patients and Doctors," June 22, 2023, http://docs.house.gov/meetings/IF/IF02/20230622/116159/HMTG-118-IF02-Wstate-AlbaneseJ-20230622.pdf; Joe Albanese, testimony before the House Committee on Energy and Commerce Subcommittee on Health, "What's the Prognosis? Examining Medicare Proposals to Improve Patient Access to Care and Minimize Red Tape for Doctors," October 19, 2023, https://docs.house.gov/meetings/IF/IF14/20231019/116487/HMTG-118-IF14-Wstate-AlbaneseMPPJ-20231019.pdf.

[2] MedPAC, "Moving beyond the Merit-based Incentive Payment System," in *Report to the Congress: Medicare Payment Policy*, March 2018, https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar18_medpac_ch15_sec.pdf; Albanese, "MACRA Checkup;" Albanese, "What's the Prognosis?"

willing to do so. For example, evidence shows that providers in rural or shortage areas are less likely to participate in advanced APMs.[3]

Second, the bonuses may not be effective. One literature review found no substantial causal evidence that they induced physicians to join advanced APMs who would not have otherwise done so.[4] Other considerations, including the costs and benefits of the APM itself, are likely more important given that many Medicare APMs are voluntary and thus more likely to attract participants who would benefit most from a particular model.

II. Alternative Payment Model Performance

Despite the optimism surrounding Medicare APMs, their track record is disappointing. Congress intended the Center for Medicare and Medicaid Innovation (CMMI) to be a major driver of value-based care and empowered it to unilaterally waive statutory requirements. But by CMMI's own admission, only five models achieved net savings in its first decade.[5]

A recent report by the Congressional Budget Office (CBO) reevaluated its assumptions about CMMI. CBO's previous methodology estimated that CMMI would save Medicare $2.8 billion from 2011 to 2020 and $77.5 billion from 2021 to 2030, but its updated figures were net losses of $5.4 billion and $1.3 billion, respectively. The flaws of CBO's previous projections were previously highlighted by other analysts as well.[6] Notably, these estimates do not factor in the costs of advanced APM bonuses, which MedPAC analysts estimated would be $650 million per year if extended.[7]

The subset of advanced APMs have not fared much better. From the most recent evaluations of nine models with advanced components, only three yielded net savings. Two of those have multiple "tracks," some of which are not advanced and lack separate evaluations.[8] Outside research has also cast doubt on the official results of these models. For example, savings figures from the Medicare Shared Savings Program (MSSP), a statutory model not designed by CMMI, are based on administrative benchmarks rather than counterfactual estimates of health care costs in the absence of the model. MSSP savings are likely much more modest than reported.[9] Continued work by MedPAC can shed more light on advanced APM performance, but the available evidence is not encouraging.

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[3] GAO, *Medicare: Information on the Transition to Alternative Payment Models by Providers in Rural, Health Professional Shortage, or Underserved Areas*, November 17, 2021, https://www.gao.gov/products/gao-22-104618.
[4] Zack Cooper et al., "A Review of the Academic and Expert Literature on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)," Yale University, Tobin Center for Economic Policy, April 2023, https://tobin.yale.edu/research/review-academic-and-expert-literature-medicare-access-and-chip-reauthorization-act-2015-macra.
[5] Brad Smith, "CMS Innovation Center at 10 Years — Progress and Lessons Learned," *New England Journal of Medicine*, February 25, 2021, https://www.nejm.org/doi/full/10.1056/NEJMsb2031138.
[6] Pete Sepp, Andrew Lautz, and Doug Badger, "Center for Medicare and Medicaid Innovation: 12 Years into the Game, Taxpayers Still Don't Know the Score," National Taxpayers Union, May 3, 2022, https://www.ntu.org/publications/detail/center-for-medicare-and-medicaid-innovation-12-years-into-the-game-taxpayers-still-dont-know-the-score; Ekemini Isaiah et al, "Analysis of CMMI Models Projects Costs Rather Than Savings," Avalere, August 25, 2022, https://avalere.com/insights/analysis-of-cmmi-models-projects-costs-rather-than-savings.
[7] Geoff Gerhardt, Brian O'Donnell, and Rachel Burton, "Considering Current Law Updates to Medicare's Payment Rates for Clinicians," MedPAC, October 5, 2023, https://www.medpac.gov/wp-content/uploads/2023/03/PFS-update-reform-MedPAC-Oct-2023-SEC.pdf.
[8] Albanese, "What's the Prognosis?"
[9] CBO, *Federal Budgetary Effects of the Activities of the Center for Medicare and Medicaid Innovation*, September 2023, https://www.cbo.gov/system/files/2023-09/59274-CMMI.pdf; J. Michael McWilliams and Alice J. Chen, "Understanding the Latest ACO 'Savings': Curb Your Enthusiasm and Sharpen Your Pencils — Part 1," *Health Affairs Forefront*, November 12, 2020, https://www.healthaffairs.org/content/forefront/understanding-latest-aco-savings-curb-your-enthusiasm-and-sharpen-your-pencils-part-1.

III. Policy Alternatives

The current framework of value-based payment to physicians under MIPS and advanced APMs rewards a government-managed approach that has been unsuccessful at improving quality while reducing costs. The evidence suggests that policy improvements would result from repealing MIPS and providing no additional payments to clinicians for APM participation, which distort provider behavior, reward those who already benefit from participation, and reduce net savings.

Absent systemic reforms to Medicare value-based care programs, it may be more effective to incentivize provider participation in any payment arrangements (regardless of participation in a Medicare APM) that require downside risk for providers. To maximize efficiency and protect taxpayers, these be scaled down from the current advanced APM bonuses or applied in a budget-neutral manner.

Even more incrementally, financial incentives could be refocused to providers participating in the All-Payer Combination Option, which would encourage private payers such as Medicare Advantage (MA) plans to innovate value-based payment arrangements. One example of this approach is the MA Qualifying Payment Arrangement Incentive Demonstration previously enacted by the Centers for Medicare and Medicaid Services, which tested whether excluding clinicians from MIPS who participate in certain payment arrangements with MA plans would drive changes in care delivery.

IV. Conclusion

Medicare APMs and the incentives for participation have failed in their execution. There are significant costs to subsidizing initiatives that do not work. This is particularly concerning in light of the fiscal pressures faced by Medicare. Economic theory and evidence suggest that policy improvements would result from providers taking on more financial risk and minimizing ineffective government distortions of the health care sector.

Sincerely,

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