The Honorable Ami Bera, M.D.  
U.S. House of Representatives  
172 Cannon House Office Building  
Washington, DC  20515

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

The Honorable Kim Schrier, M.D.  
U.S. House of Representatives  
1123 Longworth House Office Building  
Washington, DC  20515

The Honorable Michael C. Burgess, M.D.  
U.S. House of Representatives  
2161 Rayburn House Office Building  
Washington, DC  20515

The Honorable Earl Blumenauer  
U.S. House of Representatives  
1111 Longworth House Office Building  
Washington, DC  20515

The Honorable Brad R. Wenstrup, D.P.M.  
U.S. House of Representatives  
2419 Rayburn House Office Building  
Washington, DC  20515

The Honorable Bradley Scott Schneider  
U.S. House of Representatives  
300 Cannon House Office Building  
Washington, DC  20515

The Honorable Marianette Miller-Meeks, M.D.  
U.S. House of Representatives  
1716 Longworth House Office Building  
Washington, DC  20515

SUBMITTED ELECTRONICALLY VIA macra.rfi@mail.house.gov

Dear Representatives Bera, Bucshon, Schrier, Burgess, Blumenauer, Wenstrup, Schrier, and Miller-Meeks:

The Society of General Internal Medicine (SGIM) welcomes the opportunity to provide feedback on this request for information (RFI) to inform legislative efforts to stabilize the Medicare payment system and improve the Centers for Medicare and Medicaid Services (CMS) Quality Payment Program (QPP) authorized under the Medicare Access and CHIP Reauthorization Act (MACRA).

While SGIM supports the transition to value-based health care, we believe that the longstanding imbalance in the Medicare Physician Fee Schedule (MPFS), which has undervalued non-procedural physician services, has impacted access to primary care services. MACRA attempted to encourage the move towards value-based care. However, health systems must determine how to allocate resources within alternative payment models (APMs), and to do so on the distorted legacy of the MPFS would undermine the goal of value-based care. Moreover, the distortions in the MPFS have contributed to the slow transition to value-based care. Given that health systems and provider organizations have been allowed to move
slowly, it is unsurprising that voluntary participation remains low when a fee-for-service system remains lucrative and stable for many services and specialties.

Recent updates and increased valuations of the evaluation and management (E/M) code families are a positive change. However, within Medicare’s budget-neutral framework, the impact has not been as significant as anticipated because of the associated conversion factor decreases, which Congress has only partially mitigated. Within the relative-value system under which Medicare operates, there is more work to be done to appropriately recognize the value of primary care and other non-procedural services. In order to improve the health of our nation, there must be a shift towards a health care system that protects and properly values primary care and preventive services. With appropriate investment, many costly, acute interventions may be avoided. Without proper relative valuation, the shortage of primary care physicians will continue. Additionally, the reductions to the conversion factor, which have led to across-the-board payment reductions to Medicare providers, indicate that CMS must do something to address the distortions in the MPFS to end the cycle of annual payment cuts requiring Congressional intervention.

The Effectiveness of MACRA
CMS published results of innovative models of care and payment from 2012 to 2020, indicating that six of 18 models demonstrated net savings after accounting for performance payments. These models included Accountable Care Organizations (ACOs) and surgical bundle models which generated savings by reducing inpatient hospitalizations and utilization of post-acute care services. It is important to note that only four models demonstrated improvements in mortality. Some APMs by private insurers (e.g., Blue Cross Blue Shield of Massachusetts Alternative Quality Contract) have demonstrated a slower growth in medical spending, resulting in net saving on claims in later years. While the effective models are worth expanding, there is extensive data on the negative impact of value-based programs on safety net systems, independent primary care practices, and nursing homes which have been overburdened by administrative reporting tasks due to elaborate reporting requirements, and facing penalties despite demonstrating improvement over time. Additionally, participation in value-based models has not been uniform, with smaller, rural, and safety net systems participating at lower rates. These issues must be addressed, and SGIM outlines our recommendations below.

How to Increase Provider Participation in Value-based Payment Models
Small independent primary care practices and health care systems providing care to underserved communities struggle to stay afloat as they face administrative burden related to MACRA and reimbursement disparities, further complicated by the COVID-19 public health emergency. We recommend active engagement of multidisciplinary groups of frontline

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4. https://www.jabfm.org/content/33/6/942.long
5. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2789442
clinicians, including physicians, nurses, physician-assistants, therapists, etc. in the process of developing models of care and performance metrics. Additionally, we recommend active work to identify the barriers to participation from safety net settings and historical non-participants. Adequate support must be provided to overcome these participation barriers (e.g., up-front infrastructure funding, incentives to recruit and retain staff, delayed and/or reduced downside risk, accounting for medical and social complexity of population, longer model run-time, and reduced reporting/administrative burden).

Additionally, payments must be adjusted to account for social drivers of health. This will simultaneously demonstrate the necessary focus on equity, end the historical underpayments and over penalization of safety net systems in value-based programs, and support historical non-participants in making the voluntary transition to value-based models.

Recommendations to Improve MIPS and APM Programs
SGIM believes that hybrid payment models are an appropriate transition to value-based care, allowing some stability of revenue from fee-for-service payments, with some movement towards capitated payments, allowing health systems to adopt a new revenue stream. However, the current landscape of quality measures of uncertain significance and high reporting burden continues to impede progress. Fewer, more aligned measures, and a lower initial emphasis on bonuses and penalties based on quality performance will allow movement towards prospective payments. A higher emphasis on performance-based modification to payments can be implemented over time, after health systems are accustomed to prospective, capitated payments.

While the total number of metrics in use in the health care industry is unknown, it has been reported that 1,700 metrics are used by CMS alone. Smaller independent primary care practices report seeing less patients since the enactment of MACRA, due to involvement in administrative tasks and reporting requirements. Safety net systems, in particular, struggle to meet reporting requirements. As such, SGIM recommends the following:

- Implementation of fewer, more simplified measures – Some CMS Innovation Center models use a streamlined set of measures, whereas MIPS uses hundreds, with some specialties able to select from dozens of measures.
- Multi-payer alignment of measures – The process of collecting and reporting metrics should be simplified and standardized across payers to reduce the administrative burden of reporting metrics that health care systems face. This will allow for the redirection of valuable resources to better facilitate patient care.

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6 https://jamanetwork.com/journals/jama/fullarticle/2685141
7 https://www.jabfm.org/content/33/6/942.long
• Adoption of health equity measures – Health equity measures must be introduced to ensure a focus on advancing health equity. SGIM would be pleased to have the opportunity to discuss this in further detail.

Thank you for the opportunity to provide this feedback. Should you have any questions or require additional information, please contact Erika Miller at emiller@dc-crd.com.

Sincerely,

LeRoi Hicks, MD, MPH
SGIM President