AMERICA'S PHYSICIAN GROUPS

July 27, 2023

H. Morgan Griffith
Chairman
Subcommittee on Oversight and Investigations
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Chairman Griffith:

Thank you for the opportunity to respond to the question from the Oversight and Investigations subcommittee following the June 22, 2023, hearing, "MACRA Checkup: Assessing Implementation and Challenges That Remain for Patients and Doctors."

The question raised was as follows: "What should CMS look at to ensure the APM bonuses are reasonable enough to allow specialists to be included so that collaboration between primary care and specialists is encouraged and rewarded?"

There is no simple answer to this question. To answer it, CMS would have to "get under the hood" of the many ways in which providers operate within the various Advanced Alternative Payment Models (AAPMs) for which providers can obtain MACRA bonuses. CMS would need to examine not only whether the bonuses are sufficient to draw both primary care providers and specialists into these arrangements, but also whether these arrangements themselves result in collaboration among primary care clinicians and specialists. It is certainly possible that CMS could require an evaluation of these questions, although it would be a painstaking study with multiple quantitative and qualitative components.

Such a study could explore several key questions, as follows:

- To what degree have specialists benefited from MACRA's original 5 percent bonus for clinicians participating in AAPMs (now changed by law to a 3.5 percent bonus for performance year 2023)?
- To what degree have the bonuses induced specialists to enter and remain in AAPMs?
- To what degree have the bonuses encouraged collaboration between primary care clinicians and specialists?

We have derived some anecdotal evidence on some of these questions from discussions with APG members and other health care organizations, leading us to the following four conclusions:

1. Based on this limited anecdotal evidence, we can assert that the bonus has produced modest financial benefits for health care entities engaged in AAPMs – and particularly for hospital and health systems that employ specialists and have been encouraged to enter and remain in

Medicare ACOs. Health care entities have used these funds to defray some expenses associated with entering AAPMs. However, far greater financial benefits have come from participation in the models themselves.

2. The bonuses do not appear to have been a major force in inducing specialists to join AAPMs.
3. It is unknown how much collaboration has resulted between primary care physicians and specialists engaged in AAPMs. Primary care doctors in arrangements that have taken on global risk, as in the ACO REACH model, have great incentives to collaborate with specialists, or to make referrals to specialists whom they believe will provide the most appropriate and cost-effective care. Some APG members also report that the bonuses have been helpful in defraying some start-up costs for models in which primary care and specialist collaboration is essential, such as Kidney Care First. But it is unclear whether the AAPM bonuses have induced more specialists to enter AAPMs and work in these collaborative relationships with primary care. In addition, as discussed below, it is more likely that specialists employed by hospitals and participating in hospital led ACOs are more greatly incentivized via compensation formulas that emphasize RVUs.

Below, we offer some additional analysis and insights that may be helpful as the subcommittee continues exploring these questions.

Background: Specialists and AAPM Bonuses

Today, most physicians in most specialties are in one of several categories: They are either employed by, or are owners of, large specialty or multispecialty groups; they are employed by hospitals or health care systems; or, if they are in independent practices, many are likely to be members of Independent Practice Associations (IPAs). The proportion of specialists in these categories varies by specialty, among other factors such as geography. For example, survey data from 2019 indicate that more than 70 percent of cardiologists are employed by hospitals and health systems, whereas the share of orthopedic surgeons employed by such systems is roughly 50 percent.[1]

For specialists employed by large medical groups or health systems, any bonuses earned may go to the group or system, rather than to the individual specialist who has technically earned them based on fee-for-service claims.

For example, my organization, Austin Regional Clinic, received approximately $400,000 in AAPM bonuses in 2022 on our attributed Medicare Shared Savings Program population of 18,000 patients. Because we employ about 400 physicians, the bonuses amounted to $1,000 per physician. As an organization, we used that money to build additional population health resources and create infrastructure, rather than passing along $1,000 to each individual doctor. By contrast, the shared savings that we derived from participating in MSSP have been far greater and have amounted to $70 million over nine years.

[1] American College of Cardiology, 2019, at https://www.acc.org/Membership/Sections-and-Councils/Cardiovascular-Management-Section/Section-Updates/2019/11/06/09/49/Has-Employment-of-Cardiologists-Been-a-Successful-Strategy-Part-1#:~:text=Today%2C%20analyses%20by%20a%20number,by%20hospitals%20or%20health%20systems; also https://www.beckersasc.com/orthopedics-tjr/orthopedic-surgeon-salary-hospital-employment-on-the-rise-3-statistics.html

Similarly, it is our understanding that for hospital systems engaged in ACOs, AAPM bonuses received on top of the fee-for-service claims billed go to the hospital system, not to individual physicians. Specialists employed by these systems typically have compensation formulas that at least in part reward them based on RVUs. It is not likely that any portion of their overall compensation is, strictly speaking, related to the AAPM bonuses, and if it were, their share of any bonuses would likely constitute at best a very small element of their compensation. For example, a urologist's typical compensation might be $800,000, whereas the total AAPM bonuses this physician could earn may total as little as $20,000.

Because the bonuses have been structured as a proportion of provider fee-for-service Medicare revenues, the incentive inherently favors health systems that are engaged in ACOs and that employ large numbers of specialists. Health systems in this category can thus derive up to several million dollars annually. They may retain these sums and put them toward population health programs that are aligned with the goals of value-based care; in any case, they do not typically share these revenues with specialists. It is our understanding that many health systems engaged in ACOs view these bonus-related revenues as shielding them from some of the risks of participating in ACOs and facing financial risks of losses. We would also note that the bonus payments are made with a two-year lag, a fact that makes it difficult to frame them as a major incentive for inducing specialists' participation in AAPMs.

These comments and observations should in no way be construed as dismissing the importance of involving specialists in AAPMs and in value-based care arrangements generally. Specialists are in prime positions to affect the costs and quality of care through various means: the selection of cases they treat; their decisions to treat these cases aggressively or conservatively; their selection of the site of service, such as a hospital outpatient department or an ambulatory center; as well as their referrals to home, home health care, post-acute care, or other care sites and services.

However, in terms of whether the 5 percent AAPM bonus should be restored in the interests of incentivizing more specialists to join ACOs, we would contend that the evidence is insufficient to restore the bonuses for this reason alone.

Given that federal resources are constrained, if there is a desire to spend additional sums to stimulate the move toward value-based health care, other measures could be much more effective. One option would be structuring bonuses as flat per-beneficiary amounts that could be paid to providers for each patient attributed to an ACO, including to ACOs not in two-sided risk arrangements, as J. Michael McWilliams proposed in his testimony at the MACRA hearing.[2] The advantage of bonuses structured as per-beneficiary payments, rather than as a percentage of fee-for-service payments, is that they could equalize the benefit of bonuses across primary and specialty care. An alternative would be to provide such bonuses to primary care clinicians only, given the need to draw more primary care clinicians into AAPMs and to support smaller independent physician practices in doing so.

Collaborative Relationships Between Primary Care and Specialists

As noted above, the AAPM bonuses do not seem to have been a major factor in drawing specialists into AAPMs. On the other hand, the bonuses appear to have played at least a small role in enabling entities

[2] McWilliams JM, Testimony Before the U.S. House Committee on Energy & Commerce Subcommittee on Oversight & Investigations, June 22, 2023.

to enter AAPMs that do depend on collaboration between primary care clinicians and specialists for their success. In APG's experience, the most collaborative relationships form when primary care clinicians and specialists in a clinical area proactively decide to work together to enter AAPMs to achieve specific goals of patient care. Often, these care goals are motivated by the need and desire to achieve the specific objectives of AAPMs, such as reducing hospitalization, readmissions, and unnecessary care.

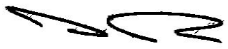
A case in point is the relationship forged at UCLA Health, an APG member, between primary care and the nephrology department around kidney care. Chronic and end-stage kidney disease are among the costliest medical conditions and can be devastating for patients. UCLA undertook an end-to-end redesign of kidney care, creating a patient-centered medical home model for chronic kidney disease through participation in the Center for Medicare and Medicaid Innovation's Kidney Care First model. The model requires collaboration between primary care and nephrology care – the members, in effect, of the "medical neighborhood" – as the basis for its success.

The driving force for participating in this model and creating greater collaboration between primary care and nephrology care was the model itself, and the incentives built into the model – namely, the opportunity to gain experience in a specialty-based value model, as well as adjusted capitation payments for managing the care of aligned beneficiaries with Stage 4 or 5 chronic kidney disease and for those entering or on dialysis. These payments are adjusted based on health outcomes and utilization, compared to both the participants' own experience and performance on quality measures.

In short, the financial and operational structure of the model itself, not the bonuses, provided the main impetus for collaboration and care redesign. However, according to UCLA Health, the bonus monies (when they are eventually received, as there is a two-year lag in payment) will be helpful in mitigating the cost of designing and implementing the model. As such, these funds are particularly helpful when organizations have startup costs for entering an AAPM, but do not know that they will ultimately succeed financially in the model.

I hope that these responses have been helpful. Please let us know if we can provide any further information.

Kind regards,



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cc: Representative Kathy Castor, Ranking Member, Subcommittee on Oversight and Investigations