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Statement of
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before the
Committee on Ways and Means
Subcommittee on Health
United States House of Representatives

IMPROVING VALUE-BASED CARE FOR PATIENTS AND PROVIDERS

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* The views expressed are my own and should not be attributed to the Urban Institute, its trustees, or its funders.

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Chairman Buchanan, Ranking Member Doggett, and members of the subcommittee:

I sincerely appreciate the opportunity to provide testimony to the committee as it attempts to determine why the value-based payment approaches adopted in the Affordable Care Act (ACA) and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) have not succeeded in improving quality or lowering the rate of spending growth and what changes might be warranted. It is a subject I have been deeply involved with throughout most of my career: I have served as a general internist in a practice just a few blocks from here; medical director of a preferred provider organization and two independent practice associations; senior official at the Centers for Medicare and Medicaid Services (CMS) in the Clinton administration in charge of provider payment policy in traditional Medicare and contracting with private risk plans, now known as Medicare Advantage plans; vice-chair of the Medicare Payment Advisory Commission (MedPAC); and an initial member of the Provider-Focused Payment Model Technical Advisory Committee (PTAC).

As an Institute fellow at the Urban Institute for the past 20 years, the majority of my work has focused on issues related to payment to physicians and other clinicians, in Medicare and more generally. I write frequently on why and how physician payment reform has gotten off track and have advocated for more value-based *care*, higher quality, and reduced spending increases while still ensuring access. Where I strongly disagree with the direction of health policy is on current concepts embedded in the value-based *payment* provisions of the ACA and MACRA.

In 2013, I testified before the Energy and Commerce Committee on the topic of building a future Medicare physician payment system. In that testimony, I expressed the view that central elements of how value-based payments were being considered were simplistic and would not improve care. I offered an alternative view of what would move payment to support enhanced care value. Congress proceeded to adopt MACRA provisions that I had testified would fail, while at the same time ignoring the long-standing need to fix the broken Medicare Physician Fee Schedule. As MedPAC vice-chair, I did support repealing the dysfunctional Sustainable Growth Rate (SGR), whose pervasive shadow had chilled interest in considering needed fee schedule reforms.

In short, Congress chose the wrong quid pro quo—the term then commonly applied to the trade-off for SGR repeal. Instead of making long-needed improvements to the Medicare fee schedule that would have substantially improved the value of care for beneficiaries and taxpayers, MACRA doubled down on "pay for performance" in the form of a merit-based incentive payment system (MIPS) and provided modest incentives for clinicians to participate in alternative payment models (APMs).

The evidence has shown that MIPS has failed and become a high-cost burden for clinicians without actually improving the quality of care. Demonstrations of APMs are needed but will continue to have limited impact without substantial fee schedule fixes. Now, 11 years after my testimony, as important MACRA provisions expire, I am experiencing a Yogi Berra moment of "*déjà vu* all over again." I reviewed my previous testimony and found major parts to be as relevant now as they were then. I cannot say it is better today, so I will quote some text from that testimony[1]:

[1] Robert A. Berenson, "SGR: Data, Measures and Models: Building a Future Medicare Physician Payment System," Statement before the Energy and Commerce Committee, February 14, 2013.

> "Value can be improved not only by improving how well particular services are provided but also by improving the kind and mix of services that beneficiaries are receiving. The Medicare fee schedule for physicians and other health professionals produces too many technically oriented services, including imaging, tests, and procedures, and not enough patient-clinician interaction to diagnose and develop treatment approaches consistent with a patient's values and preferences, and continuing engagement to assure implementation of mutually agreed upon treatment plans. Similarly, the fee schedule does not encourage care coordination and other patient-centered activities that would actually improve patient outcomes, including their own sense of well-being. In urging more attention to modifying payments and payment methods to obtain a better mix of clinician services, I want to emphasize that while I agree with the conventional policy wisdom that fee-for-service as a payment method has substantial, inherent flaws and over time needs to be replaced—mostly—fee-for-service gets an undeservedly bad reputation because of its flawed implementation in Medicare and by private payers, which largely rely on the Medicare Fee Schedule in setting their own fee schedules.
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> …In fact, I believe it is necessary, if seemingly paradoxical, to take firm steps to improve the fee schedule in order to implement new and improved payment reform models for a number of reasons. First, the migration to new payment models that better reward prudent care will not be easy or quick. Despite hopes for a fast track to new payment approaches, it will take years for the Medicare payment pilots to be tested, refined, and then scaled up to be implemented on a widespread basis. Second, fee schedule prices are building blocks for virtually all of the payment reform approaches being tested, most notably bundled episodes, but also shared savings and global payments for accountable care organizations. Errors in individual fees in the Medicare fee schedule would therefore be carried over into the bundled episodes and shared savings calculations.
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> Third, entities like ACOs will work best when formed around multispecialty group practices and independent practice associations, which would be well positioned to accept care responsibility for a population and to organize needed services across the spectrum of providers. But specialties that continue to be generously rewarded from distorted prices under current public and private fee schedules, such as cardiology and radiology, prefer to continue in large single specialty practices or to cash out and accept hospital employment rather than join with primary care physicians to form and maintain the medical group. Perpetuating the current, nearly 3:1 compensation differences between important specialists and primary care will frustrate the transition to ACO–like delivery systems, even if they are supported by new payment approaches."

'Pay for Performance' (P4P) Is Fatally Flawed

Quality-of-care experts and other policy analysts are increasingly joining earlier skeptics, including myself, to question whether using direct financial rewards and penalties to perform better on a small number of quality and cost measures—known as pay for performance (P4P)—can achieve their goals. Elizabeth McGlynn, widely acknowledged as a leading quality-of-care expert, noted in 2020, "Despite nearly two decades of experimentation with standardized measurement, public reporting, and reward-and-penalty programs, average quality performance in US health care remains about the same."[2] Michael McWilliams, a Harvard policy researcher and a leading evaluator of accountable care

[2] Elizabeth A. McGlynn, "Improving the Quality of US Health Care—What Will It Take?" *New England Journal of Medicine* 383, no. 9 (2020): 801–4.

organizations (ACOs), recently wrote, "After two decades of efforts relying on quality measurement and performance-linked payment incentives, we need new ideas and new conversations."[3]

My Urban Institute colleague Laura Skopec and I recently published an issue brief concluding that P4P approaches, which Congress has mandated across 20 different provider payment systems in Medicare[4] have failed for many reasons, which we grouped into two basic categories: (1) serious flaws with the measures used and their lack of reliability, and (2) serious adverse effects from the obsessive focus on measuring performance.[5] One of the most serious effects has been the preoccupation of providers and Medicare Advantage (MA) plans with their ratings, to the exclusion of other, often more useful approaches to actually improving care value. Lara Gotein, a physician trying to improve the quality of care in her small New Mexico hospital, observed in *Health Affairs*, "Ironically, metrics-based programs can undermine quality improvement by shifting resources and attention to measurement and reporting and away from actually improving quality."[6] Many trying to improve quality echo the same complaint about the role of the so-called measurement industrial complex. Measuring seemingly has become an end in itself rather than a facilitator of improved value.

P4P in Medicare takes several forms: bonus only, balanced bonuses and penalties, and penalty only. The Quality Bonus Program in Medicare Advantage provides windfall profits to most MA plans, yet the research evidence is clear that, overall, the quality of care in Medicare Advantage is about the same as in traditional Medicare,[7] acknowledging that certain MA plans—especially some special needs plans and group practice–based HMO–model MA plans, based on anecdotal reports—provide exemplary care.

MACRA's MIPS theoretically assesses both bonuses and penalties for clinician performance on a small number of quality measures, with funds collected from penalties used to finance bonuses. CMS deserves great credit for minimizing the potentially harmful impact of flawed measurement in MIPS by exempting nearly 500,000 clinicians, largely due to what CMS considered insufficient Medicare patient volume, and by minimizing the size of the penalties and bonuses received.[8]

A major P4P program created by the ACA is the Hospital Readmission Reduction Program (HRRP), the primary penalty-only P4P program in Medicare, which I supported at the time of ACA passage. Unfortunately, HRRP has exhibited various measurement problems and produced unanticipated

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[3] J. Michael McWilliams, "Professionalism Revealed: Rethinking Quality Improvement in the Wake of a Pandemic," *NEJM Catalyst* 1, no. 5 (2020).

[4] Douglas B. Jacobs, Michelle Schreiber, Meena Seshamani, Daniel Tsai, Elizabeth Fowler, and Lee A. Fleisher. "Aligning Quality Measures across CMS–The Universal Foundation," *New England Journal of Medicine* 388, no. 9 (2023): 776–79.

[5] Robert A. Berenson and Skopec Laura, "The Medicare Advantage Quality Bonus Program: New Ideas and New Conversation" (Washington, DC: Urban Institute, 2024), https://www.urban.org/research/publication/medicare-advantage-quality-bonus-program-new-ideas-and-new-conversations.

[6] Lara Goitein, "Clinician-Directed Performance Improvement: Moving Beyond Externally Mandated Metrics," *Health Affairs* 39, no. 2 (2020): 264–72.

[7] Robert A. Berenson, Bowen Garrett, and Adele Shartzer "Understanding Medicare Advantage Payment: How the Program Allows and Obscures Overspending" (Washington, DC: Urban Institute, 2022), https://www.urban.org/research/publication/understanding-medicare-advantage-payment.

[8] US Senate Committee on Finance, "Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B" (Washington, DC: US Senate Committee on Finance, 2024), https://www.finance.senate.gov/imo/media/doc/051723_phys_payment_cc_white_paper.pdf.

negative effects. Indeed, my colleague Skopec and I recently published an article documenting that the rates of preventive hospitalizations and emergency room visits have never been validated as legitimate quality measures, even as they have been adopted widely in research and policy.[9] When adjusted for hospitals redesignating inpatient admissions as observation stays—the designation for short-stay hospitalizations, which are not measured in HRRP—the data do not show that readmissions for the selected conditions have declined.[10] Even worse, initial research suggests that reduced hospitalizations for congestive heart failure, the leading cause of hospitalization in Medicare, can reduce quality for those patients.[11] An extensive literature also demonstrates that the program exacerbates inequity across hospitals, because hospitals serving a poorer population with fewer community and family resources will naturally have greater difficulty providing necessary care on an ambulatory basis.

In short, HRRP has not worked as envisioned. Congress urgently needs to reconsider its two-decade commitment to P4P approaches across Medicare payment systems. It can start by repealing MIPS and instead work on addressing the poor value produced by the Medicare fee schedule.

Alternative Payment Models

In contrast to P4P, quality and efficiency can be advanced with the implementation of alternative payment models. APMs for physicians, which constitute the bulk of APMs being tested by the Center for Medicare and Medicaid Innovation (CMMI), need to be built on a solid, well-functioning fee schedule foundation. CMS initially, and later CMMI's affiliated Health Care Payment Learning and Action Network (LAN), have long held that fee-for-service provides "no link to quality and safety."[12] I strongly disagree. How physicians and other health professionals spend their clinical time and what additional services they provide, order, or refer have as much or more to do with the value of care furnished as do the marginal incentives that APMs contain. Other countries produce as good or better quality at much lower costs relying on fee-for-service-based fee schedules rather than APMs.[13] A more accurate fee schedule should be a strong foundation for APMs.

The LAN typology that dismisses fee-for-service as having no link to quality exalts so-called population-based payment, previously called capitation (payment per capita rather than for services furnished), as having the greatest potential link to care value. That designation ignores the central reality that every payment method has strengths and weaknesses, such that the objective of value-

[9] Robert A. Berenson and Laura Skopec, "How Preventable Hospitalizations Became A Widely Used But Flawed Quality Measure," *Health Affairs*, June 3, 2024, https://www.healthaffairs.org/content/forefront/preventable-hospitalizations-became-widely-used-but-flawed-quality-measure.

[10] Amber K Sabbatini, Karen E. Joynt-Maddox, Joshua M. Liao, et al., "Accounting for the Growth of Observation Stays in the Assessment of Medicare's Hospital Readmissions Reduction Program," *JAMA Network Open* 5, no. 11 (2022).

[11] Ankur Gupta and Gregg C. Fonarow, "The Hospital Readmissions Reduction Program—Learning from Failure of a Healthcare Policy." *European Journal of Heart Failure* 20, no. 8 (2018): 1169–74.

[12] Health Care Payment Learning and Action Network (HCP LAN), *Alternative Payment Model APM Framework* (Baltimore, MD: HCP LAN and The MITRE Corporation, 2017), https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf.

[13] Naoki Ikegami, "Fee-for-Service Payment—An Evil Practice that Must Be Stamped Out?" *International Journal of Health Policy Management* 4, no. 2 (2015): 57–9.

based payment reform should be to mix and match different payment methods to accentuate the positives and mitigate the negatives.

There is growing recognition among beneficiaries and policymakers that pure payment methods—such as fee-for-service and per capita payment—can produce major adverse effects that should be mitigated. Many MA plans funded by pure capitation are able to siphon off a substantial portion for their own profits while inappropriately denying service to their enrollees and obligated payments to providers.

Although I had been a proponent of pure population-based payments to organizations like ACOs to give them more control over how to allocate resources to better serve their enrolled or attributed populations, I now see the merits of blending fee-for-service and population-based payment to clinicians and shared savings to the ACOs. One challenge that needs to be addressed is the mismatch between the ACO's desire to achieve shared savings and the way its constituent physicians are paid via the Medicare fee schedule, which incentivizes more care, needed or not. ACOs can assist care delivery choices and reduce spending for certain activities, such as reducing the often unneeded referrals to skilled nursing facilities (SNFs) or inpatient rehabilitation after a common joint replacement surgery. However, for the bread-and-butter care provided by physicians, the distorted fees in the fee schedule undermines ACOs' ability to achieve savings.

To its credit, responding to recommendations from the primary care panel at the National Academy of Medicine, CMS recently announced an ACO Primary Care Flex option under the Medicare Shared Savings Program waiver authority, under which primary care clinicians would be paid through a "hybrid" payment—part fee-for-service and part per capita payments. In contrast to current value-based payment notions, the hybrid payment approach in essence attempts to minimize payment incentives to do too much or too little but rather seeks incentive neutrality so that the practice can serve the patient's best interests rather than their own. The National Association of Accountable Care Organizations and the Primary Care Collaborative worked with CMS to design the hybrid model, which is scheduled for initial implementation in 2025.

Anticipated lessons from ACO Flex and from the already completed CMMI primary care demonstrations should provide the needed experience to allow adoption of a hybrid payment model for all primary care clinicians in Medicare,[14] the point being that "fee-for-service" and "fee schedules" are not synonymous. The Medicare fee schedule already includes examples of bundled payments (10- and 90-day global periods) for most surgical and other procedures, rather than separate payments for post-procedure hospital and office visits, such as a monthly per capita payment for managing dialysis and a monthly chronic care management payment. Given explicit authority to include prospective payment in the fee schedule, CMS could proceed to adopt a hybrid payment approach for primary care clinicians in the Medicare fee schedule through regular rule making.

When I served as an initial member of PTAC, my colleagues and I found that many submitted proposals had thoughtful concepts and could produce desirable care improvements that did not require

[14] Robert A. Berenson, Adele Shartzer, and Hoangmai H. Pham, "Beyond Demonstrations: Implementing a Primary Care Hybrid Payment Model in Medicare," *Health Affairs Scholar* 1, no. 2 (2023).

CMMI to test an entirely new payment model, which would then need to pass muster with the CMS Office of the Actuary for broad adoption in Medicare. Instead, the proposals from specialty societies and others constituted suggestions that seemed more appropriate for adoption within the Medicare Physician Fee Schedule, with the challenge often coming down to issues of operational feasibility. The relevance for this subcommittee's consideration is that APM development and adoption and Medicare fee schedule maintenance and improvement are currently in separate substantive and organizational silos at CMS, consistent with Congress's erroneous view that the fee schedule and APMs are wholly separate endeavors.

PTAC could be reconfigured, first, to report to the CMS administrator, the logical place to have its views expertly considered, rather than to the secretary of the US Department of Health and Human Services. Second, PTAC should expand its advice beyond just APMs to include considerations of process improvements to coding and payment in the fee schedule.[15] Additionally, CMS will require a technical advisory committee to support CMS staff as they determine what fixes are needed to the process of setting fees in the fee schedule, as proposed in draft Whitehouse-Cassidy legislation.

The AMA Proposal

Last year, the American Medical Association (AMA) initiated a major campaign "to explore long-term payment solutions for the broken Medicare physician payment system."[16] However, instead of proposing fixes to what we agree is a broken system, the AMA merely proposed updating annual fee increases for inflation in practice costs and changing the budget-neutrality provision that dilutes the value of relative value units for established codes in the fee schedule. The AMA's supporting analysis claims that Medicare fee schedule payments have substantially lagged inflation in practice expenses for two decades. However, as MedPAC has shown, actual payments—as reflected in spending per beneficiary, rather than prices—were much higher because of substantial growth in service volume.[17] Although cumulative fee update growth over the time frame was 12 percent, compared with Medicare Economic Index (MEI) growth of 45 percent, growth in per beneficiary spending was a cumulative 94 percent, meaning that volume growth more than offset the gap between the MEI and annual fee updates.

Although a partial MEI update for the 50 percent of fees that represent practice expenses has merit, the far greater problem (as the AMA writes but then ignores), is that the Medicare physician payment system is broken, and as such prevents the successful adoption of value-based payments in Medicare. Congress could adopt a far better quid pro quo than it did in MACRA, this time in exchange for a partial annual MEI update factor. The trade-off should be specific actions to improve the Medicare fee

[15] Robert A. Berenson and Paul B. Ginsburg, "Improving the Medicare Physician Fee Schedule: Make It Part of Value-Based Payment," *Health Affairs* 38, no. 2 (2019): 246–52.

[16] "Medicare Basics Series: The Medicare Economic Index," American Medical Association, June 3, 2024, https://www.ama-assn.org/practice-management/medicare-medicaid/medicare-basics-series-medicare-economic-index.

[17] Medicare Payment Advisory Commission, *Medicare Payment Policy* (Washington, DC: MedPAC, 2023), https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_v2_SEC.pdf.

schedule, as outlined in a recent comment letter with contributions from former CMS and MedPAC career staff responsible for the fee schedule.[18]

Enacted in the Omnibus Reconciliation Act of 1989, the current Medicare Physician Fee Schedule has been in place, largely unchanged, for 32 years. Although many payment codes have come and gone, the basic legislative requirements for what fees should reflect—relative resource costs—need to be reconsidered if Congress is truly interested in adopting value-based payment for services provided by physicians and other clinicians. More immediately, Congress should understand that APMs by themselves cannot achieve what Congress seeks without urgent attention toward fixing the major fee distortions that directly influence clinician behavior.

[18] Medicare Payment Advisory Commission, *Medicare Payment Policy*.