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The Honorable John Joyce, MD
Co-Chair, GOP Doctors Caucus
2102 Rayburn House Office Building
Washington, DC 20515

The Honorable Kim Schrier, MD
Chair, Congressional Doctors Caucus
1110 Longworth House Office Building
Washington, DC 20515

The Honorable Greg Murphy, MD
Co-Chair, GOP Doctors Caucus
407 Cannon House Office Building
Washington, DC 20515

Dear Drs. Joyce, Murphy, and Schrier:

The AAMC (Association of American Medical Colleges)[1] appreciates the opportunity to respond to the GOP Doctors Caucus and Congressional Doctors Caucus request for information (RFI) on improving aspects of the Medicare and CHIP Reauthorization Act (MACRA, P.L. 114-10). We appreciate your bipartisan approach to gathering feedback and working on potential policies to improve MACRA.

We recognize that you and the members of the Caucuses are very familiar with academic medicine and the missions of our member institutions. Through their mission of providing the highest quality patient care, teaching physicians who practice at academic health systems and teaching hospitals provide care in what are among the largest physician group practices in the country, often described as "faculty practice plans," because many of these physicians teach and supervise medical residents and students as part of their daily work. These plans are typically organized into large multi-specialty group practices that deliver care to the most complex and vulnerable patient populations, many of whom require highly specialized care. Often, care is multidisciplinary and team-based. These practices are frequently organized under a single tax identification number (TIN) that includes many specialties and subspecialties. Recent data shows that faculty practice plans range in size from a low of 315 individual national provider identifiers (NPIs) to a high of 5,692 NPIs, with a mean of 1,857 and a median of 1,479.[2] These practices

[1] The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, clinical care, biomedical research, and community collaborations. Its members are all 162 U.S. medical schools accredited by the Liaison Committee on Medical Education; nearly 500 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 210,000 full-time faculty members, 99,000 medical students, 162,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Through the Alliance of Academic Health Centers International, AAMC membership reaches more than 60 international academic health centers throughout five regional offices across the globe.
[2] Data derived from The Clinical Practice Solutions Center (CPSC), developed by the Association of American Medical Colleges (AAMC) and Vizient.

support the educational development of residents and physicians who will become tomorrow's physicians.

Teaching physicians are vital resources for their local and regional communities, providing a significant volume of primary care services and other critical services, including a large percentage of tertiary, quaternary, and specialty referral care in the community. Their patient base may span regions, states, and even the nation. They also treat a disproportionate share of patients for whom issues such as housing, nutrition, and transportation contribute significantly to additional health challenges, adding greater complexity to their care.

AAMC member faculty physician practices continue to highlight struggles that they encounter under the implementation of MACRA, in particular, the frequent annual pay cuts that can occur. While Congress has mitigated some of these cuts, the uncertainty necessitates difficult decisions regarding staffing, patient care, and facility maintenance. We are pleased to have the opportunity to respond to your questions and submit the following:

1. What legislative reforms are most needed to ensure future CMMI models deliver real improvements in cost and quality, while also ensuring successful scaling of innovations?

The AAMC believes that, while the Center for Medicare and Medicaid Innovation (CMMI) has done worthwhile work, two key reforms are needed to both alleviate the burden on AAMC members, improve quality, and ensure that models are focused on patient access to care:

Provide Additional Guardrails on CMMI's Waiver Authority
As currently designed, the Centers for Medicare and Medicaid Services (CMS) has broad waiver authority for model tests under the Sec. 1557 authority that established the Innovation Center. The AAMC believes this waiver authority should be reined in regarding the development of mandatory models where health care providers have no choice whether or not to participate. While the AAMC understands that mandatory models may be necessary to ensure CMS meets the goal of 100% of Medicare patients in accountable care relationships, guardrails must be in place to ensure providers forced to participate in models have the necessary and appropriate supports to succeed. The AAMC believes CMMI should be limited to developing mandatory models where there is no financial downside risk in the first performance year, and that downside risk should only be introduced where CMS has meaningfully shared critical data with model participants for a year to inform care redesign necessary for model success. For example, where a mandatory model has a one-year ramp-up period of performance without downside risk, CMS could only transition to downside risk in the second performance year, where it is able to demonstrate timely data sharing with participants during the first performance year.

Include "Access to Care" as a Condition for Model Expansion
Current statutory requirements for expanding CMMI models focus on reducing spending while preserving or enhancing the quality of care. The AAMC believes a third prong should be introduced. Specifically, requiring models to maintain or improve Medicare patients' access to care. While access may be a measure of quality under the current expansion conditions, it is not

expressly so, and thus, access could deteriorate under a model. Under such conditions, a model that generates savings by reducing patients' access to care should not be eligible for expansion.

2. If MIPS were to be reformed or replaced entirely, what would a new physician-led quality program look like? How can we ensure a new program reduces administrative burdens and is applicable to all types of clinicians in all settings, while focusing meaningfully on real outcomes.

The AAMC recommends that any reform or replacement of MIPS advance a quality program that meaningfully improves patient outcomes, supports participation in value-based care, and reduces administrative burden for clinicians across all settings. To achieve these goals, Congress should strengthen and sustain Advanced Alternative Payment Models (AAPMs), remove barriers to participation, and make targeted improvements to MIPS to ensure fair measurement, appropriate risk adjustment, and more meaningful, less burdensome reporting, including the following:

Extend the Advanced APM Bonus
One goal of MACRA was to provide physicians with a glide path to transition from fee-for-service (FFS) to advanced alternative payment models (AAPMs). To encourage this transition, Congress established a 5% bonus payment for clinicians who participate in AAPMs from 2019-2024.

For the 2023 performance year (which correlates with the 2025 payment year), Congress established a 3.5% bonus payment. And for the 2024 performance year (2026 payment year), Congress established a 1.88% bonus payment. Unfortunately, in performance year 2025 and subsequent years, there is no further statutory authority for an AAPM bonus payment. However, beginning with performance year 2024, which correlates with CY 2026 payment, there will be two different PFS conversion factors depending on whether the services are furnished by an eligible clinician who is a qualifying participant (QP) for the year. In the 2023 PFS rule, CMS noted that the updates for QPs in AAPMs are not expected to match the anticipated maximum available positive payment adjustment potentially available under the Merit-based Incentive Payment System (MIPS) until after CY 2038. The AAPM incentive payments served as an important tool for attracting clinicians to participate in advanced APMs, and the AAMC is concerned that the expiration of these incentive payments will hinder the ability of clinicians to participate in AAPMs.

Value-based care is improving patient care and successfully reducing costs in the health care system. These payment system reforms have been a good investment for the government. For example, accountable care organizations (ACOs) participating in the Shared Savings Program have saved Medicare $13.3 billion in gross savings since 2012, and, according to a Department of Health and Human Services (HHS) Inspector General Study, ACO clinicians have

outperformed FFS providers on 81 percent of quality measures.[3] APMs give providers tools to innovate and coordinate care, resulting in improved outcomes for beneficiaries.

Under AAPMs, participating clinicians bear financial risk for the cost and quality of care. The bonus payments have been critical to clinicians in covering the investment costs of moving to new payment models and reinvesting the 5 percent bonus payment into practice redesign to better manage care. This includes investing in new electronic health records (EHRs), additional staff, telehealth managers, telehealth platforms, and other areas that will enable them to better manage care when they bear the financial risk. For example, ACOs have used these incentives to fund wellness programs, pay for patient transportation and meals programs, and hire care coordinators. Although these services are not typically reimbursed under the Medicare program, they have been shown to improve health outcomes.[4,5]

The AAMC is concerned that the lack of a financial incentive under the QPP for APMs for the CY 2028 payment will limit participation in AAPMs in performance year 2026 and subsequent years. While there will be a higher update to the conversion factor beginning in the 2026 payment year for QPs in an AAPM as compared to non-QPs, we do not believe that this higher update will be sufficient to incentivize participation. Therefore, we urge Congress to pass legislation, such as the Value in Health Care Act (H.R. 5013) from the 118th Congress, which would extend the AAPM 5 percent bonus for an additional 6 years.

Modify Thresholds to Achieve Qualifying Participants (QPs) Status in AAPMs
To be classified as a QP or partial QP in an AAPM, providers need to meet or exceed thresholds based on the number of patients seen or payment received for services provided through AAPMs. These thresholds, which were established by Congress in 2015, have been progressively increased per statute since the start of the program. Originally, the Medicare statute set higher thresholds for CY 2023 payment. Beyond that, the law increased the requirements so that a QP must have at least 75 percent of their revenue in the Medicare FFS program received through a Medicare APM, or 50 percent of their Medicare FFS patients would need to receive services through the APM. These thresholds are very high and would have made it much more difficult for an eligible clinician to be considered a QP and to receive the 5 percent bonus payment in 2023. Congress recognized this problem and addressed it in the Consolidated Appropriations Act, 2021, which froze the thresholds for CYs 2023 and 2024 at the CYs 2021 and 2022 levels. In the Consolidated Appropriations Act of 2024, Congress extended the existing thresholds through payment year 2026. The AAMC supported the change to these thresholds.

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[3] US Department of Health and Human Services Office of the Inspector General, "Medicare Shared Savings Program Accountable Care Organizations Have Shown Potential for Reducing Spending and Improving Quality," Report (OEI-02-15-00450) (August 2017)
[4] Shier et. al., Strong Social Supports, Such as Transportation and Help for Caregivers, Can Lead to Lower Health care use and Costs, Health Affairs Vol. 32, No. 3 (March 2013).
[5] Williams et. al., Sustainable care coordination: a qualitative study of primary care provider, administrator, and insurer perspectives, BMC Health Serv Res. (February 2019).

The AAMC remains deeply concerned about the increases to the thresholds that occur for the CY 2027 payment year (2025 performance year) and subsequent years without Congressional intervention. The increasing thresholds that must be met to be considered qualified participants in an AAPM will discourage participation, thereby limiting beneficiary access to high-quality and better coordinated care. It is very difficult for AAPMs to increase the volume of payments received through the AAPM or the number of Medicare FFS patients who receive services through the AAPM. It is especially difficult for ACOs in rural areas and those that include specialists, since primary care services are used to determine ACO assignment. We urge Congress to give CMS the authority to set thresholds in the future at a level that will incentivize participation in advanced alternative payment models.

Improve AAPM Participation Through Additional Policy Changes
While the bonus payments are very important, other factors affect an eligible clinician's decision about whether to participate in an AAPM. Providers consider whether the APM model aligns with care goals for their patient populations, especially whether the APM will enable them to be reimbursed for providing more coordinated, high-quality care than the current system. In addition, providers assess the overall financial opportunity of participation in the APM, including:
1) the availability of shared savings;
2) whether the benchmark methodology sets financial targets that are adequately risk-adjusted ;
3) whether there is sufficient volume of patients so that a small number of outliers do not impact success;
4) administrative burden associated with data submission requirements; and
5) whether there is enough time for implementation before downside risk applies.

Making changes to the program that address these factors can make it more attractive for providers to participate in AAPMs and improve health outcomes. Specific actions that would encourage participation in AAPMs include changing the benchmarking methodology, increasing shared savings opportunities, reducing administrative burden, allowing more flexibility, and allowing longer transitions to downside risk.

Specifically, for the Medicare Shared Savings Program, we recommend:

- **Removing ACO beneficiaries from regional benchmarks** to ensure ACOs are not penalized as they achieve savings for their assigned populations.
- **Eliminating high/low revenue distinctions** for ACOs and basing distinctions on patient characteristics instead.
- **Considering approaches to address population health**, such as incorporating upstream drivers of health in risk adjustment to financial benchmarks to ensure that APM participants are not disadvantaged for serving medically and socially complex beneficiaries. Alternatively, consider paying for services that address upstream drivers of health that do not penalize providers in comparison to historical spending.
- **Allowing advance payments** for all new, inexperienced ACOs to assist in the upfront costs needed to become an ACO.

- **Slowing the Path to Risk** for all new ACOs to encourage participation in the program.

Additional Improvements Under MIPS
The AAMC urges Congress to make additional changes to the Quality Payment Program (QPP) to make reporting and performance more meaningful for physicians and consumers and to encourage participation by increasing the pool of dollars available for payment incentives.

The MIPS incentives are budget-neutral so that any positive payment adjustments are funded by penalties. The only exception to budget neutrality has been a separate $500 million pool of funding established under MACRA for eligible clinicians who exceed the exceptional performance threshold. Under the MACRA statute, the $500 million funding allocation expired at the end of the 2022 performance year (2024 payment). Due to budget neutrality, this exceptional performance funding pool made up the bulk of positive payment adjustments received by clinicians. Even when this funding was available, the annual MIPS maximum payment adjustments were very low relative to the maximum percentages that were allowed under MACRA. Eligible clinicians who achieved the MIPS performance threshold had positive adjustments around zero, and those who achieved the exceptional performance threshold had positive adjustments below 2 percent.

To make reporting and performance more meaningful for physicians and patients, the AAMC recommends that cost measures used in MIPS be appropriately adjusted to account for the clinical and social complexity of patients. Differences in patient clinical complexity and health-related social needs can drive differences in average episode costs and performance on other measures. Without accurately accounting for the full complexity, the scores of physicians who treat vulnerable patients will be negatively and unfairly impacted, and their performance will not be adequately reflected in their MIPS score. Physicians at academic medical centers care for a vulnerable population of patients who are sicker, poorer, and more complex than many patients treated elsewhere.

It is critical that when measuring performance under MIPS, there is an accurate determination of the relationship between a patient and a clinician to ensure that the correct clinician is held responsible for the patient's outcomes and costs. This is complicated given that patients often receive care from multiple clinicians across several facilities and teams within a single practice or facility. The attribution method should be clear and transparent to clinicians. We suggest that better data sources and analytic techniques should be explored in the future to support attribution.

The AAMC also recommends that Congress and CMS explore ways to reduce administrative burden under MIPS so that eligible clinicians can focus on providing high-quality care to their patients. One way to reduce burden for clinicians is to further ensure that AAPM participation is less burdensome than MIPS, as originally intended by Congress. We are concerned about the burden of recent CMS policies, such as the 2024 Quality Payment Program rulemaking establishing MIPS as the baseline for all clinicians regardless of AAPM participation, and the

future sunsetting of traditional MIPS reporting for MIPS Value Pathways.[6, 7] We urge CMS to continue to make MVP reporting voluntary for the foreseeable future, given some of the conceptual challenges with the MVP reporting. Practices should be given the opportunity to assess the advantages and disadvantages and select whichever option is most meaningful and least burdensome for participating in the QPP under MIPS.

On behalf of America's medical schools, academic health systems and teaching hospitals, and physician faculty, we thank you for your work to address these issues, and we look forward to collaborating with you in the future. We are proud to have so many physicians serving in Congress and are very interested in making bipartisan improvements to the health care system. If you have any questions regarding these requests, please contact me (dturnipseed@aamc.org) or my colleague, Ally Perleoni, Director, Government Relations (aperleoni@aamc.org).

Sincerely,

Danielle Turnipseed, JD, MHSA, MPP
Chief Public Policy Officer
Association of American Medical Colleges

CC: David Skorton, MD, AAMC President and CEO

[6] Community Letter to CMS on CEHRT Policies for Value-Based Care (April 2024).
[7] 90 FR 49266, at 49841 (Nov. 5, 2025).