Medical Group Management Association

Statement for the record

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

Re: Implementation of MACRA's Physician Payment Policies

Anders Gilberg, MGA
Senior Vice President, Government Affairs
agilberg@mgma.org

1717 Pennsylvania Ave NW Suite 600
Washington, DC 20006
202.293.3450
(f) 202.293.2787

March 22, 2018

The Medical Group Management Association (MGMA) commends the Committee on Ways and Means Subcommittee on Health for convening this hearing on "Implementation of MACRA's Physician Payment Policies." MGMA represents 12,500 medical group practices of all sizes, specialties, types and structures, which collectively provide almost half of the healthcare in the United States.

MGMA appreciates Congress' ongoing leadership and oversight efforts to ensure successful implementation of the sweeping payment reforms enacted in the Medicare Access and CHIP Reauthorization Act (MACRA). We applaud Congress making technical corrections to MACRA in the Bipartisan Budget Act, another example of its continued support for the innovative care delivery improvements taking place in group practices across the country. We are optimistic that these changes will be a catalyst for improving the Merit-based Incentive Payment System (MIPS) beginning in 2019 and expanding Advanced Alternative Payment Model (APM) opportunities in the near future.

Since MACRA passed, MGMA has partnered with Congress and the administration to help physician practices succeed in the Quality Payment Program (QPP). We have hosted numerous educational events that connect our members directly with Centers for Medicare & Medicaid Services (CMS) staff, served as informational and educational resources for our members by dispensing news and information related to MIPS, and provided suggestions to policy makers based on feedback from our members. On March 15, MGMA offered several MACRA-specific

recommendations to this Subcommittee at the "Red Tape Relief Initiative" Roundtable. We also collaborate with other stakeholder groups as part of various coalitions, including a MIPS workgroup that submitted to CMS comprehensive suggestions for reducing clinician burden, several of which are reflected in these comments.

We appreciate Congress' work to support physician practices transitioning to value-based payment in Medicare by passing MACRA and exercising oversight authority to help facilitate implementation. We hope these comments will help Congress and the administration improve the QPP, align it with congressional intent in MACRA, and ensure a successful transition to a new Medicare payment system centered around high-value care.

Reduce Medicare quality reporting documentation requirements

Group practices are now 81 days into a 365-day quality reporting period without the most basic information regarding whether they are eligible to participate in MIPS this year. This information gap is exacerbated by the burden of full-year quality reporting with little evidence of care improvement compared to a 90-day reporting period. This is unnecessarily burdensome for those reporting providers who will ultimately be deemed excluded from the program and moreover, at odds with Congress' goal of reducing the cost of healthcare, as full-year quality measure tracking and reporting is estimated to cost medical groups close to $700 million in 2018.[1]

Based on a study of MGMA member practices, this cost estimate may be low. [2] Our research determined that each year physician practices in four common specialties spend, on average, 785 hours per physician and more than $15.4 billion on quality measure reporting programs. Most of the time spent on quality reporting consists of "entering information into the medical record only for the purposes of reporting for quality measures from external entities."

We urge this Subcommittee to provide immediate relief by working with CMS to shorten the current MIPS quality reporting period to 90 consecutive days. There is precedent for this action. In response to the introduction of legislation[3] to shorten the Meaningful Use EHR reporting period from a full year to three months, CMS retroactively amended its regulations to relieve the onerous reporting burden in 2014, 2015 and 2016. Congress should consider using its influence in the same way to relieve the quality reporting burden in MIPS.

Put patients over paperwork in MIPS

MGMA strongly supports CMS' goal to emphasize "high-value care and patient outcomes while minimizing burden on eligible clinicians" in MIPS.[4] Unfortunately, rather than relieve the burdens of participation, the current MIPS program exacerbates them. Rather than maintain a stable, already robust reporting period minimum of 90 days across all MIPS categories in year

[1] 82 Fed. Reg. 53577, *Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year*, CMS-5522-FC and IFC.
[2] Lawrence P. Casalino, David Gans, Rachel Weber, Meagan Cea, Amber Tuchovsky, Tara F. Bishop, Yesenia Miranda, Brittany A. Frankel, Kristina B. Ziehler, Meghan M. Wong and Todd B. Evenson, "US Physician Practices Spend More Than $15.4 Billion Annually to Report Quality Measures," Health Affairs 35, no.3 (2016).
[3] H.R. 3940. The Meaningful Use Hardship Relief Act of 2015.
[4] 82 Fed. Reg. 30011, *Medicare Program; CY 2018 Updates to the Quality Payment Program*, CMS-5522-P.

two, CMS quadrupled the reporting period for quality measures. Rather than realize the goal of MACRA to streamline quality reporting under one program, CMS continued the siloed approach of PQRS, Meaningful Use, and the Value Modifier by drawing bright lines between the four MIPS categories, each of which has a unique, complex reporting and scoring scheme.

Not only does this increase in regulatory burden contradict CMS' initiative to promote patients over paperwork, it coincides with growing skepticism that MIPS as implemented neither reflects nor incentivizes clinical quality improvements in medical groups. According to a recent study of more than 750 MGMA member practices, more than 70% of respondents were very or extremely concerned about the lack of clinical relevance to patient care. [5] Articulating a theme we hear regularly across the country, one practice leader wrote: "We are a GI single specialty clinic. I can use the specialty measures for the MDs but not the mid-level providers as they don't apply. I have to have two sets of MIPS requirements and measures. It's extremely burdensome."

To assist CMS in resetting its approach and achieving its stated goals of reducing clinician burden in MIPS and enhancing patient care, MGMA encourages Congress to instruct CMS to make the following high-impact improvements to MIPS:

1. **Permanently shorten the minimum MIPS reporting period to any 90 consecutive days** using sampling and attestation methodologies that ensure statistical validity. Participants should have the option to report more data as needed.

2. **Decrease the number of measures across MIPS**. Physician group practices' finite resources are spread across at least 15 measures, including a minimum of six quality measures, two cost measures, five advancing care information (ACI) measures, and two improvement activities. CMS should structure MIPS to allow practices to prioritize effective and impactful improvements to patient care, rather than comply with sprawling reporting mandates.

3. **Simplify MIPS and reduce redundancies by awarding cross-category credit.** As implemented, MIPS reflects a continuation of the agency's historically siloed approach to quality reporting, consisting of four programs under one umbrella. To reduce burden, CMS should award credit in multiple categories for overlapping efforts. For instance, clinicians should receive credit in both the quality and ACI categories when they report quality measures via end-to-end electronic reporting using certified electronic health records.

4. **Provide clear and actionable feedback about MIPS performance at least every calendar quarter,** as recommended by the statute. Without timely feedback, MIPS is essentially a reporting exercise that enters data into a "black box" only understood by CMS, rather than a useful barometer practices can leverage to drive clinical improvement.

5. **Release critical MIPS information prior to the start of the performance period**. To participate successfully and, more importantly, implement evidence-based actions at the

[5] MGMA 2017 Regulatory Burden Survey, *Summary of Findings*, available at www.mgma.org/regrelief.

point of care, groups need time to plan and review key program details, such as the quality measure specifications and benchmarks, qualified vendor lists, and clinician and group practice eligibility determinations.

Support the development of more APMs

MGMA agrees with Congress that APMs are a key piece of the transition to a value-based payment system. However, with seven qualifying models accepting new applicants this year and only two among these being specialty models, APMs are hardly the robust alternative to MIPS Congress envisioned. Congress should work with CMS to encourage and support the approval of a large and diverse set of new APMs, particularly before the 2022 performance year when the 5% lump sum bonus is set to expire under current statute. There are several immediate steps Congress could take to work with CMS to significantly expand the APM pathway.

First among these is relieving some of the unnecessary restrictions CMS has placed on current Medicare APMs, such as the arbitrary 50-clinician cap for the Comprehensive Primary Care Plus Program and "primary care focus" requirement[6] to qualify as a Medical Home Model. Congress could also direct CMS to establish a separate, lower risk threshold for such practices. In many cases, small and rural practices who may be interested in joining an Alternative Payment Model but may not have the same ability to take on risk as larger health systems. Expanding the definition of Advanced APMs to include federal payers other than traditional Medicare would also quickly expand participation. MGMA is encouraged by CMS' plans to implement a Medicare Advantage (MA) demonstration and appreciates this subcommittee's attention to that matter in a recent letter to the agency. We echo the sentiment in that letter that CMS should roll out the demonstration as expediently as possible.

Under MACRA, Congress had the foresight to create an All-Payer Option to qualify for the APM threshold, recognizing the significant role APMs play in the market. Under the statute, non-Medicare APMs may count toward the All-Payer Option starting in 2019. Despite this, CMS does not plan to count private payer models until 2020, which is all-the-more concerning given the 5% lump sum bonus expires at the end of 2021. The process by which non-Medicare payers must request APM determinations is also unnecessarily burdensome, requiring developers to resubmit every year, even if nothing has changed. We urge Congress to direct CMS to rethink both these policies to facilitate faster development and participation in APMs.

We commend Congress for creating the Physician Focused Payment Model Technical Advisory Committee (PTAC) and its continuing support of the important role PTAC plays in the development of APMs by explicitly permitting PTAC to provide model developers with initial feedback under the Balanced Budget Act. However, PTAC's work is only valuable if HHS acts on its recommendations. To date, the Secretary has responded to three models, which took nearly five months. Two more proposals are still awaiting a response after more than six months. The chair and co-chair of PTAC expressed frustration with HHS' lack of direction and inaction during a congressional hearing before the Energy and Commerce Health Subcommittee last November. We urge Congress to direct HHS to be more collaborative with PTAC and to codify a

[6] 42 CFR 414.1305

timeline by which the Secretary is expected to respond to PTAC recommendations. MGMA believes sixty or ninety days would be appropriate.

The key features that make APMs less burdensome and a more appealing alternative to one-size-fits-all MIPS are choice and flexibility. These core principles are violated when the federal government mandates participation. According to an MGMA poll taken last month, 72% of over 1,100 medical group practices who responded opposed mandatory participation in Medicare APMs, citing lack of evidence and a negative impact on practice innovation.[7] Rather than taking a shortcut to boosting numbers by mandating participation in certain models, CMS should focus on continuing to develop new APMs that meet the needs of a diverse range of practices of varying types, sizes and specialties that will inherently drive more widespread participation.

Participation in Advanced APMs has been slower than anticipated, due in large part to the slow pace at which new models have been developed. Since the start of 2017, one new Advanced APM has been announced. As a result, CMS estimates less than 250,000 clinicians will participate in Advanced APMs nationwide this year.[8] Many practices, particularly specialty practices, may be interested in joining Advanced APMs, but are unable to do so because there are not yet viable options. HHS has signaled that more APMs are coming, but has not specified when. The 5% bonus Congress instituted under MACRA is a powerful incentive for practices to participate in APMs, but it is set to end by 2022. Congress should consider extending it by an additional one to two years to continue incentivizing practices to participate in APMs as more models are developed that may offer some practices an opportunity to participate in an APM for the first time.

Modernize antiquated fee-for-service policies that undercut value-based transformation

In passing MACRA, Congress took a step toward modernizing our payment system. Unfortunately, remnant fee-for-service policies conflict with value-based incentives and undercut the Medicare payment transformation that Congress originally envisioned. As the healthcare industry transitions to a value-driven payment environment, we urge you to work with the U.S. Department of Health and Human Services (HHS) to modernize outdated regulations designed for a fee-for-service reimbursement model.

We recommend the Subcommittee reevaluate the usefulness of out-of-date billing requirements for telehealth, home health, and other high value services. This is particularly important for Advanced Alternative Payment Models, which are held accountable for total cost of care and should not be subject to a duplicative set of requirements, which hinder care coordination. Congress should urge HHS to modernize these policies in light of MACRA and ensure they do not needlessly interfere with care delivery innovations.

Finally, the time has come for Congress to reevaluate the utility of fraud and abuse laws as we evolve further from the FFS payment environment for which they were intended. The Federal Physician Self-Referral (Stark) Law is a prime example. Over a quarter of a century, the law has evolved into an excessively complex set of regulations. As Medicare continues to shift towards a

[7] "MGMA Poll: Medical group practices oppose mandatory Medicare alternative payment models." mgma.com/stat
[8] 82 Fed. Reg. 30011, *Medicare Program; CY 2018 Updates to the Quality Payment Program*, CMS-5522-P.

value-based payment landscape, the Stark law and Anti-Kickback Statute have outlived their usefulness and interfere with the very types of incentive-based compensation relationships that drive improved quality and reduce cost. Congress should pass the Medicare Care Coordination Improvement Act (H.R. 4206/S. 2051), which would expand HHS' fraud and abuse exception and waiver authority and remove the "volume or value" prohibition in Stark Law to facilitate the development and operation of APMs.

Conclusion

Thank you for the opportunity to share our comments regarding implementation of MACRA's Physician Payment Policies. MGMA stands ready to work with Congress, HHS, and other stakeholders in ensuring the QPP supports physician practices' transition to value-based care delivery models by reducing administrative burden, improving the clinical relevance of MIPS, increasing opportunities to move into APMs, and modernizing outdated federal rules impeding care coordination. Should you have any questions, please contact Suzanne Falk at sfalk@mgma.org or 202-293-3450.

Regards,

/s/

Anders Gilberg
Senior Vice President, Government Affairs