**Statement of the**

**Medical Group Management Association**

**before the**

**Committee on Finance**
**United States Senate**

**Re: Medicare Physician Payment Reform After Two Years: Examining MACRA Implementation and the Road Ahead**

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**May 8, 2019**

The Medical Group Management Association (MGMA) commends the Senate Finance Committee for convening this hearing on "Medicare Physician Payment Reform After Two Years: Examining MACRA Implementation and the Road Ahead." MGMA is the premier association for professionals who lead medical practices. Since 1926, through data, people, insights, and advocacy, MGMA empowers medical group practices to innovate and create meaningful change in healthcare. With a membership of more than 45,000 medical practice administrators, executives, and leaders, MGMA represents more than 12,500 practices of all sizes, types, structures, and specialties that deliver almost half of the healthcare in the United States.

Through repealing the problematic sustainable growth rate and retiring an overly complex and duplicative hodgepodge of quality reporting programs, the Medicare Access and CHIP Reauthorization Act (MACRA) charted a value-based trajectory for the Medicare payment system by valuing innovative, patient-centric, and efficient care delivery over check-the-box bureaucracy.

We appreciate this Committee's oversight efforts to ensure successful implementation of MACRA's sweeping payment reforms. We also applaud Congress for making technical corrections to MACRA through the Bipartisan Budget Act of 2018, another example of its

continued support for the innovative care delivery improvements taking place in physician group practices across the country.

Since MACRA passed, MGMA has partnered with Congress and the Administration to help 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, developed informational and educational resources related to the Merit-based Incentive Payment System (MIPS) and alternative payment models (APMs), and provided suggestions on how to improve the current program to policymakers based on feedback from our members.

At this critical juncture in Medicare's transition from fee-for-service toward value-based reimbursement, Congress has an opportunity to make refinements to the program that would align it more closely with the original intent of MACRA. We hope these comments will help guide the Committee as it seeks to improve the QPP, align it more closely with congressional intent in MACRA to improve physician payment, and ensure a successful transition to a new Medicare payment system centered around high-value care.

**Continue the 0.5 percent Medicare payment update beyond CY 2019**

MACRA stabilized annual updates under the Physician Fee Schedule (PFS) and is a vast improvement to the previous, draconian sustainable growth rate methodology. Under MACRA, PFS payment updates increased by 0.5 percent between 2015-2018, 0.25 percent in 2019, and then will be frozen for six years between 2020-2025.

As the healthcare community transitions toward a value-based payment environment, fee-for-service does not need to be abandoned entirely, but it does need to be updated appropriately. Physician practices face a challenging environment with escalating costs, flat reimbursement updates, and an increasingly complex regulatory environment. To continue supporting these practices as they implement the changes necessary to ensure success in new delivery models, MGMA urges Congress to continue the stability in physician payments by extending the 0.5 percent adjustment to the conversion factor beyond CY 2019.

**Encourage the development and availability of physician-focused APMs**

MGMA strongly supports efforts to advance value-based care delivery through APMs that reward high quality and efficient care delivery. MGMA agrees with Congress that the APM pathway is a promising door to value-based reimbursement without imposing undue administrative burden. We are encouraged by CMS' recent efforts to implement new primary care APMs through the Primary Care First and Direct Contracting models.[1]

Despite this progress, however, the healthcare system is still learning how to effectively transform care delivery. We are now past the three-year mark for implementation of MACRA, yet there are still limited opportunities for physician practices to participate in an APM, particularly those that qualify as "advanced" under CMS regulations. CMS estimates that less than 220,000 clinicians will become qualifying participants in advanced APMs this year,

[1] "HHS To Deliver Value-Based Transformation in Primary Care," HHS Newsroom (Apr. 22, 2019).

compared to the 798,000 clinicians expected to participate in MIPS.[2] Many practices are interested in joining an APM, but are unable to do so because there are not viable options for practices of their size, specialty, or location. In a 2018 survey of MGMA members, 55% of over 400 respondents reported that Medicare does not offer an advanced APM that is clinically relevant to their practice.[3]

Congress established the Physician Focused Payment Model Technical Advisory Committee (PTAC) to leverage private sector development and expedite the availability and implementation of APMs. Dozens of APMs have been submitted to PTAC, however CMS has yet to implement or test on a limited scale any of the models recommended by PTAC. We urge Congress to direct the Administration to be more collaborative with PTAC, including testing and adopting new physician-focused payment models.

**Extend the APM bonus beyond CY 2024 when it currently expires**

MGMA appreciates Congress' work to support physician practices transitioning to value-based payment in Medicare by providing incentives to participate in APMs, including a five percent bonus payment for significant participation in APMs. This five percent bonus is a powerful incentive for practices to participate in APMs, but it is set to end in 2024. Momentum toward practice participation in these value-based models could be lost without this support. We urge Congress to consider extending the availability of the five percent payment to continue incentivizing practices to participate in APMs as more models are developed that may offer practices an opportunity to participate in an APM for the first time.

Furthermore, the five percent bonus is not only an incentive to participate in an APM, it also lends financial support to practices incurring extra expenses when making the transition into a new care delivery model, which may include start-up costs, hiring and training additional support staff, making technology upgrades, and the use of time and resources for high-value, yet non-covered, services.

We share Congress and the Administration's goal of expediting the process for physician practices to participate in APMs and believe an important step to achieving this goal is to extend the availability of the five percent incentive payment beyond 2024 when it is currently set to expire, so that group practices have the opportunity to receive the support Congress intended.

**Modify the APM risk standard**

We recommend modifying the APM financial risk standard to account for start-up costs as well as ongoing expenses incurred by a group practice as they participate in an APM. Start-up costs alone can easily exceed millions of dollars by CMS' own estimates, and these amounts should be counted towards an APM's nominal amount standard. Incorporating these financial risks could lead to many more APMs entering this track of MACRA and additional APMs finally being recognized for the very tangible risk they are assuming.

[2] 83 Fed. Reg. 59452, 59721 (Nov. 23, 2018).
[3] "MGMA 2018 Regulatory Burden Survey" (Oct. 2018).

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

As practices explore new payment models, they face outdated payment requirements and fraud and abuse rules that hinder their ability to coordinate care. To allow for greater care coordination within the construct of APMs, MGMA recommends that Congress assess and modify the existing physician self-referral (Stark Law) prohibition and/or create new waivers for APM participants from certain fraud and abuse rules and payment requirements.

There is a growing consensus supporting the expeditious modernization of existing fraud and abuse rules, such as the Stark Law and Anti-Kickback Statute (AKS). While well-intended, the Stark Law and AKS are broadly construed such that they effectively prohibit or introduce uncertainties regarding clinical and financial integration arrangements that have the potential to improve care for patients.

Congress has recognized the incongruity between the current fraud and abuse framework and the development and implementation of APMs and other value-based payment arrangements. Congress authorized the Administration to issue waivers for select programs, such as those created through the Center for Medicare and Medicaid Innovation (CMMI) and for accountable care organizations in the Medicare Shared Savings Program. Waivers do not offer sufficient protection, however, as they are issued on a case-by-case basis, are limited in duration, and only protect arrangements within specific programs. Uncertainty about the application of fraud and abuse rules, and potential for severe penalties for any violation, have had a chilling effect on innovation and slowed the progression toward cost-efficient, quality-driven models.

As the healthcare industry transitions to a value-driven payment environment, we urge Congress to enact legislation that modernizes these outdated rules and creates flexible waivers for APMs, which are already held accountable for utilization and quality of care as inherent aspects of model design. Congress should pass the Medicare Care Coordination Improvement Act (S. 966/H.R. 2282), which would expand the Secretary's 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. Additionally, we support broader reforms, such as eliminating the compensation prong from the Stark Law to return its focus to governing ownership arrangements.

Lastly, we recommend the Committee reevaluate the usefulness of out-of-date billing requirements for telehealth and other high value services. This is particularly important for APMs, which are held accountable for total cost of care and should not be subject to a duplicative set of requirements.

**Streamline and simplify MIPS reporting requirements**

As medical group practices transition to value-based payment to improve the delivery of healthcare, they are hamstrung by burdensome and outdated government mandates that impede innovation, drive up costs, and ultimately redirect resources away from patients. Through its oversight authority, Congress should ensure CMS does more to streamline and significantly simplify reporting requirements and scoring for MIPS. CMS should reduce the overall number of measures required for full participation in MIPS and use a flexible set of measures that are proven to be statistically reliable, clinically valid, outcomes-focused, and, most importantly,

patient-centered. Furthermore, CMS should base MIPS point values for individual measures on their relative value to the total MIPS score.

Minimizing regulatory burden to the greatest extent possible, such as burdens related to quality reporting requirements, allows physician practices to allocate more time toward improving patient care. 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:

- **Decrease the number of measures across MIPS.** Physician group practices' finite resources are spread across a minimum of nearly 20 measures required to meet MIPS requirements. CMS should structure MIPS to allow practices to prioritize effective and impactful improvements to patient care, rather than comply with sprawling reporting mandates.
- **Significantly simplify the scoring scheme.** CMS should simplify the overall MIPS scoring structure by basing point values for individual measures on their relative value to the total MIPS score.
- **Increase CMS' flexibility to appropriately score MIPS performance.** On top of simplifying the overarching scoring scheme of MIPS, Congress should add legislative language to MACRA to increase flexibility in MIPS scoring methodology to expressly allow CMS to provide clinicians and group practices with credit across categories for performing certain activities that touch on multiple MIPS categories. For instance, reporting quality measures via certified EHR technology should count toward fully meeting the promoting interoperability category, rather than merely toward bonus points.
- **Do not prematurely measure cost.** Many features of the cost performance category are still unfinished. Currently, CMS is overhauling two MIPS cost measures to address longstanding, significant concerns related to flawed attribution and insufficient risk-adjustment methodologies; adding new condition-based measures; and testing patient relationship codes. Group practices should not be evaluated on measures with unresolved methodological flaws. While CMS continues to finetune the cost component of MIPS, Congress should encourage the agency to weight the cost category to ten percent to allow sufficient time to significantly overhaul existing cost measures. CMS' own data has shown that the current methodology discriminates against physicians who treat the sickest patients. The agency needs time to develop better risk adjustment and attribution methodologies. It is crucial for CMS to understand the complexities of patient attribution and take this opportunity to fully test any new code set, such as the patient relationship codes required under MACRA, to ensure the agency achieves the desired outcome of appropriately assigning costs to providers who have control over the care.
- **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.

**Conclusion**

Thank you for the opportunity to share our comments regarding implementation of MACRA. MGMA stands ready to work with Congress, the Administration, and other stakeholders in ensuring MACRA 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 Mollie Gelburd at mgelburd@mgma.org or 202-293-3450.