Medical Group Management Association

Statement for the record

Committee on Energy and Commerce
Subcommittee on Health
United States House of Representatives

Re: MACRA and MIPS: An Update on the Merit-based Incentive Payment System

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The Medical Group Management Association (MGMA) commends the Committee on Energy and Commerce Subcommittee on Health for convening this hearing on "MACRA and MIPS: An Update on the Merit-based Incentive Payment System." 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 the Committee's 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, which demonstrated your 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. 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 Medicare payment system centered around high-value care.

Reduce Medicare quality reporting documentation requirements

Repealing the problematic sustainable growth rate and retiring a hodgepodge of quality reporting programs, 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. However, the final 2018 MIPS rule maintains an overly complex set of rules that reward the quantity of reporting rather than the quality of care provided to patients. One of the most onerous requirements in MIPS is the mandatory 365-day data collection and reporting period.

CMS' own estimates show 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. 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.[2] 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 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.[3] 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. 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 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

[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.

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.[4] 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 quality 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 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.

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

Support the development and availability of physician-focused APMs

MGMA agrees with Congress that APMs are a key piece of the transition to a value-based payment system. However, in the eight years since it was created, the Centers for Medicare and Medicaid Innovation (CMMI) has yet to deliver a robust pathway for interested physician practices to move away from fee-for-service and take on appropriate financial risk for the care within their control. 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.

It is imperative that CMS revisit the unnecessary regulatory restrictions placed on current Medicare APMs, such as the arbitrary 50-clinician cap for the Comprehensive Primary Care Plus Program and "primary care focus" limitation to qualify as a Medical Home Model. Congress should also direct CMS to establish a separate, lower risk threshold for such practices. In many cases, small and rural practices interested in joining an APM have limited capital and resources to take on financial risk, particularly when compared to 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, although we encourage CMS to consider participants as qualifying Advanced APM participants as opposed to merely exempt from MIPS.

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. Unfortunately, in a June 13 letter, the Secretary of the U.S. Department of Health and Human Services (HHS) wrote that HHS would not test the APMs that were developed by frontline physicians and withstood rigorous review by PTAC. 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 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 a recent MGMA poll, 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.[5] 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 2017, just one new Advanced APM has

[5] "MGMA Poll: Medical group practices oppose mandatory Medicare alternative payment models." mgma.com/stat

been announced. As a result, CMS estimates less than 250,000 clinicians will participate in Advanced APMs nationwide this year.[6] 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. 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 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.

Conclusion

Thank you for the opportunity to share our statement 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 me at agilberg@mgma.org or 202-293-3450.

Regards,

/s/

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[6] 82 Fed. Reg. 30011, *Medicare Program; CY 2018 Updates to the Quality Payment Program*, CMS-5522-P.