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Examining Barriers to Expanding Innovative Value-Based Care in Medicare

Statement for the Hearing Record
submitted by

American Society for Gastrointestinal Endoscopy

to the
U.S. House of Representatives
Committee on Energy and Commerce
Subcommittee on Health

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The American Society for Gastrointestinal Endoscopy (ASGE) and it's 14,000 members thank the Subcommittee for its interest in understanding the barriers to physician participation in innovative value-based payment and delivery models in Medicare. We appreciate the opportunity to submit the following statement for the hearing record highlighting two areas that we believe are impeding physician movement toward value-based care, as well as more coordinated care that has the potential to improve patient quality of care and outcomes and reduce health care spending: 1) the lack of Advanced Alternative Payment Model (APM) opportunities for physician specialists; and 2) Stark Law restrictions.

Improving the Availability of Advanced APMs

Most Medicare providers, physician specialists in particular, are disadvantaged by the lack of choice within the Quality Payment Program (QPP) by not having Advanced APMs available to them. Immediate and bold steps are needed to improve Advanced APM opportunities for physician specialists, including acting on the recommendations of the Physician-Focused Payment Model Technical Advisory Committee (PTAC), as established by the Medicare and CHIP Reauthorization Act. The physician stakeholder community held out great hope that the PTAC and its process for reviewing and commenting on proposed physician-focused payment models (PFPMs) put forth by individuals and other stakeholder entities would create greater APM opportunities for specialty physicians and an alternative to the Merit-based Incentive Payment System (MIPS). Yet, the lack of progress is disappointing.

At a hearing on APMs held by this Subcommittee on Nov. 8, 2017, Jeffrey Bailet, MD, chair of the PTAC, stated that there has been "tremendous" interest by the physician specialty community in the PTAC process and that the PTAC is reviewing a number of specialty PFPMs. Unfortunately, the

Centers for Medicare and Medicaid Services (CMS) has yet to implement a single APM recommended by PTAC, including Project Sonar which was recommended for limited testing. Project Sonar is a physician-focused APM that is designed to improve care for patients with Inflammatory Bowel Disease (IBD).

Removing Stark Law Barriers

While conversations with CMS regarding Project Sonar continue, gastroenterologists are seeking to implement the model with commercial payers. This chronic care management model, with a prospective payment (per member per month payment) and retrospective reconciliation based on an expected target price, encourages care coordination and patient engagement. Under an optimal scenario, participating gastroenterologists would be encouraged to either internalize or arrange contract terms involving gainsharing with a Designated Health Services (DHS) entity for providing advanced imaging and with a hospital for complex outpatient procedures that can't be performed in the ambulatory surgery center and for inpatient care.

As a next phase, in which physicians take on greater risk for the care and management of IBD patients, a gastroenterology practice, for optimal care management, may involve the use of tests — some of which are not uniformly covered now by payers — but allow for treatment decisions that ultimately improve outcomes and yield cost savings. These complex patients also have nutritional needs and often psychologic and psychosocial issues that would benefit from the involvement of dietitians, social workers and psychologists. The involvement of any of these components may require independent contracting and could involve shared savings or other non-traditional payment arrangements. Stark laws and regulations, however, serve as a barrier to the creation of these types of arrangements.

The federal physician self-referral law, or "Stark Act," is a labyrinth of exceptions, rules and regulations. Physician practices interested in innovative payment and delivery arrangements that have the potential to improve patient care and reduce costs are deterred by the mere threat of violating the Stark Law and the incredible cost of lawyers and consultants to ensure compliance.

Stark laws and regulations should not inhibit the creation of these types of arrangements, which, to work and achieve cost savings and higher quality, requires hospitals, physicians and all parties involved to enter into alternative payment arrangements.

ASGE believes the most straightforward approach to reduce confusion and anxiety associated with compliance of the Stark Law and to consequently encourage physician participation in innovative payment and care delivery design is for CMS to create a single, comprehensive waiver to the Stark Law for participants in any Medicare APM that can reasonably be expected to meet the "triple aim" of improved individual beneficiary quality of care; improved quality of care for patient populations; and lower growth of health care expenditures. A waiver should also be extended to physicians and entities providing DHS that participate in Other Payer APMs, as distribution of shared savings, incentive payments, and the provision of infrastructure necessary to earn non-Medicare bonuses also raise concerns under the Stark Law.

Creation of a waiver for physicians and other providers who participate in Medicare and Other Payer APMs will ensure that those APM entities and participants can utilize financial incentives, including the distribution of shared savings, that are otherwise prohibited under the Stark Law but are necessary for care coordination and for APMs to meet their intended goals.

ASGE endorses the "Medicare Care Coordination Improvement Act of 2017" (H.R. 4206) authored by Rep. Larry Bucshon and Rep. Raul Ruiz which would remove the "value or volume" prohibition of the Stark Law. This protection would apply to practices that are developing or operating an APM, including, Advanced APMs, APMs approved by the PTAC, MIPS APMs and other APMs.

The key impediment to APMs is that these types of arrangements inevitably link payments to the volume or value of physician referrals. Many of the Stark exceptions require that any compensation involved be calculated in a manner that does not take into account the volume or value of referrals between parties.

As noted in the models described above, physician groups may decide to enter into independent contractor arrangements. Under current Stark regulations, the agreement must satisfy either the Stark "personal services" or "fair market value" safe harbor. Those safe harbors require that compensation must be set in advance, consistent with fair market value and not determined in a manner that takes into account the volume and value of referrals or other business generated by the referring physician. These restrictions impede better management of a physician's referral patterns, utilization of ancillary services, and collaboration with high-quality or cost-efficient partners. As examples, for hospitals to work with medical staff members to improve quality and lower costs for specialty care, a traditional hourly "fair market" fee for work will not capture the complexity of teams of various practitioners working together on quality improvement projects and pathways to address episodes of care. Within APMs, there may be a variety of capitation and subcapitation for specialty case rates, incentive withhold pools, gainsharing or quality bonus payments. These will frequently be tied to volume and require agreements to refer within the "network" of providers within the APM.

Enactment of H.R. 4206 would constitute an important and necessary step to removing barriers to innovative value-based care and better care coordination.

Making Advanced APMs a Viable Pathway for Physicians

We believe Congress made a very prudent decision when it gave, as part of the Bipartisan Budget Act of 2018, CMS three additional years of flexibility for the implementation of MIPS. Another area that we suggest would benefit from congressional intervention is to modify the threshold for eligible clinicians to earn the status of Qualifying APM Participant. To become a Qualifying APM Participant, a clinician must meet a specific Medicare payment or patient count threshold, which may not be easily attainable depending on a practice's mix of services. For example, gastroenterologists may be interested in participating in CMS' new Bundled Payments for Care Improvement Advanced model, which is an Advanced APM, but because all the gastroenterology-related bundles are inpatient bundles, gastroenterologists are unlikely to meet either the required revenue or patient count thresholds. Only Advanced APM participants that meet the thresholds qualify for the APM bonus payment and a guaranteed exemption from MIPS.

To encourage development and participation in Advanced APMs, ASGE supports and encourages Congress to act on the proposal in the President's Fiscal Year 2019 Budget that would allow clinicians to receive a five percent bonus on physician fee schedule revenue received through the APMs in which they participate regardless of whether they meet or exceed the payment or patient thresholds. As explained in budget documents, this change would reward clinicians along a continuum for their participation in Advanced APMs without imposing arbitrary participation thresholds. Removing the thresholds would also simplify the QPP.

Conclusion

The ASGE asks the Subcommittee to support physicians as they transition to new value-based payment models by fostering early opportunities for success and eliminating barriers that impede advancement toward new payment and delivery designs. Congress can support physicians during this transition by:

- encouraging CMS to adopt the recommendations of the Physician Technical Advisory Committee;

- removing Stark law barriers to APM development and physician participation by passage of the Medicare Care Coordination Improvement Act of 2017 (H.R. 4206); and

- removing reference of payment or patient count thresholds from the definition of a Qualifying APM Participant at Section 1833(z)(2) of MACRA.

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