June 22, 2023

The Honorable Morgan Griffith
Chairman
House Energy and Commerce Committee
Oversight & Investigations Subcommittee
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Kathy Castor
Ranking Member
House Energy and Commerce Committee
Oversight & Investigations Subcommittee
2322 Rayburn House Office Building
Washington, D.C. 20515

Re: MGMA Testimony — "MACRA Checkup: Assessing Implementation and Challenges that Remain for Patients and Doctors"

Dear Chairman Griffith and Ranking Member Castor:

On behalf of our member medical group practices, the Medical Group Management Association (MGMA) would like to thank the Subcommittee for holding this important hearing on "MACRA Checkup: Assessing Implementation and Challenges that Remain for Patients and Doctors." We appreciate the opportunity to provide feedback on this important topic.

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 group medical practices ranging from small private medical practices to large national health systems representing more than 350,000 physicians. MGMA's diverse membership uniquely situates us to offer the following policy recommendations as the Subcommittee and lawmakers assess the current challenges surrounding MACRA and physician reimbursement in general.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) sought to stabilize physician payment rates in the Medicare fee-for-service (FFS) system and incentivize physicians to move into new value-based payment models. Despite its positive intent, the quality component of the program has proved burdensome and costly due to excessive reporting requirements and inadequate alternative payment model (APM) participation options. Under MACRA's revised methodology for annually updating the Medicare physician fee schedule (PFS), physician payments have not kept up with inflation or the cost of running a medical practice. MGMA commends the Subcommittee for its leadership, and we look forward to partnering with Congress to develop sustainable policies that provide appropriate payment as to ensure physician practices can continue providing high-quality care.

Key Recommendations

- **Reform Medicare Part B to provide annual inflation-based physician payment updates based on the Medicare Economic Index (MEI).** Congress should pass the *Strengthening Medicare for Patients and Providers,* which would provide an annual Medicare physician payment update tied to inflation, as measured by the MEI. Additionally, Congress should extend the exceptional performance bonus, which expired at the end of the 2022 performance year, and

extend the Small, Underserved, and Rural Support (SURS) program, which expired on Feb. 15, 2022.

- **Provide positive financial incentives to support practices transitioning into value-based care.** Congress should extend the APM incentive bonus at 5% for at least six years, provide resources to assist practices with the transition into APMS, and allow CMS the ability to set the qualifying participant threshold at an appropriate level that does not discourage APM participation.
- **Oppose efforts to use sequestration and PAYGO rules to offset unrelated congressional spending to the detriment of Medicare providers.** MGMA has long opposed sequester cuts — a tax that penalizes medical practices for Congress' inability to meaningfully address the country's budgetary affairs.
- **Advance policies that incentivize and reward Part B providers to reduce the total cost-of-care in the overall Medicare program.**

Background

MACRA repealed the flawed Sustainable Growth Rate (SGR) and reformed Medicare's approach to physician payment. MGMA supports the underlying intentions of MACRA — to pay medical groups based on quality and value through the Quality Payment Program (QPP). The QPP created two new reporting pathways to transform care delivery for Medicare beneficiaries — the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). Unfortunately, MACRA's goal of moving practices into value-based care arrangements never came to fruition, despite medical groups' desire to do so. Overall implementation of the QPP has been fraught with challenges since its inception.

The program's administrative burdens, coupled with the current inflationary environment, staffing, and reimbursement challenges, are simply unsustainable. In its 2023 annual report, the Medicare Trustees stated, "While the physician payment system put in place by MACRA avoided the significant short-range physician payment issues resulting from the SGR system approach, it nevertheless raises important long-range concerns that will almost certainly need to be addressed by future legislation. In particular, additional payments totaling $500 million per year and annual bonuses are scheduled to expire in 2025 and 2026, respectively, resulting in a payment reduction for most physicians. In addition, the law specifies the physician payment updates for all years in the future, and these updates do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases. The specified rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large. Absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term." Moreover, the American Medical Association's analysis of Medicare Trustees report data found that Medicare physician payment has been reduced by 26% when adjusted for inflation over the past 20 years. **A congressional solution is needed to address these pervasive issues.**

Ongoing challenges and legislative solutions

Physician reimbursement

MACRA included modest positive payment updates for payment under the Medicare Physician Fee Schedule (PFS) through 2020. Currently, there is no positive payment update until 2026. Once the freeze is lifted, the update resumes, but at a nominal rate of 0.25%— this update would not remotely address the

gap between physician practice inflationary expenses and reimbursement rates. **An inflation-based update is an appropriate, commonsense solution.**

In addition to no annual positive payment update, medical groups also experience annual reimbursement cuts stemming from 2021 PFS changes and correlating budget neutrality requirements. MGMA appreciates Congress' intervention over the past three years to mitigate these payment cuts and we urge further action before the end of the year. The exact reimbursement cuts in 2024 will not be known until the PFS is finalized, but MGMA expects further cuts due to the phase-in of a complexity add-on code, which was previously delayed through 2023. **Congress should reexamine the current PFS budget neutrality requirements and explore alternatives.** For example, Congress could increase the $20 million budget neutrality trigger and exempt certain services from budget neutrality.

MGMA conducted a survey of 517 medical group practices, ranging from small practices to large 2,500 physician health systems, assessing the impact of potential Medicare payment cuts, and evaluating how physician practices would respond. Practices would consider limiting the number of new Medicare patients, reducing charity care, reducing number of clinical staff, and closing satellite locations. Ninety-two percent of medical groups responded that Medicare reimbursement in 2022 did not adequately cover the cost of care provided.

Congress must provide annual inflation-based physician payment updates based on the MEI. Congress should pass the *Strengthening Medicare for Patients and Providers Act*, which would provide an annual Medicare physician payment update tied to inflation, as measured by the MEI. MGMA and approximately 100 physician organizations joined together to create the "Characteristics of a Rational Medicare Payment System" which focused on ensuring financial stability and predictability, promoting value-based care, and safeguarding access to high-quality care. These principles, which would ensure alignment and predictability for physician practices, should be considered as well.

QPP: Challenges with MIPS

Undue costs and resources

Under the MIPS program, physician payments are adjusted based on performance in four categories — quality, costs, promoting interoperability, and improvement activities. Unfortunately, benefits of the program are overshadowed by the time and resources required to comply. A study found that in 2019, physicians spent more than 53 hours per year on MIPS-related activities. The researchers concluded that if physicians see an average of 4 patients per hour, then these 53 hours could be used to provide care for an additional 212 patients per year. The same study found MIPS cost practices $12,811 per physician to participate in 2019. Congress originally appropriated funds for an exceptional performance bonus — MIPS participants who exceeded the exceptional performance threshold were eligible. The $500 million funding for the exceptional performance bonus expired at the end of the 2022 performance year — this is a critical pool of funds that helped mitigate the impact of the problematic tournament-style of Medicare payments stemming from budget neutrality. **MGMA urges Congress to extend the exceptional performance bonus, which will support physician practices as they work to comply with tedious MIPS requirements.**

Another critique of MIPS is that it may penalize physician practices for factors outside of their control. Rural, small, and medically underserved practices could be disproportionally disadvantaged under MIPS. Unfortunately, the funding appropriated under MACRA to help these practices comply expired in February 2022. **MGMA encourages Congress to extend and fund the Small, Underserved, and Rural**

Support (SURS) program and provide direct support for those practices. This program is critically needed to assist practices in understanding continuously changing policies in MIPS.

Reporting

Current quality reporting programs require reporting many measures, but they are often not drivers of meaningful improvements. MGMA has longstanding concerns that MIPS cost measures unfairly penalize clinicians and group practices for costs over which they have no control. MGMA regularly hears from members that clinicians and group practices do not understand how CMS evaluates them on MIPS cost measures and that the lack of actionable, timely information makes this category a "black box" that they have little to no control over. Eighty-six percent of practices report that CMS' feedback is not actionable in assisting their practices in improving clinical outcomes or reducing healthcare costs related to the cost performance category. Medical groups need timely access to analyses of their claims data and should only be held accountable for costs they control or direct. **Congress should modify the cost category to target spending variability within the control of medical groups.**

MVPs

This is the first year that practices may voluntarily report under the MIPS Value Pathways (MVP) program. CMS currently has 12 MVPs available that are meant to ease reporting burden and align measures across performance categories to be more relevant to a specialty. The measures in MVPs must allow practices to meaningfully transition to APMs if it is to fulfill its promise and not exacerbate the current problems with MIPS performance measures. MVP participation may increase reporting burden for multi-specialties groups who will be required to form and report under subgroups in 2026. **MGMA urges Congress to maintain traditional MIPS as a reporting option alongside voluntary MVP reporting under the QPP, while working to ensure that MVPs are not repackaging existing problems within MIPS.**

QPP: Challenges with APMs

APM development

MGMA has long supported group practices having the choice to move away from fee-for-service and into value-based care arrangements such as APMs. We joined many other specialty societies in endorsing the American Medical Association's characteristics of a rational Medicare payment system which outlines principles to help promote value-based care. While MACRA intended to facilitate the transition to APMs, current problems within the QPP program have stifled this goal.

The development of APMs has not reflected the reality group practices face as a majority of MGMA members do not have a clinically relevant APM in which to participate. Seventy-eight percent of medical groups reported Medicare does not offer an Advanced APM that is clinically relevant to their practice, with 61% of members being interested in participating in a clinically relevant model. This incongruity is exemplified by issues within the APM development process.

Both the Centers for Medicare & Medicaid Innovation (CMMI) and private sector entities, such as physicians, can develop APMs. Private entities submit APM models for review to the Physician-Focused Payment Model Technical Advisory Committee (PTAC). PTAC can evaluate and endorse an APM and recommend it to CMMI who has the sole responsibility to test and implement the APM. CMMI has yet to test any of the models PTAC has recommended, missing an important opportunity to offer more methods of participation. **MGMA supports the improved development of new, voluntary physician-led APMs that meet the needs of practices of various size, type, and specialty.**

APM incentive bonus and qualifying participant threshold

Shifting program requirements and financial incentives instituted by MACRA do not align with facilitating APM participation. Congress had to act at the end of last year to extend the APM incentive bonus at 3.5% for an additional year, when it had previously been set at 5%. This bonus is vital to covering costs, supporting investments, and safeguarding the financial viability of medical groups in the program. **MGMA recommends Congress reinstate the 5% payment bonus for APM participation for at least six years.**

Further, the qualifying participation (QP) threshold to participate in an APM is unreasonably high. Participants need to meet this threshold to qualify for the APM incentive bonus and to avoid reporting under MIPS; it was set to increase this year but Congress intervened by freezing the threshold in the *Consolidated Appropriations Act of 2023*. Practices should not be subject to an excessively high threshold that fosters uncertainty and hinders their ability to participate. **MGMA supports giving CMS the flexibility to adjust the QP threshold so that the criteria to achieve QP status is not set arbitrarily high.**

Resources and investments

Medical groups need appropriate support to assist with the transition from fee-for-service to APM participation. A recent MGMA Stat poll of 424 medical groups found that 93% of respondents believe that Medicare has not done enough to incentivize the adoption of value-based care. Eighty-seven percent of members said positive incentives would be more effective than negative incentives to encourage participation. Small and rural practices have limited resources and available capital to take on financial risk and join an APM. **Participants must have access to upfront resources, investments, and tools to succeed in an APM. Regulatory flexibilities and financial incentives must be included in APMs to provide adequate support to group practices.**

Conclusion

We thank the Subcommittee for its leadership on this critical issue. We look forward to working with you and your congressional colleagues to craft commonsense policies that will allow medical group practices to continue providing high-quality patient care. If you have any questions, please contact Claire Ernst, Director of Government Affairs, at cernst@mgma.org or 202-293-3450.

Regards,

/s/

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