June 14, 2024

The Honorable Ron Wyden
Chairman
Senate Committee on Finance
215 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
Senate Committee on Finance
215 Dirksen Senate Office Building
Washington, DC 20510

Re: MGMA Response to the Senate Committee on Finance's White Paper, "Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B"

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of our member medical group practices, the Medical Group Management Association (MGMA) would like to thank the Committee for releasing its white paper on bolstering chronic care through physician payment and seeking feedback on ways to fix the flawed Medicare payment system. Significant reforms are needed to stop the harmful yearly Medicare reimbursement cuts and support medical groups' ability to offer high-quality care to patients with chronic conditions.

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical group 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.

Medicare physician reimbursement is on a dire trajectory and annual cuts to physician payment coupled with a lack of an inflationary update continue to undermine the ability of medical group practices to keep their doors open and function effectively. Medical groups have had to make drastic decisions due to the perilous payment environment — the current situation is untenable and cannot continue.

Comprehensive reform is needed to address the multi-faceted issues undermining Medicare reimbursement; this marks an important opportunity to make long-overdue changes to stabilize the Medicare payment system. MGMA offers the following recommendations to strengthen Medicare payment and sustainably support medical groups.

Key Recommendations

- **Pass legislation to implement an annual inflation-based physician payment update tied to the Medicare Economic Index (MEI)** to ensure medical groups have a functioning reimbursement system moving forward that keeps pace with rising costs. Without providing an annual inflationary update for physicians — similar to other payment systems under Medicare — medical groups will continue to face financial barriers to providing access to care for patients with chronic conditions in their communities. The *Strengthening Medicare for Patients and*

Providers Act would provide this long-needed annual MEI-based update to Medicare physician reimbursement.

- **Reform the budget neutrality aspect of the Medicare Part B payment system** to avoid continued across-the-board payment cuts harming medical groups' financial viability.
- **Improve the Merit-based Incentive Payment System (MIPS)** to alleviate significant administrative burden.
- **Provide positive financial incentives to support practices transitioning into value-based care.** The *Value in Health Care Act of 2023* would reinstate the Advanced Alterative Payment Model (APM) incentive payment at 5%, allow CMS to set the qualifying APM participant (QP) thresholds at an appropriate level, and institute additional polices to properly incentivize and assist practices transitioning to value-based care arrangements.
- **Pass the *Chronic Care Management Improvement Act of 2023*** to ensure Medicare patients with chronic conditions are able to access high-quality care.
- **Permanently institute many of the telehealth flexibilities currently in place** to allow for appropriate continuity of care.

Stabilize Medicare reimbursement by passing an annual inflationary payment update

The *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA) was enacted to repeal the flawed Sustainable Growth Rate (SGR) formula, stabilize payment rates to physicians in Medicare fee-for-service, and incentivize physicians' transition to value-based care models through the Quality Payment Program (QPP). While well-intentioned, MACRA's methodology for updating the Medicare Physician Fee Schedule (PFS) does not keep pace with rising practice costs and inflation, and simultaneously cuts reimbursement for physicians.

The Centers for Medicare & Medicaid Services (CMS) finalized a 3.37% cut to the Medicare conversion factor in its 2024 Medicare Physician Fee Schedule (PFS). From Jan. 1 to March 8 of this year, medical groups absorbed a 3.37% reduction to reimbursement. Following congressional action to partially mitigate 1.68% of the cut in the *Consolidated Appropriations Act of 2024* (CAA, 2024), physician practices are left with a 1.69% reduction for the remainder of the year.

These ongoing cuts are unsustainable and must be averted to ensure the financial viability of physician practices. The 2024 Medicare Board of Trustees' annual report outlines the inadequacy of Medicare payment and its potential impact on Medicare participation: "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 … 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."[1] This echoes what medical groups are saying, with 87% of groups having reported that reimbursement not keeping up with inflation impacts current and future Medicare patient access.[2]

In the face of ongoing Medicare cuts, the cost of running a medical practice continues to rise — according to MGMA data, physician practices saw total operating cost per FTE physician increase by over 63%

[1]2024 Medicare Board of Trustees Annual Report, May 6, 2024.
[2] MGMA, 2023 Annual Regulatory Burden Report, Nov. 2023.

from 2013–2022, while the Medicare conversion factor increased by only 1.7% over the same timeframe. Eighty-nine percent of medical groups reported an increase in operating costs in 2023.[3]

An annual physician payment update tied to inflation, as measured by the MEI, is needed to prevent further damage to independent medical groups' ability to continue operating. Congress should pass the *Strengthening Medicare for Patients and Providers Act of 2023* — this bipartisan bill introduced by congressional doctors currently has 144 cosponsors and is essential to ensuring medical groups are reimbursed fairly.

Modernize Medicare's antiquated budget neutrality policies

Compounding the lack of an inflation-based update are the annual reimbursement cuts medical groups continue to face stemming from 2021 Medicare PFS changes, the phase-in of the E/M complexity add-on code (G2211) that CMS implemented in 2024, and corresponding budget neutrality requirements. The *Provider Reimbursement Stability Act of 2023* would modernize many aspects of Medicare budget neutrality and would make significant changes to alleviate the adverse effects practices are experiencing. The legislation would increase the triggering threshold from $20 million to $53 million (while adding an update to keep pace with inflation), institute new utilization review requirements to better reflect the reality of providers using certain services compared to CMS' estimates, and more.

MGMA urges Congress to make changes to budget neutrality in unison with the long-needed annual inflationary update. These current policies work in concert to undermine the financial viability of medical practices, as medical groups will be facing another cut in 2025 absent congressional intervention. Addressing both problems would go a long way toward establishing an appropriate and sustainable Medicare reimbursement system.

MIPS reform

MACRA instituted MIPS under the Quality Payment Program (QPP) which was intended to be an on-ramp in the transition to value-based care for medical groups to join APMs. Unfortunately, the program has been beset with issues — it includes onerous reporting requirements that do not drive meaningful clinical improvements and unfairly penalize clinicians. Physician practices cannot continue to divert financial and staff resources away from patient care to comply with duplicative MIPS requirements. A study found that in 2019, physicians spent more than 53 hours per year on MIPS-related activities and MIPS cost practices $12,811 per physician to participate.[4]

There are many factors contributing to increased administrative burden under MIPS for medical practices. The MIPS program requires clinicians to report on quality measures that are not clinically relevant to them. The cost reporting measure holds clinicians accountable for costs outside of their control. It is a time-consuming and laborious process to comply with these requirements. Compounding these issues is the lack of adequate and timely feedback by CMS on measure performance. Without receiving appropriate feedback about which patients are assigned to them and what costs outside of their practice they must account for, physicians are unable to correct issues and improve compliance.

A study from the Weill Cornell Medical College found that MIPS scores inconsistently relate to

[3] MGMA Stat Poll, July 12, 2023.
[4] Dhruv Khullar, Amelia Bond, Eloise May O'Donnell, *Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System*, Jama Network, May 14, 2021.

performance on process and outcome measures.[5] The study found that physicians treating more medically complex patients were more likely to receive low MIPS scores despite providing high-quality care. Medical groups report that MIPS reporting requirements detract from patient care efforts due to significant program compliance costs that could be more efficiently allocated to clinical priorities. The QPP reporting burden is substantial — 67.19% of MGMA members surveyed for the 2023 Annual Regulatory Burden Report found QPP reporting to be extremely or very burdensome.[6]

Small practices are disproportionately impacted by MIPS policies as they often do not have the same resources, staff, and capital as large systems. In 2022, the Small, Underserved, and Rural Support (SURS) technical assistance program ended due to a lack of congressional funding. This program was vital in assisting small practices' compliance with the constantly evolving policies in MIPS, and its expiration further impedes their ability to meet program requirements.

CMS proposed to increase the MIPS performance threshold from 75 points in 2023 to 82 points in the 2024 proposed Medicare Physician Fee Schedule (PFS). While we are thankful the agency maintained the current threshold at 75 points, this number is already too high, and a further increase of the threshold would result in even more physician practices receiving a negative adjustment.

Taken together, the above picture of MIPS illuminates the need for significant reform to allow the program to function more efficiently and support physician practices treating Medicare beneficiaries. MGMA offers the following policy solutions that were developed in collaboration with physician organizations:

- ***Improve the performance threshold.*** The current MIPS threshold of 75 points results in many providers being unnecessarily penalized. Congress should freeze the threshold at 60 points for three years to allow medical groups to continue recovering from myriad significant events such as COVID-19 and the Change Healthcare cyberattack. Further, the Government Accountability Office (GAO) should submit a report to Congress and HHS in consultation with physician organizations that details recommendations for a replacement performance threshold.
- ***Reduce reporting burden and better align performance measures with clinical care.*** Congress should remove the siloes between the different performance categories; providing multi-category credit for MIPS measures that fulfil multiple categorical functions would avoid the duplicative steps of documenting and reporting on the same activities. The MIPS Cost performance category has numerous issues related to measuring costs outside of a provider's control and opaque scoring procedures — it is important to significantly revise this category. Additional changes are needed to improve reporting on quality measures and allow providers reporting through clinical data registries to automatically satisfy Promoting Interoperability and Improvement Activities requirements.
- ***Reform how payment adjustments are calculated.*** The current tournament-style model of MIPS needs to be eliminated to stop undermining the financial viability of practices participating in MIPS who receive a negative payment adjustment. A new model where payment adjustments would be tied to the annual payment update would be more equitable while also continuing to incentivize groups to improve their performance. Groups who score below the performance

[5] Amelia M. Bond, PhD; William L. Schpero, PhD; Lawrence P. Casalino, MD, PhD, Association Between Individual Primary Care Physician Merit-based Incentive Payment System Score and Measures of Process and Patient Outcomes, JAMA Network, Dec. 6, 2022.
[6] *Supra* note 2.

threshold would receive a reduced payment update compared to those at or above the threshold. The penalties would fund bonuses for the high performers and go towards an improvement fund.

- ***Ensure timely and actionable feedback from CMS.*** Providers do not receive the timely and accurate feedback from CMS needed to understand their performance and be able to make changes to reduce costs or improve scores. A redesigned MIPS program must include this vital feedback, and if quarterly reports are not provided, then medical groups should be held harmless from any penalties.

Support physician practices transitioning into value-based care arrangements

Value-based care arrangements such as APMs can help physician practices successfully treat patients with complex and chronic conditions, but Congress needs to do more to ensure practices have adequate financial support to voluntarily make the transition from fee-for-service. Congress recently extended the APM incentive payment at 1.88% for 2024 — a decrease from 3.5% in 2023, and 5% in 2022. MGMA strongly urges Congress to reinstate the full 5% as this payment is necessary to cover costs, support investments, and safeguard the financial viability of medical groups in the program.

Congress also froze the QP thresholds at the 2023 level for the 2024 performance period in the CAA, 2024. This was a welcomed extension, as CMS' increase of these thresholds would have made it extremely difficult for many medical groups to reach QP status and qualify for the APM incentive bonus and avoid onerous reporting requirements under MIPS. We suggest the Committee give CMS the ability to adjust these thresholds under statute to allow them to be set at reasonable levels, as drastic increases to QP thresholds make it impossible for many practices to join or continue participating in APMs. The *Value in Health Care Act of 2023* includes language to this effect and would implement additional policies, such as extending the 5% APM incentive payment, to better assist practices transitioning into value-based care arrangements.

Support patients with chronic conditions by enacting the *Chronic Care Management Improvement Act of 2023*

Chronic care management (CCM) is an integral part of care coordination for patients with chronic conditions. Medicare started paying for CCM services in 2015 for primarily non-face-to-face CCM services. While we support this initiative to improve the ability to manage patients' chronic conditions, these services created a beneficiary cost-sharing obligation.

The 20% coinsurance requirement for CCM services is a barrier to care for beneficiaries who are not used to cost sharing for care management services. The *Chronic Care Management Improvement Act of 2023* would waive this coinsurance requirement, thereby improving patients' ability to receive the chronic care they need. We urge the Committee to pass this important piece of legislation.

Institute permanent telehealth flexibilities

MGMA appreciates the Committee reviewing how essential telehealth services are for patients with chronic conditions in its white paper. The *Preserving Telehealth, Hospital, and Ambulance Access Act* would extend certain telehealth flexibilities for two years, such as removing geographic and originating site restrictions, delaying the in-person requirements for telemental health services, allowing for audio-only telehealth services, and more. While we support the extension of these flexibilities, we urge the Committee to permanently institute many of the telehealth policies currently in place in a comprehensive

fashion to help allow for appropriate access and continuity of care for patients no matter where they are located — the *CONNECT for Health Act* would make many of these changes permanent.

Conclusion

MGMA thanks the Committee for its leadership in examining Medicare payment reform. We look forward to collaborating with the Committee and its colleagues to craft sensible payment policies that will reinforce practices' ability to offer high-quality care to patients with chronic conditions. If you have any questions, please contact James Haynes, Associate Director of Government Affairs, at jhaynes@mgma.org or 202-293-3450.

Sincerely,

/s/

Anders Gilberg
Senior Vice President, Government Affairs