

Statement of

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On

Medicare Physician Payment Reform after Two Years: Examining MACRA Implementation and the Road  
Ahead

Before the

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Chairman Grassley, Ranking Member Wyden, and distinguished members of the Senate Finance Committee, thank you for the opportunity to testify on behalf of AMGA, where I serve as Chair of its Public Policy Committee and Member of their Board of Directors. AMGA represents 450 multispecialty medical groups and integrated delivery systems across the United States. More than 175,000 physicians practice in AMGA member organizations, delivering care to one in three Americans.

I am board certified in internal medicine, endocrinology, diabetes, and metabolism, and am Crystal Run Healthcare's Chief Quality Officer, as well as Medical Director and physician leader for our medical specialties division. Crystal Run Healthcare employs more than 450 providers across 50 different primary care, medical, and surgical specialties in 20 locations throughout the lower Hudson Valley of New York State. We were among the first 27 Accountable Care Organizations (ACOs) to participate in the Medicare Shared Savings Program (MSSP) since 2012. In my role as Chief Quality Officer, I have helped develop and implement the clinical programs necessary to deliver value-based care to our patients.

I want to thank Congress for eliminating the Sustainable Growth Rate (SGR) formula in its attempt to bring more stability to the Medicare Part B program. The SGR formula necessitated continuous fixes every year, forcing policymakers to think in the short term, and we appreciate that we now have the opportunity and ability to plan for the future. Congress' passage of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 represents an opportunity for providers to move away from the current fee-for-service reimbursement model and transition towards value-based care by adjusting payments based on quality and other key factors.

The Centers for Medicare & Medicaid Services (CMS) envisioned that MACRA would help achieve three goals for the healthcare system—better care, smarter spending, and healthier people. The law and regulations would achieve this by rewarding physicians who performed well in three key areas: payment incentives, care delivery, and information sharing.

Policymakers in Congress and the administration have made clear their intent to transform the way health care is financed and delivered in this country. The need to move Medicare to value is evident today, more than ever, and I believe Congress passed MACRA to drive that transition to value in

Medicare Part B. Our current fee-for-service payment system is not sustainable and is not the model best suited to provide coordinated, high quality, cost effective care to our patients. AMGA members are looking to Congress for a stable, predictable value program that creates meaningful and realistic incentives that motivates them to make the multimillion-dollar investments needed to chart a course to value.

Congressional passage of MACRA aimed to bring more stability to Medicare physician reimbursement by granting providers predictable payments until this year, when two new systems would be fully implemented: the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). AMGA members, like Crystal Run Healthcare, have invested considerable time and resources to deliver the best possible care while embarking on this pathway to value, and have concerns with the implementation of these two systems.

### What it Takes to Deliver Value-based Care

The competencies necessary to deliver coordinated, value-based care are not incentivized in a fee-for-service system. Over the past decade, Crystal Run Healthcare has invested tens of millions of dollars in the infrastructure, personnel, and technology needed to deliver care that improves quality and lowers cost. Crystal Run care managers, for example, act as liaisons and points of contact between visits to ensure that our patients understand and comply with their personalized care plans. Our technology solutions risk stratify the population to identify the most vulnerable patients under our care. Homegrown analyses evaluate variations in care to increase awareness of, and adherence to, evidence-based practice guidelines. A Care Optimization Team reaches out to patients identified to have gaps in care in an effort to reengage them and get them the care that they need. None of this is rewarded in a transactional, fee-for-service system. Provider groups like Crystal Run rely on dependable, value-oriented payment models from CMS in order to continue to provide such services.

These services have a direct, positive impact on our patients. In the MSSP program in 2017, which is the most recent year for which we have finalized data, we reduced inpatient admissions per 1000 patients by 3.4% when compared to 2016. We reduced our readmission rate from 16.3% to 14.25%, we reduced our emergency room (ER) utilization by 4.9%, and we reduced our per member per month spend on skilled nursing facilities by 9%. In total, we saved CMS \$5.6 million on the nearly 15,000 beneficiaries we were accountable for that year. As significant as this may be on a population level, it is more impactful to understand how care is different, and better, on an individual patient level.

Take patient A as an example. Patient A is a Medicare beneficiary in the MSSP program who was referred to the endocrinology clinic for uncontrolled diabetes. During the history and examination it was discovered that her blood sugar was four times normal and she was significantly dehydrated. Intravenous fluids and subcutaneous insulin were administered immediately in the clinic and the patient started to feel better. Upon further questioning, she said that she had not been exercising of late due to developing chest tightness and shortness of breath whenever she walked up an incline. A cardiology consult was immediately sought and the patient was transported across the hall to the cardiology clinic. There she had an EKG and echocardiogram that suggested she had unstable angina. An interventional cardiologist was called and advised his colleague to send Patient A to the local ER where he would admit her for a cardiac catheterization. That study revealed two blockages that were able to be stented and the patient was admitted for observation and discharged the next day. The series of events from office visit to catheterization occurred over the course of less than twelve hours because care was coordinated and provided in a multispecialty setting.

Contrast Patient A with one of my relatives (Patient B) who obtains his medical care in a typical community setting. Patient B called his primary care physician complaining of worsening back pain. He was told to go to the ER because he had no open appointments that day. Upon arrival in the ER, he was given one dose of intravenous pain medication and waited four hours to see a physician. That physician did a cursory examination and told Patient B that he needed to make a follow-up with the on call orthopedic surgeon. The first available appointment was in two weeks. At that appointment, the nurse told Patient B that the surgeon he was scheduled to see was a shoulder specialist, not a back specialist so he needed to reschedule his appointment since the back surgeon was not in the office that day. Two weeks later, Patient B finally saw the back specialist and was told that he needed surgery pending medical clearance. Since Patient B's primary care physician and cardiologist were in different practices from the orthopedic surgeon, it took nearly six weeks to obtain the necessary clearance for surgery. Luckily, the surgery went smoothly but Patient B was forced to remain in the hospital an extra day because there was confusion on who was supposed to discharge him. That extra time in the hospital resulted in a urinary tract infection that worsened Patient B's dementia and required an additional two days in the hospital and a brief stay in a skilled nursing facility (SNF) after discharge. Given the experiences of Patient A and Patient B, in which setting would you like your children or parents to receive care?

#### Merit-based Incentive Payment System

MIPS was designed as a transition tool – an on-ramp to value-based payment in the Medicare program. However, CMS has not implemented MIPS as Congress intended. Under MACRA, MIPS providers would have the opportunity to earn positive or negative payment adjustments based on their performance, starting at +/-4% in 2019 and increasing to +/-9% in 2023. By putting provider reimbursements at risk, Congress intended to move Medicare to a value-based payment model where high performance was rewarded and poor performers were incentivized to improve with lower payment rates.

Despite Congress' goals, CMS has excluded nearly half of eligible clinicians from MIPS requirements through its MACRA regulations. Because MIPS is budget neutral, these exclusions result in insignificant payment adjustments to high-performing providers. For example, in 2020, CMS expects a 1.5% payment adjustment for high performers, compared to a potential 5% adjustment provided for in the law. And in 2021, CMS expects a 2% payment adjustment for high performers, but the statute allows for a potential 7% adjustment. By excluding half of providers from MIPS, the system has devolved into an expensive regulatory compliance exercise with little impact on quality or cost.

I understand my colleagues' concerns for physicians practicing in solo or smaller practices, and that the reporting burden on them is at times significant. However, we must recall that the MIPS program is a continuation of quality programs that have existed for years, namely the Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (VBM), and the Meaningful Use (MU) programs, where previously no one was excluded from participating – especially not half of eligible clinicians. In fact, under prior law, combined penalties for failure to participate in PQRS, VBM, and MU could be up to negative 11%.<sup>i</sup> Additionally, there is an opportunity for bonus points for high performers under MIPS.

Congress correctly anticipated that small and rural providers may need extra assistance and authorized funding in MACRA to provide that help. With this funding CMS created the Small, Underserved, and Rural Support initiative to provide free, customized technical assistance to clinicians in small practices. This serves both the small clinicians and the overall Medicare program better than simply excusing them

from participation. If we want to be successful in moving our healthcare system to value, policymakers should no longer exclude providers from participating in MIPS.

### Advanced Alternative Payment Model Program

For Advanced APMs, the other pathway to value under MACRA, the system's requirements need to be revised to allow for increased APM participation. To qualify for the program, providers must meet or exceed minimum revenue thresholds from APMs, or minimum numbers of Medicare beneficiaries in these models. For example, for performance year 2019, in order to become a qualified participant, a provider must receive at least 50% of their Medicare Part B payments, or see at least 35% of Medicare patients through Advanced APMs. The threshold increases to 75% of revenue for performance year 2021. However, AMGA members report APM requirements are unrealistic, unlikely to be met, and will not attract the numbers of physicians and medical groups necessary to ensure the program's success.

In order for more providers to transition to value, there is a need for Congress to offer meaningful incentives so providers will make the multimillion-dollar investments to build a value-based platform. By eliminating or revising these arbitrary thresholds, and extending the APM program beyond its 2024 sunset date, Congress would strongly demonstrate to the healthcare community its commitment to offering a stable and predictable risk platform to providers ready to move to value.

### *Accountable Care Organizations*

Participants in the federal ACO program, like Crystal Run Healthcare, have been moving towards value while making improvements in care processes and the delivery of high-quality care, all while reducing healthcare utilization. However, ACOs have encountered significant obstacles in program design that threaten not only their own success, but also the future sustainability of the program. AMGA members have invested considerable financial, clinical, operational, and leadership resources to establish sophisticated care management infrastructures and organizational cultures necessary to support the goals of the ACO program. ACOs need a workable financing and operational structure that adequately incentivizes their move to value. In order to maintain the viability and structure of the ACO program, AMGA has several recommendations.

Providers that willingly assume financial risk for a patient population require a consistent regulatory framework. In the ACO program, rules that shift depending on what level of risk is accepted is counterproductive, as the care delivery processes must change to adapt to new program rules. Lessons learned under one set of rules may not apply to a care process that must account for a different set of requirements or options. For example, rather than use payment waivers or beneficiary incentive programs as an incentive to take on risk, Congress should synchronize rules across all federal ACO levels. This will allow providers who participate in the program to create delivery models that incorporate payment waivers such as the 3-day qualifying inpatient stay for SNF care and other post-discharge home-visit supervision requirements. Limiting these waivers or any beneficiary incentives to a subset of ACOs creates a situation that requires providers to adjust how they deliver care with no benefit to patients. Indeed, why patients should be required to stay in a hospital for three days or more before they are discharged to a SNF penalizes the patient for no other reason than a provider is in a different ACO level than another. The only meaningful difference in ACOs should be the level of financial risk a provider is willing to accept as an ACO moves up the risk continuum.

Appropriate and accurate risk adjustment is a vital aspect of any performance-based program. When determining the risk adjustment factor, CMS has become overly concerned about coding efforts. Instead, the risk adjustment methodology should be chiefly concerned with the health status of the population assigned to the ACO. CMS uses Hierarchical Condition Category (HCC) prospective risk scores to account for changes in severity and case mix. It is possible that year-over-year the population's health status may improve. Conversely, it may worsen. As such, a risk adjustment factor should be concerned with just that: the health status of the ACO's beneficiaries.

CMS' recent decision to set a 40% shared savings rate for ACO Basic Levels A and B only weakens financial incentives to move providers to risk. This level is insufficient and less than what was originally included in the MSSP. The levels of shared savings need to be increased to encourage participation and recognize the investments ACOs make.

We should adjust ACO regional benchmarking so that they are not competing against themselves. Currently, CMS incorporates historical spending when resetting subsequent agreement period benchmarks. Historical spending should factor into a reset benchmark for those ACOs that are spending more than their region. These ACOs will then have the incentive to address their spending and align their costs to that of their region. However, those ACOs that have demonstrated an ability to deliver care below the regional cost should be evaluated against their region, as it would be increasingly difficult for an ACO to consistently perform better than its historical costs.

Lastly, new repayment mechanisms should be provided for ACOs. As of 2015, CMS no longer allows ACOs to purchase reinsurance policies as a repayment mechanism. Allowing for ACOs in two-sided risk-based contracts to purchase a reinsurance policy would allow them to mitigate significant financial losses.

I truly believe Congress passed MACRA to drive the transition to value in Medicare Part B. However, since 2017, the first performance year for MIPS, we have clearly taken a step back from this transition, by excluding half of eligible clinicians from MIPS and enforcing arbitrary threshold requirements for Advanced APMs. Additionally, providers in the MSSP need one, and only one set of rules to follow. Creating different programmatic rules depending on which track a provider is on requires ACOs to develop new care processes based not on what is best for the patient, but rather by what CMS requires. On behalf of AMGA and Crystal Run Healthcare, we are ready to work with Congress and CMS to ensure that MACRA can serve its intended purpose in moving our Medicare system to value.

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<sup>1</sup> Statement of the American Medical Association to the U.S. House of Representatives Committee on Energy and Commerce Subcommittee on Health, Re: MACRA and MIPS: An Update on the Merit-based Incentive Payment System, July 26, 2018. <https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Testimony-Barbe-%20HE-MACRA-and-MIPS-An-Update-on-the-Merit-based-Incentive-Payment-System-2018-07-26.pdf>