Senate Committee on Finance

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

May 8, 2019

9:30 am, 215 Dirksen

Purpose

To examine the Medicare Physician Payment Reform Act (MACRA) after two years.

Members Present

Chairman Grassley, Ranking Member Wyden, Senators Thune, Brown, Roberts, Warner, Cassidy, Whitehouse, Hassan, Carper

Witnesses

Dr. McAneny, President, American Medical Association
Dr. Cullen, President, American Academy of Family Physicians
Dr. Opelka, Medical Director for Quality and Health Policy, American College of Surgeons
Dr. Hines, Director, American Medical Group Association
Dr. Fiedler, Fellow USC-Brookings Schaeffer Initiative for Health Policy, Brookings Institution

Opening Statements

Chairman Grassley said that MACRA got rid of the flawed sustainable growth rate (SGR) formula. Congress established SGR to control Medicare spending but it wasn't long before it called for large reductions in payments, which then set in motion a perpetual exercise for Congress to scramble once a year to prevent physician reimbursement from being cut. For a decade, each time the can was kicked down the road without solving the underlying problem. Congress came together to pass MACRA in 2015, which showed that Congress can work together in a bipartisan manner. It bodes well for making changes to Medicare to improve patient access in rural and underserved areas. This bipartisan effort provides a glimmer of hope that Democrats and Republicans can come together to prevent Medicare from going broke, which is time better spent than expanding Medicare for All.

Ranking Member Wyden said that Robert Pear, the barometer for healthcare, passed away. He was committed to professionalism and was appreciated by Democrats and Republicans. There are a few key issues that the committee cares about. Doctors in small and rural practices cannot be left behind. Doctors should not go through bureaucratic water torture, they should be rewarded for improved quality. More value should be brought out of taxpayer dollars in Medicare. ACOs and bundled payments are some examples. The next step ought to be to guide countless seniors who are getting lost in the blizzard of modern healthcare red tape: forms, prescription requirements, pill bottles. It's too much for a lot of seniors with chronic conditions. Traditional Medicare is twice as bad as Medicare Advantage. Every senior with chronic illness ought to have a chronic care point guard to manage their care.

Testimony

Dr. McAneny said that her practice had to close three rural cancer clinics. Since MACRA was enacted, the AMA has worked with CMS to make needed improvements to MIPS each year and appreciate the technical changes to MACRA included in BBA 2018. QPP needs significant improvements. CMS and the medical community must work together to make the program better for patients. First, small and rural practices must be given the conditions to succeed. The AMA has strongly supported the accommodations made, including the low volume threshold and hardship exemptions and technical assistance grants. However, recent scores from the first performance year shows that small and rural practices scored lower than the average for MIPS eligible clinicians. All patients must succeed in MIPS to preserve healthcare delivery in rural areas. Second, MACRA aimed to provide busy physicians the path to transition to new payment models. Congress provided a five percent incentive for physicians to participate in APMs in the first year of the program. The AMA heard from many physician groups who were excited to take advantage of this opportunity, but during the first three years, too few APM options were available, and now there are too few years for physicians to transition to an APM. Physician-focused payment models must provide flexibility, such as the Primary Care First model. The APM incentive must be extended for additional six years. Third, the AMA is recommending that Congress replace the scheduled physician payment freeze beginning in 2020 with positive annual updates for physicians. The recent Medicare trustee report found that the scheduled payment freeze is not keeping pace with physician costs. Positive payment updates are needed to provide physicians a margin to maintain their practice. Finally, the AMA urges Congress to simplify MACRA and make it more clinically significant. Physicians say that the measures they are required to report take time away from patient care.

Dr. Cullen said that he staffs a critical access hospital in Alaska. After four years, the AAFP still considers MACRA an appropriate model for physician payment. The philosophy and framework remain consistent with AAFP policy, especially the delivery and payment models that support consistent coordinated primary care instead of FFS. The low volume threshold has protected many rural area hospitals from MIPS. AAFP is pleased that CMS has created a voluntary pathway for MIPS. MACRA created an opportunity for physicians to create and propose payment models through PTAC. The Primary Care First model is largely reflective of the AAFP proposal submitted to PTAC in 2017. AAFP believes there are two areas of improvement: creating a culture focused on patient care and eliminating the complexity of MIPS scoring. The volume of administrative functions is having a negative effect on patient care, creating an environment where physicians feel forced to check boxes. Primary care physicians spend two hours completing administrative tasks for every hour of patient care. MIPS has created a burdensome program that has increased practice costs and contributed to physician burnout. It detracts from physicians' ability to focus on patients. AAFP supports the Patients over Paperwork initiative but more must be done to reduce administrative burdens. AAFP has three technical corrections suggested. First, MACRA established an annual increase of 0.5 percent of physician payment from July 2015 to 2019. AAFP urges the committee to extend that for five more years. Second, AAFP recommends that the exception performance bonus payments be reimagined to reward those who

consistently outperform. Third, the AAFP recommends the five percent bonus for qualifying physicians participating in an APM be extended for three to five more years.

Dr. Opelka said that ACS is worried that a hurried CMS implementation of MACRA has left surgical care as an afterthought. Defining surgical value is simply not in the wheelhouse of the insurance industry, so CMS struggles with retrofitting a FFS model with sporadic measures to the surgical team. MIPS has not and will not serve as a driver of improvement in quality or reduction of costs. Many surgeons participate in quality reporting through CMS Web Interface and many are not even aware of the measures reported. Surgeons receive credit for how effectively their group practice immunizes patients, not their safe surgical care. Group measurement should reflect the range of services furnished by clinicians in a group, but that is not the case. The emphasis of registries and measured development funding should create more outlets for specialty development, but that has not materialized. Meaningful measure of surgical care begins with evidence based standards for care and ensuring the right systems are in place for measure verification. ACS proposes a surgical quality measurement structure with three components: verification of key standards of care, patient reported outcomes, and clinical outcome measures. In 2017, the ACS published the "red book", which is based on decades of research. Standards drawn from the red book are being used for the accreditation of hospitals. Finally, the patient reported outcomes bring in the patient's voice. ACS urges Congress to view MACRA in light of the current Medicare reimbursement rates, which do not adequately cover provider costs. ACS is greatly concerned about the modest statutory updates included in the law and there will be a six year period with no payment adjustments, which will affect patient access. ACS believes the intent of MACRA was correct. QPP incentives must be refocused towards higher quality care.

Dr. Hines said that he has helped Crystal Run, one of the first ACOs to participate in MSSP, develop and implement value-based care. The current FFS system is unsustainable and is not best suited to provide coordinated, cost effective care. AMGA is looking to Congress for a program with realistic incentives. MIPS was designed as an onramp, but CMS has not implemented MIPS as Congress intended. Congress intended to move Medicare to a value-based payment model. Despite the MACRA statutes, CMS has excluded nearly half of MIPS eligible providers from MIPS requirements through MACRA regulations. These exclusions result in insignificant payment adjustments to high performing providers, resulting in a 1.5 to two percent increase. The system has devolved into an expensive system with little impact on quality or cost. The MIPS program is a continuation of quality programs that have existed for years, where previously no one was excluded from participating. For Advanced APMS, the system's requirements must allow for increased APM participation. AMGA feels that these requirements are unrealistic and will not attract sufficient numbers of physicians. These arbitrary thresholds are a disincentive for AMGA members to move to value. By extended the APM program beyond a 2024 sunset date, Congress would be supporting providers moving to value. The past three years have been a step back by enforcing arbitrary threshold levels for APMs and excluding half of eligible clinicians from MIPS.

Dr. Fiedler said that MACRA bonuses for participation in advanced APMs have great potential. Recent research on ACOs has found that these models can reduce healthcare spending while improving quality. ACO participation has increased as MACRA bonuses increased, although other factors contributed as well. The bonuses encourages CMS to deploy stronger APMs with stronger incentives to reduce spending, such as needed improvements to benchmark calculations and how quickly ACOs must transition to two-sided risk. However, MIPS is less optimistic. It is ill-suited to creating strong, coherent incentives for improving patient care. Clinician and practice-level performance measures can be quite nosy. The fact that clinicians can choose the quality measures to report is also concerning. There is little evidence that programs like these improve the quality or efficiency of patient care, but MIPS is creating significant provider costs at $482 million in 2019. A good first step is to make the Advanced APM bonus permanent sooner rather than later and strengthen the MACRA incentives for participating in Advanced APMs, increasing participation. Congress could implement a budget-neutral bonus and penalty system. Policymakers should eliminate the cliff in Advanced APM bonus eligibility rules. The best path forward is to eliminate MIPS, which has unavoidable problems. Even a reformed MIPS would be insufficient. If MIPS continues, potential improvements include standardized measures in Quality reporting, replacing the Practice Improvement category with a targeted incentive for reporting to clinical registries, and replacing the Promoting Interoperability category with a simpler incentive for using certified EHR.

Questions and Answers

Chairman Grassley asked Dr. Opelka about the problems of physicians' limited use of data registries. **Dr. Opelka** said that putting registries into MIPS or MACRA is not taking full advantage of how to leverage data for better care. It is analogous to airplane control towers not talking to each other. Government guidance is needed for setting standards in data collection, normalizing and analyzing data. Ophthalmology, cardiac surgery and ACC registries are successful examples. **Chairman Grassley** asked what the single change would have the most impact. **Dr. McAneny** said that the most important thing to do is to have a continued positive update. Second, more opportunities and stability for Advanced APM methodology. Third, continued updates of Advanced APMs past the three years. EHRs are not good for sending data to CMS so data must be streamlined. **Dr. Cullen** said that MIPS has taken so long to roll out that members haven't been able to take advantage of it. EHRs really do not do a good job of collating data to send out. EHRs have interoperability issues. **Dr. Opelka** said create a value expression of quality over cost. Second, the concept of asymmetric risk. People want more upside gain than downside risk, so that is how most businesses are run, not CMS's symmetric risk. Third, a true Innovation Center with the ability to do small innovation. Last, data must have consistent government standards. **Dr. Hines** said increasing the uptake of APMs through waiving the current inclusion criteria; making permanent the five percent bonus payment; timely access to claims data with benchmarking; and synchronizing the rules across federal ACO programs. **Dr. Fiedler** said that the most promising path forward is to build on MACRA's incentives for Advanced APM participation.

Ranking Member Wyden asked Dr. Cullen how to expand care for people at home with chronic illness. The Primary Care First model is a path for more home-based primary care. **Dr. Cullen** said that chronic care management is the best way to reduce costs overall. Primary Care First rewards physicians for keeping people at home, which technology now allows. Patients do want to stay at home. There is a lot of interest in the seriously ill population component of Primary Care First, which is an important direction. **Ranking Member Wyden** said half of Medicare spending goes towards patients with two or more comorbid conditions. He wants to work with Portman, Isakson, Markey, and Warner to work on chronic care in Medicare again. Ranking Member Wyden asked Dr. Cullen what he thinks of the chronic care point guard. **Dr. Cullen** said that family physicians are the point guard. When people bounce around specialists, their care is worse and their cost is higher. **Ranking Member Wyden** asked for specific step-by-step suggestions in writing in building a modern Medicare program.

Sen. Thune said that the option to form virtual groups under MACRA aimed to help small and rural groups and it does increase their chances of success in MIPS. He asked all the witnesses how implementation of virtual groups has gone, such as any barriers to success. **Dr. McAneny** said that the AMA is disappointed with the uptake in virtual groups. CMS could help considerably by increasing transparency with releasing data. Getting the data a year and a half later makes it impossible to see how members of a group are doing. One of the concerns that practices have in trying to integrate with independent groups is the Stark and Anti-Kickback laws. It is difficult to obey those while trying to consolidate costs. Additional incentives and bonus payments could be provided to compensate for the increased costs of coordination. **Dr. Cullen** said that it is difficult to form groups and there has not been a lot of interest. There is a lack of multi-payer agreement. **Sen. Thune** asked for additional suggestions for ensuring the success of rural providers in delivery system reform. **Dr. Cullen** said paying them more. Many rural providers are on the brink of survival due to the difficulty of the IT infrastructure and difficult patients. Second, reducing complexity and increasing interoperability. **Dr. McAneny** said that preserving the small volume exemption would be very helpful. A positive update is important because the cost of providing medical practice increases from 2 to 3.5 percent each year, but Medicare will give a zero percent increase each year in the near future. The rural practices will be hardest hit.

Sen. Brown asked Dr. McAneny if CMS and Congress are doing enough to ensure representation of the patient voice during development and implementation of MACRA, and what more can physician organizations and CMS do to ensure patients are prioritized. **Dr. McAneny** said that patients do not have the ability to fill out forms, like the 84 page document sent to oncology patients. The AMA proposes that patient advocacy organizations are heard during sessions and to recognize what patients need during directed care. Many Americans shave prediabetes and other poorly managed chronic diseases, so the AMA is focusing on prediabetes and hypertension. **Sen. Brown** asked how many existing 424 measures in MIPS consider the patient voice. **Dr. Cullen** said he is not sure. **Dr. Opelka** said the surgical space runs its own database of patient outcomes but they are not part of a payment program.

Sen. Roberts said that MACRA is certainly an improvement over SGR. He is concerned on how it affects small and rural practices. MIPS is set to rate providers on measures that are simply too

burdensome for rural providers. Exemptions are appreciated but more work needs to be done. Small and rural providers deserve to be included in federal efforts to improve healthcare without being penalized for their location or size. He introduced MAP for rural relevant quality measures. He asked Dr. McAneny how more appropriate quality measures would level the playing field for rural providers. **Dr. McAneny** said that rural patients have less discretionary income so holding physicians accountable for those social determinants makes things incredibly difficult. Patients end up with outcomes affected by food insecurity and transportation, which are things that providers are currently not allowed to help solve. Releasing laws that constrain rural practices would be very useful. Data entry for MIPS takes a huge amount of time and effort. As AMA President, she scored 100 on MIPS and her increase was 1.88 percent, but, the subsequent adjustment lowered that increase so the entire payment she got was $3,400. The EHR cost and staff overtime made it so that she lost $100,000 to score that perfect score.

Sen. Warner asked Dr. Cullen about PTAC and Advanced Care models. It seems well-intentioned but CMS has not been good about implementation. He asked how Congress can help. **Dr. Cullen** said that the big problem with Advanced APMs have taken a long time to roll out, which is not the fault of PTAC. **Dr. McAneny** said that CMMI being able to do pilot projects might be very useful if PTAC pilots can be enacted. **Dr. Opelka** said that PTAC is going through an enormous amount of work in conceptual modeling, but then fails at CMMI since they are worried about broad scale innovation. CMMI must be much more nimble. **Sen. Warner** said a group from the committee should put pressure on CMMI. He asked Dr. Fiedler if there is a way to salvage MIPS. **Dr. Fiedler** said improvements can be made to the Quality domain so clinicians are not incentivized to select measures they can get the highest scores on, simplification of the Promoting Interoperability category, and transformation of the Improving Quality category, but he is not optimistic. **Sen. Warner** said EHRs underdelivered due to lack of interoperability. There is enormous cyber vulnerability, such as ransomware against hospitals, so basic cybersecurity hygiene must be built in.

Sen. Cassidy said that based on the mean and median data scores, small practices are capable of achieving higher scores, they just don't. He asked Dr. Cullen to what degree small practices can participate in the Direct Contracting (DC) model and if it would incentivize small practices to enter a two-sided risk arrangement. **Dr. Cullen** said Alaska is one of the pilot states in DC. Downside risk must be made minimal since a lot of rural practices are right at the margin. **Sen. Cassidy** said he knows there are tight margins but practicing physicians can make other decisions to cut costs. **Dr. Hines** said that Dr. McAneny's example shows that exclusions should be done away with so funds can reward practices that are doing a good job. There is MIPS funding for the small and rural support initiative. In theory, DC is a great model, but the devil is in the details. As long as there are limits to the network to promote high quality physicians, it has the potential to be successful. **Dr. McAneny** said that the prospective payment is key. Many small practices do not have the resources to invest in quality care up front. Risk must be scaled according to what the practice can manage.

Sen. Whitehouse asked for the answers in writing. CBO does rolling projections of total federal healthcare spend and the most recent projection is down over $4 trillion over 10 years. Coastal Medical and Integra are two of the best ACOs, and CMS has not always been their best friend.

They should feel rewarded and supported, not challenged and unwelcome. Rewarding the good performers and figuring how to propagate that is better than trying to extract as much savings from each one. One of the problems faced by the ACOs is leveraging: they only control 10 to 15 percent of their patient cost, but they bear risk on the entire cost load. That is question one. The second is end of life care. There is a space where there needs to be microcosms for innovation. CTAC is working in this space, where some of the Medicare rules can be counterproductive and don't make sense. Adam Boehler is being helpful but it would be helpful to hear more. Third, the EHR interface for doctors. Recently a bill was filed with Sen. Cassidy to get the EHR providers to change their behavior about the gag rule. There is the prospect for strong bipartisan signaling out of this committee. Last, there has been insufficient engagement at the state level. States have governors and health departments and Medicaid programs, and there needs to be a way to reward states for better outcomes.

Chairman Grassley asked how Advanced APMs can be shaped to give rural physicians the best chance of succeeding in them. **Dr. McAneny** said that MIPS is a way to start with that. Medical home can be done with very small practices. Some of the pooled processes may work, but the first step is to give those practices the resources to have the time and flexibility to innovate. That will not happen with a zero percent update for MIPS. AMA promotes the PTAC idea of starting out with how to deliver the care and then adapting the payment model to the care. **Dr. Cullen** said that prospective payment with significant upside risk will help significantly in a rural area.

Sen. Hassan asked Dr. Cullen about the specific challenges rural hospitals face with complying with reporting requirements. **Dr. Cullen** said the biggest impact is if providers close or leave. Nearly 100 small rural hospitals have been lost over the past 10 years, which has significantly impacted maternal and infant mortality. Rural hospitals do not have the sophisticated systems for reporting due to cost. Finding employees is also difficult, raising costs dramatically. **Sen. Hassan** said MACRA provides an incentive payment for providers who improve their tracking for opioid treatment, screening, and prevention. She asked if the new reporting requirements impacted reducing opioid misuse. **Dr. Cullen** said his clinic does work with opioid use disorders regardless of MIPS. It is hard to distill opioid treatment disorder into single data points since it's so labor intensive. **Dr. McAneny** said that the AMA has had a task force looking at this since 2014. Having the opioid use treatment processes as a Quality measure in MIPS would be helpful. Making the prescription drug monitoring programs more user friendly and recognizing team based care would be very useful. There should be more options for treating opioid use disorder in rural areas. **Dr. Hines** said that measures about opioid use can be helpful but it is up to physicians to recognize the importance of coordinated care.

Sen. Carper asked how many physicians participate in Medicare. **Dr. McAneny** said the vast majority of physicians do. **Dr. Cullen** said that over 90 percent of family physicians accept Medicare. **Sen. Carper** asked how Congress can increase the number of physicians participating in Advanced APMs. **Dr. Hines** said promoting APMs and synchronizing rules across ACO programs. **Dr. Cullen** said that it would be better to roll out programs more quickly and in more geographic areas. **Dr. Opelka** said ACS is looking at asymmetric risk models. **Sen. Carper** asked which APMs are best suited for improving end of life care and opioid addiction treatment. **Dr. Hines** said the Oncology Care model has provided good data. **Dr. McAneny** said the

Oncology Medical Home process found that continuity of care saved significant money on end of life care. Opioid treatment requires a team based effort, which is part of the new primary care model.

Ranking Member Wyden said that the committee has a question about how rural areas will fit with respective to innovative payment models. Both sides of the aisle care deeply about rural and underserved areas. **Dr. Cullen** said the most important thing is ensuring that APMs pay adequately for physicians to stay in business. **Dr. McAneny** said that when a small community of physicians wants to get together to provide less expensive and timelier services they are impeded by the Stark and Kickback rules. Rural areas often have more of the social determinants of health, which needs to be accounted for in the attribution, which may be a part of why they score lower in hospital and physician quality. Stability and upfront payment are needed in creating a new delivery system. The other impediment is the delayed reception of aggregated data from CMS. **Dr. Fiedler** said measurement should be improved. Rural providers should be compared to providers in similar circumstances or geographic regions. ACO programs have taken steps in that direction. **Ranking Member Wyden** said chronic care is the future of healthcare.

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