Statement for the United States Senate Committee on Finance

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

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Society of Hospital Medicine

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Dear Chairman Grassley, Ranking Member Wyden, and Members of the Committee

The Society of Hospital Medicine (SHM), on behalf of the nation's hospitalists, is pleased to offer our comments to the Senate Finance Committee regarding the recent hearing entitled, "Medicare Physician Payment Reform After Two Years: Examining MACRA Implementation and the Road Ahead."

Hospitalists are front-line clinicians in America's acute care hospitals whose professional focus is the general medical care of hospitalized patients. Their unique position in the healthcare system affords hospitalists a distinct perspective and systems-based approach to confronting and solving challenges at the individual provider- and overall institutional-level of the hospital. In this capacity, hospitalists not only manage the inpatient clinical care of their patients, but also work to enhance the performance of their hospitals and health systems. They provide care for millions of patients each year, including a large majority of hospitalized Medicare beneficiaries, and are national leaders in quality improvement, resource stewardship and care coordination.

Since the inception of the specialty of hospital medicine and the founding of SHM in the 1990's, hospitalists have been at the forefront of delivery and payment system reform. They are integral leaders in helping the healthcare system move from volume to value. Hospitalists from across the country are engaged in driving innovation aimed at achieving higher quality and lower cost care for their patients. As such, they are key leaders and partners in alternative payment model (APM) adoption, including bundled payments, the Medicare Shared Savings Program Accountable Care Organizations (ACOs), and managed care.

The Medicare Access and CHIP Reauthorization Act (MACRA) created two pathways to encourage providers to move away from Medicare fee-for-service (FFS) billing: Alternative Payment Models (APMs) and the Merit-based Incentive Payment System (MIPS). MACRA seeks to incentivize providers to utilize payment structures that focus on value, rather than volume, of care. We are very supportive of Congress' efforts to reform the FFS payment system and believe more must be done to drive innovation and align incentives for lower-cost, high quality care. Through our members' experiences in the first few years of the program, we have identified several concerns and provide suggestions below.

Barriers to Alternative Payment Model (APM) Adoption

MACRA seeks to incentivize providers to move away from fee-for-service (FFS) Medicare towards APMs. Qualified participation in an APM provides an exemption from the MIPS and a 5 percent lump sum incentive payment through 2024. In order to determine whether a provider qualifies for the APM pathway of MACRA, the law established thresholds of payment or patients. In 2019 and 2020, the thresholds are set at 25 percent of Medicare payments; 2021 and 2022 at 50 percent; 2023 and beyond at 75 percent. For patient count, providers must meet generally similar thresholds in each year. Starting in 2021, the thresholds may be met through an all-payer analysis, though providers must still reach a minimum threshold of Medicare payments or patients. We understand the law specified these

thresholds to ensure that providers are meaningfully engaged with the APM and have moved significantly away from FFS Medicare.

SHM believes that encouraging providers to move into APMs is the most important aspect of MACRA. We see APMs as the only pathway away from the costly FFS system. APMs are also important because they return a significant amount of control directly to providers. That said, the threshold model of APM participation creates a major barrier for many providers, leaving them stuck in traditional fee-for-service Medicare and the MIPS. Small fluctuations in patient mix can result in providers qualifying as APM participants one year and not the next. In addition, some of the APM models, such as Bundled Payments for Care Improvement (BPCI) Advanced, are condition-based, meaning generalists like hospitalists will be unable to collect enough payments or patients to meet the threshold. In the original BPCI, hospitalist participants that engaged with 12 different condition bundles in the model were unable to meet even the lowest thresholds set for the program.

We believe the thresholds serve as an impediment to meeting the intent of MACRA and, importantly, as a barrier to cost containment. Well-designed APMs have the potential to save a significant amount of money for the Medicare Trust Fund, while the budget-neutral MIPS does not share the same potential. To save money, we must move more providers off of fee-for-service and onto APMs.

Rethinking Exclusions Under the MIPS

The Merit-based Incentive Payment System (MIPS) was developed to transition the traditional Medicare fee-for-service payment system into value-based payments. We have serious concerns about the effectiveness of the program, as nearly 60 percent of providers are completely exempt from the program under current Medicare policies. Since the MIPS is a budget-neutral program, the money used to incentivize high performers is taken from underperforming providers who are penalized. As more providers are exempted from the program, the pool of potential payments for high performing providers has decreased significantly. To ensure compliance in the MIPS, providers that are not exempt have had to invest significantly in data infrastructure, administration and reporting under the program. However, with such large numbers of exempt providers, the potential return on those investments are negligible. With so many providers exempt from the program, we also have serious concerns about the relevance and accuracy of data reflected by measures that are being reported in the MIPS.

CMS has indicated through rulemaking that they believe exemptions from the program are necessary because of concerns about the validity of data in measures with small case volumes and the financial burdens placed on providers for reporting. We believe these exemptions and the reasoning for them are evidence of serious structural flaws within the program. Policymakers should focus on refinements aimed at achieving a meaningful program that yields simple and actionable feedback for all Medicare providers.

Pay for Performance: Are We Measuring the Right Things?

Measurement has become a central feature of the Medicare system. The use of measurement in pay-for-performance programs is built around an assumption that measurement can lead to improvements in quality and reductions in cost. SHM agrees that well-designed measures have the potential to yield these outcomes and may be worth the time, work, and cost to implement. Looking at the MIPS, current policies create a complicated program with measures that give providers very little meaningful and

actionable feedback. Providers spend a significant amount of time and money on reporting quality measures that may not be reflective of their entire practice or even report on most of their Medicare patients. Instead, they are participating in the MIPS as a compliance effort to avoid significant penalties.

We believe there is an ampleopportunity to step back from siloed and micromanaged quality and cost measures and focus on developing indicators for the quality and safety of healthcare and on the general health and well-being of communities. Shared accountability between providers on these broad indicators will lead to the proliferation of local-level quality improvement and cost-reduction efforts. This systems-based approach, while it does not contain the most narrowly tailored measures to specific specialties or individual clinicians, is how patients view the healthcare system and is ultimately how providers must work together to improve quality and decrease costs. We believe the goal of the MIPS should be to point providers in the right direction by aligning incentives and having simple and clear markers that are shared across providers and specialties.

Policy and Definitions that are Inconsistent with Practice Realities

Often, MIPS/MACRA definitions and policy does not align with practice realities. A clear example of this is an issue that facility-based providers, including hospitalists, are facing with the definition of hospital-based group in the Promoting Interoperability (formerly Advancing Care Information) category of the Merit-based Incentive Payment System (MIPS).

Hospital-based providers are meant to be exempt from the Promoting Interoperability (PI) category in the MIPS. This policy acknowledges that these providers are working in settings that use Certified Electronic Health Record Technology (CEHRT) and participate as providers working in eligible hospitals in the Promoting Interoperability Program (formerly EHR Incentive Program). It prevents unnecessary duplication and excessive administrative burden practices that work primarily in the hospital. We note the policy is meant to account for how hospital-based providers are already doing work for their hospitals to meet similar or identical requirements in the eligible hospital Promoting Interoperability Program. Furthermore, it protects hospital-based providers from being penalized for factors outside of their control, since they do not always have full access to or influence over the CEHRT used in their facilities.

To determine whether a MIPS eligible clinician (defined as a unique Taxpayer Identification Number-National Provider Identifier (TIN-NPI) combination) is exempt from PI as a hospital-based provider, the Centers for Medicare and Medicaid Services (CMS) uses a threshold of 75 percent of covered professional services in Place of Service (POS) codes for off-campus outpatient hospital (POS 19), inpatient hospital (POS 21), on-campus outpatient hospital (POS 22), or emergency room (POS 23) during a 12-month determination period. If a MIPS eligible clinician meets or exceeds this threshold, they are exempt from the PI category and the category weighting is reallocated to the MIPS Quality category.

To determine whether a group is exempt as a hospital-based group, CMS has indicated that 100 percent of the eligible clinicians associated with the group must be designated as hospital-based during the same 12-month determination period. This extremely restrictive definition is inconsistent with the overarching intent of the hospital-based PI exemption as it requires groups that have only a single provider whose billing deviates from the exemption to participate in PI. This does not only make sense

in the real world of medical practice but is also resulting in many hospital-based providers being subject to unfair penalties that are not of their making and have nothing to do with their performance.

It is imperative that the MIPS policies and definitions reflect practice realities in order to make the program as relevant as possible to providers. We encourage the Committee to work with CMS and with stakeholders to identify areas where policy changes must be made to ensure practices are accurately represented and assessed under pay for performance programs.

Conclusion

The Society of Hospital Medicine looks forward to working with the Committee as it looks to achieve the shared goals of MACRA: higher quality care at lower cost. We stand ready to help craft policies that are not only easier for providers to understand, but also aim toward better accomplishing the stated intent of MACRA.