MGMA Center for Research
American College of Medical Practice Executives
Medical Group Management Association

April 15, 2013

Honorable Dave Camp
Chairman, Ways and Means Committee
U.S. House of Representatives
Washington, D.C. 20515

Honorable Fred Upton
Chairman, Energy and Commerce Committee
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Camp and Chairman Upton:

The Medical Group Management Association (MGMA) is pleased to respond to your request seeking input as you work towards a permanent solution to the flawed Medicare physician payment system and a full repeal of the Sustainable Growth Rate formula (SGR). We support the overarching goals of the reform proposal presented by the Committees and appreciate the opportunity to provide feedback on the additional details of this framework.

MGMA-ACMPE is the premier association for professional administrators and leaders of medical group practices. Since 1926, the Association has delivered networking, professional education and resources, advocacy and certification for medical practice professionals. The Association represents 22,500 members who lead 13,600 organizations nationwide in which some 280,000 physicians provide more than 40 percent of the healthcare services delivered in the United States.

We reiterate our position that Congress must establish a transitional pathway that provides stability through positive funded updates until an SGR replacement takes effect. Medicare payment updates should reflect costs of providing services as well as efforts and progress on quality improvements and managing costs. It is essential that any proposed replacement framework is not implemented prior to demonstrated success, or overly complex thus establishing a bias against participation and an impediment to quality improvement goals.

Transition to alternative payment models

Alternative payment delivery models are currently being implemented and tested in a variety of practice sizes, types and locations. These models must continue to be developed and must be fully and appropriately tested across a broad variety of practices and settings before assumptions may be made regarding a suitable timeframe for incorporating models into the Medicare program, or determining which models would be appropriate to include as a payment reform model. A transition pathway is necessary to ensure that innovative payment methodologies are tested and evaluated in a variety of practice settings. An ongoing evaluation process should be created to determine if a system is ready for wider implementation, requires further testing, proves ineffective or is not scalable.

Use of alternative payment models in Medicare

Numerous Medicare proposals and initiatives that begin to test alternative payment methods have been created to promote integrated care delivery and encourage cost-effective medical treatment such as: bundled payments, partial capitation, accountable care organizations, medical homes and other hybrid approaches that couple fee-for-service payments with a risk-based bonus opportunity. MGMA supports the testing of these alternative payment

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models, with the understanding that quality and efficiency improvements should result in incentives to enhance physician payment. A new system cannot penalize physicians from the outset with a reduced "base rate" from which any remaining reimbursement must be earned through demonstrating improvements via specified metrics. Practices can best improve quality in a non-punitive environment, therefore any variable, performance-based rates as discussed in phase II of the Committees' proposal should be provided as additional, incentive payments.

For any SGR repeal framework to be successful, physicians must have the flexibility to adopt different payment arrangements and approaches based on their composition and capabilities. In some cases, the fee-for-service model will remain the most appropriate, and therefore it is imperative that any SGR replacement policy recognizes this.

Quality and efficiency improvement

MGMA supports rewarding quality and efficiency improvement, and we assert that this improvement should be assessed through a system which measures physicians against properly risk-adjusted, evidence-based measure thresholds, which take into account things such as patient compliance and the underlying evidence based guidelines, offering an opportunity for all physicians to succeed. It's critical that Medicare implement a system that puts the patient first. Simply penalizing lower performing physicians to reward higher performing physicians will not effectively advance wide-scale quality improvement in Medicare. Rewarding quality and cost effectiveness through a "tournament style" approach to foster competition within physician specialties will only lead to unintended consequences such as discouraging sharing of clinical best practices.

New alternative payment models will require sophisticated data infrastructure and skilled staff to analyze data to foster physicians' ability to share information and coordinate care. Physician practices participating in these programs should receive timely accurate data from Medicare on their respective patient populations. Patient data, including Medicare claims data, should be provided to physicians on at least a monthly basis.

Many of the tools necessary for these models to be successful in a broad array of practice settings and locations will require additional testing, modification and improvements. These include adequate risk adjustment methods and quality and cost measurement mechanisms. It is imperative that these programs measure physician performance with a high degree of accuracy. We applaud the Committees' leverage of the group practice model in the proposed framework, as we believe a group level focus can meet the goals of the framework and facilitate Medicare's ability to rely on statistically valid and reliable data for its quality and effeciency programs.

We reiterate our position that in order to find a solution to the current broken payment system, we also need to break down the silos between separate payment systems for different sectors of Medicare. Breaking down the silos, particularly between Part A and Part B, needs to be part of developing a new payment approach if we are to accommodate different practice models. The Medicare program must be flexible and give physicians credit under Medicare Part B for savings they achieve in Part A when measuring quality and efficiency. Many of the new emerging models will only succeed if the silos are broken down. This will allow, for example, physicians and hospitals to work together to prevent unnecessary hospitalizations and provide coordinated, cost-effective and patient-centered care.

Overlapping reform efforts

In many ways the Update Incentive Program (UIP) detailed in the Committees' proposal mirrors existing federal quality reporting programs such as the Physician Quality Reporting System (PQRS), and Value

Based Payment Modifier programs. MGMA restates its long-standing position that capturing data over multiple government administered programs places significant administrative burdens on practices. Efforts must be made to remove the overlap and duplication that already exists among the plethora of federal quality reporting programs by allowing providers to receive credit for all Medicare quality and efficiency criteria by reporting through one single program. Current requirements for practices to report are unnecessarily onerous and costly, and emphasize reporting over patient quality and improved outcomes.

In implementing any new quality program such as the UIP as part of a payment alternative approach, it is imperative that Congress decide whether existing federal quality improvement programs would be eliminated, or incorporated to create one single program. Coordination of these programs is critical to the future of Medicare quality measurement and reporting.

MGMA is also concerned with the Committees' proposal to separately address nonphysician providers (NPPs) in its physician payment reform and quality improvement efforts. NPPs work with physicians toward common clinical goals and outcomes and therefore MGMA asserts that NPPs working within their scope of practice under Medicare should be held to the same quality standards for services provided to beneficiaries.

Conclusion

Creating a stable payment system for Medicare providers is critical. The SGR approach has failed in this regard with its constant threats of massive Medicare physician payment cuts. Stability must be restored to program payment amounts as well as its ever-changing rules. Congress and CMS cannot continue "changing the rules of the game" every year in a piecemeal approach. Long-range savings and continued increased quality and accountable, patient-centered care will require major reforms to the current payment system. Innovative payment and delivery models should not be incorporated as a requirement in the Mecicare system until they are fully and properly tested, and have produced significant and reliable results. Any new payment system(s) must be flexible to accommodate different practice types, and complexity should be avoided to encourage robust and meaningful participation.

We appreciate this opportunity to share our feedback on this important issue. We are committed to working with the Committees to repeal the SGR formula and replace it with a fair and appropriate payment update alternative. Should you have any questions, please contact Jennifer Martin, MGMA Senior Government Affairs Representative at 202-293-3450.

Sincerely,

Susan Turney

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