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

May 25, 2012

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

Dear Chairman Camp:

The Medical Group Management Association (MGMA) is pleased to respond to your request for input on the kind of payment system that should replace the Medicare physician fee schedule. 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.

Medicare physician payment system implications

As you are aware, under current law, Medicare physician payment will be reduced by 30.9 percent on Jan. 1, 2013. Since the sustainable growth rate (SGR) formula was established, Congress has repeatedly stepped in and stopped pending cuts but has not addressed its underlying problems. Each time Congress has passed a short-term intervention it has only perpetuated practice instability, deepened the payment cuts in future years, and increased the cost of permanently resolving the problem.

There is widespread agreement among experts and stakeholders that the existing physician payment system under the Medicare program is inadequate. Although Congress has repeatedly intervened to prevent rate cuts, it has never eradicated the formula that dictates these cuts.

It is clear that the SGR does not adequately address growth in spending. According to MGMA data as illustrated in the chart below, we project the total operating cost per full time equivalent (FTE) physician increased by 56.1 percent since 2001. During that same period, physician Medicare payments only increased 2.9 percent. This widening gap is insurmountable for many physician practices as it destabilizes business operations and decreases access to care for Medicare beneficiaries.

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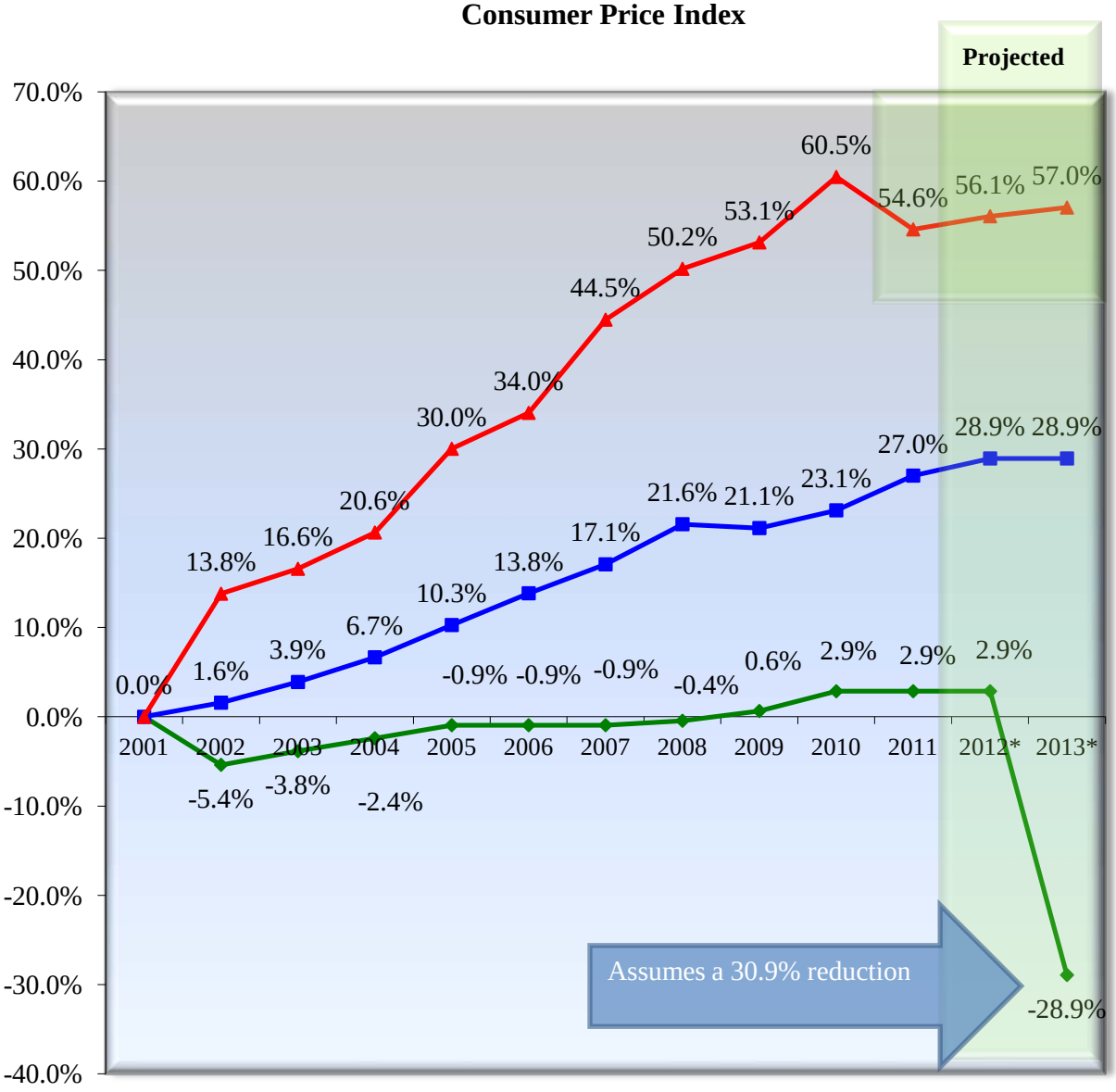
**Cumulative Percent Change Since 2001 for the Medicare Physician Payments,
Not Hospital/IDS-Owned Multispecialty Group Operating Cost, and the Consumer Price Index**



* 2011, 2012, and 2013 median operating cost values are three year moving average projections of previous years'data.
* 2012 and 2013 CPI figures are computed as an average fo the first quarter 2012 CPI reported values
* Assumed reduction figure based upon 2012 Medicare Trustees Report (April 23, 2012)

Annual Medicare Update — CPI — Total Operating Cost per FTE Physician

According to our member research, 95 percent of physician practices polled said they currently participate in Medicare. Of the 95 percent currently participating in Medicare, only 16 percent indicated they will maintain current levels of access for new Medicare patients, and over 40 percent said they would be forced to reduce clinical and administrative staff if cuts occur. Additionally, 65 percent of respondents said the uncertainty caused by the annual threat of Medicare payment cuts has already caused them to delay purchases of new clinical equipment and/or facilities, and 52 percent reported that they have had to reduce charity care. According to our estimates, there are over 2 million employees in the nation's medical group practices and these practices contribute over $207 billion dollars to the nation's economy. Short-term legislation that prevents the cuts jeopardizes the financial health of medical practices, the jobs they create and the Medicare patients they serve.

The original intent of the SGR was straightforward yet ill conceived. Ten straight years of congressional overrides have contributed to higher Medicare spending on physician services and have left the federal government with significant budget deficit exposure. SGR reform is not only integral to patient access but also the calculus of deficit reduction.

Recommendations and transition to alternative payment models

First and foremost, Congress must act to permanently repeal the flawed SGR formula used to annually update Medicare physician payment rates. MGMA strongly urges Congress to repeal the SGR, provide stable payments for a period of several years to allow testing of different payment and delivery models, and then allow for a transition to new models. We also agree with your acknowledgment that the solution to the physician payment system must not be a “one size fits all” method given the diversity of medical practices. Physicians should have the flexibility to adopt different approaches based on their composition, capabilities and community needs.

MGMA supports the testing of new payment models for delivering and reimbursing care through the Centers for Medicare & Medicaid Services (CMS) Innovation Center, private payers, and other initiatives. The Medicare payment system must work for a variety of settings and specialties. There are numerous proposals for payment models that may promote integrated care delivery and encourage cost-effective medical treatment. Options for evaluation include, but are not limited to, bundled payments, partial capitation, accountable care organizations (ACOs), medical homes and other hybrid approaches that couple fee-for-service payments with a risk-based bonus opportunity. This is consistent with what was shared by former CMS administrators at the *Medicare Physician Payments: Understanding the Past so We Can Envision the Future* roundtable held by the Senate Finance Committee on May 10.

There are a range of transitional payment methods that can enable primary care practices, specialists, and hospitals to deliver significant improvements in cost and quality for payers and patients as they build the capacity to transition to more comprehensive payment reforms. Many of these private sector models are currently underway such as blended models that reimburse physicians using a mix of capitation and fee-for-service. Physician groups working with payers have designed blended systems to achieve specific objectives—for example, combining capitation incentives for spending within budget targets with fee-for-service for promoting preventive services such as mammography, and bonus payments for encouraging providers to

meet quality and patient satisfaction targets. There are lessons to be learned from the cases where different payment and delivery systems have been attempted, however, new demonstration projects must continue to be developed, implemented and evaluated in order to make progress.

It is important that innovative payment methodologies be appropriately applied for different types of patient care and different practice types. New alternative payment models require data infrastructure and skilled staff to analyze data, as well as the ability to share information and coordinate care. Medicare should offer timely data sharing and positive financial incentives to assist medical practices that wish to experiment with alternative approaches to achieving savings as part of a transition away from fee-for-service. It is also essential that these programs are not overly complex thus establishing a bias against participation. Additionally, the cost of development and ongoing operation must be relative to the potential financial benefits.

We also need to break down the silos between separate payments 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. According to the Congressional Budget Office (CBO), physician spending only represents 13 percent of all Medicare spending versus 32 percent under Part A (hospital inpatient services and SNF). To truly address costs, incentives must be aligned to encourage physicians to reduce spending in the highest cost areas of the Medicare program. Many of the new emerging models will only succeed if the silos are broken down, allowing physicians and hospitals to work together to prevent hospitalizations and provide cost effective care.

Moving away from fee-for-service will take time. It will be challenging for many physician practices and the infrastructure investments needed for success will be substantial. An array of tools must be developed going forward. These include adequate risk adjustment methods and quality measurement. Many of these have been developed for the Medicare Advantage program and are continually being improved. As we pursue this path of transition, we must recognize that for some practices, it may be necessary to remain in a traditional fee-for-service Medicare model. For others, ACOs and additional approaches may work, but a transition period is needed so that new payment systems may be appropriately tested across a broad variety of practice types and settings.

Rewarding quality and efficiency and regulatory relief

Practices can best improve quality in a non-punitive environment. The SGR continues to be a perennial concern; however, physicians face a number of high-profile reimbursement cuts now and in the near future across a wide variety of quality reporting programs. The implementation costs of these unfunded mandates outweigh the potential for increased reimbursement and emphasize reporting over quality and improved outcomes. These programs include penalties under the electronic prescribing (e-prescribing) program, physician quality reporting system (PQRS) and electronic health record (EHR), or meaningful use, incentive program. Furthermore, the sequestration process created by the *Budget Control Act of 2011* calls for a decade of annual two percent cuts to Medicare providers beginning in 2013.

Exacerbating the problem, CMS has decided to impose payment adjustments retroactively so physicians will face penalties based on activity in years prior. For example, CMS is basing the 2012 e-prescribing penalty on a physician's e-prescribing activity in 2011. CMS is also basing the 2015 PQRS penalty on clinical quality measure reporting that occurs in 2013, and is using the 2013 year as the basis for payment adjustments for the 2015 value-based payment modifier. This approach will subject a significant number of physicians to financial penalties and slow down the ability of physicians to undertake meaningful payment and delivery reforms while under the duress of cumbersome reporting requirements.

Appropriate exemption categories are needed to protect physicians from penalties. There will be situations where physicians and group practices will legitimately be unable to meet program requirements. In these instances, an appeals process that is automated and streamlined and permits physicians to submit appeal requests by phone, in writing, and directly via a web portal is vital. Experience with the PQRS and e-prescribing programs has shown the myriad of problems in determining successful physician participation, which results in physicians being unfairly penalized, thus creating an even greater burden on practices. CMS should take a patient-focused approach and demonstrate how these programs improve quality. For these programs to achieve their intended purpose they must be results driven and not simply an exercise of reporting.

Coordination of these programs is critical to the future of quality measurement and reporting. Current requirements on practices to report are unnecessarily burdensome. Harmonization of quality measures across these programs has been modest, at best. Capturing data over multiple CMS-administered programs causes significant administrative burdens on group practices. Efforts must be made to remove the overlap in reporting requirements for physicians who may be eligible for incentive payments or subject to penalties under these CMS-administered programs. We urge the government to establish a single process to allow physicians to report identical data to multiple reporting programs. Further, we strongly recommend that physicians who successfully participate in the meaningful use incentive program are automatically deemed as successfully participating in the e-prescribing and PQRS incentive programs.

Finally, the proposed implementation of ICD-10 is another looming challenge to the healthcare system that promises to have a significant impact on group practices at the same time new Medicare payment systems are being evaluated. This new code set will affect not only billing, quality reporting and other administrative transactions. It will also require changes to clinical documentation and workflow processes and necessitate extensive clinician training.

The adoption of ICD-10 should not be considered without a revised implementation process in place. The industry is currently experiencing a significant challenge transitioning to HIPAA Version 5010. It is clear that migration to ICD-10 will be even more complex and costly. The cost for physician practices to adopt ICD-10 will be substantial. As an example, it is estimated that a 10-physician practice will incur more than $285,000 to implement ICD-10. It is critical that the government and industry stakeholders work together to identify and address concerns and agree on a more appropriate implementation approach. Further, the government should complete and make public a comprehensive cost-benefit analysis to determine the impact the changes to ICD-10 will have on each healthcare industry sector.

Failure to perform the necessary due diligence with regard to ICD-10 will almost certainly disrupt future Medicare payment reform efforts.

Conclusion

In conclusion, it is clear that long-range savings and continued increased quality and accountable care will require significant reforms to the current payment system. We urge Congress to make any new payment system flexible to accommodate different practice types. Innovative payment and delivery system models should not be incorporated into the Medicare system until they are properly tested.

We appreciate this opportunity to share our views on this vital topic. We are committed to working with you to repeal the SGR formula and replace it with an equitable payment update alternative. Should you have any questions, please contact Miranda Franco, MGMA Government Affairs Representative, at 202.293.3450 or mfranco@mgma.org.

Sincerely,

Susan Turney, MD, MS, FACP, FACMPE
President and CEO

cc:

The Honorable Wally Herger
The Honorable Sam Johnson
The Honorable Kevin Brady
The Honorable Paul Ryan
The Honorable Devin Nunes
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