June 13, 2024

The Honorable Brett Guthrie
Chairman
House Committee on Energy and Commerce
Subcommittee on Health
2123 Rayburn House Office Building
Washington, DC 20510

The Honorable Anna Eshoo
Ranking Member
House Committee on Energy and Commerce
Subcommittee on Health
2123 Rayburn House Office Building
Washington, DC 20510

Re: MGMA Testimony for House Committee on Energy and Commerce Subcommittee on Health's Hearing, "Checking-In on CMMI: Assessing the Transition to Value-Based Care"

Dear Chairman Guthrie and Ranking Member Eshoo:

On behalf of our member medical group practices, the Medical Group Management Association (MGMA) would like to thank the Subcommittee for holding this important hearing examining the state of the Center for Medicare and Medicaid Innovation Center (CMMI) and the transition to value-based care. Innovative value-based care models allow medical groups to provide cost-effective, quality-driven care. It is imperative that physician practices have feasible pathways to joining Alternative Payment Models (APMs) and are able to successfully sustain participation.

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical group practices ranging from small private medical practices to large national health systems, representing more than 350,000 physicians. MGMA's diverse membership uniquely situates us to offer the following policy recommendations.

The *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA) was enacted to repeal the flawed Sustainable Growth Rate (SGR) formula, stabilize payment rates to physicians in Medicare fee-for-service, and incentivize physicians' transition to value-based care models. While there has been progress in the development of APMs under CMMI, more work needs to be done to effectively design and deploy these models so that more medical groups are able to participate.

MGMA's policy priorities to promote the success of physician practices in APMs are as follows:

- Support the development of new, voluntary physician-led APMs that meet the needs of practices of varying types, sizes, and specialties to inherently drive more widespread participation.
- Reinstate the 5% payment bonus for APM participation beyond the 2025 payment year, for a period of at least six years.
- Lower the qualifying participation (QP) thresholds and allow CMS the flexibility to adjust them to ensure the criteria to achieve QP status is not set arbitrarily high.
- Provide support for participants through upfront investments, resources, and tools.

- Design and implement APMs that provide sufficient supports for physician practice participants, as well as appropriate financial incentives and regulatory flexibilities.[1]

APM Development

APMs must be designed to address the challenges facing medical groups if the Centers for Medicare and Medicaid Services (CMS) wants to meet its goal of having every Medicare beneficiary in an accountable care arrangement by 2030. There are numerous barriers preventing medical groups from both joining and successfully participating in APMs due to application requirements and parameters around many of the CMMI models. Seventy-eight percent of medical groups reported that Medicare does not offer an APM that is clinically relevant to their practice, with 56% of respondents being interested in participating in a clinically relevant model if one were to exist.[2] The Congressional Budget Office found that accountable care organizations (ACOs) led by independent physician groups were associated with greater savings, thereby demonstrating the value of expanding access to these arrangements.[3]

CMMI and private sector entities under the Physician-Focused Payment Model Technical Advisory Committee (PTAC) can develop APMs. Unfortunately, CMMI, who possess the sole responsibility to test and implement an APM, has yet to test any of the models PTAC has recommended.

In conjunction with a shortage of APMs, 94% of medical groups reported that moving to value-based care initiatives has not lessened the regulatory burden on their practices.[4] This is exemplified by recently finalized changes in the 2024 Medicare Physician Fee Schedule that added burdensome Promoting Interoperability reporting requirements in the Medicare Shared Savings Program, as well as certified health information technology utilization requirements that are set to take effect in 2025. One of the main benefits of joining an APM is the reduced Merit-based Incentive Payment System (MIPS) reporting burden — these policies undermine the success of groups joining value-based care arrangements.

APM Incentive Payment and Qualifying Participant Threshold

Shifting program requirements and financial incentives instituted under MACRA do not align with enabling physician practices to successfully participate in APMs. Congress recently extended the APM incentive payment at 1.88% for 2024 — a decrease from 3.5% in 2023, and 5% in 2022. MGMA strongly urges Congress to reinstate the full 5% as this payment is necessary to cover costs, support investments, and safeguard the financial viability of medical groups in the program.

Further, the qualifying participation (QP) threshold to participate in an APM is unreasonably high. Participants need to meet this threshold to qualify for the APM incentive bonus and to avoid reporting under MIPS; it was set to increase this year, but Congress intervened by freezing the threshold in the *Consolidated Appropriations Act of 2023.* Medical groups should not be subject to an excessively high threshold that fosters uncertainty and hinders their ability to participate — MGMA supports giving CMS the flexibility to adjust the QP threshold so that it is not set arbitrarily high. The *Value in Health Care Act*

[1] MGMA, Alternative Payment Models Issue Brief, 2024.
[2] MGMA, 2023 Annual Regulatory Burden Report, Nov. 2023.
[3] Congressional Budget Office, Medicare Accountable Care Organizations: Past Performance and Future Directions, April 16, 2024.
[4] *Supra* note 2.

of 2023 would work to address the APM incentive payment and QP threshold problems facing practices, along with making other important changes to APMs.

Conclusion

MGMA thanks the Subcommittee for examining the state of value-based care and CMMI. We look forward to collaborating with the Subcommittee to enact legislation to support and bolster medical groups' ability to succeed in value-based care arrangements. If you have any questions, please contact James Haynes, Associate Director of Government Affairs, at jhaynes@mgma.org or 202-293-3450.

Sincerely,

/s/

Anders Gilberg
Senior Vice President, Government Affairs