AAOS
American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

Statement for the Record

House Ways and Means Health Subcommittee Hearing on Implementation of MACRA's Physician Payment Policies

Wednesday, March 21, 2018

On behalf of more than 34,000 orthopaedic surgeons and residents, the American Association of Orthopaedic Surgeons (AAOS) thanks Chairman Roskam and Ranking Member Levin for holding the Ways and Means Subcommittee on Health hearing on the "Implementation of MACRA's Physician Payment Policies." The AAOS appreciates the continued critical examination of the Merit-based Incentive Payment System (MIPS) and alternative payment models (APMs), which provide the current framework for reimbursing physicians under the Medicare program. Further, we commend Congress for a number of important updates to MACRA included in the Bipartisan Budget Act of 2018, such as changes to the low-volume threshold determination and additional flexibility related to the cost performance category. We are encouraged to see members of Congress taking proactive steps in examining and refining the MACRA framework to ensure this legislation effectively improves delivery of care for Medicare patients across the country.

In addition to repealing the flawed Sustainable Growth Rate formula, the MACRA legislation sought to improve the previous reimbursement and reporting frameworks by streamlining requirements, reducing administrative burdens, and increasing flexibility and support for small and solo practices. However, as the rules and regulations surrounding this legislation have been released, our members are increasingly concerned about the complexity involved and the resources required to succeed in this program. As a result, we have worked with both members of Congress as well as the Centers for Medicare & Medicaid Services (CMS) to provide suggestions that would address some of these concerns and ensure the requirements do not interfere with the patient-physician relationship. We are also concerned with protecting all practice types under MACRA, especially the small, solo, and rural practices that typically have less support for meeting massive reporting changes.

Merit-based Incentive Payment System (MIPS)

The Medicare Payment Advisory Commission (MedPAC) recently recommended that Congress eliminate MIPS and establish a new voluntary value program in fee-for-service Medicare. We believe that MIPS certainly needs a lot of improvements and we support endeavors made by Congress and CMS in that regard. However, physicians and MIPS-eligible clinicians have already invested a lot in educational and practice improvement activities in order to improve

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patient care and participate in the Quality Payment Program. It will be inefficient, wasteful, and highly disruptive to take a step backward at this time. Instead, we urge Congress to continue further improvements beyond those that have been set forth by the Bipartisan Budget Act.

Specifically, for the shift to value-based health care to be successful, the MIPS program will have to be more inclusive and introduce greater flexibilities for small, solo, and rural practices. According to our most recent census report, more than half of all orthopaedic surgeons are in private practice, with 11 percent of orthopaedic surgeons in solo private practice.[1] As mentioned above, these physicians generally face the most challenges in meeting the requirements imposed by MACRA. Recent updates to the low-volume threshold certainly help in this regard, but more changes can be made. For example, the MIPS program still requires participation via expensive Certified Electronic Health Record Technology (CEHRT), which necessitates practices with limited resources to hire additional health information technology staff or pay for third-party reporting. Additionally, while recent updates surrounding virtual groups offer a valuable option for solo and small practices, providing further resources/support and flexibilities for virtual group reporting – in addition to expanding the ways that groups can qualify as a virtual group – would help ensure small and solo practitioners are able to take advantage of this option. Proposals could also explore expanding virtual group reporting options for all MIPS-eligible providers. Finally, an exemption for the solo and small practices from the Advancing Care Information category, provided they report quality measures electronically (for example, through a registry, EHR, or QCDR), would further assist these physicians in succeeding under MACRA.

On the issue of reporting and feedback, we continue to believe that the two-year lag between the performance and payment years is problematic for physicians in terms of tracking and managing their performance. Obtaining near real-time feedback for providers is critical in ensuring physicians understand payment changes and can adjust their behavior appropriately, thus creating changes toward value in health care delivery and payment. For this reason, mechanisms to allow more contemporary feedback are essential to any quality control endeavor. This could include equipping CMS to provide identifiable claims data to trusted entities and/or eliminating the 10 percent claims data threshold as part of the Qualified Entity program. We have also suggested that MIPS reporting be required for the first nine months of each performance year, allowing the last three months for reconciliation of the data.

The cost performance category under MIPS is problematic where the data is not reliably verified and tracked and the underlying methodology is lacking in transparency. The changes brought about by the Bipartisan Budget Act are a positive step in addressing this issue, and we would urge Congress to ensure that CMS effectively uses the newly granted statutory flexibility. In particular, CMS should maintain the cost category weight at 10 percent of the total MIPS score until appropriate measures have been developed and validated. This is a slow and complex

[1] https://www.aaos.org/2016censusreport/

process and AAOS continues to engage with CMS and their contractors in developing appropriated episode-based cost measures for musculoskeletal care.

Also per the changes in the Bipartisan Budget Act, in 2022, the MIPS performance threshold must be the mean or median of national historical MIPS scores. It is important for physicians and Medicare beneficiaries that CMS select one of these measures and remains committed to that. A year-to-year change will disrupt MIPS eligibility for physicians and thereby, continuation of care for Medicare beneficiaries.

Finally, even where a provider is not required to participate in the MIPS program, there should be more pathways for specialists to participate in the Quality Payment Program through the Advanced APM track, which is discussed below.

Risk Adjustment/Budget Neutrality

A recent article in the Journal of the American Medical Association highlights the dual issue of budget neutrality and risk adjustment under MACRA.[2] As the article notes, MIPS is designed to be budget-neutral, and as such, "is a zero-sum game." Essentially, bonuses for practices that score higher are offset by the penalties imposed on the practices that score poorly. Additionally, current measures to determine this scoring "fail to account for differences in patients' socioeconomic and health status," thereby potentially skewing quality scores in favor of practices that care for "higher-income, better-educated, and less-complex patients." Of course, this means that "the losers are more likely to be physicians who care for poorer or sicker patients." In addition to urging change to the budget neutrality aspect of the program, AAOS has continually requested proper risk adjustment, including socioeconomic status and clinical comorbidities, in both MIPS and within APMs.[3] More sophisticated risk adjustment is required to fully implement the principles of MACRA and ensure that physicians caring for higher risk patients are not disproportionately penalized.

Alternative Payment Models (APMs)

An important component of MACRA, APMs can be defined as a "payment approach that gives added incentive payments to provide high-quality and cost-efficient care."[4] Under MACRA, eligible APM participants must tie payments to specified quality measures, use certified electronic health record technology, and assume more than nominal financial risk. In addition to the MIPS program APMs, the second track of MACRA provides bonus payments for physicians

[2] https://jamanetwork.com/journals/jama/fullarticle/2673607
[3] https://cqrcengage.com/aaos/file/Nizv6egCiDi/AAOS_comments_MACRAPR_2018_8.21.pdf
[4] https://qpp.cms.gov/apms/overview

who participate in APMs that hold providers financially accountable for health care costs. These "Advanced APMs" enable physicians to qualify for a five percent bonus payment.

The AAOS strongly supports efforts by CMS to make appropriately structured APMs available to physicians and other providers. We have supported previous efforts by CMS through the Center for Medicare and Medicaid Innovation (CMMI) to develop voluntary bundled payment models in the area of musculoskeletal care. One such initiative, the Bundled Payments for Care Improvement (BPCI) program, addresses episode-based payment approaches to delivering care to beneficiaries with multiple types of clinical episodes, including musculoskeletal conditions. The Acute Care Episode (ACE) demonstration project also involved musculoskeletal episodes, specifically total knee and total hip replacements. These kinds of APMs have the potential to generate savings for Medicare while having positive effects on patient care. In fact, many AAOS members have been leaders in developing, implementing, and evaluating episode-of-care payments under the ACE Demonstration Project and the BPCI initiative.

However, despite the many benefits and strong interest, orthopaedic surgeons face significant challenges participating in qualifying APMs. For example, the revenue and patient thresholds for eligible clinicians to become "qualifying providers" under MACRA is quite onerous for specialty physicians. Finalized rules require that in 2019, 25 percent of Medicare payments and 20 percent of patients are qualifying thresholds to receive the increased APM bonus. These thresholds are very high for specialty physicians and mean many specialty physicians will be unable to participate. Moreover, attempts to meet these thresholds may magnify sub-specialization and incentivize procedure-focused practice. While there are some exceptions on threshold requirements for specialists who participate in multiple APMs, we are continually stressing that APM requirements under MACRA remain restrictive.

To remedy this issue, AAOS has requested reductions in unnecessary and burdensome requirements to qualify for Advanced APMs. Specifically, we ask that specialty APMs have lower, more appropriate thresholds. We have also requested a clear pathway for rapid approval and implementation of physician-directed APMs. More opportunities are needed and recognition required for providers who participate in APMs so that they qualify for the incentive bonus for value-based care that is provided by the MACRA statute. Further, while AAOS agrees with and supports the substantial role of primary care providers in coordinating care, we believe it is important for CMS to consider various models for specialist participation in Accountable Care Organizations (ACOs). Specialist physicians can and should play a vital role in ensuring the appropriate access to and use of specialty services by patients and their primary care providers. AAOS is exploring ACO-style structures that may work for orthopaedists as an Advanced APM and encourages examination of regulations/changes that would aid in this effort.

Finally, CMS recently announced a new voluntary bundled payment model that will qualify as an Advanced APM. The Bundled Payments for Care Improvement Advanced (BPCI Advanced)

model requires participants to bear financial risk, have payments under the model tied to quality performance, and use CEHRT. By meeting these requirements, participants can earn the Advanced APM incentive payment. However, CMS decided to provide precedence to the Comprehensive Care for Joint Replacement (CJR) model over BPCI Advanced in the mandatory CJR metropolitan areas. The CJR precedence, as structured currently, will limit the ability of the vast majority of independent physicians from participating in BPCI Advanced and thereby limit the ability of these specialists to participate in an Advanced APM. While physicians will be able to participate in orthopaedic episodes outside of Lower Extremity Joint Replacement (LEJR) episodes, LEJR episodes are one of the most common inpatient surgeries for Medicare patients and a cornerstone procedure for orthopaedic participants in the current BPCI initiative. This policy disrupts the patient-physician relationship and discards the valuable learning, collaboration, and work to coordinate care (pre-optimizing patients, redesigning care plans, working with post-acute care providers, etc.) already undertaken by many orthopaedic surgeons. We have written to CMS extensively about this issue[5] and would request any additional support that can help solve this problem.

Stark Law Reform

The AAOS has also noted that APMs requiring coordinated care across settings reveal limitations in the current Stark law. The Stark law is structured to control the volume of referred services, and is a strict liability statute that leads to heavy penalties for unintentional and technical errors by physicians and their staff. Strict liability statutes, like the Stark law, do not encourage physicians to participate in coordinated care models as the costs of compliance and disclosures required can be prohibitive for small and medium-sized physician practices.

Physician referrals in ACOs are theoretically exempt from the Stark law requirements through fraud and abuse waivers. The AAOS believes there should be similar exceptions and protections for physicians and physician groups participating in APMs and other care coordination efforts. Additionally, AAOS has argued for removal of the "value or volume" prohibition in the Stark law so that practices can incentivize physicians to abide by best practices and succeed in the new value-based alternative payment models. We have also urged creation of a more workable standard that only triggers penalties for knowing and willful violations of the law, which is the current standard for civil penalty provisions of the Anti-Kickback Statute Violations of the Stark law with respect to physician ownership interests.

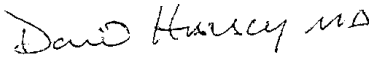
[5] https://www.aaos.org/uploadedFiles/PreProduction/Advocacy/Federal/Issues/medicare/AAOS Comments_BPCI Advanced_final.pdf

Qualified Clinical Data Registries (QCDRs)

Finally, the AAOS encourages the Committee to consider the ways in which QCDRs can play a critical role in improving quality and patient care. Under Section 105(b) of MACRA, Congress directed CMS to provide QCDRs access to Medicare claims data for purposes of linking such data with "with clinical outcomes data and [perform] risk-adjusted, scientifically valid analyses and research to support quality improvement or patient safety." In addition to easing reporting burdens, providing QCDRs timely access to this data to perform validation and analysis may encourage increased participation in APMs. The data QCDRs collect provides a wealth of clinical information for measure developers and, absent full implementation of this provision of MACRA, represents an underutilized resource. All participants should also be allowed to submit advanced APMs' quality data through a QCDR, as is the case for MIPS and some current APMs. Having an incentive bonus for participation in a QCDR for those qualifying APM participants would also encourage these qualifying providers to contribute to this valuable reservoir of clinical data.

Thank you again for holding this important hearing on Medicare's payment systems and programs. The AAOS is committed to continue working with Congress and the Administration to ensure that patients have access to the highest quality musculoskeletal care. Please contact Catherine Boudreaux Hayes, Senior Manager of Government Relation (hayes@aaos.org) if you have any questions or if the AAOS can serve as a resource to you.

Sincerely,



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