Statement

of the

American Medical Association

to the

U.S. House of Representatives Committee on Energy and Commerce
Subcommittee on Health

Re: MACRA and MIPS: An Update on the Merit-based Incentive Payment System

July 26, 2018

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The American Medical Association (AMA) appreciates the opportunity to present our views to the U.S. House of Representatives Committee on Energy and Commerce Subcommittee on Health. As the largest professional association for physicians and the umbrella organization for state and national specialty medical societies, the AMA is heavily invested in the successful implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Since the enactment of MACRA, we have worked closely with policymakers and the Centers for Medicare and Medicaid Services (CMS) to ensure that implementation of the law reflects the intent of Congress to focus on improving quality and value, and that physician practices are able to successfully participate. We remain committed to working with both Congress and CMS to promote a smooth implementation of the Quality Payment Program (QPP) that will allow physicians to be successful.

We continue to believe that MACRA, and more specifically the Merit-Based Incentive Payment System (MIPS), represents an improvement over the flawed sustainable growth rate (SGR) payment methodology and the three legacy reporting programs it replaced: the Physician Quality Reporting System (PQRS), Meaningful Use (MU), and the Value-Based Payment Modifier (VM). We recognize that the MIPS program is still in its initial stages and must continue to be improved and simplified. We commend Congress for the 2018 statutory improvements to the MACRA law which extends CMS' flexibility to set the performance threshold and reweight the cost performance category for an additional three years. We also appreciate Congress' clarifications that Medicare Part B drugs are not included in the incentive and penalty payments for the MIPS program. While we believe these changes strengthened the MIPS program, we are committed to continuing to work with the CMS and Congress to further improve the program.

Improvement Over Legacy Programs

The AMA was supportive when Congress replaced the flawed, target-based SGR formula with a new payment system under MACRA in 2015. Due partially to the fundamentally flawed concept of the SGR – namely that the threat payment cuts for all physicians would serve as an individual incentive to limit volume growth – and partially to the failure of Congress to do more than temporarily block cuts, scheduled payment cuts prior to the implementation of MACRA

exceeded 20-percent. Those cuts would have had a devastating impact on physician practices and beneficiary access to care. Under MACRA, the SGR formula was replaced with specified payment updates for 2015 and beyond. MACRA also created an opportunity to address problems found in existing physician reporting programs (i.e., PQRS, MU, and VM). In addition, the law sought to promote innovation by encouraging new ways of providing care through APMs.

MACRA was designed to offer physicians a choice between two payment pathways: a modified fee-for-service model, MIPS, or new alternative payment models that support high value services, including those not typically covered under the Medicare physician fee schedule, or APMs. While MIPS is complex, it represents an improvement over the prior reporting programs. For example, under prior law, possible combined penalties for the PQRS, MU, and VBM programs could be up to negative 11 percent in 2019 based on 2017 reporting, and PQRS did not offer an opportunity to earn an incentive. Under MIPS, the maximum penalty physicians can receive in 2019 is negative four percent based on 2017 reporting. The maximum penalty increases to negative nine percent in future years, which is at least two percentage points less than the possible penalties under legacy reporting programs. Also, there is a potential for bonus points for high performers under MIPS.

Furthermore, the AMA supports the accommodations for small practices that are included in the MIPS program. Specifically, the low volume threshold exemption excludes numerous small practices or physicians who see very few Medicare patients. In 2018, physicians with annual Medicare allowed charges of $90,000 or less or 200 or fewer Medicare patients, are exempt from the QPP altogether. In 2019, CMS proposes to also exclude physicians who provide 200 or fewer covered professional services to Medicare Part B beneficiaries. The AMA has also supported reduced reporting requirements for small practices, hardship exemptions from the Promoting Interoperability MIPS performance category for qualifying small practices, bonus points for small practices, and technical assistance grants to help small practices succeed in the program. Among small practices that are not exempted by the low volume threshold, CMS estimates that 91 percent of eligible professionals in practices of one to 15 physicians will experience a positive or neutral payment adjustment in 2020 based on 2018 reporting. The AMA believes this is a notable improvement over the barriers small practices faced in previous reporting programs.

Each performance category under MIPS also contains improvements over the legacy reporting programs. For example, in the Quality performance category, physicians are required to report six measures as opposed to the nine they were required to report under PQRS, and they can now receive partial credit for reporting fewer than six measures. CMS' recent proposals for the Promoting Interoperability performance category in 2019 eliminate the base and performance categories and reduce the number of required measures, many of which were problematic for physicians as they led to physicians being scored based on the actions of others. In the Cost category, CMS has been working to develop a new suite of episode-based measures, the first eight of which they propose for use during the 2019 performance period.

Physicians participating in APMs also benefit under MACRA. While there are currently a limited number of Advanced APMs, physicians participating in these models will receive a five percent bonus payment for the first six years of the program. MACRA also allows favorable treatment for qualified medical homes as Advanced APMs and in the MIPS Improvement

Activities category. In addition, certain APMs, such as Track 1 accountable care organizations in the Medicare Shared Savings Program, are defined as MIPS APMs and allow their physician participants to meet their entire MIPS reporting requirements through their APM participation. The AMA strongly supports the development of additional APMs to offer more patients and physicians the opportunity to participate in models that help reduce costs and improve the quality of health care.

Support for Technical Corrections

The AMA strongly supports the changes to MACRA in the Bipartisan Budget Act of 2018 (BBA18). We believe these technical changes to the statute will help simplify and improve the MIPS program. Since the enactment of BBA18, CMS released the *Medicare Program: Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for 2019; Medicare Shared Savings Program* proposed rule. We are in the process of thoroughly evaluating the proposed rule and will be submitting our comments to CMS by the September 10 deadline.

We commend Congress for excluding Medicare Part B drug costs from MIPS payment adjustments. Including these additional items and services created significant inequities in the administration of the MIPS program. Although in the past CMS included Medicare Part B drugs in the calculation and comparison of physician costs under the VM, none of the legacy programs applied adjustments to reimbursement for the drugs. Excluding Medicare Part B drug costs from MIPS payment adjustments eliminates a significant departure from previous policy that could have penalized some physicians whose patients require high-cost Part B drugs and created a potential windfall for others whose patients can be treated with less costly drugs. This policy also would have underpaid physicians for the cost of acquiring drugs if they received a low MIPS score, and overpaid them if they received a high MIPS score. We also commend CMS for proposing to implement the revised Part B drugs policy beginning in 2019.

We also appreciate the flexibility given to CMS to reweight the Cost performance category to not less than ten percent for the third, fourth, and fifth years of MIPS. We agree that, while development of resource use measures is an ongoing effort, more time is needed to test them and make any necessary changes. Unlike the program's quality measures there was no physician input in the development and review of resource use measures prior to the enactment of MACRA. The AMA strongly supported additional flexibility for CMS to reweight the Cost performance category and believed that allowing three additional years for the cost score to be weighted at less than 30 percent would allow additional time for CMS to build on its ongoing initiative to utilize panels of physicians to develop, test and refine resource use measures. We are concerned, however, that CMS is proposing to increase the Cost category score to 15 percent in the 2019 performance period, given that 2019 is the first year it is testing eight newly developed episode-based cost measures. We question whether proposal does not align with Congress' intent to keep the weight of the Cost performance category low until episode-based cost measures are adequately tested and available for a variety of physician specialties, and will be providing comments to CMS to this effect.

In addition, we strongly support the ability for CMS to exercise flexibility in setting the

performance threshold for three additional years. Physicians are still becoming familiar with the MIPS program, and allowing CMS three additional years of flexibility in setting the performance threshold will help smooth the transition to a performance threshold at the mean or median. As Congress intended, we believe the goal of the program should be to help doctors succeed, not to cause doctors to fail. In the proposed rule, CMS is proposing to double the performance threshold from 15 points in 2018 to 30 points in 2019. While the 30 point performance threshold is likely lower than the mean or median for 2019, we continue to urge CMS to use the flexibility provided by Congress to increase the performance threshold very gradually during the first five years of the program.

Finally, we strongly support the ability for the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to provide initial feedback on proposed APM models regarding the extent to which they meet criteria and an explanation of the basis for the feedback. With the creation of the PTAC, Congress sent a strong signal to HHS and CMS that implementing physician-developed APMs is a critical element of the transition to value-based payment models for Medicare patients. Therefore, we are extremely concerned that none of the APM models recommended by PTAC to the Secretary of the U.S. Department of Health and Human Services (HHS) have been tested or implemented to date. We are particularly concerned given that the MACRA statute only provided six years of bonus payments to facilitate physicians' migration to Advanced APMs, yet we are approaching the three-year mark for the initial implementation and there is still not a robust APM pathway for physicians. See our recent letter to HHS for more details on our concerns.

Further Improvements are Needed

CMS has also proposed numerous policies that the AMA strongly supports. For example, we support the addition of a third criterion of providing fewer than 200 covered professional services to Part B patients for physicians to meet the low-volume threshold, and the ability of physicians to opt-into the MIPS program if they meet fewer than three of the low-volume threshold determinations. We also support the retention of bonus points for small practices and physicians who treat complex patients. We believe CMS' proposal to consolidate the low-volume threshold determination periods with the determination periods for identifying a small practice, non-patient facing physicians, and hospital-based physicians will reduce confusion and program complexity. We also commend CMS for eliminating the performance and base scores, reducing the number of measures physicians must report on, and providing physicians more flexibility in the Promoting Interoperability performance category. Furthermore, we support the option for facility-based physicians to use facility-based scoring in the Quality and Cost performance categories beginning in 2019. Finally, we were very pleased to see CMS propose the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) demonstration and strongly support allowing physicians participating in risk arrangements in MA similar advantages to those enjoyed by physicians participating in traditional Medicare APMs.

While we commend CMS for these proposals, we also believe there are numerous additional improvements that can further simplify MIPS and help physicians succeed in reducing health care costs while improving health care quality. Our overarching goals in shaping MACRA regulations continue to be choice, flexibility, simplicity and feasibility.

For example, there are several steps CMS can take now to simplify the overly complex scoring system including harmonizing the scoring across the four separate components of MIPS so that physicians can more easily calculate their progress toward achieving success and increasing opportunities for physician reporting to be counted across multiple categories in a more coherent payment system.

CMS should also change Promoting Interoperability reporting requirements to attestation alone and develop new measures that utilize not only certified electronic health records (EHRs), but also technology that builds on certified EHRs.

Furthermore, the AMA has strongly urged CMS to move away from the siloed, check-the-box legacy programs to a single program that is more holistic and clinically relevant. Specifically, the AMA has worked with state and specialty medical societies to develop a proposal that would allow physicians to focus on activities that fit within their workflow and address their patient population needs, while receiving credit for those activities across multiple MIPS performance categories.

In addition, there are further changes to the program that would reduce physicians' administrative burden, including reducing the number of quality measures a physician is required to report within the Quality performance category and allowing physicians the option to report for a minimum of 90-days in all performance categories to better align reporting periods. CMS should also expand the facility-based definition to provide physicians in settings such as post-acute care facilities and long-term care facilities a meaningful way to participate in MIPS. Our recommended changes would reduce physicians' administrative burden, allowing them to spend more time with their patients.

The AMA remains committed to ensuring that the MACRA program is successful. We appreciate the opportunity to provide our comments on the current MACRA program, and we look forward to continuing to work with the Committee and CMS to make further improvements.