



## **Statement for the Record**

### **Senate Finance Committee Hearing**

#### **Medicare Physician Payment Reform After Two Years: Examining MACRA Implementation and the Road Ahead**

**May 8, 2019**

The American College of Physicians (ACP) appreciates the opportunity to share our views regarding Medicare physician payment reform under MACRA, the implementation of this law after two years, and the road ahead for physicians to ensure a health care delivery system that rewards the value and quality of care provided to patients. We thank Senate Finance Chairman Grassley and Ranking Member Wyden for hosting this hearing to hear the view of physicians concerning MACRA in order to ensure that it is implemented successfully and as intended by Congress. As Congress considers oversight or potential legislative changes to MACRA, we urge you to take steps to improve Medicare payment policies in ways that better align payments with the value of care provided to patients, reduce unnecessary administrative burdens that divert physicians away from patient care, ensure that performance measures used for payment or public accountability are evidence-based, clinically relevant, and appropriate, and create more opportunities for physicians to lead and participate in alternative payment models.

ACP is the largest medical specialty organization and the second largest physician group in the United States. ACP members include 154,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

#### **Overview of the First Two Years of MACRA**

In order to provide an accurate assessment of whether the new payment systems under MACRA have provided adequate support and reimbursement for physicians to continue to provide high quality value-based care for their patients, it is essential to examine how physicians fared during the first two years of MACRA implementation. ACP has examined the results of the Quality Payment Program (QPP) Experience Report based on the 2017 participation rate in Merit Based Incentive Payment System (MIPS) and advanced Alternative Payment Models (APM's). There are several positive results from this survey that acknowledge in some degree that MACRA is working as it intended. The 2017 results show that the participation rate of physicians in MACRA was 95 percent and that only five percent of the

physicians received a penalty. However, the bar for entry into MACRA was set very low, by design, to ensure that in the first year physicians could adequately transition into MIPS or advanced APM's. In the 2017 Quality Payment Program, known as Pick Your Pace, physicians could avoid a penalty by submitting only three points, which could have been as easy as submitting one quality measure on one patient for the entire year. We may find a more accurate reading of how well physicians fared under MACRA by looking at the 2018 data, when it is released, where physicians were required to submit 15 points to avoid a penalty. The performance standard for physicians is even higher in 2019, as they are now required to submit 30 points to avoid a penalty.

The 2017 QPP results also show that small practices lagged behind larger practices in their overall performance rating for the QPP. The average score for small practices was more than 30 points lower than the average overall score, and rural groups also lagged 11 points behind. Small practices were almost 20 percent less likely to earn a bonus and 14 percent more likely to get a penalty than the average across all practices. One factor that may prohibit smaller practices from succeeding in the QPP is that they often do not have the capital to build the office infrastructure necessary to make investments in their practices so that they may meet the requirements of the QPP program.

Small practices were also less likely to report more than 90 days of quality data which was optional in 2017 but became mandatory in 2018. The data show that while 74 percent of all practices reported quality data for a full year only 67 percent of rural and 44.5 percent of small practices reported a full year of QPP data.

**ACP is disappointed that despite repeated objections from the vast majority of stakeholders including the College, CMS continues to require a full year of quality and cost data. We ask the Senate Finance Committee to weigh in with CMS in the strongest possible terms to urge the agency to reconsider this policy and reconsider instituting a consistent, minimum 90 consecutive day minimum reporting period across all MIPS performance categories.** Lowering the minimum reporting period to 90 consecutive days would drastically reduce reporting burden, allow time to implement EHRs or other innovative technologies without risk of compromising MIPS reporting or performance, allow for more timely performance feedback, and reduce the two-year lag between performance and payment. Moreover, 90 days would be a minimum; while 90 days is a sufficient length of time to capture reliable data for the majority of measures, individual measures could have their own separate minimums so that data accuracy would not be compromised.

### **THE MIPS PROGRAM**

The majority of physicians participate in the QPP through the MIPS track, which builds on traditional fee-for-service payments by adjusting them based on a physician's performance. The MIPS program measures physicians' performance based on a scoring structure that requires physicians to report performance data to CMS in four weighted categories: Quality Measurement (45 percent-weight), Improvement Activities (15 percent), Promoting Interoperability (25 percent), and Cost (15 percent). Physicians receive a score based on how

well they perform in each of these categories, which then determines their Medicare payment. This scoring structure is unnecessarily complex because each category has its own unique scoring methodology and because the value of any measure or activity is scored out of an arbitrary number of points that has no correlation to its weight relative to the final MIPS score. Moreover, the categories are siloed, preventing any cross-category credit, and the measures on which physicians must report are overly burdensome and do not measure what matters.

The MIPS program was intended to create a more streamlined approach for physicians to report performance measures through a unified program rather than through several different performance measurement programs as required prior to the authorization of MACRA. This program has not worked as Congress intended. **We urge the Senate Finance Committee to exercise their oversight authority to urge CMS to simplify the scoring structure and reporting requirements under MIPS in order to fulfill Congress' intent of a more streamlined program that reduces burdens on physicians.**

### ***MIPS Scoring***

The College reiterates our previous concerns that the separate reporting requirements and scoring methodologies for each category are confusing for clinicians and counter to CMS' efforts to minimize burden and create a unified program. One simple solution would be to assign point values for each measure proportionate to their overall value relative to the MIPS composite score. The total points in the PI Category would total 25 for example, and so on. This methodology has the support of a number of physician groups, and also would allow CMS to continue distinguishing high-priority measures and categories with more value while creating a more intuitive, streamlined scoring approach. We encourage CMS to take every opportunity to award cross category credit. Doing so will create synergy between the various performance categories and align incentives to drive meaningful improvement in critical priority areas, rather than spreading practices too thin across too many metrics. This will lead to better patient outcomes and less burden on clinicians and practice staff.

### ***Quality Category***

**This category, and MIPS in general, needs more relevant, accurate, and effective quality measurement, particularly measures based on patient outcomes. We urge the Finance Committee to weigh in with CMS to reduce the number of measures required for full participation in this category from six to three measures.** ACP's Performance Measurement Committee (PMC) conducted a study of many of the performance measures included in the MIPS program, applicable to internal medicine, and found that only 37 percent were rated as valid, 35 percent as not valid, and 28 percent as of uncertain validity. Measures should be evaluated against four critically important criteria: importance to measure, scientifically acceptable, usable and relevant, and feasible to collect. CMS should collaborate with specialty societies, frontline clinicians, patients, and EHR vendors in the development, testing, and implementation of new quality measures with a focus on integrating performance measurement and reporting within existing care delivery protocols to maximize clinical improvement while decreasing clinician burden. A majority of new MIPS measures finalized for

2019 have received only conditional support from the Measure Application Partnership (MAP), and previously adopted measures remain despite being recommended for “continued development” by the MAP, a designation reserved for measures that lack evidence of strong feasibility and/or validity. MAP is a multi-stakeholder partnership that guides the U.S. Department of Health and Human Services (HHS) on the selection of performance measures for federal health programs.

It is imperative CMS ensure that a transparent, multi-stakeholder process is used to evaluate all measures used in its programs. The National Quality Forum (NQF), for instance, evaluates measures against four critically important criteria: importance to measure, scientifically acceptable, usable and relevant, and feasible to collect. CMS should also collaborate with 8 specialty societies, frontline clinicians, patients, and EHR vendors in the development, testing, and implementation of new quality measures with a focus on integrating performance measurement and reporting within existing care delivery protocols to maximize clinical improvement while decreasing clinician burden. Further, the criteria and processes CMS uses to make its final decisions regarding which measures to remove from the program and which to continue using should also be fully transparent. This would allow stakeholders to better plan their efforts in terms of measure development and review and provide more meaningful feedback to the Agency in the future.

### ***Cost Category***

**Under current statute, MACRA will require CMS to increase the weight of the cost category to 30 percent by performance year 2022, but we urge Congress to revise the timeline to afford CMS additional flexibility just as it did with the Bipartisan Budget Act.** The problem with maintaining the current timeline for an increase in the weight of the cost category is that the measures used to evaluate the cost of care are not adequately reliable and accurate. We appreciate CMS’ repeated efforts to engage stakeholders in the measure development process. However, we have serious concerns about moving forward with eight new episode-based cost measures that have low average reliability and have not been given an adequate opportunity to be fully vetted by stakeholders. ACP shares the goal of the cost category to reward physicians who are delivering high quality, efficient care, but this only works with accurate cost and quality measurement. Otherwise, a host of unintended consequences could ensue, such as clinicians being penalized for treating sicker or older patients that may require more expensive care.

### ***Promoting Interoperability (PI) Category***

ACP continues to call for the PI Category to be re-conceptualized into a performance category that promotes the use of health IT to improve patient care and support practical interoperability. While we appreciate CMS’s attempt to simplify and streamline the PI category in the 2019 QPP final rule, the Agency continues to use the same “EHR-functional-use” measures that clinicians have found to be cumbersome and inappropriate and do little to help clinicians move forward in using their health IT to improve the value of patient care. **CMS should further update the PI performance category such that the current “EHR-functional-use” measures (e.g., e-prescribing and health information exchange [HIE] measures) are not**

scored on an “all-or-nothing” basis and that one minor misstep by a clinician could result in a score of zero for the entire category. CMS should then add in optional measures and activities (similar to the Improvement Activities component of MIPS) where clinicians can choose and attest to health IT activities that leverage health IT to improve patient care and better fit certain specialties and scopes of practice.

### ALTERNATIVE PAYMENT MODELS

Although we are pleased that CMS recently announced the creation of two new APM’s (Primary Care First and Direct Contracting) that will be available for physicians to join in the future, we are disappointed that to date, there are only eight active distinct types of Advanced APM’s. The number of available models falls well short of the robust pathway to value-based reform that Congress had envisioned for APMs and does not support the Agency’s own stated goal of shifting physicians into APMs.

We encourage the Senate Finance Committee to use their oversight authority over CMS to encourage the agency to leverage the Physician-Focused Payment Model Technical Advisory Committee (PTAC) which could be an invaluable tool to facilitating the implementation of innovative new physician-led APMs but to date has unfortunately been underutilized. Few of the now 11 models recommended for limited scale testing or full-scale implementation have been adopted by CMS. Many of these models have a proven track record of working in the private sector; it is to CMS’ benefit to capitalize on the substantial investment and testing that has already gone into these models. Moreover, we have already seen a decline in the number of submissions to PTAC. The longer CMS goes without adopting any models, what could be a great launching pad for a variety of innovative new payment models could cease to serve any practical purpose as enthusiasm wanes and developers cease to invest the resources and time into developing models without a realistic chance of those models ever being adopted.

Physicians who qualify to deliver care in an advanced APM also receive a five percent bonus if they meet certain metrics and use certified Electronic Health Record Technology, which then excludes them from MIPS reporting requirements, a huge incentive. Unfortunately this 5 percent bonus is set to expire in 2022 unless Congress approves legislation to extend it. We are concerned that if physicians are not assured that this five percent bonus will be available in the future, they would be less inclined to invest in the necessary infrastructure transformation in their practices to deliver care in an Advanced APM. **Because one of the goals of MACRA was to encourage physicians to transform their practices into advanced APM’s, we urge Congress to extend the 5 percent bonus beyond 2022 to continue to provide the necessary incentives for physicians to deliver care in this model.**

An additional barrier that prevents physicians from transforming their practices into Advanced Alternative Payment Models is that physicians are required to bear significant financial risk, either 3 percent of estimated expenditures or eight percent of average estimated Medicare Parts A and B revenue in order to participate in an APM. CMS intended for this threshold of participation as the standard for “nominal” risk so that additional practices to transform into APM’s but this threshold is simply too high to be considered a nominal financial risk. CMS

should also consider that physicians have to invest a significant amount of capital in order to afford the infrastructure improvements and practice transformation required to participate in an advanced APM. This threshold is especially difficult for smaller and rural practices who desire to participate in APMs but often lack the sophisticated infrastructure, financial reserves to purchase technologies required for interoperability or quality improvement, and ability to take on risk that immediately puts them on uneven ground when it comes to participating in Advanced APMs. **We encourage the Finance Committee to support a separate, lower Advanced APM nominal amount standard to encourage additional participation in Advanced APMs especially for small and/or rural practices.**

### **NEW PAYMENT MODELS ANNOUNCED BY CMS**

ACP is encouraged that CMS is testing new delivery and payment models to support the role of care provided by primary care physicians. Last month, the Department of Health and Human Services announced the creation of two new payment models, known as Primary Care First and Direct Contracting. These models are intended to recognize the value of primary care physicians in our health care system by offering sustainable and predictable prospective monthly payments to practices, to reduce administrative burdens for clinicians, to increase the quality of care for patients, and to allow practices and their physicians to share in savings from keeping patients healthy and out of the hospital whenever possible.

Internal medicine specialists are uniquely trained to provide adult patients with primary and comprehensive care throughout their lifetimes, and ACP is supportive of new primary care models that recognize and support their contributions to bringing greater value to their patients. The new models are important steps in this direction. Specifically, ACP is pleased that CMS has considered our recommendations to provide a variety of payment and delivery models that support internal medicine and primary care practices, from smaller and independent practices to larger integrated ones. Of note, ACP is optimistic that the new models will emphasize the important role primary care plays in value-based care delivery, that models are voluntary and have a range of risk options, and that practices should use population health management data to reap potential benefits. Additionally, ACP is supportive of the fact that the new models aim to reduce administrative burdens—potentially allowing physicians to spend more time with their patients.

We are especially interested in the Primary Care First Model that “will focus on advanced primary care practices ready to assume financial risk in exchange for reduced administrative burdens and performance based payments. As noted in the [CMS fact sheet](#) on this model:

- **Primary Care First Model** – to be eligible to participate in the PCF model, a practice must include “primary care practitioners, (MD, DO, CNS, NP and PA), certified in internal medicine, general medicine, geriatric medicine, family medicine and hospice and palliative medicine.” It must have 125 attributed Medicare beneficiaries at a particular location, have primary care services account for at least 70% of the practices’ collective billing based on revenue, and in the case of a multi-specialty practice, 70% of the practice’s eligible primary care practitioners’ combined revenue must come from

primary care services. It must also “have experience with value-based payment arrangements or payments based on cost, quality, and/or utilization performance such as shared savings, performance-based incentive payments, and episode-based payments, and/or alternative to fee-for-service payments such as full or partial capitation.”

There are elements of the PCF model that suggest that CMS is on the right track to building models that will improve patient care and that will support the work of primary care physicians. It provides a variety of payment models that will support internal medicine and primary care practices, from smaller and independent practices to larger integrated ones; it includes a range of risk options available to practices, and it could potentially reduce administrative burdens that would allow physicians to spend more time with their patients.

However, a lot of details related to risk adjustment, attribution, and financial benchmarking are still missing that may determine how many physicians and practices will seek to participate. Also, unless other payers join Medicare in supporting the PCF model, practices may not experience the reduction in administrative burdens and predictable revenue that CMS anticipates. Presumably, CMS will be releasing such information soon, prior to the enrollment period it intends to begin this fall. As CMS moves forward with the development of new care models, we urge the continued creation of new Advanced APM’s that include multiple payers so that all patients, not just Medicare beneficiaries, may benefit from the innovations and improvements to patient care that these models may provide. This will also allow those practices that voluntarily support these innovative care delivery system reform models to focus on a unified set of metrics and goals, allowing them to focus on truly improving patient care in key strategic areas and get back to delivering patient care, rather than juggling dozens of sets of varying reporting metrics.

Although there is great potential that these models will reinvigorate the practice of primary care physicians, we believe the success and viability of these models will depend on the extent that they are supported by payers in addition to Medicare and Medicaid, are adequately adjusted for differences in the risk and health status of patients seen by each practice, are provided predictable and adequate payments to support and sustain practices (especially smaller independent ones), are appropriately scaled for the financial risk expected of a practice, are provided meaningful and timely data to support improvement, and are truly able to reduce administrative tasks and costs, among other things. ACP will continue to evaluate the new payment and delivery models based on such considerations, and we look forward to working with CMS and to continue advocating for ways to support the value of primary care for physicians and for all patients across the health care system.”

## **THE FUTURE OF MACRA**

After MACRA was passed in 2015, the law established a period of positive Medicare payment updates of .5 percent until the end of 2019, which are then adjusted upward or downward based on reporting on performance measures. After this year, physicians will receive a zero percent Medicare baseline payment update from 2020-2025. We remain concerned that a zero percent update from 2020 -2025 does not provide adequate support for physicians to continue to make

the necessary adjustments to perform at a high level on standards set by MACRA to measure quality, clinical improvement, interoperability, and cost data related to their practices. As noted in the testimony concerning this hearing submitted by the American Medical Association, the recent 2019 Annual Medicare Trustees Report found that scheduled physician's payment amounts are not expected to keep pace with average rate of physician cost increases, which are forecast to average 2.2 percent per year in the long range. The Medicare Trustees Report also found that absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term. **We encourage members of the Senate Finance Committee to introduce and pass legislation that would replace the zero percent baseline payment updates under Medicare, scheduled to take effect in 2020, with positive updates.**

### **SUMMARY OF ACP KEY RECOMMENDATIONS**

As the Senate Finance Committee conducts oversight over CMS implementation of the Quality Payment Program under MACRA and also considers legislative changes to this law, we offer the following key recommendations to ensure that MACRA is implemented successfully and as intended by Congress.

**Members of the Senate Finance Committee should encourage and provide incentives to physicians who transform their practices into Advanced APMs and continue to provide stability for physicians in the MIPS program by introducing and passing legislation that would do the following:**

- **Extend the five percent Qualified APM participant bonus beyond the 2022 performance year.**
- **Replace the zero percent baseline payment updates under Medicare, scheduled to take effect in 2020, with positive updates.**
- **Revise the timeline to afford CMS with additional flexibility to determine the weight of the cost category within MIPS. It is scheduled to be 30 percent by performance year 2022.**

**Members of the Senate Finance Committee should exercise its oversight authority over CMS and urge it to implement the following recommendations:**

- **Expedite approval of more Advanced Alternative Payment models (APMS), particularly those that work for small and specialty practices.**
- **Provide a separate, lower Advanced APM nominal amount to encourage participation in Advanced APM's by small and/or rural practices**
- **Simplify the scoring structure and reporting requirements under the Merit-Based Incentive Payment System (MIPS) in order to fulfill Congress' intent of a more streamlined program that reduces burdens on physicians.**



- **Institute a consistent 90 consecutive day minimum reporting period across all MIPS performance categories**
- **Reduce the number of measures required for full participation in the MIPS quality category from six to three measures**
- **Restructure the Promoting Interoperability Category within MIPS to remove the “all-or-nothing” scoring component and provide more flexibility and options for clinicians to use their health IT to improve value-based care**

## **CONCLUSION**

ACP appreciates the Senate Finance Committee’s convening this hearing to examine the implementation of MACRA and chart the road ahead for this law in the future. We look forward to working with you to ensure that MACRA works to improve the value and quality of care delivered to patients, provides support for physicians to continue to meet performance standards measured by this new law, and additional pathways for physicians to transition into Advanced APMs.