



Statement for the Record

American College of Physicians

U.S. House Committee on Ways and Means Subcommittee on Health

Hearing on Implementation of MACRA's Physician Payment Policies

March 21, 2018

The American College of Physicians (ACP) is pleased to submit the following statement for the record regarding the hearing on implementation of the Medicare Access and CHIP Reauthorization Act's (MACRA) physician payment policies. ACP is the largest medical specialty organization and the second largest physician group in the United States. ACP members include 152,000 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.

ACP has been a strong supporter of MACRA and embraces its shift from a volume-based payment and delivery system, as was the case under the preceding fee-for-service system with yearly adjustments based on Medicare's Sustainable Growth Rate (SGR) formula, to one of value, accountability, and patient-centered care. The College has been active in providing feedback on the implementation of the Quality Payment Program (QPP) as established by MACRA via its letters on both the [2017](#) and [2018](#) final rules, as well as on the [Measure Development Plan](#) and other requests for information and feedback from the Agency. Similarly, ACP appreciates the ongoing congressional oversight of MACRA as is being conducted by the relevant committees of jurisdiction so as to ensure its successful implementation. Repeal of the SGR was a priority of ACP's, and nearly all of medicine, for more than a decade. Thanks to the enactment of MACRA in 2015, physicians and their patients no longer have to be concerned with impending yearly payment cuts as a result of the flawed SGR formula. However, as noted earlier, MACRA not only repealed the SGR, it also has led to a true shift in the Medicare program from a volume-based payment and delivery system to one of value, accountability, and patient-centered care—an

approach the College strongly embraces. ACP recognizes the importance of MACRA in helping to ignite movement by Medicare toward payment systems that incentivize value rather than volume.

As Congress, and more specifically the House Ways and Means Committee, performs its oversight role in implementation of MACRA and the Quality Payment Program (QPP), the College wishes to highlight a number of recommendations, comments, and concerns. These comments and concerns are covered in more detail in ACP's recent comment letter on the [QPP final rule](#), the Center for Medicare and Medicaid Innovation (CMMI) ["New Direction" request for information](#), and other recent letters.

Merit-Based Incentive Payment System (MIPS)

Simplification of MIPS

ACP strongly believes that CMS should make significant efforts to simplify QPP, especially in the MIPS pathway, by reducing the administrative burdens associated with reporting and standardizing the approach to scoring. The College appreciates that Congress included several changes to MACRA in the Bipartisan Budget Act of 2018 (H.R. 1892) that allow CMS additional flexibility in weighting the Cost performance category and setting performance threshold for an additional three years to allow for a slower, incremental ramp up in reporting requirements. Additionally, while we appreciate that CMS allowed for "pick your pace" options during the 2017 performance period to allow a simple test option to avoid a negative payment adjustment, similar clear-cut options do not exist in 2018 leaving clinicians to try to navigate the complicated MIPS scoring system and changing policies to avoid a payment cut. More specifically, ACP has called on CMS to make a number of policy changes including:

- Further simplify and standardize the scoring approach within MIPS in order to allow the point value for each measure or activity to be fully reflective of its value within in the overall composite performance score (CPS). The point values within the performance scoring methodology have not been simplified sufficiently and the points available with each measure are not reflective of the value a measure or activity has in the overall composite performance score in most cases.
- For the basic scoring system, continue modifying the point values within the overall MIPS performance scoring to reflect a more unified approach by making the points available for performance on each category and measure reflective of the value it has in the overall CPS.

- This means that all of the available points within the quality component would add up to a total of 50 points – counting for 50 percent; the points within improvement activities would add up to 15 – counting for 15 percent; the points within Advancing Care Information (ACI) would add up to 25 – counting for 25 percent; and under the current rule, cost would add up to 10 points if 10 percent; 30 points if 30 percent.
- For physicians with reweighting exceptions or special circumstances, ACP urges CMS to develop an easy-to-use online tool that will allow ECs to input circumstances and receive a breakdown of how the point values for measures and activities translate to the CPS.
- Consider additional options in rulemaking to promote taking on quality improvement activities that crossover into multiple performance categories to strengthen MIPS and make the program more comprehensive rather than siloed.
- Make changes to MIPS performance categories as outlined below and in ACP’s [comments](#) on the 2018 final rule.

Small Practice Considerations

ACP appreciates that CMS made several additional changes for the 2018 performance period to better accommodate the needs of small practices. These include increasing the low-volume threshold to \$90,000 in Part B allowed charges or 200 Part B patients, creating a virtual groups policy, adding a small practice bonus, and implementing a hardship exception policy for the Advancing Care Information performance category for small practices. These policies will help create a playing field that allows small practices and those in rural and underserved areas more opportunities to succeed. As Congress performs its oversight role, the College encourages consideration of the following additional recommendations for small practices:

- Allow clinicians below the \$90,000 or 200-patient low-volume thresholds to have the option of opting into MIPS and receiving payment adjustments associated with their performance. We are concerned that the policy excluding clinicians below the low-volume threshold from MIPS participation poses a risk of stalling these exempted practices in making progress toward value based payment, which is contrary to the Congressional intent of MACRA and the overarching movement toward value in the healthcare system.
- Consider options for allowing practices that may not meet the strict definition of small practices under Agency rules but are otherwise similar in challenges, structure, etc. to qualify for the same exemptions and special rules as other small practices.

- In addition to an ACI hardship exemption for those who choose to accept it, provide more assistance to small practices that are willing to try to integrate information technology but cannot accomplish the task without additional help.
- Extend the small practice bonus to clinicians in rural and underserved areas.
- Allow practices (TINs) to subdivide into smaller groupings (i.e., specialties, practice sites, etc.) for performance assessment purposes to allow for selection of performance measures and activities that are most relevant to a clinician’s scope of practice and patient population.
- Consider offering lower nominal risk standards (i.e., the medical home model standard) for small practices and those in rural and underserved areas that choose to participate in Advanced APMs.

Quality Performance Category

ACP strongly supports CMS’ “Meaningful Measures” and “Patients over Paperwork” initiatives and looks forward to working with the Agency to ensure that patients and physicians are the focal point of any policy changes that result from these initiatives. The College has been a strong advocate for reducing the burdens of regulatory and administrative tasks, as evidenced in the launch of our [Patients before Paperwork](#) initiative in 2015. ACP has strongly advocated for CMS and other payers to ensure that measures used in reporting are evidence-based and go through a multi-stakeholder evaluation process. This not only includes filling critical measure gaps, but also removing measures that are poor quality as needed. CMS and other payers must monitor the measurement/reporting system to identify and mitigate any unintended consequences including clinician burden and work to have measurement data collection and submission be part of the clinician workflow – and not an added burden. We have also called on developers and payers to work to ensure that measurement does not exacerbate, and ideally reduce, disparities in care including through incorporating adjustments for socioeconomic status.

As measurement specifically pertains to QPP, the College has a number of concerns and recommendations related to the policies in place for the Quality performance category in the 2018 performance period including:

- Reduce the finalized reporting period requirement for the Quality performance category from 12 months to a minimum of a 90-day performance period in order to align it with the other reporting categories of Advancing Care Information and Improvement Activities. This will allow clinicians to gradually prepare for full participation and for CMS to continue to facilitate the idea of a learning health care system focused on value over volume.

- Prioritize moving the performance period closer to the payment adjustment year as soon as possible. This, combined with providing clinicians and practices with much more timely feedback on their data submission, will serve to better facilitate meaningful improvement--and an ability for clinicians to experience incentives in a timely and understandable manner.
- Reduce the finalized 60 percent data completeness requirements for quality reporting for the second performance period to 50 percent, as was proposed. Increasing the data completeness requirements on measures, many of which may not be focused on outcomes that are meaningful to physicians and patients, seems to directly contradict CMS' recent commitments to focusing on "Meaningful Measures" and "Patients over Paperwork."
- Provide more transparency regarding the evaluation criteria for qualified clinical data registry (QCDR) measures and the data QCDRs must provide for these measures at the time of self-nomination.

Advancing Care Information (ACI) Performance Category

ACP recommends that CMS take steps to re-conceptualize the Advancing Care Information (ACI) performance category to facilitate the enabling infrastructure of HIT to improve quality and value rather than satisfy regulatory compliance. The College commends Congress for taking a first step to make this feasible by including Section 50413 in the Bipartisan Budget Act of 2018 (H.R. 1892), which removes the requirement that CMS make the Medicare EHR incentive programs more stringent. ACP has provided extensive comments to CMS on how to improve the ACI category, including the following key recommendations:

- Re-conceptualize and rescore the ACI category such that it more closely resembles the approach taken to the category of Improvement Activities. Instead of base and performance categories, ACI should have base and elective categories – each with point values; and satisfaction of these categories would be (except where prohibited by legislation) by attestation.
- Modify the base score component of ACI and remove the threshold requirements of 1 or "yes" for all proposed base measures except for the protecting patient health information attestation which ACP believes is integral to the use of health IT. The proposed base measures, which are the same measures that physicians have already found to be cumbersome and inappropriate, do little to help clinicians move forward in using health IT to improve value of care. The College could support the base score requirement to report ACI measures – but only where the requirements do not contribute to poor usability, where the numerator and denominator of

each measure were automatically calculated from the EHR, and where there were no base thresholds or performance requirements.

- Change the performance score component of ACI to an elective category – where options that better fit certain specialties and scopes of practice are available for selection; and all (similar to the Improvement Activities component of MIPS) elective categories are satisfied by attestation. Examples include adding data management and analysis capabilities, adding capabilities to share relevant clinical data among care team members, and adding new functions such as care plan management. Moreover, clinicians are facing a steep learning curve when it comes to implementing new health IT in their practices and should also have the option to select health IT education opportunities in addition to the base score component EHR functional measures. CMS should then focus the review and improvement of ACI measures on the value of the measures and whether they assist practices in applying health IT to improve the quality and value of care and not focus on the performance levels of the measures.

Cost (Resource Use) Performance Category

ACP appreciates that Congress added an additional three years of flexibility in setting the weight of the Cost (formerly Resource Use) performance category in Sec. 51003 of the Bipartisan Budget Act of 2018 (H.R. 1892). This additional flexibility will provide much-needed time for CMS to continue developing and refining new episode groups, patient relationship categories, and patient condition categories. However, in light of the concerns outlined below, the College is disappointed that Congress locked in a minimum of 10 percent weight for the Cost performance category for 2018 through 2021. CMS had the authority under MACRA as enacted to weight Cost down to zero percent in year 2 (2018) and even proposed doing so, while ultimately finalizing a 10 percent weight in light of the 30 percent mandatory weight in year 3. Given the additional 3 years of flexibility provided by the BBA, we believe CMS would have been inclined to revisit the Cost weighting in year 2 and potentially revise it down to zero percent pending the development of adequate measures. ACP recommends that the Cost performance category be weighted at zero percent for the 2018 performance period and that CMS have the flexibility to set the Cost weight as low as zero percent in the next three years as CMS works to develop adequate measures as well as attribution and risk adjustment methodologies.

The College continues to have significant concerns with the claims-based measures that were carried over from the value-based payment modifier program as well as the newly developed episode-based measures that will be used to calculate the Cost performance category score. The total per capita cost

measure and the Medicare Spending per Beneficiary (MSPB) measure lack sufficient attribution methodology and inappropriately attribute broad-based costs to physicians for services that are outside of their control and that they do not have the ability to impact such as costs associated with hospitalizations and other care settings that occur outside of the physician's practice. The College also believes that the new episode-based measures developed by CMS and Acumen need further development and testing in order to determine their validity and reliability in measuring resource use for internal medicine physicians and subspecialists. Additionally, the cost measures also lack proper risk adjustment methodologies and factors such as socioeconomic status, which creates a system that inappropriately penalizes physicians with higher numbers of lower income or frailer patients. Therefore, ACP strongly recommends that Congress consider legislation to allow CMS to revise the Cost performance category weight down to zero percent in 2018 as well as over the next three subsequent years.

In the interim, ACP recommends that CMS:

- Continue to focus on the refinement of the claims-based total per capita cost measure and the MSPB measure as well on providing performance feedback that includes specific patient-level data, individual physician and group-level information, and peer comparisons to allow clinicians to understand what areas they can take action in to improve their performance.
- Continue development of new episode-based code sets to ensure that when cost is accounted for in the composite performance score, it is done in a more appropriate manner that factors in components such as patient condition and the costs associated with clinicians in the role in which they treat each patient.
- Develop and provide thorough education to clinicians on the new episode-based cost measures as well as the impact of cost measures on physicians' overall performance in the Cost performance category.
- Consider the College's April 2017 letter on Episode-Based Cost Measure Development for the Quality Payment Program¹ related to the development of episode-based cost measures for chronic conditions as well, as a possible pilot to voluntarily test new cost measures and patient relationship codes.

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https://www.acponline.org/acp_policy/letters/acp_comments_on_cms_episode_based_cost_measure_development_for_macra_qpp_2017.pdf

Improvement Activities Performance Category

ACP appreciates that CMS is continuing to add to the Improvement Activities category to ensure sufficient activities are available to provide meaningful options to variety of different types of practices and specialties. We also appreciate that CMS has made efforts to expand the list of Improvement Activities that allow bonus credit in the ACI category when performed using CEHRT. The College believes that more should be done to minimize the burdens associated with this category, including the following recommendations that were made to CMS:

- Remove the weighting of individual Improvement Activities, as it adds unnecessary complexity and it is unclear what evidence might indicate why certain activities might be considered medium versus highly weighted.
- Consider allowing other third parties that may be collecting information that is indicative of completion of an Improvement Activity to submit lists to CMS that would allow credit to be awarded absent a submission by an EC, group, or third-party intermediary.
- Remove or reduce the new requirement require that 50 percent of practice sites be certified PCMHs or comparable specialty practices in order to receive full credit for improvement activities and reconsider this requirement in interim rulemaking.

Alternative Payment Models (APMs)

ACP strongly supports expanding the options that are available for internal medicine physicians and subspecialists to participate in value-based models through the Advanced APM pathway. Currently, there are few APMs available for internal medicine physicians, especially subspecialists, to participate in through the Innovation Center, and those that include the most participants, such as the Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs) in Track 1, do not even qualify as Advanced APMs due to strict financial risk requirements. Those Advanced APMs that are available are often very limited in scope and only allow participants in certain regions or who meet very limited criteria. Many specialists and subspecialists lack any Advanced APMs that are relevant to their specialization. And for primary care physicians, a patient-centered medical home model that is an Advanced APM simply is not available yet.

ACP recommends that the Center for Medicare and Medicaid Innovation (CMMI) take into account a number of options and considerations to make Advanced APMs more readily available including:

- **Expand opportunities for primary care physicians to participate in medical home models as Advanced APMs.** Additional medical home models should include both models that meet the

medical home model nominal amount standard, as well as by using 1115A(c) authority to expand PCMH models that do not have a nominal risk requirement. The details of ACP's recommendations regarding medical home options can be found in our comments on the 2018 QPP rule.² The College also would like to re-iterate our strong support for the Comprehensive Primary Care Plus (CPC+) program.

- **Apply medical home model standards to specialty practice models.** On the MIPS side, certified/recognized PCMHs and comparable specialty practice models are treated the same when it comes to receiving full credit for improvement activities. For APMs, CMS should allow comparable specialty practice models that are Advanced APMs to qualify for the medical home model nominal amount standard as well as utilize the non-risk-bearing standard for PCMHs that meet the criteria for expansion under 1115A(c).
- **Eliminate arbitrary limits on number of clinicians in an organization to be considered an Advanced APM.** We urge CMS to remove any limitations on Medical Home Models based on the number of clinicians in the organization that owns and operates the practice site. A TIN may have many practice sites under it but only one or two that are primary care and therefore able to be recognized PCMHs—or, more specifically, CPC+ practices. These practice sites are then not able to receive the bonus payments for being an advanced APM when they are performing the same functions as other CPC+ practices.
- **Maintain or reduce nominal amount standards for risk to create stability as models are being developed.** Groups that are designing APMs expend significant time and resources during the development process, potential review by the PTAC, and possible work with CMS to further refine and implement. By the time this process, which can take years, is completed and a model is being tested, nominal amount standards will likely have changed or increased over what they were during the development process. In order to expand the available Advanced APMs, CMS should at a minimum maintain the current nominal amount standards indefinitely so that groups developing models know what risk target they need to meet. To bring models and participants into the fold more rapidly, a reduction in the arbitrary nominal amount standards should be considered.
- **Consider adding flexibility to the nominal risk standards for other-payer Advanced APMs.** Models that are being implemented by other payers often do not necessarily fit neatly within the CMS-defined nominal amount standard for Medicare Part B models as well as other design

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https://www.acponline.org/acp_policy/letters/cms_comment_letter_re_cy_2018_macra_qpp_proposed_rule_2017.pdf

structures in Medicare models. More flexible standards for other payer APMs will expand options for participating in Advanced APMs.

- **Create lower nominal amount standard for models focused on small practices and those in rural areas and health professional shortage areas (HPSAs).** In recognition of the challenges that small and rural practices face in accepting the general nominal amount standard of risk, CMS should allow these practices to join Advanced APMs under a lower nominal risk standard (e.g., the medical home model standard). This would include small and rural practices that are part of a medical home model and those that join larger APM entities.
- **Consider the upfront costs of participating in APMs as well as the ongoing maintenance costs when determining whether models meet nominal financial risk criteria.** Significant “at risk” capital requirements are necessary to start and maintain APMs such as ACOs. The College reaffirms its belief that Track One MSSP ACOs should qualify as meeting the nominal risk requirement for determining an Advanced APM. This position was more fully articulated in a joint comment letter signed-onto by the College dated March 25, 2016.³
- **Ensure that reporting and other administrative tasks within current and new advanced APMs are developed, implemented, and monitored in a manner that ensures they do not add unnecessary burden to the clinician practice and/or to their patients and families.** This approach is aligned with the Administration’s recently announced “Patients Over Paperwork” initiative and with the College’s “Patients Before Paperwork”⁴ initiative that has been in place since 2015, as well as our policy paper “Putting Patients First by Reducing Administrative Tasks in Health Care.”⁵

Conclusion

ACP thanks Chairman Roskam, Ranking Member Levin, and the Ways and Means Health Subcommittee for convening this hearing and for your commitment to providing oversight of the implementation of MACRA and QPP. We greatly appreciate the Committee convening this hearing and for your continued desire to see that the value-based system, as established under MACRA, is successfully implemented. We very much want to be part of this process and to provide feedback whenever needed. Please contact Richard Trachtman at rtrachtman@acponline.org or (202) 997-0206 with any questions or if additional information is needed.

³ https://www.acponline.org/acp_policy/letters/joint_comment_mssp_aco_benchmarking_2016.pdf

⁴ <https://www.acponline.org/advocacy/where-we-stand/patients-before-paperwork>

⁵ <http://annals.org/aim/fullarticle/2614079/putting-patients-first-reducing-administrative-tasks-health-care-position-paper>