



**Statement for the Record**

**American College of Physicians**

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**Medicare Access and CHIP Reauthorization Act of 2015: Ensuring Successful Implementation of Physician Payment Reforms**

**July 13, 2016**

The American College of Physicians (ACP) applauds Chairman Hatch and Ranking Member Wyden for holding this hearing on the implementation of the Medicare Access and CHIP Reauthorization Act (MACRA). The College appreciates the opportunity to provide a statement to the Senate Finance Committee that includes our recommendations to improve the implementation of MACRA. These recommendations are based on a comment [letter](#) that ACP sent last month to the Centers for Medicare and Medicaid Services (CMS) Acting Administrator Andy Slavitt that provides our ideas for improvements to the proposed rule that was released earlier this year by CMS to implement MACRA.

ACP has developed three principles that Congress should use to ensure that this law is implemented in a manner that truly improves care for Medicare beneficiaries and thus the policy that is developed to guide these new value based payment programs must be thoughtfully considered in that context. We believe that these principles are also consistent with the manner that Congress intended the law to be implemented. These principles are:

- **That the new payment systems should reflect the lessons from current and past programs and effectively allow for ongoing innovation and learning. The agency must constantly monitor the evolving measurement system to identify and mitigate any potential unintended consequences.**
- **CMS should work to ensure that patients, families, and their relationships with their physicians are at the forefront of thinking in developing the new payment systems.**
- **CMS should collaborate with specialty societies, frontline clinicians, and Electronic Health Records (EHRs) vendors in the development, testing, and implementation of measures with a focus on integrating the measurement of and reporting on performance with quality improvement and care delivery and decreasing clinician burden.**

We ask Congress to not only use these principles to guide the oversight process, but also offer a series of concrete recommendations to CMS that we believe will help ensure that the law is implemented in a manner that serves the interests of our patients and also follows Congressional intent. We look forward to working with Congress to ensure that these recommendations are implemented as our physicians prepare to move toward a new value-based payment system.

Among the detailed suggestions, we have outlined a set of top priority asks for CMS, including the following:

- **Implement an alternative Merit-Based Incentive Payment System (MIPS) scoring methodology, developed by ACP, which combines, simplifies, aligns, and reduces the complexity of the four reporting categories.**
- **Provide better opportunities for small practices to succeed, including via the creation of virtual groups for assessment under MIPS, while holding practices of nine or fewer eligible clinicians harmless from any potential downward adjustments until such time that a virtual groups option is made available.**
- **Make significant improvements to simplify, harmonize and reduce the burden of quality measurement and reporting for MIPS both over the short and longer term.**
- **Simplify reporting requirements within CMS's Advancing Care Information (ACI) program that is to replace the current Meaningful Use program.**
- **Change the start date for the First Performance Year in the Quality Payment Program (QPP) to July 1, 2017.**
- **Improve the opportunities for Patient-Centered Medical Homes (PCMHs) and PCMH Specialty Practices in MIPS and for PCMHs as advanced Alternative Payment Models (APMs).**
- **Implement changes that would make more advanced APMs available for physicians in all specialties, especially including those in internal medicine and its subspecialties.**

At this time, we believe that CMS is sincerely open to making improvements from its proposed rule, and do not believe that it is necessary or desirable for Congress to make any legislative changes to MACRA. Rather, we encourage the Senate Finance Committee, and the House Medicare committees of jurisdiction, to exercise oversight over CMS's implementation, and specifically, to be supportive of the following recommendations in ACP's comment letter on the NPRM.

#### **Implement an Alternative Scoring Methodology for MIPS**

**ACP recommends that CMS simplify and clarify performance scoring in the final rule to allow physicians to better assess the scoring and weighting within each category.** The scoring approach included in the proposed rule had different points systems and scales for each of the four reporting

categories, making it unnecessarily complicated; ACP's alternative would put the points all on the same scale, combining them into one simplified and harmonized program as Congress intended.

ACP proposed to CMS a more simplified alternative that would make all available points within the quality component add up to a total of 50 points, not 80 – which then counts for 50 percent; the points within resource use would add up to a total of 10 or less; the points within Clinical Practice Improvement Activities (CPIA) would add up to 15; and the points within ACI would add up to 25 (and not 131, with only 100 of those points actually “counting,” as currently proposed).

By simplifying the scoring to allow the maximum points for each measure or activity to directly translate to its contribution to the overall CPS, the scoring will be streamlined to better account for MIPS as one comprehensive program rather than silos for each performance category. This will allow physicians to better focus their efforts on the activities and measures that are most meaningful to their patients and practice.

**Provide better opportunities for small practices to succeed**

Section 1848(q)(5)(I) of the Act establishes the use of voluntary virtual groups for certain assessment purposes. The statute requires the establishment and implementation of a process that allows an individual MIPS eligible clinician (EC) or a group consisting of not more than 10 MIPS ECs to elect to form a virtual group with at least one other such individual MIPS EC or group of not more than 10 MIPS ECs for a performance period of a year. While the rule recognizes this requirement, it proposes to delay the onset of this provision until the 2018 performance year based on identified significant barriers regarding the development of a technological infrastructure required for successful implementation and the operationalization of provisions that would make this a conducive option for MIPS ECs or groups.

The College believes that the implementation of the virtual groups' provision is an important step towards establishing a viable and effective quality payment program. It will allow small practice clinicians to aggregate their data to allow for more reliable and valid measurement as well as serve as a platform to facilitate shared accountability and collaborative efforts. While we recognize and appreciate the barriers mentioned towards implementation in time for the 2017 performance period, ACP is not supportive of the planned delay in implementation. It places small practices in a situation in which payment adjustments based upon the 2017 performance year will likely be based upon suspect data.

**Therefore, ACP strongly urges CMS to include in the final rule for the 2017 performance period a policy that allows small practices to join together as virtual groups for the purposes of MIPS assessment in the initial performance period.** This is a critical option that small practices should be permitted in order to allow greater assessment opportunities under MIPS. To accomplish creating a virtual group option for the first performance period, the College notes that CMS can utilize Interim Final Rulemaking processes.

**If the Agency is unable to provide a virtual group option through rulemaking for the first year, then as a backup, ACP recommends that CMS treat small practices in a manner similar to how they were treated in the phase-in of the Value-based Payment Modifier (VBM) program. Under this option, CMS**

would allow solo clinicians and groups of 2-9 ECs who report under MIPS to be held harmless from any potential downward adjustments until such time that a virtual groups option is made available. They should still be eligible for upward adjustments.

**Make significant improvements to quality measurement and quality reporting for MIPS and over the longer term**

In our comments on the quality component of MIPS, it seems imperative to reiterate our call for CMS to use the opportunity provided through the new MACRA law to actively build a learning health and healthcare system. It is critically important that the new payment systems that are designed through the implementation of MACRA reflect the lessons from the current and past programs and also effectively allow for ongoing innovation and learning. Overall, quality measurement must move toward becoming more relevant and accurate, and toward effective approaches of measuring patient outcomes.

We provide these specific recommendations for CMS to properly implement the new Quality Performance Category:

- 1. The College recommends that CMS collaborate with specialty societies, frontline clinicians, and EHR vendors in the development, testing, and implementation of measures with a focus on integrating the measurement of and reporting on performance with quality improvement and care delivery and on decreasing clinician burden.**

It is critically important to constantly monitor the evolving measurement system to identify and mitigate any potential unintended consequences, such as increasing clinician burden and burn-out, adversely impacting underserved populations and the clinicians who care for them, and diverting attention disproportionately toward the things being measured to the neglect of other critically important areas that cannot be directly measured (e.g., empathy, humanity).

- 2. We recommend that ideally any measures CMS proposes to use outside of the core set identified by the Core Quality Measures Collaborative be endorsed by the Measure Application partnership.**

ACP is appreciative that CMS has proposed to reduce the overall number of measures required for reporting from nine measures to six, as well as removing the requirement that these measures fall across all of the National Quality Strategy domains. However, the College would like to reiterate our overall concerns with the performance measures that are currently in use within the Physician Quality Reporting System (PQRS) program, as well as many of those proposed for use within MIPS. To begin to address this issue in the short term, in our comments on the draft Measurement Development Plan (MDP), ACP called on CMS to utilize the core set of quality measures identified by the Core Quality Measures Collaborative.

- 3. CMS should consider the recommendations made by ACP's Performance Measurement Committee with regard to measure selection within MIPS.**

These recommendations, as listed on the ACP website (with a thumbs up, down, or sideways), are based upon a scientific review process that involves four domains: purpose and importance to measure, clinical evidence base, measure specifications, and measure implementation and applicability.

**4. CMS should take concrete actions to provide clear options for those specialties and subspecialties that may be most impacted by too few appropriate measures.**

Many of these specialties may already be impacted under the current proposal—particularly by a lack of outcomes and/or high priority measures—and certainly would be affected if a number of the measures available were to be reduced through a more focused and needed approach of ensuring measure validity, clinical relevance, and ability to implement. These actions should include:

- Developing a process to determine, in advance of the reporting year, which quality measures are likely applicable to each EC—and only holding them accountable for these relevant measures (i.e., weighting performance on the remaining measures higher, rather than penalizing them with a score of zero on unreported measures).
- Putting a process in place, for the short term, to address the significant issues of validity and ability to implement associated with using measures that are not endorsed by the National Quality Forum (NQF), and/or ACP recommended.
- Establishing safe harbors for entities that are taking on innovative approaches to quality measurement and improvement and also provide clear protections for individual clinicians who participate in these types of activities— this could be done by having the entities register certain measures as “test measures.”
- Ensuring that the flexibility for Qualified Clinical Data Registries (QCDRs) to develop and maintain measures outside of the CMS selection process is protected.

**Simplify Reporting Requirements for the ACI Program**

ACP proposed significant improvements to simplify the reporting requirements for the ACI program that is to replace Meaningful Use in the new law. ACP has been a consistent advocate of physicians and other clinicians leveraging EHRs and other health information technology (IT) to improve care. As such, ACP was a strong supporter of the goals of the HI-TECH Act and of the Meaningful Use program, although we have expressed concerns regarding the implementation of the Meaningful Use program, specifically due to the uniform (or one-size-fits-all) and overly prescriptive approach taken by CMS, which turned what should have been an incentive program towards specialty-specific optimization of the emerging health IT infrastructure into a “check the box” compliance exercise. That said, the ACP believed that the Meaningful Use program accomplished many of its objectives, and with the coming of Medicare’s QPP via MACRA, CMS had a golden opportunity to fix Meaningful Use into something truly meaningful for physicians, clinicians, and patients.

Instead, what is proposed for Meaningful Use inside of MIPS is even more complicated than what was proposed for Stage 3, and with even higher thresholds. This legacy – if not significantly changed in the MACRA/MIPS final rule, will not be one of using the enabling infrastructure of health IT to improve quality and value – but rather using it to satisfy regulatory compliance. What doctors, clinicians, and

clinical informatics leaders should be doing now—analyzing and improving workflows and targeted use of health IT for specific quality and value purposes—will not happen. Instead, just as has occurred with each stage of Meaningful Use, they will be taking significant time to understand the rules and the FAQs that are certain to follow and continuing to develop workarounds and configuration “gimmicks,” particularly where the metric is not consistent with workflow.

In summary, the ACP believes that there is a place for Meaningful Use within MIPS, but it is one that plays a supportive role to improving care quality and value, and not one that promotes care information over patient care. Please see our specific recommendations and comments below, as well as an alternate proposal for Meaningful Use within MIPS, which we believe is responsive to the legislative requirements of MACRA.

- 1. We urge CMS to simplify the reporting requirements and scoring methodology within the proposed ACI Category and not require the volume and complexity specified in the base and performance scores.**

In the new ACI system offered in the proposed rule, each practice will be challenged to track and manage so many activities of so many people and systems if it is to successfully complete the ACI component. The likelihood of a costly error will be high. Further, the amount of effort that will be required to perform, manage, and report all the measures that make up ACI is more than would have been required under the Meaningful Use Stage 2 modification rule for 2017. The number of required activities greatly exceeds the numbers for the other components of MIPS.

- 2. For the 2017 performance period, ACP recommends that the ACI measurement period be 90 days instead of the full calendar year as done previously with the EHR Incentive Program performance period.**

It is extremely unlikely that all ECs will be prepared to report measures in the new system on January 1, 2017. Therefore, many ECs will be required to report on CMS’ alternate ACI proposal of modified objectives for the 2017 performance period. CMS should acknowledge this in the final rule. Assuming a best case scenario, most practices will spend the 2017 MIPS performance period converting from a 2014 Certified Electronic Health Record Technology (CEHRT) system to a 2015 CEHRT system that will negatively impact their ability to perform all ACI measures for the full calendar year.

- 3. The College urges CMS to 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.**

This modification will support CMS’ public statements and those of its Acting Administrator, Mr. Slavitt, outlining goals that give ECs the ability to select measures that are relevant and that move them forward in using health IT to improve value of care. ECs are going to need health IT capabilities that they do not yet have, and the ACI program should be used as a vehicle to help them make the needed transitions.

The proposed base measures, which are the same measures that physicians have already found to be cumbersome and inappropriate, do little to help ECs move forward.

**Change the start of the initial performance period under the QPP to July 1, 2017**

The College urges CMS to delay the initial performance period under the QPP to July 1, 2017 rather than the proposed January 1, 2017 start date. The performance period should remain as one year in length overall, ending on June 30, 2018. ACP believes that this later start date for the performance period better matches Congressional intent that the performance period be as close to the payment adjustment period as possible, while still allowing for the related payment adjustments to take place in 2019 as mandated by MACRA.

Given that the final rule implementing the initial performance period for MACRA will likely not be issued until October 2016 at the earliest, CMS, physician organizations, ECs, and other affected parties would have less than three months to prepare for implementation of an entirely new Medicare payment system, QPP. While it may be feasible for the physician fee schedule to be issued and implemented in a short time frame, the MACRA rule is different because it is not simply issuing revisions to a rule that has previously been implemented. Rather the MACRA rule entails digesting long, complex policies on MIPS and APMs that have never been in existence. Significant efforts will be required by CMS, physician organizations, and others to prepare educational materials and tools and provide practices opportunities to learn how they can succeed in QPP and best meet the needs of their patients. CMS should also use the time between the issuance of the final rule and the later July 1, 2017, start date to refine the feedback mechanisms that will be utilized for QPP performance and allow for appropriate user feedback and end-to-end testing.

**Improve the opportunities for PCMHs and PCMH Specialty Practices in MIPS and for PCMHs as advanced APMs**

**PCMHs and PCMH Specialty Practices in MIPS**

The College sincerely appreciates CMS' active implementation of this component of the law—as it is critically important to facilitate movement by all clinicians toward care that is truly patient-centered, coordinated, and comprehensive. ACP has been a leader in supporting the medical home model, particularly in light of the plethora of currently available research linking the model to higher quality and lower costs.

ACP recognizes that there will be a significant number of clinicians in PCMH practices that will be included in the MIPS pathway, even if CMS establishes a deeming process that would allow clinicians in medical home practices participating in programs run by states, other non-Medicare payers, and employers to become qualified advanced APM participants. These MIPS PCMH practices have taken significant steps to improve care for their patients through ongoing, meaningful, practice improvement approaches and therefore should be given the opportunity for full credit within the CPIA performance category. A number of these practices will, in fact, fall within the proposed definition from the agency (as outlined above); however, ACP believes that a number of clinicians in truly innovative PCMH

practices could be left out of this opportunity and will therefore have the burden of documenting additional CPIA.

**ACP recommends that CMS broaden its definition of the PCMH for the purposes of full CPIA credit to specifically be inclusive of programs that have a demonstrated track record of support by non-Medicare payers, state Medicaid programs, employers, and/or others in a region or state (but that do not yet meet all of the requirements to be deemed an advanced APM):**

- The programs to be included should be clearly articulated by CMS in advance, along with transparent criteria and methodology for the addition of new PCMH programs. With regard to “comparable specialty practice,” ACP also recommends that CMS broaden its definition to not only include those practices recognized by National Committee for Quality Assurance (NCQA), but also those practices that may be certified in some manner by other nationally recognized accreditation bodies or programs implemented by non-Medicare payers, state Medicaid programs, employers, and others in a region that may become available.
- Additionally, the College recommends that specialty practices should be able to attest directly to CMS and document that they meet standards comparable to those for primary care medical homes as recognized through an accreditation body, other certification process, or direct application to CMS or one of its carriers.

#### **PCMHs as advanced APMs—there should be multiple pathways available**

The College commends CMS for its recognition within the proposed rule regarding the unique status of the medical home within the advanced APM portfolio. *However, we are greatly concerned that CMS did not meet Congress’ intent that medical homes be able to qualify as [advanced] APMs without being required to bear more than nominal risk (even via the less stringent Medical Home Model Standard for financial risk and nominal amount).* The following explains our interpretation of the Congressional intent of the law and proposes specific steps that should be taken to modify the proposed rule to meet this intent.

A reasonable reading and interpretation of the statute provides what we believe to be the clear congressional intent—that CMS should allow a medical home to qualify as an [advanced] APM, without bearing more than nominal financial risk; if it is a medical home that meets criteria comparable to medical homes expanded under section 1115A(c). While this language is included in the discussion of the all-payer option that begins in 2021 (which is when other payer payments can be counted toward the threshold to determine if one is a qualifying APM participant), it makes clear that the intent of the law is to incentivize medical homes that are aligned with Medicare initiatives—and therefore ACP sees no reason to unnecessarily limit the initial opportunities for practices to become advanced APMs that are clearly meeting comparable criteria.

Criteria “comparable to medical homes expanded under section 1115A(c)” means:

(1) the Secretary determines that such expansion is expected to—

(A) reduce spending under applicable title without reducing the quality of care; or

(B) improve the quality of patient care without increasing spending;

(2) The Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce (or would not result in any increase in) net program spending under applicable titles; and

(3) The Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under the applicable title for applicable individuals. In determining which models or demonstration projects to expand under the preceding sentence, the Secretary shall focus on models and demonstration projects that improve the quality of patient care and reduce spending.

In sum, the Congressional intent and even the statutory language and criteria clearly do not require medical homes to bear more than nominal financial risk in order to qualify for payments as [advanced] APMs.

Nor does it require that the Secretary and the Chief Actuary determine/certify that medical homes would reduce net program spending—**rather, the applicable standard is that the Secretary determines they would “reduce spending ... without reducing the quality of care or “improve the quality of patient care without increasing spending’ and the Chief Actuary certifies they “would reduce (or would not result in any increase in) net program spending.”** The College believes that there is abundant evidence that medical homes, at the very least, can improve the quality of care without increasing spending (although there is growing evidence from the many PCMH programs around the country that can also bring about reductions in costs).

Therefore, ACP recommends that CMS take the following steps to provide multiple pathways for medical homes to be included in the advanced APM pathway, in addition to the Comprehensive Primary Care Plus pathway proposed by CMS:

- 1. Immediately initiate plans to undertake an expedited analysis of the results of the Comprehensive Primary Care Initiative (CPCi) to determine whether the statutory requirements for expansion by the Secretary are met.**
- 2. Establish a deeming program or process to enable practices enrolled in medical home programs run by states (including state Medicaid programs), other non-Medicare payers, and employers as being deemed to have met criteria “comparable to medical homes expanded under section 1115A (c).”**
- 3. Allow inclusion of medical home programs as advanced APMs that meet the Medical Home Model Standard for financial risk and nominal amount as outlined in the proposed rule.**

**Implement changes that would make more advanced APMs available for physicians in all specialties, especially including those in internal medicine and its subspecialties**

The College expresses significant concern regarding the limited number of opportunities currently available for non-primary care specialists /subspecialists to participate in recognized APMs and Advanced APMs.

ACP makes the following specific recommendations to address this problem:

- 1. Provide priority for consideration through the Physician Focused Payment Models Technical Advisory Committee (PTAC) and for Center for Medicare and Medicaid Innovation (CMMI) testing for models involving physician specialty/subspecialty categories for which there are no current recognized APMs and Advanced APM options available.** We further recommend that CMS provide a clear pathway for models recommended by PTAC to be implemented as APMs under MACRA.
- 2. Reduce the nominal risk requirement for potential advanced APMs other than the Medical Home model. The current nominal risk requirement for these models is onerous -- essentially requiring a maximum risk of 4 percent of total health expenditures for the attributed population.**
- 3. Create a platform to expedite the testing for APM recognition of bundled payment and similar episodes of care payment models.**
- 4. The College recommends the addition of a new Track within the Medicare Shared Savings Program (MSSP) that helps bridge the transition for one-sided to two-sided risk.** The feedback we have received from our members currently involved in Track One MSSP is that despite their ability presently to stay within Track One for a second 3-year contractual term, few of the participating physician-led entities currently feel they would be able—even after that 6-year period—to assume the currently required downside risk of Tracks 2 and 3. Therefore, as a means of addressing this issue, the College has recommended that CMS add a Track to the MSSP program that includes two-sided risk, but at a level that would not place the participating practices at unreasonable financial jeopardy.

### **Summary and Conclusion**

We look forward to working with the Congress to ensure that the new MACRA law is implemented in a successful manner that is consistent with the intent of Congress. The recommendations we offered to CMS in our letter, as summarized above, would serve to ensure the law truly improves care for Medicare beneficiaries. With these improvements, the QPP could go a long way to achieving Congress' goal of aligning payments with high quality care without imposing more unnecessary administrative burden on physicians.