Statement for the Record

American College of Physicians

Hearing before the Energy and Commerce Health Subcommittee

On

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

July 26, 2018

The American College of Physicians (ACP) is pleased to submit this statement for the record and appreciates the efforts of Chairman Burgess and Ranking Member Green in convening this hearing on the Merit-based Incentive Payment System (MIPS). Thank you for your shared commitment in wanting to ensure that the payment and delivery system reforms created under the Medicare Access and CHIP Reauthorization Act (MACRA) are implemented successfully and as intended by Congress. We also appreciate the subcommittee and full committee inviting input from the physician community throughout the implementation process, and for your continued oversight of the Quality Payment Program (QPP). We wish to assist in these efforts by offering our input and suggestions on the ongoing implementation of MIPS, as noted in detail below.

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 ACP's VIEWS ON MACRA

To reiterate what ACP has stated in its many communications to Congress on MACRA and the QPP, the College has been a strong supporter of MACRA and embraces its goal of creating

incentives for physicians and other clinicians to improve quality and to adopt alternative payment models (APMs) aligned with the result in better value for patients and the program. MACRA remains a major improvement over the preceding fee-for-service (FFS) system with yearly adjustments based on Medicare's Sustainable Growth Rate (SGR) formula, to one of value, accountability, and patient-centered care. However, continued improvements are needed for the QPP, as created by MACRA, to fully deliver on its intent.

The College has been active in providing feedback on the QPP via its comment letters to the Centers for Medicare and Medicaid Services (CMS) on both the 2017 and 2018 final rules, the Center for Medicare and Medicaid Innovation's (CMMI's) request for information on a "new direction," and the Measure Development Plan, as well as numerous other requests for information and feedback from the Agency.

The Merit-based Incentive Payment System (MIPS)

The College believes that MIPS plays an important and essential role in offering a pathway for physicians who continue to be reimbursed under the traditional Medicare FFS system to make changes in their practices to improve the value of care provided to patients as a step toward participating in more transformative APMs. That said, despite important steps being taken by the current and previous administrations to make MIPS as effective as possible, many ACP members remain concerned that reporting on many of the measures used by MIPS is overly burdensome, measures the wrong things, and is not likely to bring about real improvements in outcomes. Indeed, ACP's Performance Measurement Committee has reviewed many of the measures currently being used by MIPS and has determined that they lack validity, or are of uncertain validity. Other aspects of MIPS could also be simplified and improved. ACP specifically believes MIPS could be more effective if the following changes were made:

1. Simplify MIPS

Congress envisioned MIPS as a solution to the discounted and siloed legacy programs of the past. MIPS was designed to be a single, consolidated, and streamlined federal quality reporting program that aligned reporting objectives and measures into straight-forward requirements

that minimize burden on clinicians and practices. Unfortunately, certain aspects of MIPS' original design have led to unexpected challenges, resulting in ongoing complexity and little improvement in the harmonization of reporting requirements. Therefore, the College appreciates that Congress recognized the need for CMS to have additional flexibilities in certain areas to allow for a number of improvements and updates via several technical changes in the Bipartisan Budget Act of 2018 (H.R. 1892). This law enabled CMS to adjust the weighting of the Cost Performance category and make important changes to the methodology for establishing the performance threshold.

ACP offered the following additional suggestions to further simplify the program:

- CMS must simplify the overall scoring approach so that the point value for each measure or activity reflects its relative value within the composite performance score (CPS). For example, the points within the Quality component would total 50 points, which reflects the current weight of that category.
- CMS should 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.
- The Promoting Interoperability category of the program should be even further simplified. Currently, clinicians must contend with a scoring methodology that divides the category into three separate components, each scored a different way, that add up to a total of 155 points, while the category is actually scored out of 100 points. Of note, in the recently released notice of proposed rulemaking with changes to the QPP for the 2019 performance year, CMS does propose to "overhaul" scoring for this category, including getting rid of the separate "base" and "performance" scores, evaluating all measures on the same performance basis, and creating alignment between MIPS and other Medicare programs. ACP is encouraged by these proposals and will be reviewing them closely in order to provide feedback to the Agency.

2. Increase support for small practices and those in rural and underserved areas

Small practices and those in rural and underserved areas are repeatedly outperformed by their larger and more integrated counterparts on MIPS metrics. Often however, this is more a reflection of their lack of resources and ability to strategize than a true reflection of their value of care. To help address these concerns, we offer the following recommendations:

- Support CMS' recent proposal in the 2019 QPP rule to allow clinicians who would otherwise qualify for exemption from MIPS under the low-volume threshold, the option to "opt in" to MIPS. This would increase participation in the program without imposing additional undue burden on physicians and is strongly supported by the ACP.
- Increase assistance specifically geared to small practices, including possibly financial assistance for purchasing technologies such as Electronic Health Record (EHR) systems or registries, which can be instrumental in leveraging access to real-time data to drive high-value care, but can often be prohibitively expensive, particularly for small and rural practices. Even for practices that already have implemented an EHR and/or other technology solutions, there are significant costs associated with paying for the necessary upgrades due to the annual changes in the MIPS program requirements.
- Urge CMS to extend the small practice bonus to clinicians in rural and underserved areas.
- Urge CMS to establish a separate, lower nominal risk amount standard for small and rural APM entities, such as one that aligns with the medical home model nominal risk standard. This will allow practices that do not have the same sophistication of infrastructure or liquid financial resources as larger practices the opportunity to participate in innovative APMs to improve care and reduce costs for their patient populations.

3. Reduce administrative burden

Physician practices spend $15.4 billion per year, or approximately $40,000 per physician, to report on performance. In addition to costing practices financial resources and hours of staff time, the administrative burden created by MIPS and other federal programs is a leading contributor to physician burnout. ACP has made reducing the burdens of regulatory and administrative tasks one of our top advocacy priorities, as evidenced in the launch of our Patients before Paperwork initiative in 2015. We strongly support CMS' "Meaningful Measures"

and “Patients over Paperwork” initiatives but believe there is more opportunity for improvement in this area. Congress can help to support these important, ongoing efforts to reduce administrative burden in the following ways:

- Urge CMS to award cross-category credit, where one high priority activity or measure could earn points in multiple performance categories. This would allow practices to focus in on meaningfully driving improvement in key strategy priority areas. For instance, practices could report through their EHR system that they began participating in a prescription drug monitoring program, which could potentially earn that practice points in the Improvement Activities, Quality, and Promoting Interoperability categories while helping to combat the nation’s opioid epidemic.
- Urge CMS to reduce the minimum quality reporting period from a full year to 90 consecutive days to align with the Promoting Interoperability and Improvement Activities categories. This will have an immediate impact on reporting burden, will create consistency across the performance categories, and will allow for much-needed flexibility. Should practices experience any difficulties throughout the reporting year, such as technical malfunctions by their EHR product, which are reported commonly by our members, rather than claiming a hardship exception for an entire performance year, the practice would simply report on another 90-day window unaffected by the technical glitch.
- Urge CMS to move the performance period closer to the payment adjustment year as soon as possible. As it stands currently, clinicians receive performance feedback six months after the performance year has concluded. Payments are impacted two years later. Such a delayed cycle can hardly be considered to drive quality and generates mass confusion because reporting requirements and scoring rules change year-to-year. Shortening the reporting, feedback and payment cycle will allow clinicians to receive more timely feedback so that they can truly leverage that information to drive improvement in their practices, rather than simply engaging in a reporting exercise after the fact. Ideally, CMS would provide access to real-time Medicare claims data.
- Urge CMS to allow for an appropriate amount of time for practices to transition to new 2015 Edition CEHRT. The College supports the transition to the new 2015 Edition Certified

EHR Technology (CEHRT) to place greater emphasis on improved interoperability between EHR systems. However, upgrading this technology takes time and comes at a significant expense to practices. It cannot occur overnight. It will take time for vendors to reconfigure the systems to accommodate the new standards, as well as for practices to train clinical and administrative staff on the new requirements and system functionalities. Allowing only a few months between the release of the final rule and the proposed implementation date of Jan. 1, 2019 is likely to result in widespread software glitches that could pose risks to patients' health. The College recommends a minimum of six months for vendors and practices to perform the necessary system upgrades and staff training to ensure a smooth transition on such a massive scale.

- Under the Promoting Interoperability category, CMS currently scores certain measures on an "all-or-nothing" basis, where clinicians must report on all required measures or be given a score of zero for the entire performance category. In the recently proposed rule with changes to the QPP for the 2019 performance year, CMS proposes to overhaul the scoring methodology for the Promoting Interoperability category, as noted previously. However, the proposals technically expand the number of required measures that, if not reported, would lead to a total score of zero in this category. ACP has expressed serious concerns about this approach in the past and the burden it imposes on physician practices that could report the vast majority of measures, but may struggle with a single measure for any number of reasons, including relevant patient population, EHR functionalities, etc. One of the improvements that Congress had the foresight to make to the QPP under MACRA compared to the legacy programs was to stop using this cliff-based scoring approach under which a clinician could fulfill the majority of requirements but be awarded zero credit for failing to report a single measure. Instead, MACRA specifically calls on CMS to implement a "sliding scale" scoring approach that rewards clinicians proportionally for the amount of data they report. We urge Congress to use its oversight authority to impress upon CMS that this all-or-nothing scoring approach that continues to be used for the Promoting Interoperability category conflicts with Congressional intent under MACRA and subjects practices to undue administrative burden and financial risk, given the substantial expense of EHR systems.

- We understand the need to collect meaningful data, but only in the case where it is pulled from the EHR without additional steps required by the physician.

4. Improve the accuracy of MIPS measures and data

Nearly two thirds of practices reported that the current measures do not accurately capture the quality of care they provide. ACP has strongly advocated for CMS and other payers to ensure that reported measures are evidence-based, outcomes-focused, and aligned within the existing clinical workflow, and that they undergo a multi-stakeholder evaluation process. We offer the following specific recommendations to further refine and improve the accuracy of MIPS data:

- Urge CMS to collaborate in a multi-stakeholder evaluation process to develop, test and implement both new and existing measures to create a streamlined set of evidence-based, outcomes-focused quality measures that align within existing clinical workflows, thereby minimizing clinician burden. This not only includes filling critical measure gaps, but also removing measures that are poor quality as needed. Our Performance Measurement Committee conducted an in-depth scientific review of the validity of 86 QPP quality measures relevant to ambulatory general internal medicine and found that just one third were valid (35 percent were not valid and 28 percent were of uncertain validity). We urge Congress and the administration to look to these recommendations first when considering internal medicine measures. Next, Congress and the administration should look to measures endorsed by the Core Measures Collaborative and recommended by the Measure Application Partnership. Of note, in the proposed 2019 QPP rule, CMS proposes to retire 34 and add 10 new quality measures. While ACP is still closely analyzing the impact of these proposed measure additions and removals, we are encouraged that CMS is taking steps to remove what it considers to be low-value measures. However, we underscore the importance of taking concrete actions to ensure specialty clinicians have a sufficient number of measures to report so that they can successfully participate in the program.
- Urge CMS not to increase the weight of the Cost category in the same year that new measures are being introduced. 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), which will provide much-needed time for CMS to continue developing and refining new episode groups, patient relationship categories, and patient condition categories. However, next year, CMS proposes to introduce eight new episode-based cost measures while simultaneously increasing the weight of the Cost category from 10 percent to 15 percent. The Cost category should not increase above its current weight of 10 percent until CMS is able to fully evaluate the reliability and accuracy of these new measures.

- Urge CMS to address current flaws in risk adjustment methodologies that fail to accurately account for socioeconomic status, which create a system that inappropriately penalizes physicians with higher numbers of lower income or frailer patients. It is vitally important that MIPS help to reduce, rather than exacerbate, current disparities in care due to social inequities. Properly controlling for socioeconomic factors is critical to both learning more about these populations and understanding ways to help reduce this gap, and ensuring clinicians are not adversely penalized for caring for at-risk or more complex patient populations, which could result in access issues for vulnerable patients.
- Urge CMS to address flawed patient attribution methodologies for the total per-capita cost and Medicare Spending per Beneficiary (MSPB) measures, which were carried over from the Value-Based Payment Modifier legacy program 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 care settings outside of the physician's practice.
- Encourage CMS to allow practices 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.

ACP TOOLS AND RESOURCES ON MACRA

ACP wants to give internists and subspecialists the best chance possible to succeed in the QPP, be it through the MIPS or APM pathway. To that end, ACP has developed tools and resources

for its members to help them navigate through the QPP; chief among them is the Quality Payment Advisor®.

Quality Payment Advisor®

The Quality Payment Advisor® is an educational tool that is intuitive to the needs of clinicians participating in the QPP. This tool provides a systematic approach to succeed in the QPP by helping to determine who is eligible for the QPP, which reporting pathway is best, as well as assistance with quality measure/activity selection and implementation. Each question offers information and resources to guide the user through the algorithm toward understanding which pathway is most appropriate for their practice. The modules provide guidance and resources to select and implement measures and activities. It should be noted that this tool cannot help with all measures or activities but to the extent possible the ACP hopes that it proves to be useful in implementing quality measures and activities most commonly applicable to internal medicine and sub-specialty practices.

Top Ten Ways to Succeed under the QPP

In addition, ACP has created a host of resources on the QPP, including a Top Ten list of things that clinicians should be doing to be successful under the QPP. This list provides ACP members with a roadmap to understanding and complying with all the demands and opportunities within the MIPS and APM pathways.

Conclusion

ACP greatly appreciates the subcommittee convening this hearing and for its 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 as implementation continues and to provide feedback whenever needed. Please contact Jonni McCrann at jmccrann@acponline.org with any questions or if additional information is needed.