



Statement

of the

American Medical Association

to the

U.S. Senate Committee on Finance
Subcommittee on Health Care

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

May 8, 2019

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The American Medical Association (AMA) appreciates the opportunity to present our views to the U.S. Senate Committee on Finance Subcommittee on Health Care. As the largest professional association for physicians and the umbrella organization for state and national specialty medical societies, the AMA has invested heavily in efforts to achieve successful implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

Since the enactment of MACRA, the AMA has worked closely with both Congress and the Centers for Medicare and Medicaid Services (CMS) to promote a smooth implementation of the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) under the Quality Payment Program (QPP). We continue to believe that MACRA represents an improvement over the flawed sustainable growth rate (SGR) payment methodology. However, the implementation of a new Medicare quality and payment program for CMS and physicians has been a significant undertaking, and further refinements are still needed to improve the program and reduce administrative burden for physicians.

MACRA included modest positive payment updates in the Medicare Physician Fee Schedule, but it left a six-year gap from 2020—next year—through 2025 during which there are no updates at all. Following this six-year freeze, the law specifies physician payment rate updates of 0.75 percent or 0.25 percent for physicians participating in APMs or MIPS, respectively. By contrast, other Medicare providers will continue to receive regular, more stable updates.

The recent *2019 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (Medicare Trustees Report)* found that scheduled physician payment amounts are not expected to keep pace with the 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.”¹ The AMA agrees and urges Congress to replace the upcoming physician payment freeze with annual positive payment updates over the next several years to provide physicians with a

stable and sustainable revenue source that allows them a margin to invest in practice improvements in order to transition to more efficient models of care delivery to better serve Medicare patients.

One goal of MACRA was to provide physicians with a glide path to transition into APMs. To help facilitate this transition, Congress provided a five percent bonus for physicians who participate in Advanced APMs during the first six years of the program. Unfortunately, through the first three participation years—half the time this bonus was to be available—few physicians have had the opportunity to participate in Advanced APMs. Consequently, the AMA is urging Congress to extend the Advanced APM bonus payments to fulfill Congress’ original intent and provide support to physicians as they transition to new payment models.

In addition to a sustained glide path to allow physicians to transition to APMs, the AMA urges Congress and CMS to continue to make MIPS more meaningful for physicians. We hear from our physician members that there is no link between many of the MIPS measures they are required to report and improving clinical care for their patients. The AMA has engaged the physician community through workgroups to develop creative solutions to simplify and streamline the QPP, while making it more meaningful for physicians. We look forward to working with Congress and CMS to implement some of these creative solutions and continue to improve MIPS.

Improvement Over Legacy Programs

The AMA was supportive when Congress replaced the flawed, target-based SGR formula with a new payment system under MACRA in 2015. Scheduled payment cuts prior to the implementation of MACRA exceeded 20 percent. Those cuts would have had a devastating impact on physician practices and patient access to care. Under MACRA, the SGR formula was replaced with specified payment updates for 2015 through 2019 and for 2026 and beyond. MACRA also created an opportunity to address problems found in existing physician reporting programs. In addition, the law sought to promote innovation by encouraging new ways of providing care through APMs.

Support for Technical Corrections

The AMA strongly supported the changes to MACRA in the Bipartisan Budget Act of 2018 (BBA18). These technical changes helped many practices avoid penalties that they likely would otherwise have incurred under the MIPS program. Specifically, we commend Congress for excluding Medicare Part B drug costs from MIPS payment adjustments, as including these additional items and services created significant inequities in the administration of the MIPS program. In addition, we appreciate the flexibility given to CMS to reweight the Cost performance category to not less than ten percent for the third, fourth, and fifth years of MIPS, and to set the performance threshold for three additional years. As Congress intended, we believe the goal of the program should be to help physicians succeed, not to cause physicians to fail, and we believe these technical changes, along with other changes, will allow CMS to increase the program requirements gradually and transition to a more meaningful program over time.

We also appreciated the BBA18 provision that allowed the Physician-focused Payment Model Technical Advisory Committee (PTAC) to provide initial feedback to proposal submitters. Unfortunately, the PTAC has indicated that it is still not able to provide technical assistance and data analyses to stakeholders who are developing proposals for its review. Additional technical corrections may be needed to provide the PTAC with more flexibility in this regard.

Support for Small and Rural Practices

The AMA appreciates the accommodations for small practices that are included MIPS. Specifically, the low-volume threshold exemption excludes numerous small practices or physicians who see very few Medicare patients. In 2018, physicians with annual Medicare allowed charges of \$90,000 or less or 200 or fewer Medicare patients were exempt from the QPP altogether. In 2019, CMS extended the low-volume threshold to physicians who provide 200 or fewer covered professional services to Medicare Part B beneficiaries. The AMA has also supported reduced reporting requirements for small practices, hardship exemptions from the Promoting Interoperability MIPS performance category for qualifying small practices, bonus points for small practices, and technical assistance grants to help small and rural practices succeed in the program.

Despite these improvements, the AMA and our physician members still have significant concerns regarding the ability for small and rural practices to succeed in the MIPS program. In 2017, the national mean and median scores for all MIPS eligible clinicians were 74.01 and 88.97 points. However, the mean and median scores for rural and small practices were 43.46 and 37.67, and 63.08 and 75.29, respectively. Given the lower scores achieved by small and rural practices compared to all MIPS eligible clinicians, the AMA urges Congress and CMS to continue to implement policies that help small and rural physician practices succeed in MIPS.

Glide Path into APMs

Extend the Advanced APM Bonus

MACRA was intended to create a gradual glide path to move physicians into more innovative value-based care payment models. Changing the way physicians deliver care requires significant investment into new technologies and workflow systems. In order to help physicians implement these changes, MACRA provided a five percent bonus for the first six years of the program for physicians who participate in an Advanced APM. These bonus payments were intended to create a margin for physicians to invest in changing the way they deliver care. We heard from many physician groups who were excited to take advantage of the opportunity to move to an Advanced APM.

Unfortunately, there were a limited number of Advanced APMs in which physicians could participate during the first three MACRA performance years, and there are only three years left in the program for physicians to receive an APM bonus. The dearth of Advanced APMs available for physicians limited their ability to take advantage of the APM bonus that Congress provided to assist physicians with moving to new, innovative payment models.

The AMA is greatly encouraged by the recent steps taken by Department of Health and Human Services Secretary Azar, CMS Administrator Verma, and Center for Medicare and Medicaid Innovation (CMMI) Director Boehler. They are working to implement and further develop new models based on stakeholder proposals to the PTAC. We believe there will be increased opportunities for physicians in various practice group sizes and specialties to participate in Advanced APMs as CMMI continues to release new models. However, given the small number of physicians who have been eligible to receive the APM Qualified participant (QP) bonus to date, the AMA strongly urges Congress to extend the APM bonus for an additional six years to provide physicians a realistic onramp to participation in value-based care. As CMMI continues to test and develop new models, the AMA hopes that physicians will have access to APMs that give them the resources and flexibility to redesign the delivery of patient care and support their efforts to achieve good health outcomes.

Modify Thresholds to Achieve QP Status

In addition to extending the period of time that the QP bonus payments are available to APM participants, the AMA recommends that Congress revisit the payment thresholds set by MACRA. Under current law, these thresholds escalate from 25 percent to 75 percent of APM participant revenues over a five-year period. Many APM participants are concerned that these thresholds are too high, especially for episode-based APMs. MACRA set the payment thresholds but gave limited authority to CMS to set patient thresholds to achieve QP status. The AMA recommends that CMS' statutory authority be expanded so it can set both the payment and patient thresholds for QP status and could set different thresholds for different types of APMs.

Further Improvements are Needed

The AMA urges Congress to make additional technical changes to MACRA to simplify the program and make reporting more clinically meaningful for physicians. We were pleased CMS established transition policies for the first year of MIPS and, as a result, 93 percent of eligible clinicians received a modest positive payment adjustment and nearly three-quarters qualified for an additional exceptional performance bonus. However, we continue to hear from physicians that the program needs to be streamlined and more clinically relevant. To assist Congress and CMS in making the program cohesive and meaningful to physicians and patients, the AMA convenes MIPS and APM workgroups made up of representatives from across the physician community, which have developed creative solutions to improve the QPP. These solutions include ways to simplify scoring, create more integrated approaches to reporting across performance categories, and improve the physician reporting experience.

For example, Congress and CMS can make MIPS more cohesive and meaningful to physicians and patients by allowing physicians to focus their participation around a specific procedure, condition, or public health priority. By allowing physicians to focus on activities that fit within their workflow and address their patient population needs, rather than focusing on segregated activities that fit into the four disparate MIPS categories, the program could improve the quality of care and be more meaningful and less burdensome for physicians. The AMA has worked closely with the physician community to develop a streamlined MIPS participation option that would hold physicians accountable for the cost

and quality of care around a specific episode. For instance, a cardiologist could participate in a MIPS episode evaluating cost and quality using valid and reliable measures, as well as health IT use, around Percutaneous Coronary Intervention procedures and primary care physicians could focus on lowering costs and improving quality by maximizing patient engagement through a Patient-Centered Medical Homes. This participation option in MIPS would also be a bridge to APMs by giving physicians an opportunity to gain experience and see their data before taking on financial risk in a bundled payment or advanced primary care model.

Additional suggestions for technical changes to improve MACRA from the workgroups include:

- updating the Promoting Interoperability performance category to allow physicians to use certified electronic health record technology (CEHRT) in more clinically relevant ways;
- developing a separate threshold for small and rural practices to ensure a level playing field for all physicians;
- prioritizing cost measures that are valid and actionable and that have stronger correlation between costs and the physicians' influence over those costs;
- incentivizing reporting on new quality measures, especially specialty developed and recommended measures;
- eliminating the requirement to set the performance threshold at the mean or median so CMS, rather than a pre-set formula, can determine whether physicians are ready to move to an increased threshold based on available data; and
- aligning and improving the methodologies of MIPS calculations and Physician Compare. Currently, physicians receive two different scores and reports, which is confusing to physicians and patients and does not lead to quality improvement.

The QPP is a complex program that remains complicated for CMS to implement and difficult for physicians to understand; however, the AMA is confident that if Congress, CMS, and the medical community continue to work together to improve the program, we can ensure physicians have the opportunity to be successful and provide high value care to patients.

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

ⁱ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. (April 22, 2019). *2019 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. Retrieved from <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Trustees-Reports-Items/2016-2019.html>