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October 31, 2022

The Honorable Ami Bera, MD
U.S. House of Representatives
172 Cannon House Office Building
Washington, DC 20515

The Honorable Earl Blumenauer
U.S. House of Representatives
1111 Longworth House Office Building
Washington, DC 20515

The Honorable Larry Bucshon, MD
U.S. House of Representatives
2313 Rayburn House Office Building
Washington, DC 20515

The Honorable Brad R. Wenstrup, DPM
U.S. House of Representatives
2419 Rayburn House Office Building
Washington, DC 20515

The Honorable Kim Schrier, MD
U.S. House of Representatives
1123 Longworth House Office Building
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The Honorable Bradley Schneider
U.S. House of Representatives
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The Honorable Michael C. Burgess, MD
U.S. House of Representatives
2161 Rayburn House Office Building
Washington, DC 20515

The Honorable Mariannette Miller-Meeks, MD
U.S. House of Representatives
1716 Longworth House Office Building
Washington, DC 20515

Dear Representatives Bera, Bucshon, Schrier, Burgess, Blumenauer, Wenstrup, Schneider, and Miller-Meeks:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to respond to the Congressional Request for Information (RFI) on strategies for Medicare payment reform that Congress should consider to stabilize the Medicare physician payment system (MPS). The AMA shares your concerns with the flaws in the current MPS and applauds you for recognizing the important need for systemic reforms. Reforming the MPS continues to be our top advocacy priority.

The AMA is deeply alarmed about the growing financial instability of the MPS due to a confluence of fiscal uncertainties physician practices face related to statutory payment cuts, lack of inflationary updates, the ongoing impact of the pandemic, and significant administrative barriers. The MPS is on an unsustainable path that is jeopardizing patient access to physicians.

The AMA is engaged with our national specialty and state medical association Federation partners to determine the best path forward to lead the MPS to a more sustainable track. The AMA, along with our Federation partners, developed the Characteristics of a Rational Medicare Physician Payment System, endorsed by over 120 state medical and national specialty societies, including those representing primary care, surgical care, and other medical specialties. These core set of principles serve as the basis for

reforming the broken physician payment system. We are also working to increase awareness of the problems in the current system among Members of Congress and look forward to working with you to seek permanent solutions.

This letter will address the following requested topics:

A. The effectiveness of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA);
B. Regulatory, statutory, and implementation barriers that need to be addressed for MACRA to fulfill its purpose of increasing value in the U.S. health care system;
C. How to increase provider participation in value-based payment models; and
D. Recommendations to improve Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) programs.

## A. The effectiveness of MACRA

The physician community stands ready to work with Congress to develop long-term solutions to the systemic problems with the MPS in order to preserve patient access to care. We appreciate that Congress passed the Protecting Medicare and American Farmers from Sequester Cuts Act and delayed for 12 months a "perfect storm" of Medicare payment cuts that, if enacted, would have severely impeded patient access to care. Unfortunately, these delayed cuts combined with some new payment reductions, will take effect in 2023, absent Congressional intervention.

As a result, before the end of the year, we strongly urge Congress to:

- Provide relief from the scheduled -4.42 percent budget neutrality cut in Medicare physician fee schedule payments;
- End the MACRA mandated annual freeze to the Conversion Factor and provide a Medicare Economic Index (MEI) update for the coming year;
- Extend the 5 percent APM participation incentive payments for six years, as well as halt the revenue threshold increase, which will have a chilling effect on participation, to encourage more physicians to transition from fee-for-service into APMs; and
- Waive the 4 percent Medicare cuts associated with the Statutory PAYGO sequester triggered by passage of the American Rescue Plan Act.

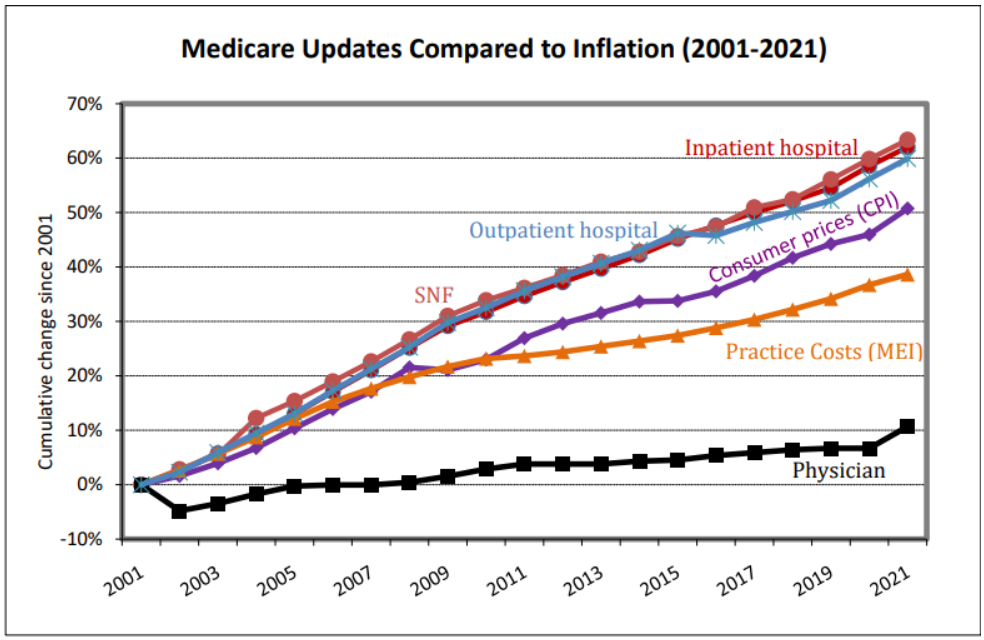
**Recommendation**

- At a minimum, Congress must establish a stable, annual Medicare physician payment update that keeps pace with inflation and practice costs and allows for innovation to ensure Medicare patients continue to have access to physician practice-based care.

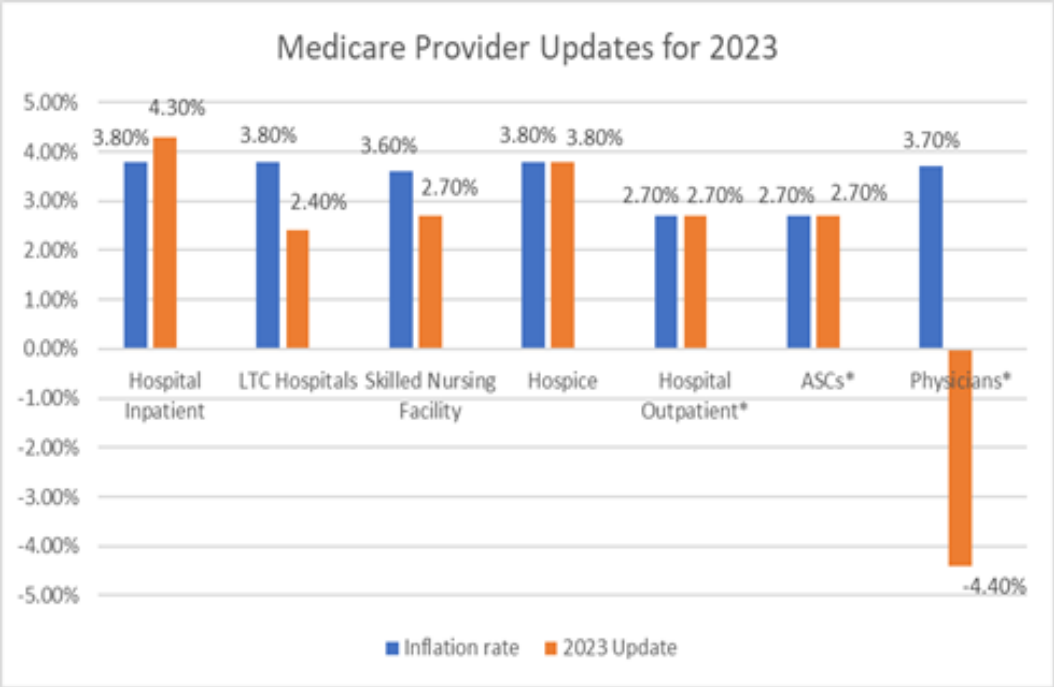
1. **Need for inflationary based updates to physician payment**

MACRA repealed the Sustainable Growth Rate (SGR) and instituted significant reforms to Medicare by shifting the program's approach to physician payment—paying physicians and other health professionals based on quality, value, and the results of care delivered rather than the number of services provided. Unfortunately, logistical challenges have plagued MACRA almost since its inception. In its 2021 annual report, the Medicare Trustees expressed concern that, although the physician payment system put in place in 2015 avoided the significant short-range physician payment issues, it "nevertheless raises important long-range concerns that will almost certainly need to be addressed by future legislation." The Trustees noted, for example, that "the law specifies the physician payment updates for all years in the future, and these updates do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases."

The Medicare physician payment system lacks an adequate annual physician payment update, unlike those that apply to other Medicare provider payments. As indicated in the charts below, physicians are the only Medicare provider not receiving an inflationary update in 2023. This is particularly destabilizing as physicians, many of whom are small business owners, contend with a wide range of shifting economic factors when determining their ability to provide care to Medicare beneficiaries.




Sources: Federal Register, Medicare Trustees' Reports and U.S. Bureau of Labor Statistics

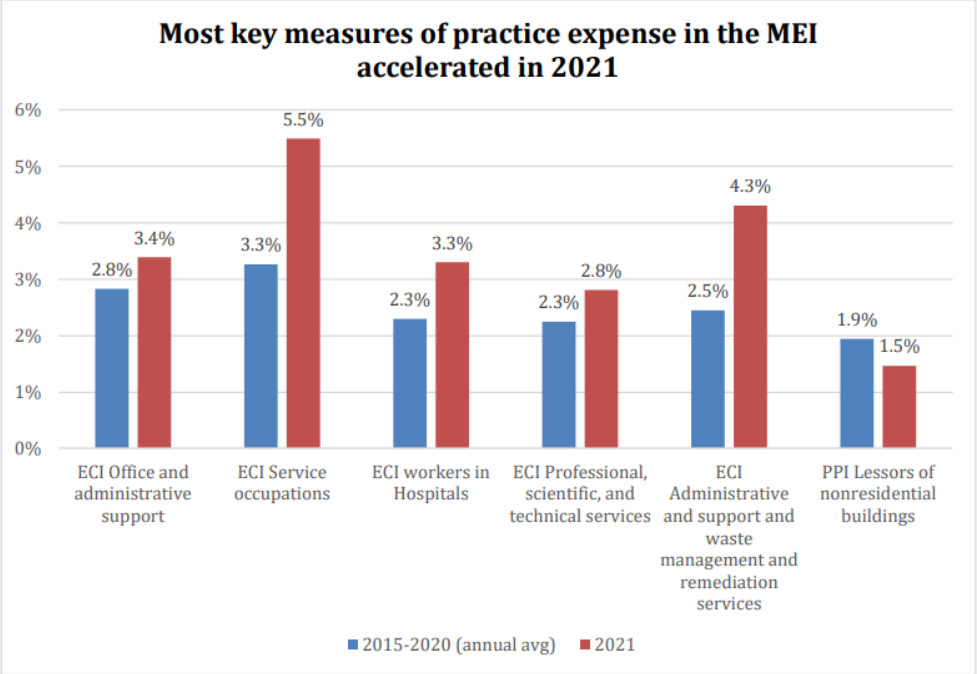



Adjusted for inflation in medical practice costs, as measured by the MEI, Medicare physician payment rates declined 20 percent from 2001 to 2021.

In addition, Medicare spending per enrollee has been falling for physician payment schedule services even as it has risen steeply for other Medicare benefits.

Furthermore, a freeze in annual Medicare physician payments, as mandated by MACRA, is scheduled to last until 2026, when updates resume at a paltry rate of only 0.25 percent a year indefinitely, well below the rate of medical or consumer price index inflation. Current government data on key elements of the MEI make it clear that, without an inflation-based update, the gap between frozen physician payment rates and rising inflation in medical practice costs will widen considerably.

Employment Cost Index (ECI) and Producer Price Index (PPI) data from the U.S. Bureau of Labor Statistics indicate that growth in key contributors to the MEI is much higher now than in previous years, which threatens to significantly widen this gap.



Source: U.S. Bureau of Labor Statistics

Medicare payment rates for all Medicare services except those on the physician payment schedule, such as inpatient and outpatient hospital services and skilled nursing facility services, have updates tied to inflation. Physician payment rates have been further eroded by the manner in which rates are adjusted to meet budget neutrality requirements, as well as Medicare sequestration. **At a minimum, Congress must establish a stable, annual Medicare physician payment update that keeps pace with inflation and practice costs and allows for innovation to ensure Medicare patients continue to have access to physician practice-based care.**

## 2. Budget Neutrality

*Reconciliation of Budget Neutrality*

CMS actuaries have on occasion grossly overestimated the impact of Relative Value Units (RVUs) changes in the fee schedule, resulting in permanent removal of billions of dollars from the payment pool. For example, a previous administration based the 2013 budget neutrality offset for Transitional Care Management (TCM) on a significantly greater estimate of initial utilization of the service than what actually occurred. At that time, CMS estimated there would be 5.6 million claims for TCM when actual utilization was just under 300,000 the first year and still less than one million after 3 years of implementation. For 2013, the Obama Administration reduced Medicare physician fee schedule spending by more than $700 million based on its overestimate of TCM utilization. Similarly, CMS overestimated

Chronic Care Management (CCM) utilization when adopting that code one year later (4.7 million estimated claims versus 954,000 in the first year).

The overestimates of the utilization for TCM and CCM and the budget neutrality adjustments resulted in permanent reductions in Medicare Physician Fee Schedule (MPFS) payments disadvantaging physicians. On the horizon, there is the potential for a further overestimate of utilization for an add-on code for "inherently complex" Evaluation and Management (E/M) services. While Congress passed a moratorium on implementation of this code until 2024, CMS believes this service will be billed 100 percent of the time when billable. This assumption is highly speculative given CMS' past overestimates of TCM and CCM utilization.

Given the statutory authority for budget neutrality adjustments to be made "to the extent the Secretary determines to be necessary," current law allows CMS to account for past overestimates of spending when applying budget neutrality. **Congress should consider requiring a look-back period (as have been implemented in other payment systems) that would allow the Agency to correct for overestimates and return inappropriately reduced funding back to the payment pool.**

*Raising the $20 million Budget Neutrality Trigger*

The $20 million threshold that establishes whether RVU changes trigger budget neutrality adjustments was established in 1989—three years before the MPFS took effect. There have been no adjustments for inflation. As a result, the amount should be increased to $100 million to best account for past inflation.

*Services Exempt from Budget Neutrality Adjustments*

Benefits or services for which utilization is expected to increase due to changes in law or regulations should be exempt from budget neutrality adjustments, including:

- Newly covered Medicare services (e.g., A&B scores from the United States Preventive Services Task Force related to preventive services, new types of facilities or health professional services added to the MPFS);
- Services that are being incentivized (e.g., physician bonuses, or no patient copay to encourage update of preventive services);
- Services specifically designed to be used within an APM that are already intended to lower Medicare expenditures;
- Benefit or access expansions (e.g., telemedicine); and
- New technology (i.e., things that could not be done before, like remote patient monitoring).

**B. Regulatory, statutory, and implementation barriers that need to be addressed for MACRA to fulfill its purpose of increasing value in the U.S. health care system**

**1. Merit-based Incentive Payment System**

Since the enactment of MACRA, the AMA has worked closely with Congress and the Centers for Medicare & Medicaid Services (CMS) to promote a smooth implementation of MIPS. We supported MACRA's goals to harmonize the separate, burdensome, and punitive Meaningful Use, Physician Quality Payment System, and Value-Based Payment Modifier programs. However, the implementation of a new Medicare quality and payment program for CMS and physicians has been a significant undertaking, which was disrupted by the COVID-19 pandemic, and further refinements are still needed to achieve the goals of MACRA and reduce administrative burden for physicians.

MIPS was largely paused in 2020, 2021, and to a lesser degree 2022, due to the COVID-19 pandemic. The AMA strongly advocated for and supported policies to hold physician practices harmless from penalties as physicians cared for patients with COVID-19 during multiple surges, postponed non-essential procedures, and transitioned to telehealth when feasible. While we supported these much-needed flexibilities, it means that MIPS was disrupted during four of the first six years of the program.

As MIPS requirements resume in full following what was hopefully the worst of the COVID-19 pandemic, CMS expects a substantial rise in the number of physicians who will receive MIPS financial penalties. In the 2023 MPFS proposed rule, CMS estimates one-third of eligible clinicians will receive a financial penalty averaging -1.64 percent starting on January 1, 2025, based on 2023 performance. These penalties are likely to disproportionately impact small and rural practices, as well as practices that care for low-income patients. The maximum MIPS financial penalty is -9 percent, and CMS expects that 16,614 eligible clinicians who will receive the maximum penalty will be in small practices. How will these small practices continue to see Medicare beneficiaries and keep their lights on when they have only begun to recover from the financial hardships of COVID-19, face rising costs, substantial staffing problems, and will face a nearly 10 percent cut to their Medicare payments?

In addition to the dire warnings about the increase in MIPS penalties, there is mounting evidence that the program, as implemented, is causing significant burden; raising costs for physician practices; disadvantaging small, independent, and rural practices; and exacerbating health inequities. Below is a summary of the additional problems with the program:

- MIPS is administratively burdensome and costly.
    - Researchers found it costs $12,811 and 201 hours per physician, per year to comply with the complex and ever-changing MIPS requirements, and, on average, physicians themselves spent more than 53 hours per year on MIPS-related tasks. These 53 hours are equivalent to a full week of patient visits.
- MIPS disadvantages small and independent practices.

    - According to a study in *JAMA*, MIPS eligible clinicians affiliated with a health system were associated with significantly better 2019 MIPS performance scores.
- MIPS exacerbates health inequities.
    - According to a study in *JAMA* that looked at the first year of MIPS, physicians with the highest proportion of patients dually eligible for Medicare and Medicaid had significantly lower MIPS scores compared with other physicians.
- MIPS may penalize physicians for social factors outside of their control and, due to budget neutrality requirements, transfer resources from those caring for poorer patients to those caring for more affluent patients. Rural and medically underserved practices face challenges participating in MIPS.

    - Physicians in rural and medically underserved areas face several barriers to participating in MIPS, including lack of technology; lack of vendor support and high costs of ongoing investments needed for participation, staffing shortages, and challenges staying abreast of program requirements. According to another GAO report, similar challenges limit rural practices' ability to transition to APMs, meaning they are largely stuck in MIPS.

Since the passage of MACRA, the AMA has made numerous recommendations to CMS to make MIPS more clinically relevant and less burdensome, including in letters, town halls, and meetings with CMS staff. We have made progress where CMS has statutory authority and flexibility, such as increasing the low-volume threshold or reducing the total number of required measures in the forthcoming MIPS Value Pathways (MVPs). However, we have run into statutory roadblocks when we have recommended more impactful improvements to MIPS. In particular, we wish to bring to your attention the following statutory barriers that need to be addressed for MACRA to fulfill its goal of increasing value in the U.S. health care system:

- Expiration of the $500 million funding for exceptional performance in the 2023 performance period and corresponding 2025 payment year.
- Expiration of funding for the Small, Underserved, and Rural Support (SURS) program on February 15, 2022.
- Budget neutrality in MIPS limits CMS' ability to incentivize new measures and new participation options, such as a new payment pathway that could serve as a bridge to an alternative payment model.
- Requirements in the Cost Performance Category, such as mandating an increase to the weight of this category after cost measures were unable to be measured during the COVID-19 pandemic and holding physicians accountable for costs outside of their control, which detract from cost measures that are valid and actionable.

- Overly narrow definition of a meaningful user of health information technology, which should be expanded to include technology that interacts with certified electronic health record technology (CEHRT) and qualified clinical data registries.
- Two separate evaluations of a single quality measure in the MIPS quality performance category versus Physician Compare in addition to no alignment in the benchmark methodologies between MIPS and Physician Compare programs.

Several of the statutory constraints in MACRA stem from the statute's specificity and lack of flexibility for CMS to incentivize movement away from a check-the-box compliance program toward one that supports changes in care delivery to improve patient outcomes and reduce unnecessary costs, which may create a glidepath to participation in APMs if they are an option for all physicians regardless of specialty, practice size, and geographic location. Specifically, the AMA points to the following statutory constraints where CMS needs greater flexibility to:

- Set the performance threshold based on current data and circumstances, rather than a pre-set formula.
- Tie together quality, cost, health information technology (promoting interoperability), and clinical improvements together as appropriate, rather than requiring separate reporting and using separate scoring methods in four siloed components of MIPS.
- Test and incentivize new or significantly refined measures or methods of participation, such as MVPs, and allow for alternative benchmarking and scoring approaches, such as pay-for-reporting.

In addition, physicians and specialty societies need timely access to their claims data analysis to identify variations in spending that are not accounted for by differences in patient needs and to eliminate unnecessary costs.

The AMA makes detailed recommendations in Section D about opportunities to remove these statutory impediments to get closer to achieving the goals of MACRA to move toward value-based care while reducing administrative burden on physicians.

### C. How to increase physician participation in value-based payment models

**Recommendations:**

- Congress should pass H.R. 4587, the Value in Health Care Act, which would extend the Advanced APM incentive payments created under MACRA for an additional six years and authorize the Secretary to set the revenue threshold for physicians to be eligible for these incentive payments. Absent Congressional intervention, 2022 marks the last year physicians are

eligible to qualify for an APM incentive payment and the associated revenue thresholds jump from 50 percent to 75 percent on January 1, 2023.

- Congress should work with the Administration to increase opportunities for physicians in all specialties and types of practice to voluntarily participate in well-designed, patient-centered APMs, including development of a pathway to permit people with Medicare to access health care through stakeholder-developed APMs such as those recommended by the Physician-Focused Payment Model Technical Advisory Committee (PTAC).

**1. Advanced APM Incentive Payments Need to Be Continued**

One of the most important criteria for physicians in deciding whether to participate in an APM is whether the APM will give them the ability to deliver higher-quality care to their patients than is possible under current payment systems. The current payment system creates many barriers that prevent physicians from improving care for their patients. One barrier is that there is often no payment available to support the kinds of services that would improve outcomes and reduce unnecessary spending.

For example, many patients who come to an emergency department with symptoms, such as chest pain or syncope, could return home instead of being admitted to the hospital if the emergency physician could be sure the patient would receive the necessary assistance to return home safely, and that the patient would receive prompt follow-up care from a primary care physician. Medicare does not pay emergency physicians for the time needed to: locate the patient's primary care physician and develop a coordinated discharge plan; help identify community-based health and social services for the patient; or hire a nurse or community health worker to help the patient return home safely. As a result, the only safe option may be for the emergency physician to admit the patient to the hospital.

The American College of Emergency Physicians developed an APM proposal to fix this problem by paying for these discharge planning and transitional care services. Although the proposal was unanimously endorsed by the PTAC, which was created by MACRA, the model has not been implemented. As a result, patients continue to be admitted to the hospital who might otherwise have been safely discharged to their home. In addition to undermining efforts by physicians to be good stewards of scarce Medicare resources, failure to implement this policy proposal will likely disproportionately affect patients with health-related social needs and contributes to health inequities.

This emergency medicine model is just one of 19 APM proposals that the PTAC recommended for further development, testing or implementation. CMS, unfortunately, to date has elected not to pursue a single APM proposal ultimately endorsed by the PTAC. There is still no nationwide Medicare primary care medical home model, and there are no APMs available for many of the conditions, episodes of care, or patient populations that many physicians manage. In addition, the APMs that have been implemented often do not really address the barriers in the current payment system.

The five percent incentive payments for participants in Advanced APMs have been a key factor in physicians' interest and even in their ability to participate in APMs. Without these incentive payments, many physicians could not otherwise cover the costs of APM participation, cover the costs of providing services that are necessary for APMs to meet their care improvement goals, handle the downside financial risk, or deal with the revenue reductions that can occur from reducing avoidable services.

**2. How the Incentive Payments Support APM Participation**

The AMA has significant concerns with regards to the negative consequence of allowing the APM incentive payments created under MACRA to expire at the end of the year. It is important for Congress to pass Section 4 of H.R. 4587, the Value in Health Care Act, which would extend the incentives for an additional six years, from 2025 through 2030. H.R. 4587 has 40 bipartisan cosponsors, most of whom joined as cosponsors in the last six months.

For physicians participating in many of the current Medicare APMs, the five percent APM incentive payments have been the only way they can be paid for delivering high-value services that are not supported by the Medicare physician payment schedule. In addition, reductions in the number of services provided when physicians are able to prevent diseases and avoid complications and exacerbations can lead to revenue losses under the payment schedule which the incentive payments can help to offset.

Physicians also face significant transition costs participating in APMs. For example, even if an APM pays for delivery of enhanced services to patients that the payment schedule alone does not adequately support, the physician practice will still have to recruit, hire, and train staff to perform those functions, which requires incurring significant costs before services and payments can begin. APM participants also make investments in data analytics, technology, and other improvements that allow them to effectively participate in the APM that the incentive payments help to offset.

Section 4 of H.R. 4587 also authorizes CMS to set the APM revenue percentages that participants in Advanced APMs must meet to be eligible for the incentive payments. The most recent report from CMS on these thresholds shows that the MACRA mandate to generate at least 75 percent of their revenue from their APM that take effects in 2023 under current law would be unattainable for many Advanced APM participants. Even participants in the largest Advanced APM model, Medicare Shared Savings Program accountable care organizations (ACOs), had an average revenue score of just 49 percent. For the Bundled Payments for Care Initiative Advanced model, the average score was just eight percent.

<u>Expand Opportunities for APM Participation</u>

Medicare's APM programs need to be modified. Like the MIPS program to date, too often APMs are designed in ways that only allow practices that are part of large health systems to participate. Financial risk requirements are too steep and administrative requirements are difficult for small and medium size practices to fulfill. In addition, episode-focused models begin after a patient has been admitted to the hospital or started chemotherapy without including opportunities for patients to benefit from APMs that

are designed to support physicians preventing hospitalizations and managing chronic conditions in outpatient settings. Medicare APMs should include payments for new services and funding for transitional costs so that physicians can implement better approaches to care delivery. They should also allow greater flexibility in the way services are delivered by supporting hybrid models that blend in-person and virtual services. Importantly, Congress and the Administration should work together to develop a viable pathway for physician practices to voluntarily participate in pilot programs of APM proposals developed by stakeholders, such as those recommended by the PTAC.

APMs should also be designed in a way that enables physicians in each specialty to deliver specialty-specific services for the kinds of patients those physicians treat on a voluntary basis. The AMA has developed a method for doing this within an ACO model that is called Payments for Accountable Specialty Care, (PASC). Under PASC, a specialist could receive an enhanced payment for delivering specific types of services to patients who are referred by primary care physicians participating in the ACO. Agreements between specialists and ACOs would describe how the specialist would use these enhanced payments to improve outcomes and/or reduce avoidable spending. Health equity would be improved by providing higher payments to help support care for patients who have complex conditions or who are at higher risk for poor outcomes due to health-related social needs or other factors.

### D. Recommendations to improve MIPS and APM programs

The AMA strongly believes that Congress must amend MIPS to allow a more flexible approach to incentivizing quality improvements and reducing unnecessary costs, while addressing health inequities. The check-the-box requirements and zero-sum game of the existing MIPS program doom it to failure. The MIPS MVPs, which aim to hold physicians accountable for the quality and cost during an episode of care, around a specific condition, or for a public health priority, represent an opportunity for improvement. Unfortunately, due to statutory barriers, MVPs are repeating the same mistakes as the traditional MIPS program.

Below, we offer nine recommendations to address the fundamental flaws in MIPS, allow MVPs to improve the clinical relevance of MIPS and provide a bridge to transition to APMs, and promote the intended goals of MACRA to improve quality, reduce costs, and leverage health information technology in Medicare while reducing burdens.

#### 1. Congress should extend the $500 million exceptional performance bonus and the SURS program.

The AMA opposes the application of budget neutrality in Medicare physician payment, including MIPS payment adjustments. Budget neutrality in MIPS means penalizing small and independent practices, as

well as practices that care for a high proportion of dually eligible Medicare and Medicaid patients,[1] to fund incentives for large health systems that have the staff and technological resources to manage and report metrics to CMS.[2] There is no evidence that this reverse Robin Hood effect improves outcomes for patients and common-sense dictates otherwise. In fact, these findings position MIPS directly counter to the current Administration's goal to improve health equity. Continuation of the $500 million exceptional performance bonus is crucial to eliminating the need for budget neutrality within the MIPS program.

However, there must be incentives to participate in MIPS. The costs and time spent by physicians each year to participate in this complex and ever-changing MIPS program are not sustainable.[3] To help ensure a return on investment in MIPS and to avert the Reverse Robin Hood effect of budget neutrality, the AMA urges Congress to extend the $500 million exception performance bonus, which expires at the end of this performance period.

In addition, SURS assistance is critical to ensure that small practices in rural and underserved areas have the support and tools necessary to succeed in the MIPS program. However, after five years of support, Quality Payment Program (QPP)-SURS ended on February 15, 2022, leaving physicians without a direct technical assistance program to help them navigate continuously changing regulations and increasing performance thresholds in MIPS. Allowing this critical infrastructure support to continue to lapse could further exacerbate disparities in communities already facing limited access to high-quality health care.

**2. Congress should establish a payment pathway bridge from MIPS to APMs and ensure there are APMs for physicians to join.**

Due to the narrowly defined MIPS and APM payment pathways under MACRA, there is no mechanism to incentivize the investments and infrastructure necessary to move from MIPS into an APM. Although CMS, the AMA, and the national medical specialty societies could envision MVPs playing this part, due to budget neutrality and separate statutory constructs for MIPS and APM participants, MVPs as currently designed are merely a rebranding of traditional MIPS. There are several statutory changes necessary to allow MVPs to function as a bridge between MIPS and APMs, including:

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[1] Khullar D, Schpero WL, Bond AM, Qian Y, Casalino LP. Association Between Patient Social Risk and Physician Performance Scores in the First Year of the Merit-based Incentive Payment System. *JAMA.* 2020;324(10):975–983. doi:10.1001/jama.2020.13129

[2] "Clinician affiliation with a health system was associated with significantly better 2019 MIPS performance scores. Whether this represents differences in quality of care or other factors requires additional research." Johnston KJ, Wiemken TL, Hockenberry JM, Figueroa JF, Joynt Maddox KE. Association of Clinician Health System Affiliation With Outpatient Performance Ratings in the Medicare Merit-based Incentive Payment System. *JAMA.* 2020;324(10):984–992. doi:10.1001/jama.2020.13136.

[3] Khullar D, Bond AM, O'Donnell EM, Qian Y, Gans DN, Casalino LP. Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System: A Qualitative Study. *JAMA Health Forum.* 2021;2(5):e210527. doi:10.1001/jamahealthforum.2021.0527.

- CMS should have the authority to create incentives for participation in a MIPS to APMs bridge payment pathway, such as an MVP, for at least the first two years like the glide path to risk in many APMs. At a minimum, physicians who participate should be held harmless from any downside risk. In the 2023 MPFS proposed rule, CMS would make it easier to form a Medicare Shared Savings Program (MSSP) ACO by providing up-front investments to qualifying physicians and by allowing up to seven years of upside-only financial risk. CMS should apply a similar logic to physicians participating in the bridge payment pathway between MIPS and APMs.
- CMS should be able to adjust payments to reflect the higher costs of caring for low-income patients and to address social determinants of health. As mentioned above, researchers have found that physicians with the highest proportion of patients dually eligible for Medicare and Medicaid had significantly lower MIPS scores compared with other physicians.[4] CMS should utilize the MIPS to APMs bridge payment pathway to correct for this disproportionate impact on physicians who care for these patients and the existing complex patient bonus in MIPS does not go far enough. Instead, CMS should ensure the payment adjustments reflect the differential cost of care for patients whose health and social determinants are intertwined.
- CMS should have the authority to test and adopt novel payment methodologies for participants in a third payment pathway of the QPP, which would serve as a bridge between MIPS and APMs. Many of the national medical specialty societies who are interested in a third QPP payment pathway have physician-focused payment models that have been evaluated by the PTAC and recommended for implementation. Those specialty societies should be able to work with CMS to incorporate unique aspects of those payment models into the third QPP payment pathway without being limited to up or down payment adjustments two years after the performance period. For example, if a third QPP payment pathway option is designed like a bundled payment model, then the payment methodology should allow for episode-based payments. This would help physicians prepare for the transition from MIPS to APMs and customize the payment methodology to match the corresponding cost and quality objectives.

Finally, while the goal is to have MVPs serve as a bridge to APM participation, with neither a nationwide, comprehensive primary care model nor specialist models widely available in Medicare, it is difficult to envision what is on the other side of the bridge. Congress must ensure that MVPs are a bridge to somewhere.

**3. Congress should require CMS to provide timely, actionable claims data analysis to physicians and provide technical assistance to help physicians translate that data into lower costs for the Medicare program and for patients.**

Physicians should only be held accountable for the costs that are within their control and should have timely access to their claims data analysis to be able to identify and reduce avoidable costs. Though

[4] *Id*. at 1.

Congress has taken action to give physicians access to their claims data, to date, physicians do not receive timely, actionable feedback on their resource use and attributed costs in Medicare. What is a lower-cost physician doing differently from a high-cost physician? For example, is it that they are better at care coordination? If we do not know the answer, we cannot achieve the goal of reducing avoidable costs and overuse. Physicians and specialty societies need access to their claims data analysis to identify variations in spending that are not accounted for by differences in patient needs and to eliminate unnecessary costs. Congress should require that CMS provide timely, actionable feedback about physicians' costs to physician practices. Congress should also establish a new technical assistance program to assist physician practices in understanding their resource utilization and how it varies from their peers. With this actionable feedback, specialty societies can target opportunities to reduce spending while improving quality through improving patient outcomes and other targeted measures.

4. **Congress should provide CMS flexibility to set performance thresholds based on data.**

CMS, as opposed to a statutorily mandated pre-set formula, is in a better position to determine each year whether physicians are ready to move to an increased performance threshold given that the Agency has access to all the previous year's performance data and can adjust based on unforeseen circumstances, such as the COVID-19 pandemic. CMS may also decide to establish different thresholds for small and large practices.

This flexibility is especially important as the COVID-19 pandemic has substantially disrupted MIPS implementation, and the program was largely paused between 2019 until 2022. When MIPS requirements ramp up in full in 2023, CMS estimates one-third of physicians will receive a MIPS financial penalty averaging -1.64 percent. These financial penalties will not be attributable to some drop in the quality of care or higher costs of care in 2023 versus 2022, but rather due to the lapse of COVID-19 flexibilities and increase in the reporting requirements in a zero-sum game. The AMA has relayed our significant concerns about the impact of these penalties on physician practices to CMS, but the Agency believes it is limited in its authority to avert this coming disaster. Congress must act now to give CMS the authority to set the MIPS performance threshold, which is the benchmark for avoiding a penalty, based on the current program data and circumstances as physicians emerge from a once-in-a-century pandemic to high inflation and a staffing crisis.

5. **Congress should enhance the cost performance category to target spending variability within the control of physicians.**

To allow CMS to prioritize cost measures that are valid and actionable, Congress should remove the requirement that episode-based cost measures account for half of all expenditures under Parts A and B. CMS should focus on episodes of care with high variability and potential high impact for change at the physician level. This could be accomplished by changing Social Security Act § 1848(r)(2)(D)(i) to read:

> *"(I) Establish care episode groups and patient condition groups~~, which account for a target of an estimated ½ of expenditures under Parts A and B.~~"*

In addition, Congress should remove the total cost of care measure requirement as the MIPS Total Per Capita Cost measure holds physicians accountable for costs outside of their control. Additional problems with the measure include patient attribution and validity. This change would also eliminate double counting of the same patient costs under multiple measures and move toward scoring measures that have stronger correlation between costs and the physicians' influence over those costs.

CMS should also be given greater flexibility to weigh the Cost performance category of MIPS appropriately as the current authority under the Bipartisan Budget Act of 2018 expired at the end of 2021. The COVID-19 pandemic rendered the cost measures unusable for the 2020 and 2021 performance periods due to a lack of accuracy and reliability. In other words, no physician was scored or received any information about their cost performance in 2020 or 2021. The last data that physicians received was about 2019 measures but since then, the Total Per Capita Cost and Medicare Spending Per Beneficiary measures were overhauled and CMS added 15 episode-based cost measures.

**6. CMS should have scoring flexibility to align quality, cost, health information technology, and improvement activities and reduce duplication.**

CMS should have explicit flexibility to base scoring on multi-category measures to make MIPS more clinically meaningful, reduce silos between each of the four MIPS categories (i.e., quality, cost, Promoting Interoperability, and Improvement Activities), and create a more unified program. This provision could also include the ability for CMS to award bonus points at the composite score level, which would allow for a simplified scoring methodology. This could be accomplished by adding language to Social Security Act § 1848(q)(2)(B)(v) stating:

> *"If a measure or activity satisfies multiple performance categories, an eligible clinician shall receive credit in each category for the measure or activity."*

The primary goal of this approach is to remedy three flaws in MIPS that have been cited by MedPAC and others as cause for repealing the program and to achieve our shared goals of rethinking MIPS so that it is streamlined and provides more opportunities to reward physicians for high-value care by:

- Tying quality, cost, health IT, and clinical improvement evaluations together as appropriate to incentivize physicians to spend more time with patients and on improving care;
- Reducing administrative burden by removing redundant and complex reporting requirements; and
- Creating a glide path towards participation in APMs by encouraging physicians to focus reporting on more clinically relevant measures and activities, improvement, and providing better value care to patients.

Multi-category credit is essential for successful implementation of MVPs—an option that CMS is implementing in MIPS with the potential to achieve Congress' goal in MACRA of moving from volume to value in Medicare. The cornerstone of MVPs involves specialty societies and other organizations with

the necessary expertise developing a framework that holds physicians accountable for improving patient health outcomes and lowering Medicare spending around a specific health condition, procedure, episode of care, or clinical priority area. Unfortunately, without multi-category credit flexibility, MVPs will fall victim to the traps of traditional MIPS and legacy programs by simply cross-walking related measures across the existing categories, continuing to fragment incentives and performance based on the unrelated and complex scoring regimes of the four categories.

**7. Congress should provide CMS flexibility to score and benchmark measures as appropriate and to test and incentivize new measures and MVPs to ensure successful implementation.**

To improve MIPS, CMS and stakeholders are developing MVPs that hold physicians accountable for quality of care and costs that the physician practice's performance can influence around a specific episode of care, condition, or health care priority, as opposed to total cost of care or large patient population measures which a particular practice has no ability to influence. CMS should have the flexibility to move to pay-for-reporting for the first two years a measure or MVP is introduced into the program and when significant refinements to the measure have been made, such as scientific evidence has changed, as well as increased flexibility to allow for alternative benchmark and scoring approaches. Precedent already exists for introducing measures via pay-for-reporting in other value-based purchasing programs. This would also incentivize MVP participation and reporting and developing new measures. Alternative benchmarking and scoring approaches may also facilitate a solution to a growing flaw in MIPS—quality and cost are scored independently. The goal of MVPs is to align all four MIPS categories toward improving their patients' care needs. CMS should have the authority to align benchmarks and scoring, as appropriate.

CMS currently benchmarks performance scores both in the quality and cost categories using 10 deciles and on only 12-months of performance data (note: there are some exceptions to the annual measurement period for some of the administrative claims-based quality measures). This approach limits CMS' ability to include measures that would be better suited to distinguishing outliers, events that are rare but important to patients' quality of life, and could misrepresent physician performance, particularly for the cost measures. CMS should be able to use different benchmarking approaches for individual measures and allow longer measurement periods when appropriate.

**8. Congress should update the Promoting Interoperability (PI) performance category.**

Physicians should be allowed to use CEHRT, or technology that interacts with CEHRT to be considered a meaningful user, or a qualified clinical data registry to participate in PI and be successful in MIPS. Doing so would engage clinicians who are non-patient facing and are currently exempt from the category (e.g., radiologists who use imaging equipment, but not EHRs). Likewise, facility-based clinicians who are currently exempt from the category due to lack of control over EHR decisions could potentially get credit for clinical data registry participation. Expanding MIPS to recognize technology that interacts with CEHRT, e.g., radiology information systems or telemedical platforms, would also reward physicians who seek to utilize emerging health information technology (health IT) for patient care, improve care

coordination, or contribute data for public health, medical research, and quality analysis purposes. This would require a new clause in 1848(o)(2)(A):

> *(iv) ADDITIONAL TECHNOLOGY – The eligible professional may choose whether to use certified EHR technology, technology that interacts with certified EHR technology, or may participate in a qualified clinical data registry (or a combination of all three technologies), to be considered meaningful EHR user.*

Additionally, Congress should direct CMS to utilize the authority it granted to the Secretary through HITECH to permit reporting in PI through yes/no attestation. Doing so would add value to the PI program because doctors would tell CMS which EHR activities are truly useful in practice as opposed to those performed simply to meet reporting program requirements. Reporting PI participation through yes/no attestations would be a major step in removing the "check-the-box" reporting requirements currently in PI. In turn, health IT developers would prioritize innovation rather than functions of little clinical importance. This can be accomplished by adding the following to 1848(q)(2)(B)(iv):

> *"For the performance category described in (A)(iv), the requirements shall be met via a yes or no attestation or other less burdensome means."*

**9. Congress should align comparisons in the MIPS Quality performance category and Physician Compare.**

Physicians are currently evaluated on two different standards for a single quality measure. One for the Physician Compare program and another for the Quality performance category of MIPS. Congress should align the legislative language around the Quality performance category and Physician Compare to reduce physician burden of having to understand two separate benchmarking methodologies and ensure consistent scoring and comparisons across programs.

<u>Long Term Improvements—Re-envisioned Quality Measurement and Improvement System</u>

The current approach to quality measurement and improvement is overly burdensome and increasingly complex, unstable and does not truly evaluate the profession's goals of improved patient care and overall quality of life. The effort is also limited in its usefulness for informing a patient when making decisions about their care. The ultimate purpose of quality measurement should be to partner with patients to achieve their goals and drive informed physicians and team members to improve outcomes, both for individuals as well as the overall population.

We must move away from a "one-size fits-all" model where quality is assessed for individual physicians using often disparate metrics. Preferably, this re-envisioned framework would be holistic and transition to one that evaluates physicians and practices based on the outcomes achieved. At a high level, a re-envisioned quality measurement and improvement system would:

- Shift the primary focus from reporting of disparate measures in order to meet reporting requirements to incentivizing quality improvement;
- Leverage existing efforts (e.g., certification programs, registries) with demonstrated improvements in care, promote innovative digital technologies, and minimize reporting burden;
- Define quality based on the care continuum that patients experience;
- Enable the profession to identify gaps for improvement, implement measures and activities that promote high quality care, and track progress on addressing these gaps; and
- Evaluate the model's effectiveness periodically.

This model would allow for a phased implementation to encourage adoption of value-based care arrangements by transitioning from silos of care toward holding physicians accountable for patient outcomes, allowing physician specialties to focus efforts and apply uniform measures across payers. It would facilitate and encourage flexibility and enable measurement to be aggregated to the level for which the clinical action is most appropriate (e.g., group, care team), while also promoting shared accountability across physicians, specialties, facilities, and other care settings.

In conclusion, the AMA appreciates the opportunity to work with Congress to provide input on the vital issue of the stability of our Medicare Physician Payment System. Without needed reforms, we are on a collision course with a payment system that threatens to destabilize the Medicare program and patient access to care. We thank you for considering our recommendations. If you have any questions, please feel free to contact Jason Marino, Director, Congressional Affairs, at jason.marino@ama-assn.org or 202-789-8511.

Sincerely,

James L. Madara, MD