

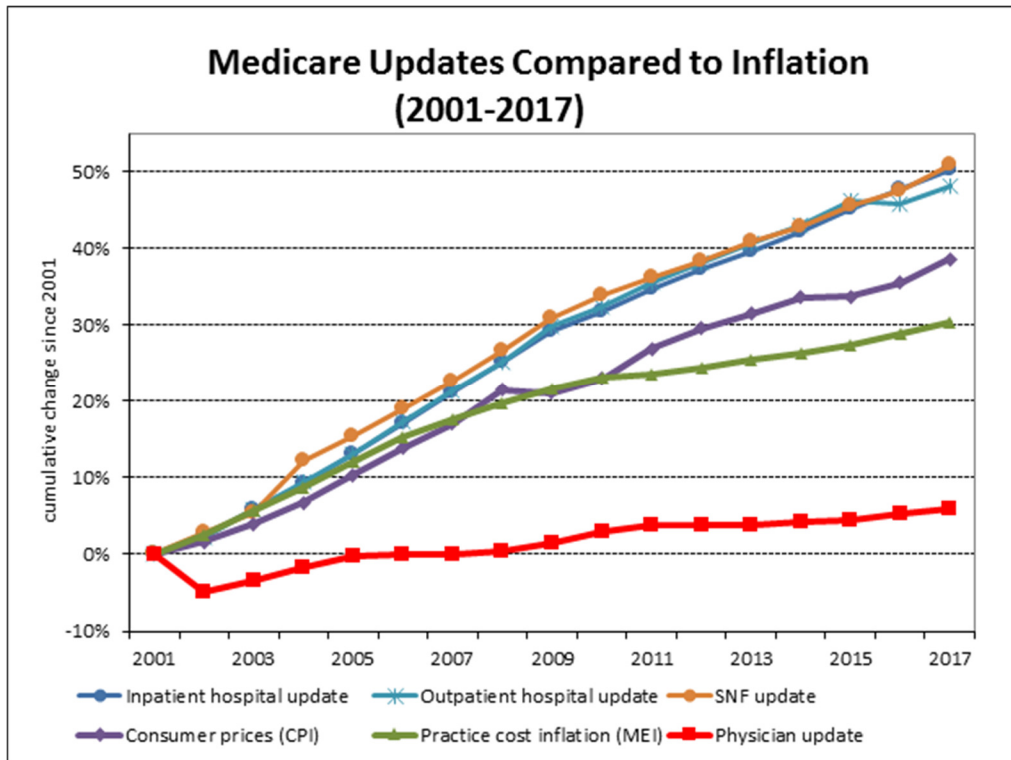
Medicare Access and CHIP Reauthorization Act (MACRA) Statutory Changes

Positive payment updates for physician payment rates for 2020-2025

Currently under MACRA, physicians are scheduled to receive a zero percent payment update for 2020-2025. Beginning in 2026, physicians participating in alternative payment models (APMs) would receive a 0.75 percent update while physicians participating in Merit-based Incentive Payment System (MIPS) would receive a 0.25 percent payment update.

According to data from the Medicare Trustees, Medicare physician pay has barely changed over the last decade and a half, increasing just 6 percent from 2001 to 2017, or just 0.4 percent per year on average. In comparison:

- Medicare hospital pay has increased roughly 50 percent between 2001 and 2017, with average annual increases of 2.6 percent per year for inpatient services, and 2.5 percent per year for outpatient services.
- Medicare skilled nursing facility pay has increased 51 percent between 2001 and 2017, or 2.6 percent per year.
- The cost of running a medical practice has increased 30 percent between 2001 and 2017, or 1.7 percent per year. Inflation in the cost of running a medical practice, including increases in physician office rent, employee wages, and professional liability insurance premiums, is measured by the Medicare Economic Index or MEI.
- Economy-wide inflation, as measured the Consumer Price Index, has increased 39 percent over this time period (or 2.1 percent per year, on average).



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

As a result, Medicare physician payment is not sufficient. Adjusted for inflation in practice costs, Medicare physician pay has declined 19 percent from 2001 to 2017, or by 1.3 percent per year on average. Centers for Medicare and Medicaid Services (CMS) actuaries believe “[a]bsent a change in the delivery system or level of update by subsequent legislation, we expect access to Medicare participating physicians to become a significant issue in the long term under current law.”¹

Merit-based Incentive Payment System (MIPS)

- Provide scoring flexibility to CMS to allow for multi-category credit

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, and create a more unified program. This provision could also allow 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 reduce administrative complexity to allow physicians to spend less time on reporting and more time with patients and on improving care, and to create a more sustainable MIPS program. It would harmonize the four MIPS categories to produce a more cohesive and holistic program and sharpen the focus on outcomes as opposed to just reporting. It also creates a glide path towards participation in alternative payment models by encouraging physicians to focus reporting on more clinically relevant measures and activities, improvement, and providing better value care to patients.

- Provide flexibility to CMS to set multiple performance thresholds

The mean and median scores to date illustrate the need to set the performance threshold lower for several more years while CMS determines how to assist small practices and enable those groups to be successful in MIPS. Because the first year of MIPS was a transition year, nearly all physicians and practices were successful. The national mean score for all participants in 2017 was 74 and the national median score for all participants was 89. However, the scores varied significantly by practice size and location.

- For large practices, the mean score was 74 and the median score was 90.
- For rural practices, the mean score was 63 and the median score was 75.
- For small practices, the mean score was 43 and the median score was 38.
- For small and rural practices, the mean score was 45 and the median score was 42.

Thus, given this stark contrast between practice types, CMS should be provided additional flexibility. CMS, as opposed to a pre-set formula, may be 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. CMS may also decide to establish different thresholds for small and large practices. Providing CMS with additional flexibility to set the performance thresholds would maintain budget neutrality in MIPS.

- Update the Promoting Interoperability performance category

Doctors should be allowed to use certified EHR technology (CEHRT), technology that interacts with CEHRT to be considered a meaningful user, or a qualified clinical data registry to participate in PI. Doing

¹ Source: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/2018TRAlternativeScenario.pdf>.

so would engage clinicians who are non-patient facing that are currently exempt from the category (e.g., radiologists who use imaging equipment, but not EHRs). It would also reward doctors who seek to utilize emerging health IT for patient care or contribute data for aggregation 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 a meaningful EHR user.

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. In turn, health IT developers can 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 attestation or other less burdensome means.”

- Improve the cost performance category

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, we recommend removing the total cost of care measure requirement. The Total Per Capita Cost measure did not receive endorsement by the National Quality Forum (NQF) in 2013 for use in physician cost measurement. Problems with the measure were linked to validity, patient attribution, and holding physicians accountable for costs over which the physician has no control. 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.

- 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.

- Incentivize new measures and ensure stability for existing measures

CMS should have the flexibility to move to pay-for-reporting for the first two years a measure is introduced into the program and when significant refinements to the measure have been made. Precedent already exists for introducing measures via pay-for-reporting in other value-based purchasing programs. This would also incentivize reporting and developing new measures.

Alternative Payment Models (APMs)

- Extend APM incentive payments

Three years into the program, there are very limited opportunities to move from MIPS into an APM. The 5 percent incentive payment was set by MACRA to be provided for 6 years as an incentive to participate in APMs and recognition of the time and costs physicians will face in transitioning to APMs. Many organizations want to see it extended because the APM pathway under MACRA has not been very robust and few physicians have qualified as APM participants. In 2017, only 9% of eligible clinicians in the QPP qualified as qualifying APM participants. To keep the score down, Congress could set a number of initial years of extension, like three, and then some trigger that could allow a further extension, such as if fewer than some percentage of eligible clinicians is achieving qualifying APM status after the additional years.

- Qualified APM Participant (QP) threshold flexibility

Many organizations are concerned that the thresholds for achieving Qualified APM Participant status are too high. The payment thresholds were set by MACRA and CMS has authority to set the patient thresholds “using the same or similar percentage criteria (as specified in this subsection and such section, respectively), as the Secretary determines appropriate.” Rather than have them set in statute, CMS should have flexibility to set payment thresholds. This might also make it possible for CMS to set different threshold amounts for different APMs. For example, the 2017 QPP Experience Report indicated that the average payment threshold score for ESRD Seamless Care Organizations (ESCO) participants was 64 and Comprehensive Primary Care Plus (CPC+) participants was 81. However, the payment threshold for Comprehensive Care for Joint Replacement (CJR) participants was only 13. Thus, the payment threshold requirements should be different for models that focus on particular clinical episodes compared to those that involve most of the care that would be provided to a patient population.

- Adjust multipayer QP thresholds

Most people see the all-payer thresholds as hurting more than helping physicians achieve Qualifying Participant (QP) status. We think this should be changed so that participating in Other Payer APMs adds to the Medicare participation and helps people reach the QP thresholds, but does not mean that their participation in APMs has to be measured as a percent of all their payers.

- Mitigate APM overlap issues

The AMA is currently examining the statutory prohibition² against participating in more than one shared-savings APM. This creates a source of tension between people who want to pursue new APMs and those in the Accountable Care Organization (ACO) community. For example, more narrowly focused models like BPCI Advanced may want to work within or alongside a larger population-focused APM. However, only one model can receive shared savings for a participant.

- Exclude revenues from Part B drugs

Physicians should not be forced to choose between the fee-for-service system or an APM that places them at risk for costs that are beyond their control. Many physicians would be comfortable taking

² Social Security Act § 1899(b)(4) (“(4) NO DUPLICATION IN PARTICIPATION IN SHARED SAVINGS PROGRAMS - A provider of services or supplier that participates in any of the following shall not be eligible to participate in an ACO under this section: ‘(A) A model tested or expanded under section 1115A that involves shared savings under this title, or any other program or demonstration project that involves such shared savings.’”).

accountability for getting complex conditions under control and preventing acute exacerbations that lead to emergency visits and hospital admissions, but they are concerned about taking risk for patients' other medical conditions that are being managed outside of their organization, or costs they cannot influence like drug prices. One way to accomplish this would be to exclude revenues from Part B drugs from calculations of revenue-based financial risk. This would be analogous to technical corrections to MIPS made in the Bipartisan Budget Act of 2018.

- Expand medical homes

CMS should allow the lower financial risk requirements for primary care medical homes to apply to all medical home model participants, whether or not the participating practice is composed of primary care physicians or has more than 50 clinicians.