

Leadership Day, May 14-15, 2019

Physician Payment under Medicare

Congress should take steps to improve Medicare payment policies in ways that better align payments with the value of care provided to patients; reduce unnecessary administrative burdens that divert physicians away from patient care; ensure that performance measures used for payment or public accountability are evidence-based, clinically relevant, and appropriate; create more opportunities for internists to lead and participate in alternative payment models, as described below in the “What is ACP Asking of Congress” section.

What’s it all about?

In April of 2015, landmark legislation was signed into law that fundamentally restructured the Medicare physician payment system. The Medicare Access and CHIP Reauthorization Act (MACRA) instituted new policies under a new payment system called the Quality Payment Program (QPP) that rewards physicians based on the quality and value of services provided. Physicians choose to participate in the QPP under one of two payment tracks: the Merit-Based Incentive Payment System (MIPS) or Alternative Payment Models (APMs). The law also established a transition period ensuring stable, positive baseline Medicare payment updates of 0.5 percent until the end of 2019, which are then adjusted upward or downward based on reporting on performance measures, at which time physicians will receive a zero percent baseline payment update from 2020-2025. While ACP supports the goals of the QPP created by MACRA, and continues to provide constructive feedback to the Centers for Medicare and Medicaid Services (CMS) on its successful implementation, the College has identified problem areas within the QPP that have led to growing physician dissatisfaction, ongoing administrative burden, and thus needs improving.

MIPS: The majority of physicians participate in the QPP through the MIPS track, which builds on traditional fee-for-service payments by adjusting them based on a physician’s performance. The MIPS program measures physicians’ performance based on a very complex scoring structure that requires physicians to report performance data to CMS in four weighted categories: Quality Measurement (45 percent-weight), Improvement Activities (15 percent), Promoting Interoperability (25 percent), and Cost (15 percent). Physicians receive a score based on how well they perform in each of these categories, which then determines their Medicare payment. This scoring structure is unnecessarily complex due to each category having its own unique scoring methodology and the fact that the value of any measure or activity is scored out of an arbitrary number of points that has no correlation to its weight relative to the final MIPS score. Moreover, the categories are siloed, preventing any cross-category credit, and the measures on which physicians must report are overly burdensome and do not measure what matters.

APMs: Fewer physicians qualify to participate in the APM track, where care is delivered through innovative models with rigorous standards that involve accepting risk based on the quality and effectiveness of care provided. Physicians who qualify under this track as “advanced” APMs receive a five percent bonus if they meet certain metrics and use certified Electronic Health Record technology, which then excludes them from MIPS reporting requirements, a huge incentive. Unfortunately, only [eight](#) national models have been approved by CMS as advanced APMs, with little to no workable options for small and specialty practices. This five percent bonus is set to expire at the end of the 2022 performance year, unless Congress takes action to extend it. ACP was very [encouraged](#) by CMS’ announcement on April 22 that it will begin testing new delivery and payment models to support the role of care provided by primary care physicians. These new models are intended to provide sustainable and predictable prospective monthly payments to practices, to reduce administrative burdens for clinicians, to increase the quality of care for patients, and to allow practices and their physicians to share in savings generated by keeping patients healthy and out of the hospital.

What’s the current status and what improvements are needed?

Congressional Oversight: Since enactment of MACRA in 2015, several congressional committees have exercised their oversight authority by holding hearings on the ongoing implementation of the law. ACP was honored to testify at one

such hearing conducted by the House Energy and Commerce Committee in 2016, and has since provided official statements on four other MACRA oversight hearings in 2018 in various committees of jurisdiction. ACP urges these committees to continue to examine MACRA's implementation, especially now that the complexities of MIPS and the way it measures performance, are creating undue burden on physicians and patients.

Simplify and Streamline MIPS Structure: CMS made some modest improvements to MIPS structure in the final 2019 Physician Fee Schedule/Quality Payment Program regulations. View ACP's [comment letter](#). However, much more needs to be done to streamline reporting and scoring under MIPS to lessen the burden on clinicians, including:

Scoring: The separate reporting requirements and scoring methodologies for each category are confusing for clinicians and counter to CMS' efforts to minimize burden and create a unified program. Simplify MIPS scoring by basing point values for individual measures on their relative value to the total MIPS score, lift the silos and allow for cross category credit, and institute a consistent minimum 90-day reporting period across all categories.

Quality Category: This category, and MIPS in general, needs more relevant, accurate, and effective quality measurement, particularly measures based on patient outcomes. Reduce the number of measures required for full participation in this category from six to three measures. ACP's Performance Measurement Committee (PMC) conducted a study of many of the performance measures included in the MIPS program, applicable to internal medicine, and found that only 37 percent were rated as valid, 35 percent as not valid, and 28 percent as of uncertain validity. Measures should be evaluated against four critically important criteria: importance to measure, scientifically acceptable, usable and relevant, and feasible to collect. CMS should collaborate with specialty societies, frontline clinicians, patients, and EHR vendors in the development, testing, and implementation of new quality measures with a focus on integrating performance measurement and reporting within existing care delivery protocols to maximize clinical improvement while decreasing clinician burden. A majority of new MIPS measures finalized for 2019 have received only conditional support from the Measure Application Partnership (MAP), and previously adopted measures remain despite being recommended for "continued development" by the MAP, a designation reserved for measures that lack evidence of strong feasibility and/or validity. MAP is a multi-stakeholder partnership that guides the U.S. Department of Health and Human Services (HHS) on the selection of performance measures for federal health programs.

Promoting Interoperability Category: The measures within this category remain cumbersome and inappropriate, adding unnecessary steps to clinical workflows in order to meet a reporting requirement. CMS should allow for some flexibility in this category and incorporate a broader list of optional HIT activities from which clinicians can choose to report on that are most appropriate to their scope of practice and specialty.

Cost: The law states that the weight of the Cost Category must increase to 30 percent by performance year 2022. However, ACP believes that refinements to improve the reliability and accuracy of Cost measures are needed before further increasing the weight of this category. Congress could revise the timeline to afford CMS additional flexibility.

What is ACP asking of Congress?

Representatives and senators should encourage and provide incentives to physicians who transform their practices into Advanced APMs and continue to provide stability for physicians in the MIPS program by introducing and passing legislation that would:

- Extend the five percent Qualified APM participant bonus beyond the 2022 performance year.
- Replace the zero percent baseline payment updates under Medicare, scheduled to take effect in 2020, with positive updates.

Representatives and senators should urge congressional committees with jurisdiction over Medicare to exercise their oversight authority and urge CMS to:

- Expedite approval of more Advanced Alternative Payment models (APMs), particularly those that work for small and specialty practices.
- Simplify the scoring structure and reporting requirements under the Merit-Based Incentive Payment System (MIPS) in order to fulfill Congress' intent of a more streamlined program that reduces burdens on physicians.

Who can I contact to learn more?

advocacy@acponline.org; Digital version of this issue brief can be found at: <https://www.acpservices.org/leadership-day/policy-priority-issues>