

Statement of the American Academy of Family Physicians

**By**

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**To**

**Senate Finance Committee**

**On**

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

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The American Academy of Family Physicians (AAFP) represents 134,600 physicians and medical students nationwide. Family physicians conduct approximately one in five of the total medical office visits in the United States per year—more than any other specialty. They deliver care in more than 90 percent of U.S. counties - in frontier, rural, suburban and urban areas. They practice in a variety of professional arrangements, including privately owned solo practices as well as large multi-specialty integrated systems and public health agencies.

Family physicians provide comprehensive, evidence-based, and cost-effective primary care dedicated to improving the health of patients, families, and communities. Family medicine's cornerstone is an ongoing and personal patient-physician relationship where the family physician serves as the hub of each patient's integrated care team. More Americans depend on family physicians than on any other medical specialty.

The *Medicare Access and CHIP Reauthorization Act* (MACRA) created a major shift in how Medicare compensates physicians for their professional services. Congress passed MACRA to move the Medicare program away from a system that rewarded volume toward one that supports value. Family physicians continue to be among the most committed physicians to value-based care and payment – and transitioning away from fee-for-service. Our most recent annual survey of members found that:

- 41% practice in Patient-Centered Medical Homes (PCMHs),
- 54% are in value-based payment models or contracts,
- 38% of CPC+ participants are AAFP members, and
- of physicians choosing to practice in an ACO more than half are in the Medicare Shared Savings program (55%).

Our recommendations on what is working under MACRA – and what must be improved – are based on these collective experiences.

### What's Working

The AAFP continues to support MACRA, most notably because it repealed the flawed sustainable growth rate formula, but also because emerging alternative payment models catalyzed by MACRA place greater emphasis on investments in family medicine and primary care. Fee-for-service payment is a barrier to many aspects of primary care transformation and the kind of primary care-based health system this country needs and deserves. The AAFP remains pleased that MACRA places a priority on the transition of physician practices from the legacy fee-for-service payment model toward alternative payment models that promote improved quality and efficiency.

Through the creation of the Advanced Alternative Payment Model pathway, MACRA created an opportunity for physicians to pursue non-fee-for-service payment. MACRA also created an opportunity for physicians to create and propose alternative payment models through the Physician-Focused Payment Model Technical Advisory Committee (PTAC). The AAFP was one of the first organizations to successfully submit a model through the PTAC. The AAFP's Advanced Primary Care Alternative Payment Model was approved by the PTAC in December 2017, receiving one of the strongest recommendations by the PTAC to date. The AAFP remains fully supportive of the PTAC's role in evaluating physician-focused payment models.

On April 22, the AAFP was pleased to join a CMS Innovation Center discussion on primary care. For more than 20 years, the AAFP and our primary care colleagues have worked to create a delivery system that encourages innovation in primary care delivery and rewards comprehensive, continuous, patient-centered care rather than single episodes of care. Throughout this time, the AAFP has provided family medicine's perspective and input. That effort is ongoing, and we continue to work with CMS and the Innovation Center to build a stronger foundation for primary care that is patient-centered and focused on value and outcomes. The announcement of the Primary Cares Initiative, which contains five new models, is a critical step toward recognizing the importance of primary care by developing payment models that value primary care. We applaud the introduction of new primary care delivery and payment models, and we look forward to working with CMS and CMMI on testing and developing these models so they are available, attractive and workable for all primary care practices, including those that are small and/or rural.

While MACRA's framework is still the right approach, operational challenges persist especially for family physicians participating in the intricate fee-for-service based MIPS program.

### What's Not Working

Our recommendations focus on five main issues:

1. Correcting the undervaluation of fee-for-service payment for primary care
2. Reducing the complexity in MIPS scoring
3. Eliminating the MIPS APM category
4. Extending the Advanced APM bonus
5. Creating a culture focused on patient care

1) Correcting the Undervaluation of Fee-for-Service Payment for Primary Care

Even though AAFP supports movement away from fee-for-service models, the fee schedule is still a critical component of physician payment and will continue to be the foundation for future payment. Congress should direct CMS to aggressively address inequities in the Medicare fee schedule that undervalue primary care services – especially the office-based evaluation and management (E/M) codes for new and established patients. The MACRA Quality Payment Program (QPP) perpetuates the undervaluation of primary care services in the fee schedule as part of MIPS. To the extent advanced alternative payment models (AAPMs) rely on current relative values assigned to primary care services under the fee schedule, the AAPM track of QPP also perpetuates these longstanding imbalances in Medicare physician payments.

Specifically, Congress should urge CMS to increase the relative value of ambulatory E/M and other primary care services to rebalance the Medicare physician fee schedule. This is not just an AAFP perspective. It's also the perspective of Congress' own advisors, the Medicare Payment Advisory Commission (MedPAC). In its June 2018 report to the Congress, MedPAC stated:

*Ambulatory evaluation and management (E&M) services . . . are essential for a high-quality, coordinated health care delivery system. These visits enable clinicians to diagnose and manage patients' chronic conditions, treat acute illnesses, develop care plans, coordinate care across providers and settings, and discuss patients' preferences. E&M services are critical for both primary care and specialty care. The Commission is concerned that these services are underpriced in the fee schedule for physicians and other health professionals ("the fee schedule") relative to other services, such as procedures. This mispricing may lead to problems with beneficiary access to these services and, over the longer term, may even influence the pipeline of physicians in specialties that tend to provide a large share of E&M services.<sup>1</sup>*

We share MedPAC's concern, and like MedPAC, we believe CMS should use a budget-neutral approach that would increase payment rates for ambulatory E/M services while reducing payment rates for other services (e.g., procedures, imaging, and tests). Primary care services must be held harmless from any necessary budget-neutrality adjustments resulting from an increase in the relative value of primary care services. Otherwise, the positive impact of those increases will be

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<sup>1</sup> Medicare Payment Advisory Commission. June 2018 Report to the Congress: Medicare and the Health Care Delivery System. P. 65. [http://www.medpac.gov/docs/default-source/reports/jun18\\_ch3\\_medpacreport\\_sec.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/reports/jun18_ch3_medpacreport_sec.pdf?sfvrsn=0) Accessed February 6, 2019.

diluted. Thus such budget neutrality should not occur by adjusting the conversion factor but rather reducing the payment rates for non-E/M services.

## 2) Reducing MIPS Scoring Complexity

The implementation of MIPS has created a burdensome and extremely complex program. Primary care practices' main priority is to remain singularly focused on delivering high-quality patient care. However, understanding the requirements and scoring for each performance category and reporting data to CMS is a complex task and detracts from primary care practices' ability to focus on patients. Unfortunately, CMS continues to struggle to provide timely and clinically actionable data because the MIPS cost category measures are flawed and hold primary care physicians more accountable for total cost of care than other sub-specialties. We urge Congress to extend CMS's authority to weigh the MIPS cost category below 30% to allow time to overhaul existing measures.

One of the more concerning portions of MIPS is the promoting interoperability (PI) category. CMS is hamstrung in PI since the agency is bound to Meaningful Use requirements by legislation, including both the *American Recovery and Reinvestment Act* and the *Affordable Care Act*. The AAFP calls on Congress to repeal Meaningful Use requirements and allow HHS to remove these requirements from the PI category. We are pleased that HHS is pursuing interoperability and stopping information-blocking through rulemaking and are preparing extensive comments, due in early June.

While the AAFP appreciates the efforts to simplify the PI category, we remain extremely concerned and adamantly opposed to the "all or nothing" nature of the category. CMS believes the category is not "all or nothing," as an eligible clinician can submit a numerator as low as one. However, failure to report one measure results in a category score of zero. For all intents and purposes, this is an "all or nothing" structure.

CMS should eliminate health IT utilization measures and remove any required measures and provide eligible clinicians the flexibility to select measures relevant to their practice. All measures within the promoting interoperability category should be attestation-based.

Congress and CMS should work together to improve the implementation of the PI category by removing legislative barriers that restrain and complicate the category. Congress should encourage CMS to simplify the scoring, remove health IT utilization measures and the "all or nothing" requirement, and hold Health IT vendors accountable for interoperability before measuring physicians on EHR use.

The AAFP is supportive of the industry's move to 2015 edition CEHRT. Yet, we have concerns with it being mandated for eligible clinicians (ECs). We must also realize that adopting a 2015 edition CEHRT does not mean that a practice or hospital will be interoperable. Mandates are more beneficial to health information technology (IT) developers than to ECs. Mandates relieve market pressures to lower the cost of upgrades and increase the value of upgraded versions. The cost of EHRs continues to rise, whereas IT cost in every other industry has decreased. We strongly encourage CMS to not mandate 2015 edition CEHRT, but rather incentivize its adoption through scoring, which benefits 2015 edition CEHRT users.

In a [letter](#) the AAFP sent HHS early this year, we discussed how Health IT and EHR vendors should be more fully regulated to address mal-aligned and self-serving behaviors by these vendors. An HHS draft report laid out a set of strategies and recommendations and the AAFP was largely supportive of them. However, the AAFP strongly urges HHS to convert the "could," "should," and "encourage" language in the report into required actions. Compliance with these mandates by vendors will significantly decrease the administrative burdens of physicians. It is time for them to be mandates and not suggestions.

Congress should guide CMS to reduce the complexity and administrative burden of MIPS. CMS could accomplish this by providing cross-category credit for measures and activities that span multiple performance categories. We believe an updated architecture where reporting once and receiving credit in multiple categories could alleviate significant burden from practices and allow them to focus their efforts on better patient care.

### 3) Eliminating the MIPS APM Category

The AAFP remains quite concerned with the MIPS APM option created by CMS but not referenced in MACRA's statutory language. The AAFP is concerned eligible clinicians may intentionally remain in MIPS APMs, given the scoring advantage they have been given, instead of progressing toward advanced APMs, which was the Congressional intent behind MACRA.

By remaining in MIPS, MIPS APMs will skew the MIPS performance threshold. This is already apparent in the 2017 performance period, where the performance threshold was three and the exceptional performance threshold was 70. MIPS APMs tend to be larger practices that are part of an accountable care organization (ACO), which has the resources and technology to better support their MIPS participation. In the 2017 Quality Payment Program (QPP) Reporting Experience report published by

CMS, MIPS APMs had a mean final score of 87.64 and median final score of 91.76. The MIPS APM final scores are higher than the national mean and median final scores which were 74.01 and 88.97. Even more disconcerting is the difference between MIPS APM scores and scores of small and rural practices. The mean and median final scores for small practices were 43.46 and 37.67, respectively. This is a significant discrepancy that favors MIPS APMs and compromises the integrity of the program.

#### 4) Extending the Advanced APM Bonus

Given the limited availability of AAPMs to date, we strongly urge Congress to extend the 5 percent Advanced APM bonus for three to five years beyond the current statutory restriction and include language giving the Secretary of HHS discretion to extend the bonus further.

#### 5) Creating a culture focused on patient care

Feedback we have received is that most family physicians, especially those in independent practices, believe that the MIPS program has a net-negative impact on their practices. While comfort with the existing fee-for-service system may play a role, the feedback we have received from family physicians, based on analysis of their practice trends, suggest that the MIPS program requirements place economic strains on their practices.

The AAFP strongly supports streamlining MIPS documentation requirements and reducing administrative burden in all health care programs—both public and private. One of the most onerous administrative burdens is prior authorization, which tops the list of physician complaints on administrative burden. This uncompensated work for physicians and staff translates into increased overhead costs for practices, disrupts workflows, and results in inefficiencies and reduction in time spent with patients. According to AMA [data](#), interactions with insurers cost \$82,975 annually per physician. Exacerbating this is most family physicians in private practice have contractual relationships with seven or more health insurance plans, including Medicare and Medicaid. In coalition with 16 other medical organizations, the AAFP has called for the reform of prior authorization and utilization management requirements that impede patient care in [Prior Authorization and Utilization Management Reform Principles](#). In addition, the AAFP has published, [Principles for Administrative Simplification](#), calling for an immediate reduction in the regulatory and administrative requirements family physicians and practices must comply with daily.

Quality measure reporting is another source of administrative burden for physicians and their practices. According to [study](#) discussed in *Health Affairs*, physician practices spend, on average, 785 hours per

physician and more than \$15.4 billion annually to report quality measures. Quality reporting takes considerable time away from patient care while causing a considerable financial strain on practices, particularly those that are small and/or rural.

The AAFP strongly supports the CMS “Patients Over Paperwork” initiative but believe more must be done to improve patient care within the MIPS program by reducing administrative burdens. So that family physicians can devote more time to patient care, we urge Congress to influence action by all payers to reduce the administrative complexity so that physicians can more fully focus on patient care.

### Additional Recommendations

The AAFP makes the following recommendations to improve Medicare payment systems:

1. Congress should extend the 0.5 percent baseline conversion factor update until 2026. Doing so would help mitigate budget-neutrality cuts required by separate laws such as the *Protecting Access to Medicare Act* (PAMA) and help adjust for inflation. This rate of increase does not match increase in cost or inflation, but it does provide a minimum level of economic growth.
2. Congress should encourage CMS to continue to focus on outcomes and patient-reported outcome measures that are more impactful for a practice and for patients.
3. The AAFP asks Congress to reimagine how the exceptional performance positive payment adjustments are applied to reward practices that achieve significant year-over-year improvement versus rewarding those practices at the upper levels of annual performance. In 2019, practices that achieve a final score of 75 points are eligible for up to an additional 10% positive payment adjustment. While we applaud these high-performing practices, it is our belief that additional positive payment adjustments would be better used if they were focused on rewarding the hard work of practices that achieve year-over-year improvements.

### Conclusion

Once again, thank you for the opportunity to discuss with this Committee the impact of MACRA on family physicians and its potential to build a patient-focused health care delivery system built upon a well-resourced foundation of primary care.