



Sound Policy. Quality Care.

**Maintain a Viable Medicare Fee-For-Service Option,
Extend Positive Physician Payment Updates, & Improve the Quality Payment
Program to Ensure Opportunities and Adequate Incentives for Specialists**

REQUEST

The Alliance of Specialty Medicine (Alliance) urges Congress to **extend positive physician payment updates to the conversion factor and Advanced Alternative Payment Models (A-APM) incentive payments**--which are scheduled to expire--to ensure that Medicare fee-for-service (FFS) and the programs under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) continue to be viable options.

SUMMARY OF LEGISLATIVE REQUESTS

The Alliance thanks Congress for enacting MACRA technical corrections into law last year in the Bipartisan Budget Act of 2018 (BBA of 2018). These provisions significantly improved the ability of Medicare physicians, particularly specialists, to continue to participate in quality improvement activities and, specifically, in the Merit-based Incentive Payment System (MIPS). However, additional changes are needed to ensure we maintain a viable Medicare fee-for-service (FFS) option, extend positive physician payment updates, and improve the Quality Payment Program (QPP) to ensure opportunities and adequate incentives for specialists.

Extend Positive Physician Payment Updates to the Conversion Factor – MACRA provided a much-needed 0.5% positive payment update to the conversion factor for all physicians for five years. However, the BBA of 2018 reduced the 2019 physician payment update to 0.25%. Further, beginning in calendar year (CY) 2020, the Medicare physician payments formula will receive no increases for six years, until 2026, thus creating a scenario where the Medicare Physician Fee Schedule conversion factor is likely to go down because of rules governing budget neutrality. Beginning in 2026, physicians participating in MIPS will receive a 0.25% update, while those providing a significant portion of their services in A-APMs will receive a 0.75% update. Even before these smaller updates, physician reimbursement has failed to keep up with inflation and the cost of participating in the Quality Payment Program (QPP). The Medicare Trustees' report projects that inflation will increase physician costs by about 2.2%. At the same time, physicians will face an increasingly higher bar in regard to reporting requirements, eligibility and QPP performance thresholds. **The Alliance urges Congress to extend positive payment updates to the conversion factor to ensure practices can continue to make investments in the tools needed to participate effectively in the QPP.**

Extend A-APM Incentive Payments – Physicians participating in A-APMs receive a 5% bonus, which is scheduled to expire after the 2022 performance year. While there are currently only limited opportunities for specialists to participate in A-APMs, CMS and other stakeholders are expected to increase the pace of developing and testing new models over the coming years. Current A-APM models are primary care-focused and not well-suited for specialists, but if the Center for Medicare and Medicaid Innovation (Innovation Center) approves new models developed by specialists, more specialists will want to implement them. Initially, however, if specialists can participate in new models, the financial risk and additional administrative costs of implementing the models will need to be offset by the incentive payment. Therefore, **we encourage Congress to extend the A-APM incentive payment for an additional six years, which would help facilitate physician movement toward new and innovative**

models that has not yet materialized due to the lack of specialty-appropriate A-APMs.

Streamline and Simplify MIPS Scoring – The MIPS program has four categories each with unique scoring methodologies that can be difficult for physicians to understand. **The Alliance urges Congress to provide CMS the authority to:**

- Make MIPS scoring more flexible, such as allowing multi-category credit for certain activities; and
- Center physician participation around specific episodes of care or conditions relevant to the physician's specialty and practice.

Enact Additional MACRA Technical Improvements – The Alliance urges Congress to enact the following technical improvements to strengthen the MACRA program:

- Allow CMS to set the MIPS performance threshold at an appropriate level, rather than the mean or median of the previous year's score, and give CMS the authority to set multiple performance thresholds, such as a separate one for small and rural practices;
- Give CMS authority to modify the participation thresholds for achieving Qualified Participant (QP) status in an A-APMs and to exclude Part B drug costs from APM financial risk calculations;
- Modify the MIPS Promoting Interoperability category to award credit for using technology, such as qualified clinical data registries, that interact with certified EHRs;
- Modify the MIPS Cost category by removing the primary care-based total per capita costs measure mandate that potentially holds physicians responsible for costs outside of their control and by removing the requirement that episode-based measures account for at least 50% of Part A and B expenditures to ensure CMS can instead prioritize cost measures that are valid and reliable;
- Allow pay-for-reporting on new measures or when significant refinements to a measure have been made; and
- Provide authority for the Physician-focused Payment Model Technical Advisory Committee (PTAC) to provide technical assistance and data analyses to stakeholders who are developing proposals for its review.

BACKGROUND

The Alliance is concerned that recent proposals put forward by the Medicare Payment Advisory Commission (MedPAC), included in the President's FY 2020 budget proposal, and recent comments by the Secretary and CMS Administrator that fee-for-service is "antiquated" are aimed at eliminating fee-for-service and transitioning physicians into primary care-focused A-APMs or evaluating them in large virtual groups on population-based measures that do not reflect specialty care.

Fee-for-service (FFS) remains the most appropriate reimbursement structure for many specialists. Generally, specialists and sub-specialists treat specific diseases and organ systems, providing focused interventions that may include pharmaceutical, procedural, or surgical services. This specialization has led to efficient care delivery, eliminating variations in cost and quality for key conditions and related services. As a result, specialty care may not be well-suited for reimbursement models other than FFS.

The Alliance has testified before Congress on these issues. For more information, please see:

<https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Testimony-Parekh-%20HE-MACRA-and-MIPS-An-Update-on-the-Merit-based-Incentive-Payment-System-2018-07-26.pdf>