AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

Statement of
American Academy of Family Physicians
Submitted for the Record

House Committee on Ways and Means
Subcommittee on Health

Hearing on Implementation of MACRA's Physician Payment Policies

March 21, 2018

AAFP Headquarters
11400 Tomahawk Creek Pkwy.
Leawood, KS 66211-2680
800.274.2237 • 913.906.6000
fp@aafp.org

AAFP Washington Office
1133 Connecticut Avenue, NW, Ste. 1100
Washington, DC 20036-1011
202.232.9033 • Fax: 202.232.9044
capitol@aafp.org

The American Academy of Family Physicians (AAFP), which represents over 129,000 family physicians and medical students across the country, respectfully submits this statement for the record to the House Ways and Means Subcommittee on Health, on the Implementation of the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA).

1. The AAFP is Committed to the Quality Payment Program's Long-Term Success

Family physicians participate overwhelmingly in Medicare[1] are accordingly committed to the success of the new Quality Payment Program (QPP), as well as the Medicare program as a whole. The AAFP recognizes and appreciates the significant efforts of Congress and the Centers for Medicare and Medicaid Services (CMS) over the years to repeal and replace the failed Sustainable Growth Rate (SGR) formula, and to establish a payment system that promotes opportunities to deliver value-based care. As the Subcommittee looks back on the first year of physician participation under the QPP, the AAFP takes this opportunity to highlight key opportunities and challenges that we believe this Subcommittee can address in order to ensure the QPP's long-term success.

2. The AAFP Urges the Subcommittee to Take All Steps Possible to Promote Primary Care Alternative Payment Models (APMs).

MACRA included bipartisan support for Medicare to transition away from the legacy fee-for-service payment model for physician services to alternative payment models (APMs) that are designed to both improve quality outcomes and lower the total cost of care. **The AAFP urges the Subcommittee in the strongest possible terms to push for the testing, evaluation, and expansion of these new models—in particular those that allow primary-care physicians to evolve from, or even fully exit, the fee-for-service payment system.**

While fee-for-service payment may be appropriate for some aspects of acute or episodic care, it remains a suboptimal way to pay primary-care practices for the active management of patient populations over time. Unfortunately, the health-care infrastructure is still primarily built around the fee-for-service framework relegating the physician-patient relationship to brief face-to-face interactions. Paying by the individual episode or procedure encourages physicians to simply treat acute sickness when it presents, whereas broadening the payment to the patient incentivizes the primary-care physician to what they long to do: perform longitudinal, comprehensive patient health through prevention and chronic disease management.

Four primary-care APMs are in varying stages of refinement, testing, and evaluation, and we urge the Subcommittee to encourage the Secretary and CMS to bolster them:

- **Advanced Primary-Care APM (APC-APM)**. The AAFP has designed a new primary-care payment model that is currently under consideration within several groups under the Department of Health and Human Services. In December 2017, the Physician-Focused Payment Model Technical Advisory Committee (PTAC) recommended unanimously that the Centers for Medicare and Medicaid Innovation (CMMI) test the model. Under APC-APM, primary-care practices

would be paid a risk-adjusted monthly global sum for most aspects of primary-care delivery (both direct patient-facing services and care management), as well as a performance bonus for decreasing hospital and emergency visits. Like CPC+ (see below), the APC-APM is designed to be a multi-payer model. The AAFP believes that the APC-APM provides an ideal opportunity to demonstrate that global payments for primary care can dramatically improve care delivery, while reducing overall cost and practice burdens. Accordingly, we call for the Subcommittee to strongly encourage HHS and CMS to test and implement the model as aggressively as possible.

- **Comprehensive Primary Care+**. CMS has designated the CPC+ initiative as an advanced APM under the QPP, meaning that CMS will pay practices that participate and achieve certain revenue benchmarks in the model a 5-percent bonus in each year between 2019-2024. CPC+ is a multi-payer model under which CMS and other commercial payers (including Medicaid programs and Medicaid Managed Care Organizations) make enhanced payments to physician practices to support advanced primary-care delivery. CMS is currently supporting CPC+ in 18 states. The AAFP has worked closely with CMS in the design and testing of this model; in fact, several of AAFP's senior leaders are CPC+ participants. The AAFP urges the Subcommittee to accelerate the testing and expansion of this model nationwide.

- **Independence at Home Demonstration**. Independence at Home (IAH) is a statutory demonstration project that pays primary-care practices to deliver care to chronically ill beneficiaries in their homes. The model has shown great promise at both improving quality and lowering the cost of care. Through the leadership of Chairman Peter Roskam and other members of this Subcommittee, Congress in February extended this demonstration program for two additional years. As the enrollment in this demonstration remains limited, the AAFP urges Congress to make this demonstration permanent and scale it up nationwide.

- **Other Programs**. The **Medicare Shared Savings Program** (MSSP) has had mixed results since its implementation. However, there is growing evidence that the physician-led accountable care organizations (ACOs) in Track 1 and Track 1.5 are providing high quality care and doing so in a manner that reduces the overall health care spend for the attributed population—particularly those with a primary-care base.[2] The AAFP also continues to support the **direct primary care model** (DPC). DPC, like other advanced primary care models, liberates primary care from fee-for-service and reduces the administrative burdens associated with traditional payment models. Subcommittee members Erik Paulsen and Earl Blumenauer have introduced legislation (H.R. 365, the *Primary Care Enhancement Act*) that would remove a legal barrier in the Internal Revenue Code, currently blocking the roughly 23 million Americans with a health savings account (HSA) from using their HSA funds for this model. The AAFP supports this legislation

3. The AAFP Urges the Subcommittee to Take All Steps Possible to Simplify MIPS

In addition to urging Congress and CMS to maximize opportunities for family physicians to practice in APMs, the AAFP also wants those physicians who elect to remain in fee-for-service to continue to succeed. Accordingly, the AAFP has devoted substantial resources to educating and supporting physician members who wish to remain in the QPP's fee-for-service pathway, known as the Merit-Based Incentive Payment System (MIPS).

A. Reporting Burdens Must be Scaled Back for MIPS to Succeed

Awareness of the detrimental impact of regulatory burden on physician practices has reached a tipping point. On one hand, the AAFP is gratified that policymakers, health plans, and regulators more fully appreciate that the crush of reporting mandates is impeding patient care. On the other hand, awareness alone is not enough—the AAFP calls on the Subcommittee to take swift action to remove red tape from Medicare, and particularly the MIPS program.

The AAFP urges the Subcommittee to follow the recommendations of both the Trump Administration and the Medicare Payment Advisory Commission (MedPAC), insofar as they recommend that Congress remove reporting for physicians among the four MIPS performance categories (quality, cost, improvement activities, and advancing care information). The President's FY2019 Budget Request to Congress envisions a MIPS program that "would not require any reporting from clinicians, thereby leaving more time for clinicians to focus on patient care."[3] Similarly, MedPAC's most recent annual report to Congress (published March 15, 2018) recommends that Congress re-design MIPS in a way that "eliminates manual clinician reporting."[4]The AAFP appreciates the work being done in this area now (for example this Subcommittee's Red Tape Relief Initiative, and CMS's Patients over Paperwork Initiative), and asks that the Subcommittee find a way to remove or at least dramatically simplify reporting in MIPS. Congress should at a minimum extend continuous-quarter reporting (rather than full year reporting) for MIPS across those performance categories that require reporting: quality, improvement activities, and advancing care information.

B. MIPS Scoring Must Be Fair

The AAFP is concerned that MIPS scoring—which ultimately pits physicians to compete with one another—may not be reasonably calculated to compare physicians fairly across specialties and across groups. The AAFP applauds Congress for giving CMS three additional years of authority in the *Bipartisan Budget Act of 2018* to set the MIPS performance threshold in a flexible manner as it continues to gain experience scoring physicians. Congress and this Subcommittee have wisely recognized that transitioning to value-based physician payment takes time and patience.
More flexibility will improve the program, however. The AAFP makes the following additional recommendations to the Subcommittee, in order to strengthen the system and inspire confidence in MIPS scoring:

(1) As long as reporting is required under MIPS, CMS should ensure parity in reporting across physician specialties. CMS currently requires physicians in MIPS to report six quality measures. While many more than six of the 271 MIPS clinical quality measures are suitable for family medicine, many specialties do not have six suitable measures, and therefore are not held accountable for reporting measures. Family physicians' performance should not be judged against physicians in specialties that are not required to report on all six measures. In addition, CMS should require all physicians to report data on six measures, using cross-cutting measures if necessary.

(2) The cost measures under development at CMS are still evolving and potentially unreliable for measuring the value of primary care—particularly at the solo and small-practice level. The two cost measures that CMS plans to use for 2018 reporting (Medicare spending per beneficiary and total per capita costs for all attributed beneficiaries) were developed for use at the tax identification number (TIN) level and are not suitable for small and solo practices. For the purposes of the cost category and until CMS can create a more even and meaningful playing field of cost measurement, the AAFP would urge that physicians be held harmless if they cannot reliably be measured against at least one episode-based cost measure.

(3) Physicians should have maximum flexibility in participating in MIPS. Physicians in similar practices that might be part of a larger, multi-specialty group should be allowed to report as a smaller sub-group, specifically for quality reporting. The AAFP also remains supportive of an opt-in pathway for physicians who are not eligible for MIPS due to the low-volume threshold.

---

[1] According to 2017 AAFP membership survey data, over 90 percent of AAFP's active members participate in Medicare, and over 80 percent accept new Medicare patients.

[2] See, e.g., Department of Health and Human Services Office of Inspector General, *Medicare Shared Savings Program Accountable Care Organizations Have Shown Potential for Reducing Spending and Improving Quality* (August 2017) (finding that during the first three years of the MSSP program, "a small subset of ACOs showed substantial reductions in Medicare spending while providing high-quality care." Further, these ACOs "maintained high use of primary care services, which can lower utilization and costs for other care, and reduced the use of costly services such as emergency department visits.").

[3] U.S. Department of Health and Human Services, Budget in Brief for FY2019, at 66 (February 12, 2018).

[4] Medicare Payment Advisory Commission, Report to the Congress, at 166 (March 15, 2018).