REPORT OF THE BOARD OF TRUSTEES

B of T Report 6-A-19

Subject: Redefining AMA's Position on ACA and Healthcare Reform

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At the 2013 Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy D-165.938, "Redefining AMA's Position on ACA and Healthcare Reform," which called on our American Medical Association (AMA) to "develop a policy statement clearly outlining this organization's policies" on a number of specific issues related to the Affordable Care Act (ACA) and health care reform. The adopted policy went on to call for our AMA to report back at each meeting of the HOD. BOT Report 6-I-13, "Redefining AMA's Position on ACA and Healthcare Reform," accomplished the original intent of the policy. This report serves as an update on the issues and related developments occurring since the most recent meeting of the HOD.

IMPROVING THE AFFORDABLE CARE ACT, AND AN UPDATE ON MEDICARE EXPANSION EFFORTS

Efforts are currently underway on Capitol Hill to enact polices to support the ACA and address recent efforts to weaken the law. The termination of cost sharing payments, for example, has increased premiums for those not eligible for the ACA's premium subsidies, resulting in significant decreases in enrollment among that population. In March, the House Committee on Energy and Commerce began efforts to enact legislation to support state reinsurance programs or to provide financial assistance to reduce out-of-pocket costs for those enrolled in qualified plans. Separate legislation would reverse cuts to the ACA Navigator program and expand program duties as they relate to Medicaid and the Medicare, Medicaid, Children's Health Insurance Program (CHIP). The committee will also consider legislation to again make funding available for the establishment of state-based marketplaces. The AMA remains engaged on this and other efforts to preserve current coverage options and make improvements where necessary.

Following the mid-term Congressional elections in 2018, a great deal of attention has been paid to efforts to enact legislation creating a Medicare for All program. As proposed, this single-payer system would replace the Affordable Care Act (ACA), CHIP and all private health insurance options available through employers or the individual market.

Our AMA is currently engaged in efforts with other partners across the health care sector to raise the awareness of the shortcomings of single-payer systems and, consistent with AMA policy, to continue to promote improvements to the current system which provides quality coverage to more than 90 percent of Americans while working to expand options to cover those who remain uninsured. Though polling on the general topic shows strong public support, that support quickly erodes when the details of a such a system are explained and people begin to comprehend the significant disruptions that would occur to the coverage and access to care they currently enjoy.

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) AND ALTERNATIVE PAYMENT MODELS

Our AMA continues to work to make refinements to the Merit-based Incentive Payment System (MIPS) that was established by the Medicare Access and CHIP Reauthorization Act (MACRA). Work has proceeded through workgroups comprised of policy staff from state and national medical specialty societies as well as a CEO Working Group. At this writing, several policy modifications have been discussed which would not require statutory changes, while others would require Congressional action. Among proposals which can be implemented without Congressional action are:

- Keeping cost weighted at 15 percent for at least one additional year while new episode-based measures are developed and tested and phase in new measures.
- Ultimate elimination of the Total Per Capita Cost (TPCC) and Medicare Spending Per Beneficiary (MSPB) measures which double count costs and will potentially triple count costs once the cost-based episode measures are in place.
- Improve the accountability of cost measures so that physicians can make informed decisions about their cost effectiveness without being inappropriately penalized for care outside of their control or for caring for medically and socially complex patients.
- Reduce the requirements for reporting quality measures and propose a reporting option based on clinical continuums of care.
- Revise the quality measure benchmark methodology.
- Modify policies to encourage reporting via Qualified Clinical Data Registries (QCDRs).
- Increase transparency in the Improvement Activities category.
- Accept activity modifications and new activities on an accelerated timeline to reflect the pace of change in medicine.
- Allow multi-category credit for activities and measures that overlap performance categories to simplify the scoring methodology and make the program more clinically relevant.
- Propose (as opposed to seeking comment on) alternative scoring methodologies for promoting interoperability.
- Further simplify and reduce physician reporting burden through a yes/no measure attestation and leverage health IT vendors' reporting on utilization of Certified EHR Technology – Centers for Medicare & Medicaid Services (CMS) functionality.

Proposals which would likely require statutory changes by Congress include:

- Implement positive updates for physician payment rates for 2020-2025.
- Extend CMS' flexibility to set the performance threshold lower than the mean or median beyond 2021 performance year or permanently remove the "mean or median" requirement.
- Update the Promoting Interoperability category by including language that explicitly allows vendors as well as eligible professionals to submit the data necessary for eligible professionals to be considered a "meaningful user" and decouple the Promoting Interoperability performance category from the old EHR Meaningful Use program.
- Adopt a provision granting CMS explicit flexibility to base scoring on multi-category measures to reduce silos between each of the four MIPS categories and create a more unified program.
- Aid smaller practices by adding provisions that allow more flexibility for the development of virtual groups if CMS sees low numbers of physicians joining virtual groups in the first two years of the program.
- Remove the requirement that episode-based cost measures account for half of all expenditures under Parts A and B.

- Align benchmark/reporting language for the Quality performance category in MIPS and physician compare.

On March 1, 2019, the AMA wrote to Health and Human Services Secretary Alex Azar and CMS Deputy Administrator for Quality and Innovation Adam Boehler to put forth policy recommendations for HHS and CMS to consider as a means of generating more successful alternative payment models (APMs) that will achieve better outcomes for patients and more savings for Medicare. The recommendations fell into six policy areas:

- Limiting accountability to costs and outcomes that physicians can control;
- Making payment models simple but flexible;
- Providing physicians with the data needed to deliver high-value care;
- Encouraging the implementation of APMs developed by practicing clinicians;
- Trying multiple approaches to delivery and payment reform; and
- Extending MACRA APM incentives for a longer period.

Our AMA will continue to work with the Administration and Congress as appropriate to implement these and other steps that can improve the environment surrounding payment and delivery system reform efforts for physicians.

STEPS TO LOWER HEALTH CARE COSTS

As a follow up to multiple hearings over the summer of 2018, the Chairman of the Senate Committee on Health, Education, Labor and Pensions, Sen. Lamar Alexander of Tennessee, requested information from a broad range of stakeholders on specific steps that could be taken to reduce the cost of health care. In a March 1 response to the Chairman, the AMA put forth several recommendations.

One area in which the AMA made recommendations was the high administrative costs in the health care system, particularly related to burdensome prior authorization requirements and the enormous amount of physician and staff time spent in these tasks that add little to patient care and in many cases, delay medically necessary care. Other areas addressed to the committee were:

- Increased price and data transparency to empower patients;
- Prescription drug price and cost transparency;
- Value-Based Insurance Design;
- Alternative Payment Models; and
- Lowering health care costs with an increased focus on prevention, particularly the AMA's work on preventing diabetes and controlling hypertension.

CONCLUSION

Our AMA will remain engaged in efforts to improve the health care system through policies outlined in Policy D-165.938 and other directives of the House of Delegates.