

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 243
(A-19)

Introduced by: Texas

Subject: Improving the Quality Payment Program and Preserving Patient Access

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

1 Whereas, The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires that
2 the Merit-Based Incentive Payment System (MIPS) under the Quality Payment Program (QPP)
3 be a budget-neutral program where incentive payments are funded from physician practices that
4 receive payment penalties, creating winners and losers among physicians and other clinicians in
5 Medicare; and

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7 Whereas, Many of the MIPS clinical quality and cost metrics that physicians are scored on are
8 not in physician control nor are they often evenly distributed in the population, resulting in
9 physicians being penalized if they serve disproportionate numbers of disadvantaged or high-risk
10 patient populations; and

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12 Whereas, The MIPS program's one-size-fits-all approach adversely affects small and rural
13 practices, a concern the Centers for Medicare & Medicaid Services (CMS) has acknowledged in
14 its past proposed rules stating that "physicians in these practices tend to have patient
15 populations with a higher proportion of older adults, as well as higher rates of poor health
16 outcomes, co-morbidities, chronic conditions, and other social risk factors, which can result in
17 the costs of providing care and services being significantly higher, compared to physicians in
18 other areas"; and

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20 Whereas, CMS further acknowledged concerns that physicians in small and rural practices "may
21 be disproportionately more susceptible to lower performance scores across all performance
22 categories and negative MIPS payments adjustments, and as a result, such outcomes may
23 further strain already limited resources and workforce shortages, and negatively impact access
24 to care (reduction and/or elimination of available services)"; and

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26 Whereas, MACRA requires that CMS, based on individuals' health status and other risk factors,
27 assess and implement appropriate adjustments, but after three years of program
28 implementation, while few bonus points are provided to small practices and those who care for
29 complex patients, the agency has not yet proposed any methodology for properly risk adjusting
30 MIPS cost and quality measures. This lack of compliance with congressional intent results in
31 flawed performance measurement methodologies, inadequate and/or unfair scoring policies,
32 lower performance scores for many physicians, and tarnished physician reputations via data
33 publicly reported on Medicare's Physician Compare website, and these problems may have the
34 unintended consequence of physicians deciding not to treat certain patients; and

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36 Whereas, On March 21, 2019, CMS published the 2017 QPP Experience Report with an
37 accompanying appendix that failed to provide a full account of physicians' experience for the
38 first year of the QPP or to successfully illustrate the successes and challenges experienced by
39 ALL physicians; and

1 Whereas, Limited state and national data; questionable, misleading, and incomplete data;
2 selection bias; lack of meaningful clinical data; poor electronic health record participation;
3 limited-to-no return on investment; no data insights on vendors; and an inaccurate definition of
4 physician are among the numerous flaws and/or troubling results found in the 2017 QPP
5 Experience Report; and
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7 Whereas, The 2017 QPP Experience Report showed that mean and median final scores for
8 physicians and other clinicians who submitted data at the individual level, including physicians in
9 solo practice, were lower than for group practices, and scores for small and rural practices were
10 significantly lower than for large practices and MIPS APM participants. Most notably, among all
11 practices, small practices fared the worst, resulting in lower incentive payments or payment
12 penalties for many physicians in small practices nationwide; and
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14 Whereas, The 2017 QPP Experience Report showed that of the 51,505 clinicians who currently
15 are receiving the 4% payment penalty nationally and funding the MIPS incentive payment for
16 the rest of the country, 83% (42,678) are clinicians from small practices and 18% (9,289) are
17 clinicians from rural practices; and
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19 Whereas, Budget neutrality in the first year of MACRA implementation has proven to be harmful
20 to small and rural practices, creating financial incentives for a massive restructuring of
21 ambulatory care delivery systems, potentially eliminating small and rural physician practices
22 nationally, and significantly harming access to care; and
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24 Whereas, Physicians in small and rural practices likely will continue to be the most adversely
25 affected by CMS' flawed MIPS policies and MACRA's budget neutrality requirement; and
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27 Whereas, While the low-volume threshold policy decreases the number of physicians in small
28 practices required to participate in MIPS, the policy does not exclude ALL physicians in small
29 practices who continue to experience financial, technological, and administrative challenges to
30 program participation; and
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32 Whereas, While our American Medical Association advocates for keeping the low-volume
33 threshold policy and calls for other improvements, it has not explicitly advocated for an
34 exemption from MIPS for ALL small practices (on a voluntary basis) as per AMA policies MIPS
35 and MACRA Exemption H-390.838 and Preserving Patient Access to Small Practices Under
36 MACRA D-390.949; and
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38 Whereas, CMS has not published any data to date that show whether the QPP is meeting its
39 aims as envisioned by MACRA and Congress, such as improving the care and population
40 health of Medicare beneficiaries, lowering Medicare costs, and minimizing burden on practicing
41 physicians; and
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43 Whereas, As MIPS penalties increase to 9% and as the program becomes more complex with a
44 higher overall MIPS performance threshold along with flawed performance measurement
45 methodologies, thousands of physician practices, particularly those in small and rural practices,
46 likely will continue to receive a payment penalty every year. This threatens practice viability,
47 continued physician participation in Medicare, and access to care; therefore be it
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49 RESOLVED, That our American Medical Association strongly advocate for Congress to make
50 participation in the Merit-Based Incentive Payment System and alternative payment models
51 under the Quality Payment Program completely voluntary (Directive to Take Action); and be it
52 further

1 RESOLVED, That our AMA strongly advocate for Congress to eliminate budget neutrality in the
2 Merit-Based Incentive Payment System and to finance incentive payments with supplemental
3 funds that do not come from Medicare Part B payment cuts to physicians and other clinicians
4 (Directive to Take Action); and be it further
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6 RESOLVED, That our AMA call on the Centers for Medicare & Medicaid Services (CMS) to
7 provide a transparent, accurate, and complete Quality Payment Program Experience Report on
8 an annual basis so physicians and medical societies can analyze the data to advocate for
9 additional exemptions; flexibilities; and reductions in reporting burdens, administrative hassles,
10 and costs (Directive to Take Action); and be it further
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12 RESOLVED, That our AMA advocate that CMS increase the low-volume threshold for the 2020
13 Quality Payment Program and future years of the program for all physicians and continue to
14 offer them the opportunity to opt in or voluntarily report (Directive to Take Action); and be it
15 further
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17 RESOLVED, That our AMA reaffirm Policy H-390.838, "MIPS and MACRA Exemption," and
18 advocate to preserve patient access by exempting small practices (one to 15 clinicians) from
19 required participation in the Merit-Based Incentive Payment System and continue to offer them
20 the opportunity to opt in or voluntarily report (Reaffirm HOD Policy)

Fiscal Note: Not yet determined

Received: 05/24/19

RELEVANT AMA POLICY

MIPS and MACRA Exemption H-390.838

Our AMA will advocate for an exemption from the Merit-Based Incentive Payment System (MIPS) and Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) for small practices.

Citation: Res. 208, I-16; Reaffirmation: A-17; Reaffirmation: I-17; Reaffirmation: A-18

Preserving Patient Access to Small Practices Under MACRA D-390.949

1. Our AMA will urge the Centers for Medicare and Medicaid Services to protect access to care by significantly increasing the low volume threshold to expand the MACRA MIPS exemptions for small practices (on a voluntary basis), and to further reduce the MACRA requirements for ALL physicians' practices to provide additional flexibility, reduce the reporting burdens and administrative hassles and costs.

2. Our AMA will advocate for additional exemptions or flexibilities for physicians who practice in health professional shortage areas.

3. Our AMA will determine if there are other fragile practices that are threatened by MACRA and seek additional exemptions or flexibilities for those practices.

Citation: Res. 243, A-16; Reaffirmation: I-17; Reaffirmation: A-18

MACRA and the Independent Practice of Medicine H-390.837

1. Our AMA, in the interest of patients and physicians, encourages the Centers for Medicare and Medicaid Services and Congress to revise the Merit-Based Incentive Payment System to a simplified quality and payment system with significant input from practicing physicians, that focuses on easing regulatory burden on physicians, allowing physicians to focus on quality patient care.

2. Our AMA will advocate for appropriate scoring adjustments for physicians treating high-risk beneficiaries in the MACRA program.

3. Our AMA will urge CMS to continue studying whether MACRA creates a disincentive for physicians to provide care to sicker Medicare patients.

Citation: Alt. Res. 206, A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17

Preserving a Period of Stability in Implementation of the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) D-390.950

1. Our AMA will advocate that Centers for Medicare and Medicaid Services (CMS) implement the Merit-Based Payment Incentive Payment System (MIPS) and Alternative Payment Models (APMs) as is consistent with congressional intent when the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) was enacted.
2. Our AMA will advocate that CMS provide for a stable transition period for the implementation of MACRA, which includes assurances that CMS has conducted appropriate testing, including physicians' ability to participate and validation of accuracy of scores or ratings, and has necessary resources to implement provisions regarding MIPS and APMs.
3. Our AMA will advocate that CMS provide for a stable transition period for the implementation of MACRA that includes a suitable reporting period.

Citation: Res. 242, A-16

Reducing MIPS Reporting Burden D-395.999

Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to advocate for improvements to Merit-Based Incentive Payment System (MIPS) that have significant input from practicing physicians and reduce regulatory and paperwork burdens on physicians. In the interim, our AMA will work with CMS to shorten the yearly MIPS data reporting period from one-year to a minimum of 90-days (of the physicians choosing) within the calendar year.

Citation: Res. 236, A-18

Physician Payment Reform H-390.849

1. Our AMA will advocate for the development and adoption of physician payment reforms that adhere to the following principles:
 - a) promote improved patient access to high-quality, cost-effective care;
 - b) be designed with input from the physician community;
 - c) ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions;
 - d) not require budget neutrality within Medicare Part B;
 - e) be based on payment rates that are sufficient to cover the full cost of sustainable medical practice;
 - f) ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process;
 - g) make participation options available for varying practice sizes, patient mixes, specialties, and locales;
 - h) use adequate risk adjustment methodologies;
 - i) incorporate incentives large enough to merit additional investments by physicians;
 - j) provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols;
 - k) provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization;
 - l) attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary; and
 - m) include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.
2. Our AMA opposes bundling of payments in ways that limit care or otherwise interfere with a physician's ability to provide high quality care to patients.
3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes, quality and risk-adjustment measures only if measures are scientifically valid, verifiable, accurate, and based on current data.
4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.
5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment.

Citation: CMS Rep. 6, A-09; Reaffirmation A-10; Appended: Res. 829, I-10; Appended: CMS Rep. 1, A-11; Appended: CMS Rep. 4, A-11; Reaffirmed in lieu of Res. 119, A-12; Reaffirmed in lieu of Res. 122, A-

12; Modified: CMS Rep. 6, A-13; Reaffirmation I-15; Reaffirmation: A-16; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17

Pay-for-Performance Principles and Guidelines H-450.947

1. The following *Principles for Pay-for-Performance and Guidelines for Pay-for-Performance* are the official policy of our AMA.

PRINCIPLES FOR PAY-FOR-PERFORMANCE PROGRAMS

Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the following five AMA principles:

- 1. Ensure quality of care** - Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality of care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician's sound clinical judgment and should not adversely affect PFP program rewards.
- 2. Foster the patient/physician relationship** - Fair and ethical PFP programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.
- 3. Offer voluntary physician participation** - Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of non-participating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.
- 4. Use accurate data and fair reporting** - Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment and appeal results prior to the use of the results for programmatic reasons and any type of reporting.
- 5. Provide fair and equitable program incentives** - Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.

GUIDELINES FOR PAY-FOR-PERFORMANCE PROGRAMS

Safe, effective, and affordable health care for all Americans is the AMA's goal for our health care delivery system. The AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines augment the AMA's "Principles for Pay-for-Performance Programs" and provide AMA leaders, staff and members with operational boundaries that can be used in an assessment of specific PFP programs.

Quality of Care

- The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.
- Evidence-based quality of care measures must be the primary measures used in any program.
- 1. All performance measures used in the program must be prospectively defined and developed collaboratively across physician specialties.
- 2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.
- 3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.
- 4. Performance measures should be scored against both absolute values and relative improvement in those values.
- 5. Performance measures must be subject to the best-available risk- adjustment for patient demographics, severity of illness, and co-morbidities.
- 6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.
- 7. Performance measures must be selected for clinical areas that have significant promise for improvement.
- Physician adherence to PFP program requirements must conform with improved patient care quality and safety.

- Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.
- PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.
- PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team.
- Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing should also analyze for patient de-selection. If implemented, the program must be phased-in over an appropriate period of time to enable participation by any willing physician in affected specialties.
- Plans that sponsor PFP programs must prospectively explain these programs to the patients and communities covered by them.

Patient/Physician Relationship

- Programs must be designed to support the patient/physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.
- Programs must not create conditions that limit access to improved care.
 1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socio-economic groups, as well as those with specific medical conditions, or the physicians who serve these patients.
 2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).
- Programs must neither directly nor indirectly encourage patient de-selection.
- Programs must recognize outcome limitations caused by patient non-adherence, and sponsors of PFP programs should attempt to minimize non-adherence through plan design.

Physician Participation

- Physician participation in any PFP program must be completely voluntary.
- Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.
- Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.
- Programs should be available to any physicians and specialties who wish to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice.
- Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT).
 1. Programs should provide physicians with tools to facilitate participation.
 2. Programs should be designed to minimize financial and technological barriers to physician participation.
- Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.
- Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.
- Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.
- Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

Physician Data and Reporting

- Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act (HIPAA).
- The quality of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not create financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a non-punitive manner.
 1. Programs should use accurate administrative data and data abstracted from medical records.

2. Medical record data should be collected in a manner that is not burdensome and disruptive to physician practices.

3. Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients in the denominator.

- Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program.

- Physicians should be assessed in groups and/or across health care systems, rather than individually, when feasible.

- Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting.

1. Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet quality objectives.

2. Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.

- If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely promulgated.

- The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings.

- PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.

Program Rewards

- Programs must be based on rewards and not on penalties.

- Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.

- Programs must offer financial support to physician practices that implement IT systems or software that interact with aspects of the PFP program.

- Programs must finance bonus payments based on specified performance measures with supplemental funds.

- Programs must reward all physicians who actively participate in the program and who achieve pre-specified absolute program goals or demonstrate pre-specified relative improvement toward program goals.

- Programs must not reward physicians based on ranking compared with other physicians in the program.

- Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.

- Programs must not financially penalize physicians based on factors outside of the physician's control.

- Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.

- Programs must not financially penalize physicians when they follow current, accepted clinical guidelines that are different from measures adopted by payers, especially when measures have not been updated to meet currently accepted guidelines.

2. Our AMA opposes private payer, Congressional, or Centers for Medicare and Medicaid Services pay-for-performance initiatives if they do not meet the AMA's "Principles and Guidelines for Pay-for-Performance."

Citation: BOT Rep. 5, A-05; Reaffirmation A-06; Reaffirmed: Res. 210, A-06; Reaffirmed in lieu of Res. 215, A-06; Reaffirmed in lieu of Res. 226, A-06; Reaffirmation I-06; Reaffirmation A-07; Reaffirmation A-09; Reaffirmed: BOT Rep. 18, A-09; Reaffirmed in lieu of Res. 808, I-10; Modified: BOT Rep. 8, I-11; Reaffirmed: Sub. Res. 226, I-13; Appended: BOT Rep. 1, I-14; Reaffirmed in lieu of Res. 203, I-15; Reaffirmed in lieu of Res. 216, I-15; Reaffirmation I-15; Reaffirmed: BOT Rep. 20, A-16; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmation: A-18

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