

REPORT 15 OF THE BOARD OF TRUSTEES (I-19)
Repealing Potential Penalties Associated with MIPS Resolution (206-I-18)
Reducing the Regulatory Burden in Health Care (Resolution 231-I-18)
Improving the Quality Payment Program and Preserving Patient Access (Resolution 243-A-19)
(Reference Committee B)

EXECUTIVE SUMMARY

At the 2018 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred two resolutions, and at the 2019 Annual Meeting, a third resolution was referred, for a combined Board of Trustees (Board) Report at the 2019 Interim Meeting related to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Resolution 206-I-18, “Repealing Potential Penalties Associated with MIPS,” asks that our AMA advocate to repeal all potential penalties associated with the Merit-Based Incentive Payment System (MIPS) program. Resolution 231-I-18, “Reducing the Regulatory Burden in Health Care,” asks that our AMA work to support the repeal of the MIPS program and oppose any federal efforts to implement any pay-for-performance programs unless such programs add no significant regulatory or paperwork burdens to the practice of medicine and have been shown, by evidence-based research, to improve the quality of care for those served. Resolution 243-A-19, “Improving the Quality Payment Program and Preserving Patient Access,” and asks that our AMA strongly advocate for Congress to make participation in MIPS and alternative payment models (APMs) under the Quality Payment Program (QPP) completely voluntary, that our AMA strongly advocate for Congress to eliminate budget neutrality in MIPS and to finance incentive payments with supplemental funds that do not come from Medicare Part B payment cuts to physicians and other clinicians, and that our AMA call on the Centers for Medicare & Medicaid Services (CMS) to provide a transparent, accurate, and complete Quality Payment Program Experience Report on an annual basis so physicians and medical societies can analyze the data to advocate for additional exemptions, flexibilities, and reductions in reporting burdens, administrative hassles, and costs.

Our AMA understands that there is significant frustration with the MIPS program and continues to vigorously advocate that both CMS and Congress make needed changes. While some progress to improve MIPS has been achieved, Resolutions 206, 231, and 243 illustrate that the implementation of a new quality and payment program for physicians is a major undertaking and significant improvements to the program are still needed—there are concerns that physicians who worked diligently and achieved a top MIPS score invested more in practice improvements than they received through their resulting MIPS incentive payment; and the budget neutrality aspect of MIPS (funding positive MIPS incentive payments with penalties imposed on practices that do not score above the MIPS performance threshold) exacerbates this problem for smaller practices. In addition to urging CMS to make additional improvements to the MIPS program, our AMA joined with many state and specialty medical societies to make it a priority to advocate that Congress provide physicians with positive Medicare payment updates and extend APM payments to provide additional resources to help physicians transition to APMs. Our AMA will work with due purpose to seek positive updates as we continue to reduce MIPS burdens.

To supplement our current policy, the Board believes that our AMA should have the ability to support legislation that shifts the budget neutrality dynamic of the current MIPS program. The Board understands that eliminating the budget neutrality requirements of the MIPS program is a complex issue and that there are many ways to achieve that goal. Therefore, we offer a recommendation to support replacing or supplementing budget neutrality in a manner that provides flexibility to review and consider legislation without being so narrowly defined that we overlook an opportunity to improve the MIPS program in another way.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 15-I-19

Subject: Repealing Potential Penalties Associated with MIPS
Resolution (206-I-18)
Reducing the Regulatory Burden in Health Care
(Resolution 231-I-18)
Improving the Quality Payment Program and Preserving Patient Access
(Resolution 243-A-19)

Presented by: Jesse M. Ehrenfeld, MD, MPH, Chair

Referred to: Reference Committee B

1 At the 2018 Interim Meeting, the American Medical Association (AMA) House of Delegates
2 (HOD) referred two resolutions, and at the 2019 Annual Meeting, a third resolution was referred,
3 for a combined Board of Trustees (Board) Report at the 2019 Interim Meeting related to the
4 Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The first resolution,
5 Resolution 206-I-18, “Repealing Potential Penalties Associated with MIPS,” was introduced by the
6 Florida Delegation and asks that:

7
8 Our American Medical Association advocate to repeal all potential penalties
9 associated with the MIPS program.

10
11 The second resolution, Resolution 231-I-18, “Reducing the Regulatory Burden in Health Care,”
12 was introduced by the Pennsylvania Delegation and asks that:

13
14 Our American Medical Association work to support the repeal of the Merit-Based
15 Incentive Payment System (MIPS); and that upon repeal of MIPS, our AMA oppose
16 any federal efforts to implement any pay-for-performance programs unless such
17 programs add no significant regulatory or paperwork burdens to the practice of
18 medicine and have been shown, by evidence-based research, to improve the quality
19 of care for those served.

20
21 The third resolution, Resolution 243-A-19, “Improving the Quality Payment Program and
22 Preserving Patient Access,” was introduced by the Texas Delegation and asks that:

23
24 Our American Medical Association strongly advocate for Congress to make
25 participation in MIPS and alternative payment models (APMs) under the Quality
26 Payment Program (QPP) completely voluntary, that our AMA strongly advocate for
27 Congress to eliminate budget neutrality in MIPS and to finance incentive payments
28 with supplemental funds that do not come from Medicare Part B payment cuts to
29 physicians and other clinicians, and that our AMA call on the Centers for Medicare
30 and Medicaid Services (CMS) to provide a transparent, accurate, and complete
31 Quality Payment Program Experience Report on an annual basis so physicians and
32 medical societies can analyze the data to advocate for additional exemptions,
33 flexibilities, and reductions in reporting burdens, administrative hassles, and costs.

1 The reference committee heard mixed testimony on Resolutions 206, 231, and 243. Some testified
2 that MIPS should be repealed, as many practices that serve Medicare beneficiaries cannot sustain
3 additional reductions in their Medicare payments. Others testified that our AMA should continue
4 working with Congress and the Administration to ensure that all physician practices, regardless of
5 size or specialty, have the opportunity to succeed in the QPP. Also, there was significant testimony
6 that our AMA should continue advocating to simplify and improve the MIPS program and increase
7 the number and variety of APMs available to physicians.

8 9 BACKGROUND

10
11 Our AMA was supportive when Congress replaced the flawed, target-based sustainable growth rate
12 (SGR) formula with a new payment system under MACRA. Scheduled payment cuts prior to the
13 implementation of MACRA exceeded 20 percent. Those cuts would have had a devastating impact
14 on physician practices and patient access to care. Under MACRA, the SGR formula was replaced
15 with specified payment updates for 2015 through 2019, and for 2026 and beyond. MACRA also
16 created an opportunity to address problems found in existing physician reporting programs,
17 including the chance to earn incentives. In addition, the law sought to promote innovation by
18 encouraging new ways of providing care through APMs.

19
20 Our AMA worked closely with CMS and Congress on implementation of the MIPS program, and
21 AMA advocacy efforts resulted in a policy allowing physicians who reported on one measure, one
22 time, for one patient to avoid a penalty. This transition period allowed many physician practices to
23 be successful in the first performance year of MIPS, with 93 percent of eligible clinicians receiving
24 a modest positive payment adjustment and nearly three-quarters qualifying for an additional
25 exceptional performance bonus. (Notably, the exceptional performance bonus is funded at \$500
26 million annually in the MACRA statute and is not budget neutral.)

27
28 Following the first year of the MIPS program, our AMA was also successful in getting Congress to
29 make needed technical changes to MACRA in the Bipartisan Budget Act of 2018. These changes
30 helped many practices avoid penalties that they likely would otherwise have incurred under the
31 MIPS program. Specifically, our AMA worked with Congress to exclude Medicare Part B drug
32 costs from MIPS payment adjustments, as including these additional items and services created
33 significant inequities in the administration of the program. In addition, our AMA helped achieve
34 changes that allow CMS to reweight the Cost performance category to not less than 10 percent for
35 the third, fourth, and fifth years of MIPS, instead of increasing it to 30 percent as the law
36 previously required, and to set the performance threshold for three additional years instead of
37 basing it on the mean or median of previous MIPS scores.

38 39 DISCUSSION

40 41 *Ongoing AMA Advocacy Efforts*

42
43 Since the enactment of MACRA, our AMA has worked closely with both Congress and CMS to
44 promote a smooth implementation of the QPP. Despite these efforts, Resolutions 206, 231, and 243
45 illustrate that the implementation of a new quality and payment program for physicians is a major
46 undertaking and significant improvements to the program are still needed. As is noted in the
47 resolutions, there are numerous improvements that must still be made to the MIPS program,
48 including more accurate risk adjustment for cost and quality measures, timelier program feedback
49 for physicians, and a more cohesive program structure. In addition, physician practices, especially
50 small and rural physician practices, cannot shift to new payment models without adequate
51 resources.

1 In an effort to address these outstanding issues, our AMA has convened MIPS and APM
2 workgroups made up of representatives from across the physician community, which have
3 developed creative solutions to improve the QPP. Feedback from the MIPS and APM workgroups,
4 as well as other state and specialty medical societies, has led our AMA to focus its efforts to
5 improve the QPP on several key issues: replacing the upcoming Medicare physician pay freeze
6 with a stable revenue source that allows physicians to sustain their practice; eliminating budget
7 neutrality; extending the Advanced APM payments for an additional six years; simplifying the
8 MIPS scoring system and creating a more meaningful MIPS program; and ensuring small and rural
9 practices have the opportunity to succeed.

10
11 *Replace Physician Payment Freeze*

12
13 Resolution 206 notes that many physician practices cannot sustain additional reductions in their
14 Medicare payments. Our AMA agrees, and while MACRA included modest positive payment
15 updates in the Medicare Physician Fee Schedule, it left a gap from 2020 through 2025, during
16 which there are no updates at all. Following this six-year freeze, the law specifies physician
17 payment updates of 0.75 or 0.25 percent for physicians participating in APMs or MIPS.

18
19 Our AMA recognizes that these payment updates are not sufficient, particularly while physicians
20 are investing resources to improve the quality of patient care and shift to new payment models.
21 Therefore, our AMA recently testified before Congress, urging Congress to pass legislation
22 providing physicians with positive payment updates beginning in 2020. The Board strongly
23 supports advocating for positive payment updates, which are needed to provide physicians a
24 margin to maintain their practice, as well as transition to more efficient models of care delivery.

25
26 *Extend APM Payments*

27
28 In addition to providing positive physician payment updates, Congress and the Administration must
29 also work to provide physicians with adequate resources to move into new payment models. One
30 goal of MACRA, in addition to the MIPS program, was to provide physicians with a path to
31 transition into new, innovative APMs that could allow physicians to be paid for services that add
32 value to patient care.

33
34 To help facilitate this transition, Congress provided a five percent incentive payment for physicians
35 who participate in Advanced APMs during the first six years of the program. Unfortunately,
36 through the first three participation years, very few physicians had the opportunity to earn this
37 incentive payment due to the small number of Advanced APMs approved by CMS. While our
38 AMA is working closely with numerous physician groups, as well as the Center for Medicare and
39 Medicaid Innovation (CMMI), to develop and test physician-led APMs, it will take time to
40 implement the number of APMs needed to allow most physicians a realistic opportunity to
41 participate in these models. Therefore, our AMA is urging Congress to extend the Advanced APM
42 incentive payments to provide support to physicians as they transition to new payment models. The
43 Board strongly supports efforts to ensure there are voluntary APMs available for physicians in all
44 specialties and practices of all sizes.

45
46 *Impact of Budget Neutrality*

47
48 The Board strongly supports providing physicians with the resources necessary to improve quality
49 and patient care. The Board is therefore concerned about reports from numerous physicians who
50 have worked diligently to comply with the numerous MIPS requirements, yet have ended up
51 investing more in health information technology and care management processes than they

1 received through their resulting MIPS incentive payment. The negative return on investment from
2 MIPS participation is a serious problem. Also, several witnesses have testified in reference
3 committee that funding positive MIPS incentive payments with penalties imposed on practices that
4 do not score above the MIPS performance threshold exacerbates this problem for smaller practices.
5 The Board supports language in Resolution 243-A-19 noting that physicians need dedicated
6 funding for MIPS incentive payments in order to ensure physicians have the capital they need to
7 move into models that provide patients with the utmost value. Basing positive payment adjustments
8 on penalties also creates uncertainty in the program, which further discourages practices from
9 making the up-front investments needed to transition to value-based payment and care delivery
10 models.

11
12 While supporting the elimination of budget neutrality in the MIPS program, the Board also
13 understands that this is a complex issue that would involve some difficult trade-offs. It would be
14 extremely difficult to secure funding from Congress both for positive MIPS incentive payments,
15 which would help practices that participate in MIPS and exceed the MIPS performance threshold,
16 and funding for positive conversion factor updates, which would help all practices that care for fee-
17 for-service Medicare patients, including small practices that are excluded from MIPS because they
18 are below the low-volume threshold. In addition, physicians in large practices have generally
19 obtained higher MIPS scores than those in smaller practices, so this policy is more likely to help
20 large practices than smaller practices. Partially or fully eliminating MIPS budget neutrality may
21 also make it more difficult to achieve adoption of AMA recommendations to improve the MIPS
22 program, because Congress and the Administration would view any increase in the number of
23 physicians able to succeed in MIPS as increasing federal spending.

24
25 Despite these concerns, the Board determined that replacing or supplementing the budget neutrality
26 requirements in MIPS with incentive payments would help support physicians as they continue to
27 work to comply with the program. Therefore, the Board supports MIPS incentive payments not
28 limited by budget neutrality requirements to provide physicians a margin to transition into more
29 efficient models of care delivery.

30
31 *Simplifying and Streamlining MIPS*

32
33 Our AMA has repeatedly urged CMS to make MIPS more clinically relevant for physicians and
34 patients. As noted in Resolution 243, many physicians must report MIPS measures that are not
35 linked to improved clinical care for their patients. Our AMA's MIPS workgroup has developed
36 detailed recommendations that would make the MIPS program more cohesive and allow physicians
37 to select more relevant measures to report.

38
39 For example, our AMA has urged CMS to streamline the MIPS program by allowing physicians to
40 focus their participation around a specific episode of care, clinical condition, or public health
41 priority. By allowing physicians to focus on activities that fit into their workflow and address their
42 patient populations' needs, rather than segregated measures divided into four disparate MIPS
43 categories, the program would be more likely to improve quality of care for patients and be more
44 meaningful for physicians.

45
46 Our AMA has also urged Congress to allow CMS the flexibility to base scoring on multi-category
47 measures to make MIPS more clinically meaningful, reduce silos between each of the four MIPS
48 categories, and create a more unified program. Our AMA's goal is to help the administration
49 develop an approach that allows physicians to spend less time on reporting and more time with
50 patients and on improving care. The Board strongly supports the efforts to unify MIPS reporting
51 while also making it more meaningful for physicians.

1 *Support for Small and Rural Practices*

2

3 As noted in Resolution 231, our AMA agrees that small physician practices could be
4 disproportionately impacted by penalties under MIPS. In 2017, the national mean and median
5 scores for all MIPS eligible clinicians were 74.01 and 88.97 points. However, the mean and median
6 scores for small practices were 43.46 and 37.67. Our AMA agrees that the lower scores achieved
7 by small practices illustrate the need for AMA to continue advocating for changes to MACRA that
8 will help small practices and solo practitioners.

9

10 In order to help small practices become more successful in the MIPS program, our AMA has
11 engaged in advocacy efforts in multiple areas. First, our AMA has been a strong supporter of the
12 low-volume threshold exemption which was increased and now excludes physicians with allowed
13 charges of \$90,000 or less, 200 or fewer unique Medicare patients, or 200 or fewer covered
14 professional services to Medicare Part B beneficiaries from the MIPS program. Our AMA has also
15 supported MIPS policies including reduced reporting requirements for small practices in the
16 Quality performance category, hardship exemptions from the Promoting Interoperability
17 performance category for qualifying small practices, bonus points for small practices, and technical
18 assistance grants to help small and rural practices succeed in the program. Finally, our AMA is
19 advocating for a legislative change that would allow CMS to develop separate thresholds for small
20 and large practices, so that small physician practices are compared to practices with similar
21 resources. The Board agrees that additional changes are needed to ensure small and rural practices
22 have the opportunity to succeed in the MIPS program.

23

24 *Other Advocacy Efforts*

25

26 In addition to these major program changes, our AMA also continues to urge CMS and Congress to
27 address more nuanced issues in the QPP such as:

28

- 29 • Stabilizing the performance threshold until program improvements are tested and
30 implemented;
- 31 • Revamping the Virtual Group option to encourage small practices to participate;
- 32 • Improving risk adjustment methodologies to account for social risk factors;
- 33 • Reducing the number of quality measures a physician must report under the Quality
34 performance category;
- 35 • Maintaining a minimum point floor for physicians reporting on quality measures that meet the
36 data completeness threshold, regardless of performance on the measure;
- 37 • Eliminating the requirement that physicians must report on an outcome or high priority
38 measure and eliminating the requirement to report on all-payer data;
- 39 • Developing a phased approach for removing “topped-out” measures from MIPS and
40 improving the benchmark methodology;
- 41 • Aligning the MIPS and Physician Compare calculation methodologies;
- 42 • Maintaining the Cost performance category weight while new episode-based cost measures
43 are developed and piloted;
- 44 • Modifying the threshold levels of APM participation required to be eligible for the APM
45 incentive payments;
- 46 • Securing adoption of physician-focused payment models with realistic targets for improving
47 patient health outcomes and generating savings;
- 48 • Eliminating the Total Cost of Care and Medicare Spending Per Beneficiary measures within
49 the Cost performance category as improved episode-based cost measures are developed;
- 50 • Allowing physicians to attest to their use of Certified Electronic Health Information
51 Technology (CEHRT) in the Promoting Interoperability performance category;

- 1 • Reducing the number of measures physicians are required to report in the Promoting
2 Interoperability performance category; and
- 3 • Providing credit for the use of health information technology beyond CEHRT.

4
5 As illustrated by the list above, our AMA has spent significant staff time working with both
6 Congress and CMS to improve the QPP. Our AMA has specifically been advocating persistently
7 for MIPS to be more meaningful to physicians and less administratively burdensome, and to
8 increase the number of available APMs. Our AMA advocacy team meets regularly with both CMS
9 officials and Congressional staff to work to improve MIPS and the APM pathway for physicians
10 and will continue to do so going forward.

11
12 Among the concerns raised with seeking repeal of the MIPS penalties at this time is that the cost
13 would need to be offset and would potentially come at the expense of bonuses or across the board
14 cuts in physician payments, which would impact physicians who are currently exempt from MIPS,
15 such as small practices. Another concern is that repealing penalties associated with MIPS or
16 repealing the entire program at this time could result in an alternative quality payment program that
17 may be less desirable. Furthermore, such a shift in our AMA's advocacy position would effectively
18 preclude our AMA from continuing our advocacy efforts with state and specialty medical societies
19 in support of the Administration's and Congress' efforts to advance successful, innovative payment
20 models as well as the technologies needed to support such models.

21 22 AMA POLICY

23
24 Our AMA has numerous existing policies on MACRA including Policies D-395.999, D-395.998,
25 H-390.838, D-390.950, and D-390.949. Together, these policies direct our AMA to work with
26 CMS to advocate for improvements to MIPS, a reduction in MIPS requirements for all physicians,
27 an exemption to MIPS for small practices, a period of stability in the MIPS program to allow for
28 testing and stability and additional flexibilities for fragile practices. AMA policy also supports our
29 advocacy to increase the number and variety of APMs available to physicians, extend the
30 Advanced APM incentive payments to provide support to physicians as they transition to new
31 payment models, and modify the threshold levels of APM participation required to be eligible for
32 the APM incentive payments (Policies H-385.913, H-450.931, and H-385.908).

33 34 CONCLUSION

35
36 Our AMA understands that there is significant frustration with the MIPS program and continues to
37 vigorously advocate that both CMS and Congress make needed changes. In addition to urging
38 CMS to make additional improvements to the MIPS program, our AMA is joined with many state
39 and specialty medical societies making it a priority to advocate that Congress provide physicians
40 with positive Medicare payment updates and extend APM payments to provide physicians with
41 additional resources to help transition to APMs. The Board believes that the lack of positive
42 updates from 2020 to 2025 severely threatens physicians' ability to sustain their practices,
43 especially while at the same time implementing quality improvements. Our AMA will work with
44 due purpose to seek positive updates as we continue to reduce MIPS burdens.

45
46 While the Board recognizes that the QPP needs improvement, we also acknowledge that the MIPS
47 program is only two years old. Detailed results from the 2017 performance year were recently
48 released and CMS is still analyzing what those results mean for how practices will perform in the
49 future. Implementation of a new quality and payment program is a significant undertaking and
50 requires an iterative process with constant evaluation and improvement.

1 In addition to our current policy, the Board believes that our AMA should have the ability to
2 support legislation that could shift the budget neutrality dynamic of the current MIPS program. The
3 Board understands that eliminating the budget neutrality requirements of the MIPS program is a
4 complex issue and that there are many ways to achieve that goal. Therefore, we offer a
5 recommendation to support replacing or supplementing budget neutrality in a manner that provides
6 flexibility to review and consider legislation without being so narrowly defined that we overlook an
7 opportunity to improve the MIPS program in another way.

8
9 Therefore, the Board recommends, consistent with existing AMA policy, that our AMA continue
10 its work with CMS and Congress to improve the MIPS program, increase APM opportunities for
11 physicians, and provide additional resources for physician practices through positive updates and
12 APM payments. Given that the repeal of MACRA could result in a more burdensome quality
13 program with no opportunity to earn incentives and lower payment updates for physicians, we
14 recommend not advocating for the repeal of MIPS penalties or the MIPS program at this time.
15 However, the Board will continue to monitor the QPP's impact and burden on physicians, and if
16 improvements to the program are not sufficient, we will reevaluate our advocacy policies and
17 position in the future.

18
19 **RECOMMENDATION**

20
21 The Board of Trustees recommends that the following recommendations be adopted in lieu of
22 Resolutions 206-I-18, 231-I-18, and 243-A-19 and that the remainder of the report be filed:

- 23
24 1. That our American Medical Association (AMA) support legislation that replaces or
25 supplements the budget neutrality in MIPS with incentive payments.
26
27 2. That our AMA reaffirm Policy D-395.999, "Reducing MIPS Reporting Burden," Policy D-
28 395.998, "Opposed Replacement of the Merit-Based Incentive Payment System with the
29 Voluntary Value Program," Policy H-390.838, "MIPS and MACRA Exemption," Policy D-
30 390.950, "Preserving a Period of Stability in Implementation of the Medicare Access and
31 Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA)," Policy D-
32 390.949, "Preserving Patient Access to Small Practices Under MACRA," Policy H-385.913,
33 "Physician-Focused Alternative Payment Models," Policy H-385.913, "Physician-Focused
34 Alternative Payment Models," Policy H-450.931, "Moving to Alternative Payment Models,"
35 and Policy H-385.908, "Physician-Focused Alternative Payment Models: Reducing Barriers."

Fiscal Note: Less than \$500

EXISTING AMA POLICY

Policy D-395.999, “Reducing MIPS Reporting Burden”

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 physician’s choosing) within the calendar year.

Policy D-395.998, “Opposed Replacement of the Merit-Based Incentive Payment System with the Voluntary Value Program”

1. Our AMA will oppose the replacement of the Merit-Based Incentive Payment System (MIPS) with the Voluntary Value Program (VVP) as currently defined.
2. Our AMA will study the criticisms of the Merit-Based Incentive Payment System (MIPS) program as offered by proponents of the VVP to determine where improvement in the MIPS program needs to be made.
3. Our AMA will continue its advocacy efforts to improve the MIPS program, specifically requesting: (a) true EHR data transparency, as the free flow of information is vital to the development of meaningful outcome measures; (b) safe harbor protections for entities providing clinical data for use in the MIPS program; (c) continued infrastructure support for smaller practices that find participation particularly burdensome; (d) adequate recognition of and adjustments for socioeconomic and demographic factors that contribute to variation in patient outcomes as well as geographic variation; and (e) limiting public reporting of physician performance to those measures used for scoring in the MIPS program.
4. Our AMA will determine if population measures are appropriate and fair for measuring physician performance.

Policy H-390.838, “MIPS and MACRA Exemption”

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.

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

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.

Policy D-390.949, “Preserving Patient Access to Small Practices Under MACRA”

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.

Policy H-385.913, “Physician-Focused Alternative Payment Models”

1. Our AMA recognizes that the physician is best suited to assume a leadership role in transitioning to alternative payment models (APMs).
2. Our AMA supports that the following goals be pursued as part of an APM:
 - A. Be designed by physicians or with significant input and involvement by physicians;
 - B. Provide flexibility to physicians to deliver the care their patients need;
 - C. Promote physician-led, team-based care coordination that is collaborative and patient-centered;
 - D. Reduce burdens of Health Information Technology (HIT) usage in medical practice;
 - E. Provide adequate and predictable resources to support the services physician practices need to deliver to patients, and should include mechanisms for regularly updating the amounts of payment to ensure they continue to be adequate to support the costs of high-quality care for patients;
 - F. Limit physician accountability to aspects of spending and quality that they can reasonably influence;
 - G. Avoid placing physician practices at substantial financial risk;
 - H. Minimize administrative burdens on physician practices; and
 - I. Be feasible for physicians in every specialty and for practices of every size to participate in.
3. Our AMA supports the following guidelines to help medical societies and other physician organizations identify and develop feasible APMs for their members:
 - A. Identify leading health conditions or procedures in a practice;
 - B. Identify barriers in the current payment system;
 - C. Identify potential solutions to reduce spending through improved care;
 - D. Understand the patient population, including non-clinical factors, to identify patients suitable for participation in an APM;
 - E. Define services to be covered under an APM;
 - F. Identify measures of the aspects of utilization and spending that physicians can control;
 - G. Develop a core set of outcomes-focused quality measures including mechanisms for regularly updating quality measures;
 - H. Obtain and analyze data needed to demonstrate financial feasibility for practice, payers, and patients;
 - I. Identify mechanisms for ensuring adequacy of payment; and
 - J. Seek support from other physicians, physician groups, and patients.
4. Our AMA encourages CMS and private payers to support the following types of technical assistance for physician practices that are working to implement successful APMs:
 - A. Assistance in designing and utilizing a team approach that divides responsibilities among physicians and supporting allied health professionals;
 - B. Assistance in obtaining the data and analysis needed to monitor and improve performance;
 - C. Assistance in forming partnerships and alliances to achieve economies of scale and to share tools, resources, and data without the need to consolidate organizationally;
 - D. Assistance in obtaining the financial resources needed to transition to new payment models and to manage fluctuations in revenues and costs; and
 - E. Guidance for physician organizations in obtaining deemed status for APMs that are replicable, and in implementing APMs that have deemed status in other practice settings and specialties.
5. Our AMA will continue to work with appropriate organizations, including national medical specialty societies and state medical associations, to educate physicians on alternative payment models and provide educational resources and support that encourage the physician-led development and implementation of alternative payment models.

Policy H-450.931, “Moving to Alternative Payment Models”

1. As physician payment moves to pay-for-value, our American Medical Association will help physician practices with the following: (a) physician practices need support and guidance to optimize the quantity and content of physician work under alternative payment models; (b) address physicians' concerns about the operational details of alternative payment models to improve their effectiveness; (c) to succeed in alternative payment models, physician practices need data and resources for data management and analysis; and (d) harmonize key components of alternative payment models across multiple payers, especially performance measures to help physician practices respond constructively.
2. Our AMA will, in partnership with other appropriate physician organizations, work with the Centers for Medicare & Medicaid Services to establish an appropriate timetable for implementation of pay-for-value models that takes into account the physician community's readiness to assume two-sided risk (up-side and down-side risk).

Policy H-385.908, “Physician-Focused Alternative Payment Models: Reducing Barriers”

1. Our AMA encourages physicians to engage in the development of Physician-Focused Payment Models by seeking guidance and refinement assistance from the Physician-Focused Payment Model Technical Advisory Committee (PTAC).
2. Our AMA will continue to urge CMS to limit financial risk requirements to costs that physicians participating in an APM have the ability to influence or control.
3. Our AMA will continue to advocate for innovative ways of defining financial risk, such as including start-up investments and ongoing costs of participation in the risk calculation that would alleviate the financial barrier to physician participation in APMs.
4. Our AMA will work with CMS, the Office of the National Coordinator for Health Information Technology (ONC), PTAC, interested medical societies, and other organizations to pursue the following to improve the availability and use of health information technology (IT):
 - a. Continue to expand technical assistance;
 - b. Develop IT systems that support and streamline clinical participation;
 - c. Enable health IT to support bi-directional data exchange to provide physicians with useful reports and analyses based on the data provided;
 - d. Identify methods to reduce the data collection burden; and
 - e. Begin implementing the 21st Century Cures Act.
5. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to design risk adjustment systems that:
 - a. Identify new data sources to enable adequate analyses of clinical and non-clinical factors that contribute to a patient's health and success of treatment, such as disease stage and socio-demographic factors;
 - b. Account for differences in patient needs, such as functional limitations, changes in medical conditions compared to historical data, and ability to access health care services; and
 - c. Explore an approach in which the physician managing a patient's care can contribute additional information, such as disease severity, that may not be available in existing risk adjustment methods to more accurately determine the appropriate risk stratification.
6. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to improve attribution methods through the following actions:
 - a. Develop methods to assign the costs of care among physicians in proportion to the amount of care they provided and/or controlled within the episode;
 - b. Distinguish between services ordered by a physician and those delivered by a physician;
 - c. Develop methods to ensure a physician is not attributed costs they cannot control or costs for patients no longer in their care;
 - d. Explore implementing a voluntary approach wherein the physician and patient agree that the physician will be responsible for managing the care of a particular condition, potentially even

having a contract that articulates the patient's and physician's responsibility for managing the condition; and

e. Provide physicians with lists of attributed patients to improve care coordination.

7. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to improve performance target setting through the following actions:

a. Analyze and disseminate data on how much is currently being spent on a given condition, how much of that spending is potentially avoidable through an APM, and the potential impact of an APM on costs and spending;

b. Account for costs that are not currently billable but that cost the practice to provide; and

c. Account for lost revenue for providing fewer or less expensive services.