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AMERICAN SOCIETY OF PLASTIC SURGEONS

Reasoning Behind ASPS Opposition to H.R.2, the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015

The flawed Sustainable Growth Rate (SGR) formula has led to significant instability for physicians due to the nearly constant threat of double digit cuts to payment rates. This threatens our practices and patient access to quality care. The American Society of Plastic Surgeons supports the elimination of the SGR and the implementation of a system that provides stability for physicians and their patients, while ensuring the long-term viability of the replacement program.

On March 24, 2015 Congress introduced the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 (H.R.2), which will repeal and replace the SGR. While the bill addresses many of ASPS' core principles for repeal, ASPS is unable to support the bipartisan, bicameral legislation as it does not provide for adequate reimbursement, lacks sufficient detail, seeks to pit providers against one another in a race to avoid onerous penalties, and does not contain structures and processes to allow all providers to choose quality and performance improvement metrics that are appropriate to their practice. For the following reasons, ASPS does not support MACRA:

- **Insufficient Statutory Updates.** Payments to physicians have been flat for more than a decade, while the cost of running a practice has greatly increased. MACRA's annual fee updates – 0.5% annual fee updates through 2018, followed by 0% updates through 2023 – do not cover the cost of medical price inflation, let alone compliance with mounting federal regulations.

  Compounding the effects of insufficient updates will be cuts to physician reimbursement based on arbitrary thresholds. These will threaten the viability of private practices, most significantly for small and solo practices. The SGR must be replaced with a stable and fair mechanism that recognizes reasonable inflationary medical costs and reimburses physicians based on the actual cost of providing care.

- **Flawed Quality and Performance Improvement Program**. The effort to replace the current byzantine, redundant and punitive quality and performance improvement regime is admirable, but the proposed solution in H.R.2, the Merit-Based Incentive Payment System (MIPS), is lacking. MIPS simply combines existing programs—the Physician Quality Reporting System (PQRS), the Value-Based Modifier (VBM), and meaningful use of EHRs—under a single title and adds a performance improvement metric. There are numerous problems with this new system.

- While ASPS appreciates that MIPS would terminate current law quality program payment reductions, it would still put many physicians at risk for penalties. ASPS supports positive financial incentives for higher quality and more efficient care, not penalties and withholds.

- While we appreciate efforts to combine and streamline current reporting mandates, it is unclear to what extent MIPS would truly break down the walls between existing programs and get rid of the multiple competing requirements of current programs. Furthermore, MIPS seems to actually increase the regulatory burden that physicians now face by holding them accountable to existing program requirements, as well as additional "clinical practice improvement activities." Physicians should be given the opportunity to demonstrate engagement in innovative clinical practice improvement activities as a surrogate for satisfying existing program requirements, not *in addition to* satisfying these requirements.

- There also is an overall lack of detail on the intended structure and impact for many key components of MIPS, such as the weighting and methodologies that will be used to calculate the composite scores that will so heavily influence who is penalized and who is rewarded under the system. This lack of clarity is a major concern because a similar lack of clarity in the statutory creation of the very programs that MACRA now seeks to replace led to numerous misconstructions and problems in their implementation. This mistake should not be repeated, and Congress should be clear about what it wants and how it intends to get there.

- At its onset, MIPS will rely heavily on existing quality measures. It's widely known that many specialty providers struggle to find measures that are relevant to their practice. While the mechanisms proposed to allow for the introduction of new quality measures through specialty society qualified clinical data registries (QCDRs) are a good start, the proposal as structured in H.R.2 places small specialties at a disadvantage, as many of these still may not have the resources to develop and maintain a registry.

- MIPS employs a zero sum approach that arbitrarily picks winners and losers based on where they fall relative to a mean or median level composite score for performance across the four MIPS domains. This approach is problematic because it lumps together providers of all specialties who practice in diverse settings and see varying patient populations and assumes they should be held to the same standard. MIPS also does not ensure that high performers are only rewarded and that penalties only hit low performers. Penalties and rewards will certainly be appropriately directed at the extremes, early in the program. But as it matures, the application of rewards and penalties will become distorted and inappropriate. Even at the outset, basing the distribution on an arbitrary mid-point will penalize some providers who are producing care at an objectively efficient and good quality.

- Further, the penalties in place from 2021 are so severe that they will, in combination with statutory updates that fail to meet practice cost increases, result in the lowest performers leaving the system. When the lowest performers leave the system, the mean/median quality level will represent more efficient and higher quality care than in the previous year. On its surface, this appears to be a good thing. But the practical effect is that the number of providers who give objectively high-quality care yet still fall within the penalized range of composite scores increases; the quality of care provided by the "lowest" performing, most severely penalized and thus least viable participants increases; and when they are forced out of the system, the overall quality level considered "average" in the subsequent year increases. In the subsequent year, target scores become harder to meet, even higher-quality performers are forced out, and the problem is compounded. This is a negative feedback loop, it is a form of adverse selection, and it will put a viable fee-for-service option into a death spiral.

- Inappropriate Use of Utilization and Payment Data. Utilization and payment data, when presented in a vacuum, are not indicative of the quality or efficiency of health care professionals. Including utilization and payment data on the Physician Compare website will be misleading, and could cause consumers to reach inaccurate conclusions about physicians. Patients have the right to make informed decisions about their health care, and should be provided with information that is relevant to making those decisions. However, physicians who treat the most difficult patients, who are likely the premier providers in their specialty, may appear to consumers using Physician Compare as if they are "over-charging" or "over-utilizing". This is unfair to physicians and does not provide appropriate transparency to consumers.

While ASPS welcomes congressional action on repealing and replacing the flawed SGR, we remain skeptical of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 (H.R.2). We hope that Congress will develop legislation that not only repeals the SGR, but provides reimbursement that keeps up with inflationary and regulatory costs. We would like incentives that are clear, specialty specific, easy to report, and are not a moving target.