Alliance of Specialty Medicine

Sound Policy. Quality Care.

Same Letter Sent to House Energy and Commerce and Senate Finance Committee Leaders

March 30, 2021

The Honorable Richard Neal
Chairman
House Ways and Means Committee
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Kevin Brady
Ranking Member
House Ways and Means Committee
1139 Longworth House Office Building
Washington, DC 20515

Re: Request for an Oversight Hearing on the Implementation of MACRA and Physician-focused Value-based Care Initiatives

Dear Chairman Neal and Ranking Member Brady:

The undersigned members of the Alliance of Specialty Medicine (Alliance) are writing to urge you to consider convening an oversight hearing to examine the implementation of physician-focused value-based care initiatives authorized under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. The Alliance represents more than 100,000 specialty physicians and is dedicated to the development of sound federal health care policy that fosters patient access to the highest quality specialty care.

Our specialty society members are actively engaged in efforts to enhance quality and improve the outcomes and experiences of their patients. Alliance members are involved in a variety of value-based care initiatives, including developing clinically relevant measures, adopting clinical data registries and constructing specialty-focused alternative payment models (APMs). Unfortunately, initiatives authorized under MACRA — including the Quality Payment Program (QPP) and the Physician-Focused Payment Model Technical Advisory Committee (PTAC) — have failed to recognize or advance these efforts. Instead, the Centers for Medicare & Medicaid Services (CMS) has spurned stakeholder-driven APMs recommended by PTAC while also creating disjointed, administratively burdensome and clinically irrelevant pathways that not only deviate from the Congressional intent of the original legislation but fall well short of the goals of genuine value-based care.

More than five years ago, physicians hailed the adoption of MACRA, which ended the flawed sustainable growth rate (SGR) payment system, replacing it with a program to align physician payments to value and accelerate physician participation in APMs. The QPP's Merit-Based Incentive Payment System (MIPS) was intended to streamline siloed legacy quality programs, reduce administrative complexity and promote the use of more clinically-relevant measures. The QPP's Advanced APM track, paired with the recommendations of PTAC, was intended to incentivize physician movement towards APMs by creating opportunities for physicians to develop and participate in more applicable models. However, as we reflect on the last five years, it is evident that misguided implementation policies have severely limited the effectiveness of these physician-focused initiatives.

To ensure that these initiatives are, in fact, improving the quality and value of physician care, we urge the Finance Committee to convene an oversight hearing to evaluate MACRA's value-based care programs and explore the ongoing implementation challenges. These challenges are summarized below:

1. **Administrative Complexity of MIPS**. A key factor in the Alliance's support for MACRA was the law's promise to create a single, coordinated approach to physician quality reporting and value-focused performance measurement. Since its inception, MIPS has relied on four separate performance categories with four distinct reporting requirements and scoring rules. MIPS has failed to produce a more unified quality reporting structure by offering cross-category credit for more robust activities, such as reporting to a clinical data registry. As a result, the program is still challenging for many physicians to navigate. It relies on indeterminate targets; is unnecessarily costly and time-consuming for physicians; and for many specialties, there is no clear evidence of the value the program brings, in its current form, to patients, physicians or the Medicare program. Additionally, most MIPS measures do not align with those being used in APMs, such as the Bundled Payments for Care Improvement- Advanced (BPCI-A) model, which results in duplicative reporting. Physicians should only have to report measures once to get credit across different CMS programs.

2. **Policies that Disincentivize Meaningful Specialty Measures**. Over the last five years, CMS has adopted numerous policies that disincentivize the development and use of more focused specialty measures. This includes scoring caps for certain types of measures and overly rigorous measure testing and data validation requirements — particularly for specialty-driven Qualified Clinical Data Registries (QCDRs), a reporting mechanism intended to promote more specialty-focused measures. This also includes requiring specialty societies to "harmonize" their QCDR measure results with other disparate and non-risk stratified measures, which disadvantages specialists who care for the sickest and most complicated patients. These policies have left many specialists with few valid and meaningful measures to report and have caused specialty societies to question their future investment in measure development for purposes of MIPS. In regards to cost measures, the MIPS population-based cost measures do not help many specialists better manage resource use since they focus on treatment decisions over which specialists do not have direct control. While CMS has done some work to develop more focused episode-based cost measures, there are still many specialties and patient populations that are not yet captured by these measures. CMS also has discouraged specialty society's from developing their own cost measures by making it difficult for registries to access Medicare claims data — despite MACRA's mandate to do so — to conduct more meaningful cost analyses. As a result of these policies, the program discourages meaningful engagement and fails to appropriately incentivize higher-value care.

3. **Flawed value assessments.** MIPS relies on a rigid, one-size-fits-all approach to performance assessment that does not recognize the diversity of medical practice, particularly as it relates to Promoting Interoperability. The program should support more flexible approaches that allow physicians to demonstrate their commitment to higher quality care based on their unique setting, specialty, and/or patient population. MIPS also evaluates cost and quality independently, which results in flawed assessments of value and fails to account for the impact that cost reduction may have on patient outcomes or other quality metrics.

4. **Constantly shifting goalposts**. Each performance year, CMS significantly changes QPP eligibility rules, participation options, scoring policies and performance benchmarks, which leaves physicians and medical societies in a constant state of turmoil and impacts the accuracy of year-to-year performance comparisons. The latest set of changes is a new participation pathway, known as the MIPS Value

Pathways (MVP), which aims to reduce clinician burden, provide a more cohesive and meaningful MIPS participation experience, and better prepare clinicians for APMs. Although initially promising, our experience working with CMS on the development of MVPs has suggested that this new framework will do little to fix what is fundamentally wrong with MIPS and provide limited opportunity for the type of innovations that would result in more meaningful physician engagement and impactful improvements in patient care. For example, from the initial draft MVPs, it is clear that CMS is merely dumping already flawed quality and cost measures into a new single MVP, rather than working collaboratively with the specialties to develop MVPs that reflect meaningful measures for a given clinical area. The MVPs presented by CMS to date also have been too clinically broad to result in accurate or meaningful measurement.

5. **Unactionable and untimely performance feedback and program evaluation.** MIPS performance feedback to individual physicians is often confusing, untimely and not actionable. Similarly, CMS analyses of national QPP participation, performance and payment adjustment trends are untimely and lack critical information. The most recent "experience report," released in July of 2020, pertains to the 2018 performance year and provides little detail about specialty trends. One key piece of information that CMS has not yet made available is how many specialists vs. non-specialists participate in Advanced APMs and qualify for the incentives offered under that track. CMS also has provided little data on how different specialties and impacted by each of the cost measures. Having access to more comprehensive analytics regarding the program is essential to our overall understanding of specialty participation in the QPP and how to ensure the goals of the program are being met.

6. **Lack of coordination within CMS.** CMS seems to suffer from a right-hand/left-hand problem. Multiple offices within CMS are engaged in similar but separate quality and value initiatives, with little apparent coordination. For example, the staff responsible for administering the QPP seem disconnected from the staff administering APMs at the CMS Medicare and Medicaid Innovation (CMMI) Center. Additionally, CMS uses numerous different contractors (e.g., Ketchum, Acumen, MITRE) for all of its initiatives, which leads to confusion and situations where important decisions are being made by individuals with no institutional history and very little understanding of the clinical implications of recommendations and actions.

7. **Limited ability for specialties to develop and participate in Advanced Payment Models.** Meaningful opportunities for specialists to participate in innovative payment and delivery models are limited due to CMS' unwillingness to test models recommended by PTAC. CMS was granted significant authority to test and evaluate innovative payment and delivery models through the establishment of the Center for Medicare and Medicaid Innovation (CMMI) by the Affordable Care Act in 2010. PTAC was established under MACRA to review physician-focused payment model proposals and provide recommendations to CMS, with stakeholders largely anticipating CMMI implementation of PTAC-recommended models. The panel has reviewed over 35 models to date. While it has recommended several models for implementation, CMS has yet to advance any of these models for implementation in their original form. The Alliance is frustrated over CMMI's failure to test any of these models, despite specialty societies having spent countless hours and human and economic capital developing these proposals. This not only stymies specialists who are interested in testing more innovative models, but it delays movement towards value-based care. Although MACRA incentivizes physicians to participate in Advanced APMs by providing 5% annual bonuses to physicians who meet certain participation thresholds, only a small fraction of physicians who participate in the QPP qualify for this track. Since MACRA only authorizes these bonuses through the 2022 performance year, specialists are at a gross disadvantage.

Our organizations are committed to improving value and investing in programs that will help meet Medicare's goal of delivering high-value quality care. However, something must be done to alter the current trajectory of these MACRA programs to ensure meaningful engagement by physicians and significant improvements for patients. We, therefore, urge Congress to continue its ongoing oversight of MACRA and collaborate with the Alliance and others in the medical community to direct CMS to make the necessary programmatic changes to the QPP. A robust oversight hearing on the current state of the MACRA value-based care programs would be an important first step in getting these initiatives on track.

Thank you for considering our request. The undersigned members of the Alliance would be happy to talk with you or your staff in more detail about these ongoing issues related to MACRA implementation, as well as potential witnesses for an oversight hearing. Please contact us at info@specialtydocs.org if we may provide additional information or answer any questions.

Sincerely,

American Academy of Facial Plastic & Reconstructive Surgery
American Association of Neurological Surgeons
American College of Mohs Surgery
American College of Osteopathic Surgeons
American Gastroenterological Association
American Society for Dermatologic Surgery Association
American Society of Cataract and Refractive Surgery
American Society of Echocardiography
American Society of Plastic Surgeons
American Society of Retina Specialists
Coalition of State Rheumatology Organizations
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