

MACRA OVERSIGHT & TECHNICAL UPDATES: Ensure Meaningful Opportunities for Specialists to Engage in Value-Based Initiatives

REQUEST

The Alliance of Specialty Medicine (Alliance) urges Congress to **convene an oversight hearing of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to examine the implementation and impact of physician-focused value-based initiatives, including the Quality Payment Program (QPP) and the Physician-Focused Payment Model Technical Advisory Committee (PTAC). We also urge Congress to make technical updates to MACRA to improve these programs, including an extension of the incentive payments for Qualifying Participants (QP) in Advanced Alternative Payment Models (A-APM) to ensure that specialists can engage in meaningful Medicare value-based initiatives.**

SUMMARY OF LEGISLATIVE REQUESTS

The Alliance thanks Congress for enacting MACRA technical corrections through the *Bipartisan Budget Act of 2018 (BBA of 2018)*, which made improvements to the Merit-based Incentive Payment System (MIPS) and authorized PTAC to provide feedback to stakeholders who submit APM proposals. We also appreciate that the *Consolidated Appropriations Act, 2021*, placed a two-year freeze on the current Medicare payment and patient count thresholds for physicians to qualify for the A-APM incentive payment, thus providing more clinicians with the opportunity to qualify for this incentive. However, many of the delays authorized in law are soon set to expire, and additional technical updates to MACRA are needed to ensure its value-based initiatives are relevant and feasible for specialists, particularly in light of the COVID-19 public health emergency (PHE).

Convene a MACRA Oversight Hearing –The Alliance is concerned that over the last five years, initiatives authorized under MACRA, such as the QPP and the PTAC, have suffered from misguided implementation policies that deviate from the Congressional intent of the original legislation and fail to catalyze movement towards higher value care, particularly for specialists. The Centers for Medicare & Medicaid Services (CMS) has created disjointed, administratively burdensome, and clinically irrelevant pathways under the QPP that rely on constantly shifting goalposts, disincentivize the use of more meaningful specialty measures, and do little to enhance quality and improve the outcomes and care experiences of patients. A recent report issued by the U.S. Government Accountability Office (GAO) and mandated under MACRA noted concerns that MIPS performance feedback is not timely or meaningful, questions about whether the program helps improve quality and patient outcomes, and concerns about the program’s low return on investment. To date, CMS also has declined to implement physician-developed APMs recommended by PTAC, which is frustrating to our specialty society members who have invested significant resources into the development of these models, but also delays movement towards value-based care. **The Alliance requests that Congress convene a MACRA oversight hearing on implementation to date to evaluate the impact of the QPP and PTAC on healthcare quality and value.**

Enact Additional MACRA Technical Improvements – The Alliance urges Congress to enact the following technical improvements to strengthen MACRA’s Medicare physician payment reforms:

- **Provide CMS with the authority to make MIPS more streamlined and flexible, such as allowing multi-category credit for certain activities.** MIPS continues to rely on four separate performance categories that each have distinct reporting requirements and scoring rules. CMS has failed to produce a more unified quality reporting structure by offering cross-category credit for robust activities, such as reporting to a clinical data registry. As a result, the program is often challenging to navigate, time-consuming, and costly.
- **Allow CMS to set the MIPS performance threshold at an appropriate level and give CMS the authority to set multiple performance thresholds, such as a separate one for small and rural practices.** Under current law, CMS is required, starting with the 2022 performance year, to set the MIPS performance threshold, or the minimum points needed to avoid a Medicare penalty, at the mean or median score of all MIPS eligible clinicians during a previous performance period. In light of COVID-19 disruptions to the healthcare system and practice patterns, we request that Congress provide CMS with the flexibility to determine the most appropriate performance threshold for the coming years.

- **Modify the MIPS Promoting Interoperability category to award credit for more innovative uses of digital technology, such as qualified clinical data registries, that interact with certified EHRs.** 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 use of digital technology that is appropriate for their unique setting, specialty, and/or patient population. This is increasingly important as the diversity of digital healthcare tools and applications continues expands.
- **Allow CMS flexibility to adjust the weights of the Quality and Cost categories, which under current law, must both equal 30% starting with the 2022 performance year.** While CMS continues to develop more focused episode-based cost measures, there are still many specialists and patient populations that are not yet captured by these measures, as well as many specialists who do not benefit from the total cost measures. CMS also has discouraged specialty societies from developing their own cost measures by making it difficult for registries to access Medicare claims data— despite MACRA’s mandate to do so. CMS should have the authority to account for extenuating circumstances, such as the ongoing lack of relevant cost measures for many specialists and the impact that COVID-19 has had on patient volumes and care patterns, when setting the weights of MIPS performance categories.
- **Allow CMS to modify the MIPS Cost category by 1) removing the primary care-based total per capita costs measure mandate that could hold physicians responsible for costs outside of their control; and 2) by removing the requirement that episode-based cost measures account for at least 1/2 of Part A and B expenditures to ensure prioritization of episodes with high variability and that specialists can directly impact.** The total cost measures do not help specialists better manage resource use since they focus on treatment decisions over which specialists have little direct control. They also may result in double counting of the same patient costs across multiple measures. In terms of prioritizing episodes, the current statutory target is arbitrary and may result in measures that are not necessarily valid and actionable.
- **Extend A-APM incentive payments for an additional six years, which would help facilitate specialty physician movement toward new and innovative models that have not yet materialized.** Physicians who meet specific Medicare participation thresholds through an A-APM qualify for a 5% Medicare incentive payment and are exempt from MIPS. However, under current law, 2022 is the last year that clinicians can qualify for this incentive payment, payable in 2024. To date, there have been limited opportunities for specialists to participate in A-APMs since current models are primary care-focused and not well-suited for specialists. However, there continues to be recognition that greater opportunities for specialist participation in APMs are needed. If new specialty models are implemented, the financial risk and additional administrative costs of implementing the models will need to be offset by the incentive payment. Therefore, we encourage Congress to extend the expiring A-APM incentive payment.

BACKGROUND

More than five years ago, physicians hailed the adoption of MACRA, which replaced the flawed sustainable growth rate (SGR) payment system with programs meant to align physician payments with value and accelerate physician participation in APMs. 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 was intended to incentivize physician movement towards APMs.

CMS also 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 later 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. Although the panel has reviewed over 35 models to date and recommended several models for implementation, CMS has yet to advance any of these models for implementation in their original form.

Earlier this year, the Alliance [wrote](#) Congress requesting a MACRA oversight hearing and outlining these concerns.