Sound Policy. Quality Care.

October 28, 2022

The Honorable Ami Bera
U.S. House of Representatives
172 Cannon House Office Building
Washington, DC 20515

The Honorable Kim Schrier
U.S. House of Representatives
1123 Longworth House Office Building
Washington, DC 20515

The Honorable Earl Blumenauer
U.S. House of Representatives
1111 Longworth House Office Building
Washington, DC 20515

The Honorable Bradley Schneider
U.S. House of Representatives
300 Cannon House Office Building
Washington, DC 20515

The Honorable Larry Bucshon
U.S. House of Representatives
2313 Rayburn House Office Building
Washington, DC 20515

The Honorable Michael Burgess
U.S. House of Representatives
2161 Rayburn House Office Building
Washington, DC 20515

The Honorable Brad Wenstrup
U.S. House of Representatives
2419 Rayburn House Office Building
Washington, DC 20515

The Honorable Mariannette Miller-Meeks
U.S. House of Representatives
1716 Longworth House Office Building
Washington, DC 20515

RE: Request for Information on the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015

Dear Representatives Bera, Bucshon, Schrier, Burgess, Blumenauer, Wenstrup, Schneider, and Miller-Meeks:

The Alliance of Specialty Medicine (the "Alliance") represents more than 100,000 specialty physicians and is deeply committed to improving access to specialty medical care through the advancement of sound health policy. Today, we write to suggest actions Congress should take to stabilize the Medicare payment system while ensuring successful value-based care incentives are available for specialty physicians. Like you, we have serious concerns about structural and mounting instability in Medicare payments to physicians and request your assistance in urging the committees of jurisdiction to hold hearings to begin the process of stabilizing and improving Medicare physician reimbursement and performance programs.

Our comments below discuss the major pain points our specialty organizations and their members have been facing under the current Medicare physician payment system and quality improvement programs.

We urge Congress to take the following actions to address many of the challenges we face, and our recommendations include:

- Replace flat base payment updates with a payment mechanism that includes an appropriate inflationary index to the Medicare conversion factor that reflects rising practice costs, such as the Medicare Economic Index (MEI).
- Exempt the following from budget-neutrality adjustments:
  - Newly-covered or expanded Medicare benefits, items and services, such as preventative services and new technologies,
  - Items and services that are delivered in response to a public health emergency (PHE); and
  - Changes in relative values due to increased practice costs (e.g., clinical labor, professional liability insurance).
- Authorize the Secretary of Health and Human Services (HHS) the flexibility to waive or modify budget neutrality requirements in other circumstances, as appropriate.
- Require ongoing and consistent updates of key data inputs used to set Medicare payments to physicians, including practice expense costs.
- Evaluate the impact of the Quality Payment Program (QPP) and Physician-Focused Payment Model Technical Advisory Committee (PTAC) on health care quality and value, as well as access to care — particularly as it relates to specialty care.
- Make technical improvements to MACRA to strengthen the QPP, including:
  - Provide the Centers for Medicare & Medicaid Services (CMS) with the authority to make Merit-based Incentive Payment System (MIPS) more streamlined and flexible, including allowing physicians to earn credit across the four performance categories of MIPS for certain robust activities, such as reporting to and using data from a clinical data registry to improve care, rather than having to check the boxes of all four categories. Congress must provide CMS with the authority to truly dismantle the silos that currently prevent more accurate and efficient assessments of value.
  - Provide CMS with the authority to move away from the current one-size-fits-all approach to measurement and permit more flexibility regarding measure adoption, participation pathways, scoring, and performance thresholds to reflect better the diversity of clinical practice in terms of settings, specialties and/or patient populations. This should include:
    - Providing CMS with the flexibility to adjust the weights of the MIPS performance categories over time to reflect the current state of the healthcare landscape, shifting gaps in care, and the current state of available measures. This is particularly important with the Cost category. 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 remaining total per capita cost measures. CMS should be able to account for extenuating circumstances, such

as the ongoing lack of relevant cost measures for many specialists, when setting the weights of MIPS performance categories. Similarly, CMS should have the authority to adjust the weight of the Promoting Interoperability category — which has remained stagnant since the start of the program despite evolving industry standards and practices.

    - Allowing CMS to set the MIPS performance threshold (i.e., the minimum points needed to avoid a penalty) at an appropriate level each year based on performance trends and stakeholder input, rather than setting it at the mean or median score of all MIPS eligible clinicians during a previous performance period, as mandated by MACRA. This current mandate does not account for unforeseen circumstances, such as a pandemic, which could minimize the appropriateness of relying on historical performance trends for future payment years. CMS should also be able to set multiple performance thresholds, such as a separate threshold for small and rural practices.

  - Put pressure on CMS to better incentivize the use of Qualified Clinical Data Registries (QCDRs), specialty-specific measures, and participation pathways that are more meaningful to specialists. This includes adopting minimum standards of reliability and validity that ensure high-quality data without discouraging specialty society engagement. This also means enforcing MACRA's requirement that CMS provide access to Medicare claims data to assist specialties and their registries with a better understanding of existing gaps in care and supporting the development of quality and cost measures.
  - Allow CMS to modify the MIPS Cost category by removing the 1) primary care-based total per capita costs measure mandate that could hold physicians responsible for costs outside of their control; and 2) requirement that episode-based cost measures account for at least one-half 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 may also result in double-counting the same patient costs across multiple measures. Regarding prioritizing episodes, the current statutory target is arbitrary and may result in measures that are not necessarily valid and actionable.
  - Require that CMS may only measure cost in the context of quality. Cost measure assessments must ensure that efforts to lower costs do not result in poorer quality care or negatively impact access to care.
  - Extend the MIPS Exceptional Performance Bonus, which has funded the bulk of MIPS incentive payments to date, but expires under MACRA after the 2022 performance year/2024 payment year.
  - Improve the alternative payment model (APM) pipeline to provide specialists with more opportunities to participate meaningfully in APMs and qualify for the APM track of the QPP.
  - Extend the 5% APM incentive payments and maintain current Advanced APM (A-APM) Qualifying Participant (QP) thresholds for an additional six years, which would help

facilitate specialty physician movement toward new and innovative models that have not yet materialized. The 5% incentive payment has been a critical source of financial support for physicians investing in APMs. 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.

- Require CMS to release more granular data regarding physician participation in MIPS, APMs, and QP eligibility, by specialty.

Key Challenges with MACRA and the Medicare Physician Payment System

In 2015, MACRA was enacted — replacing the flawed sustainable growth rate physician payment formula with a payment system that sought to reward physicians based on quality, efficiency, and outcomes. Thus far, ***the implementation of MACRA's two-track value-based payment system has been ineffective and, arguably, detrimental to the delivery of most specialty medical care***.

Payments to physicians

MACRA aimed to improve Medicare payments to physicians, yet physicians are still grossly under-reimbursed for delivering care to Medicare beneficiaries. This is particularly true when comparing Medicare payment updates across various providers. For example, physicians are slated to receive a 4.42% reduction in calendar year (CY) 2023 payment under the Medicare Physician Fee Schedule (MPFS), whereas other providers will realize sizeable increases (e.g., inpatient hospitals (4.3%); inpatient rehabilitation facilities (3.9%); hospices (3.8%); and hospital outpatient departments (2.7%)). In fact, Medicare Advantage plans expect an overall increase in payments of 8.5%. This payment disparity between Medicare providers is unconscionable and indefensible and must be addressed.

As we have shared for many years — even before MACRA was enacted — the costs associated with running a physician practice have increased considerably. The prices of medical supplies, equipment, and clinical and administrative labor have risen dramatically — particularly during this period of extremely high inflation, as demonstrated by the Consumer Price Index (CPI) and MEI (*see* American Medical Association (AMA) Medicare Updates Compared to Inflation (2001-2022)). Unlike other Medicare providers that receive annual payment updates based on an inflation proxy, such as the CPI, MACRA established physician payment updates without a yearly automatic inflation adjustment. Congress anticipated that physicians would receive value-based incentives and differential payment updates based on their participation in either the MIPS or the APM tracks. However, for multiple reasons (including the budget-neutral nature of MIPS and the ongoing lack of meaningful APM participation pathways for specialists), these QPP programs have failed to produce sufficient payment updates, particularly when compared to the effort and resources physicians must devote to participate.

Instead, most specialty physicians have received flat or reduced payment updates (*see* AMA History of Medicare Conversion Factors), along with minuscule incentives for MIPS participation (with +2.33% being the highest incentive payment to date). Further, the bulk of incentives under MIPS have stemmed from the Exceptional Performance Bonus pool, which is set to expire after the 2022 performance year/2024 payment year under MACRA.

In addition, and as discussed below, most specialty physicians have struggled to engage in the APM track. According to recent statistics released in the Medicare Payment Advisory Commission (MedPAC) July 2022 Data Book, approximately 90,060 specialists reached Qualifying APM Participant status and earned an incentive.[1] However, remember that most specialists in an APM — primarily Accountable Care Organizations (ACOs) — are participating through their employment in a hospital or health system; thus, incentive payments are made to that billing entity. Additionally, the APM incentive is set to expire in CY 2024 (based on CY 2022 participation). Legislation introduced in the 117th Congress, the *Value in Health Care Act of 2021 (H.R.4587)*, would extend the APM incentive through 2030 and address other challenges that might assist specialists with their participation in ACOs. However, this legislation does not address the MIPS exceptional performance bonus that will soon expire.

Beyond the challenges in physician payment created under MACRA, the MPFS is plagued by other challenges: requirements to maintain budget neutrality and slow, irregular updates to practice expense data used to set payments. As a reminder, the CY 2021 MPFS final rule prompted a significant budget neutrality adjustment by way of CMS' implementation of increased relative values for office and outpatient evaluation and management (E/M) services, which resulted in a 10.2 percent reduction in the conversion factor. In the CY 2022 MPFS, CMS updated clinical labor prices — an exercise it had not done in 20 years — and resulted in a drastic redistribution of Medicare funds across services due to the budget neutrality adjustments within the practice expense pool. In the recent CY 2023 MPFS proposed rule, relative values for inpatient and certain other E/M services are set to increase, prompting yet another budget neutrality adjustment. Congress has intervened to temporarily mitigate the impact of these conversion factor reductions, and we look to Congress again to avert the 4.42 percent cut expected on January 1, 2023. However, we believe it would be prudent to provide additional direction and authority to the Secretary to address these issues, for example, requiring the agency to make consistent, ongoing updates to practice expense inputs and authorizing the Secretary to, in certain circumstances, waive or modify budget neutrality requirements.

In addition, we are concerned that newly-covered and expanded Medicare benefits, items and services add more pressure to the already strained Medicare physician payment system. When CMS encourages or incentivizes beneficiaries and clinicians to deliver certain health care services, such as preventative care, those services should be excluded from budget-neutrality adjustments. This would include care that is necessary to address a public health emergency (PHE).

Finally, increases in practice expenses, such as clinical labor wages and professional liability insurance premiums, fall outside the control of physicians, and they should not be penalized for these increased costs. Congress should authorize the Secretary of HHS to waive budget neutrality when relative values change due to increased practice costs.

As we have shared previously, the increasing downward financial pressure on physicians is forcing many to sell or merge their practices with hospitals, health systems, and private equity groups, which is reflected in an April 2022 report prepared by Avalere. According to the report, nearly 70% of all physicians are now employed — a figure that spiked 19% in 2021 alone. In addition, a 2020 AMA survey found that less than half of physicians are working in physician-owned practices. The consequence of

[1] According to MedPAC, nearly 237,000 clinicians nationwide qualified for the A–APM bonus. Among clinicians who qualified for an A-APM bonus in 2022, 38 percent were specialists. This means approximately 90,060 specialists qualified for incentive payments that would have been sent directly to their employer.

increasing market consolidation is rising health care costs for payers, patients and the federal and state governments. Indeed, as part of its March 2020 Report to the Congress, MedPAC explained that:

> [G]overnment policies have played a role in encouraging hospital acquisition of physician practices. For example, when hospitals acquire physician practices, Medicare payments increase due to facility fees that Medicare pays for physician services when they are integrated into a hospital's outpatient department. The potential for facility fees from Medicare and higher commercial prices encourages hospitals to acquire physician practices and have physicians become hospital employees. (p. 458)
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> Physician–hospital integration, specifically hospital acquisition of physician practices, has caused an increase in Medicare spending and beneficiary cost sharing due to the introduction of hospital facility fees for physician office services that are provided in hospital outpatient departments. Taxpayer and beneficiary costs can double when certain services are provided in a physician office that is deemed part of a hospital outpatient department. (p. 460)

To what extent the MPFS contributes to rising health care costs because it encourages consolidation is something that warrants thorough examination and correction by Congress.

Driving value

Most specialists perceive the QPP as an enormous administrative hassle that diverts critical resources away from more meaningful activities that could directly impact the quality and value of specialty care. Under MIPS, in particular, most specialty physicians often have no choice but to report on marginally relevant measures that result in data that is of little use to physicians or their patients. Further, CMS has not produced any evidence to suggest that quality, efficiency, and outcomes for Medicare's seniors, the disabled, and underserved populations has demonstrably improved as a result of the MACRA-established quality programs.

In contrast to the promises of MACRA, for most specialists, MIPS has evolved into an unnecessarily complex, disjointed, burdensome, and clinically irrelevant program. Even the U.S. Government Accountability Office (GAO), in an October 2021 report, expressed concern that MIPS performance feedback is neither timely nor meaningful, questioned whether the program helps improve quality and patient outcomes, and highlighted the program's low return on investment. The Alliance requests that Congress consider the following fundamental flaws that continue to plague MIPS:

- **Siloed Performance Categories**. CMS has failed to produce a more unified quality reporting structure, as promised under MACRA. MIPS continues to rely on four separate performance categories, each with distinct reporting requirements and scoring rules. Additionally, what is being measured on the quality side rarely aligns with what is being measured on the cost side, resulting in a flawed value equation. The Alliance has repeatedly asked CMS to provide cross-category credit for more robust value-based activities, such as reporting to a clinical data registry, which would minimize duplicative reporting and reward more innovative improvement activities. However, CMS continues to cite statutory constraints, including the mandate to measure clinicians on each of the four MIPS performance categories as dictated by MACRA. As a

result, the program is not only challenging to navigate and comply with, but it does not accurately reflect the overall value of care.

- **Constantly Shifting Goalposts**. Each year, CMS changes not only the MIPS eligibility rules and reporting requirements but also the performance thresholds. As a result, it is challenging for physicians to keep up with the program and make year-to-year comparisons regarding their performance. It is equally challenging for CMS to accurately analyze the overall impact of the program over time.

- **Lack of Incentives for Specialty Measures**. Generally, MIPS also disincentivizes the development and use of specialty-specific quality measures that are more meaningful to patients and clinicians. Whether in regards to the development of clinically relevant MIPS measures or maintaining a QCDR, CMS has made the process extremely expensive and labor-intensive for specialty societies to participate. This is unfortunate because it has had a chilling effect on the development of tools that will allow patients to make more informed decisions on the specific care they are receiving and physicians to receive actionable feedback on the services they are providing. Instead, specialists are forced to report on less relevant primary care-focused measures because they do not have any alternatives.

- **Flawed Cost Measures**. Cost measures adopted for MIPS are also extremely difficult to interpret and take meaningful action. They often reflect care decisions and costs (e.g., Part B/D drugs) that are outside of a specialist's direct control and rarely align with quality measures. Measuring the cost of care in isolation is dangerous as it fails to account for the impact that changes in spending have on care quality and access.

- **Lack of Flexibility to Promote Interoperability**. The MIPS Promoting Interoperability category continues to take a one-size-fits-all approach to care that fails to appreciate the diversity and readiness of practices across the nation. The category also continues to focus on very specific EHR functionalities rather than promote innovative use cases of health information technology, such as clinical data registries, clinical decision supports tools, and tracking data from wearables and other digital devices that are more common among specialty patients.

- **Lack of Alignment Across CMS Programs**. MIPS physician-level reporting requirements and measures largely fail to align with other CMS value-based incentive programs that apply to other providers and settings of care. This results in administrative redundancy, duplicative accountability, and conflicting incentives — particularly regarding team-based care coordination. This misalignment is costly for taxpayers and continues to make it challenging for Medicare to move the needle on the overall value of care for its beneficiaries.

- **Failure to Provide a Glidepath to APM Participation**. The intent of MIPS, as envisioned by MACRA, was to prepare physicians to move into APMs. However, the current program fails to align with APMs and does little to ready specialists to move into APMs. Further, there are ongoing barriers to APM participation among specialists, as explained below.

- **Misguided Efforts to Improve MIPS**. Although CMS' recently introduced MIPS Value Pathways (MVP) framework was intended to address many of the problems outlined above, it simply reshuffles the deck while doing very little to address the program's fundamental flaws, which increases frustration and disillusionment among physicians at a time when worker burnout is historically high.

Unfortunately, the APM track of the QPP is no less challenging. Only a few specialty models exist for a limited set of conditions. As a result, specialists either do not have access to an APM or participate passively in existing models, such as Accountable Care Organizations (ACOs), which were developed with primary care in mind and provide specialists with no direct control over measured quality or value. Specialty physicians have attempted to address these challenges, urging the Centers for Medicare & Medicaid Innovation (CMMI) to test alternative payment and delivery models that are meaningful and feasible for specialists. Part of the problem is the agency's unwillingness to test models recommended by the PTAC. Although PTAC has reviewed over 35 models to date and recommended several for implementation, CMS has yet to advance *any* of these models in their original form. This has been frustrating for several Alliance members who have invested significant resources in developing more impactful models and provided their expertise on ways that APMs could improve clinical practice and patient outcomes. This not only discourages the development of more innovative models but significantly limits the movement of specialists into value-based models. Furthermore, even in situations where specialists participate in existing APMs, such as ACOs, the models do little to meaningfully capture or incentivize the quality and overall value of their participation compared to their primary care colleagues. In fact, physician-led ACOs have limited or excluded specialists from participation, a trend that CMS publicly recognized in the CY 2023 MPFS proposed rule. Despite multiple requests, CMS and other federal agencies have refused to provide data on the number and type of specialists in APMs to help us better understand and overcome these challenges.

Making matters worse is that under MACRA, the 5% Medicare incentive payment offered since 2019 (based on 2017 APM participation) to clinicians who are QPs expires next year. Instead, those who are QPs in 2023 will receive a zero percent base conversion factor update in 2025 and then will be eligible for a slightly higher base conversion factor update (0.75 percent vs. 0.25 percent for non-QPs) going forward. MACRA also prescribes specific payment and patient thresholds that clinicians must meet to become a QP. Beginning with the 2023 performance year, the Medicare QP Thresholds will increase to 75% (from 50%) for the payment amount method and 50% (from 35%) for the patient count method, making it more challenging for physicians to meet the definition of a QP.

The Alliance is very concerned about the negative impact these shifting policies will have on the already slow movement of specialists into APMs. As mentioned earlier, there have been very limited opportunities for specialists to participate meaningfully in APMs and qualify as QPs. With the expiring 5% incentive payment, most specialists will never even have had the opportunity to qualify for this critical source of funding, which has been immensely helpful to physicians who must invest in infrastructure and analytics to participate meaningfully in an APM. Similarly, the shifting QP thresholds will result in even fewer specialists qualifying for this track.

Finally, as mentioned earlier in the context of MIPS, CMS suffers from internal disorganization regarding its Medicare value-based initiatives. Multiple offices within CMS are responsible for managing similar, but separate, value-focused initiatives authorized by MACRA, with little apparent coordination. For example, the staff responsible for administering the QPP seem disconnected from the CMMI staff administering APMs, despite the intrinsic link between the two. Additionally, to carry out these initiatives, CMS relies on numerous contractors who are not aligned or coordinated with one another, which leads to confusion, inefficiencies, and situations where individuals with no institutional history

and very little understanding of the clinical implications of their recommendations and actions are making important decisions.

Recommendations to Improve MACRA

Congress sought to provide flexible options for clinicians to engage in meaningful quality improvement and value-based care in the Medicare program. However, the implementation of these statutory quality programs has resulted in a rigid system that penalizes most physicians based on metrics and models that do not apply to them. We contend that MACRA must be overhauled and replaced with a payment system that:

- Ensures financial stability and predictability in the Medicare physician fee schedule;
- Promotes and rewards value-based care innovation that meaningfully improves patient care and outcomes, particularly within specialty care; and
- Safeguards timely access to high-quality care by advancing health equity and reducing disparities.

As stated above, to achieve this, we urge Congress to:

- Replace flat base payment updates with a payment mechanism that includes an appropriate inflationary index to the Medicare conversion factor that reflects rising practice costs, such as the MEI.
- Exempt the following from budget-neutrality adjustments:
    - Newly-covered or expanded Medicare benefits, items and services, such as preventative services and new technologies,
    - Items and services that are delivered in response to a PHE; and
    - Changes in relative values due to increased practice costs (e.g., clinical labor, professional liability insurance).
- Authorize the Secretary of HHS the flexibility to waive or modify budget neutrality requirements in other circumstances, as appropriate.
- Require ongoing and consistent updates of key data inputs used to set Medicare payments to physicians, including practice expense costs.
- Evaluate the impact of the QPP and PTAC on health care quality and value, as well as access to care — particularly as it relates to specialty care.
- Make technical improvements to MACRA to strengthen the QPP, including:
    - Provide CMS with the authority to make MIPS more streamlined and flexible.
    - Provide CMS with the authority to move away from the current one-size-fits-all approach to measurement and permit more flexibility regarding measure adoption, participation pathways, scoring, and performance thresholds to reflect better the diversity of clinical practice in terms of settings, specialties and/or patient populations.
    - Put pressure on CMS to better incentivize the use of QCDRs, specialty-specific measures, and participation pathways that are more meaningful to specialists.

    - Allow CMS to modify the MIPS Cost category by removing the 1) primary care-based total per capita costs measure mandate that could hold physicians responsible for costs outside of their control; and 2) requirement that episode-based cost measures account for at least one-half of Part A and B expenditures to ensure prioritization of episodes with high variability and that specialists can directly impact.
    - Require that CMS may only measure cost in the context of quality.
    - Extend the MIPS Exceptional Performance Bonus.
    - Improve the APM pipeline to provide specialists with more opportunities to participate meaningfully in APMs and qualify for the APM track of the QPP.
    - Extend the 5% APM incentive payments and maintain current QP thresholds for an additional six years, which would help facilitate specialty physician movement toward new and innovative models that have not yet materialized.

- Require CMS to release more granular data regarding physician participation in MIPS, APMs, and QP eligibility, by specialty.

In addition, members of the Alliance participated in efforts by the AMA to develop its "Characteristics of a Rational Medicare Payment System" and urge you to incorporate these principles in any physician payment reform solution.

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The Alliance appreciates the opportunity to share its concerns and hopes that Congress will consider holding hearings and/or a series of roundtable discussions to examine the implementation and impact of MACRA policies related to physician reimbursement and value-driven performance. At the same time, Congress must take immediate steps to stabilize Medicare physician payments while it explores more permanent solutions.

Should you have any questions or wish to schedule a meeting, please contact us at info@specialtydocs.org.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Otolaryngology-Head and Neck Surgery
American Association of Neurological Surgeons
American College of Mohs Surgery
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
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
National Association of Spine Specialists