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## Statement for the Record

### House Energy and Commerce Subcommittee on Oversight and Investigations

#### “MACRA Checkup: Assessing Implementation and Challenges that Remain for Patients and Doctors”

Alliance of Specialty Medicine  
Thursday, June 22, 2023

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. We greatly appreciate the Subcommittee’s oversight of the *Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)* and especially the implementation concerns and challenges that remain for patients and doctors. Today, we outline suggested actions that Congress should take to stabilize the Medicare physician payment system while ensuring successful value-based care incentives are available for specialty physicians. We continue to have serious concerns about structural challenges and instability in Medicare payments to physicians and request your assistance in urging the committees of jurisdiction to begin the process of stabilizing and improving Medicare physician reimbursement and performance programs through legislative reforms.

Our statement addresses 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 patients and doctors face:**

- Replacing flat base payment updates (in CY 2024 and 2025) and improving nominal base payment updates (in CY 2026 and beyond) with annual payment updates to the Medicare conversion factor that are based on an appropriate inflationary index that reflects rising practice costs, such as the Medicare Economic Index (MEI);
- Exempting 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,

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- Changes in relative values due to increased practice costs (e.g., clinical labor, professional liability);
- Authorizing the Secretary of Health and Human Services the flexibility to waive or modify budget neutrality requirements in other circumstances, as appropriate;
- Requiring ongoing and consistent updates of key data inputs used to set Medicare payments to physicians (e.g., practice expense and liability insurance) and holding physicians harmless from these updates, which are outside their control;
- Evaluating 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;
- Making technical improvements to MACRA to strengthen the QPP, to include:
  - Providing CMS with the authority to make MIPS more streamlined and flexible, 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.
  - Providing CMS with the authority to truly dismantle the silos that currently prevent more accurate and efficient assessments of value.
  - Providing CMS with the authority to move away from the current one-size-fits-all approach to measurement and permit more flexibility in regard to measure adoption, participation pathways, scoring, and performance thresholds to better reflect the diversity of clinical practice in terms of settings, specialties, and/or patient populations, to include:
    - Providing CMS with the flexibility to adjust the weights of the MIPS performance categories over time to reflect the current state of the health care landscape, shifting gaps in care, and the current state of available measures.
    - 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.
    - Allowing CMS to set multiple performance thresholds, such as a separate threshold for small and rural practices.
    - Providing CMS with the flexibility to provide MIPS credit for more innovative and comprehensive investments in quality and value, such as ongoing data collection and performance feedback for purposes of Board certification, performance measurement taking place under other CMS programs, and quality and cost analyses under alternative payment models (APMs), so long as minimum standards of reliability and validity are met.
  - Requiring CMS to better support and encourage the use of specialty-focused Qualified Clinical Data Registries (QCDRs), the development and use of specialty-specific measures, and participation pathways that are more meaningful to specialists.
  - Enforcing MACRA's requirement that CMS provide access to Medicare claims data to assist specialties and their registries with better understanding existing gaps in care and supporting the development of quality and cost measures.
  - Allowing CMS to modify the MIPS Cost category by:

- Removing the primary care-based total per capita costs measure mandate that could hold physicians responsible for costs outside of their control.
- 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.
- Requiring that any evaluation of cost also account for any changes in quality among the same patient population to ensure cost-containment efforts do not result in poorer quality care or negatively impact access to care.
- Improving the APM pipeline to provide specialists more opportunities to participate meaningfully in APMs and qualify for the APM track of the APP.
- Further extending the 3.5% APM incentive payments, which expire following the 2023 performance year/2025 payment year, and maintain current QP thresholds to facilitate specialty physician movement toward new and innovative models that have not yet materialized.
- Requiring CMS to release more granular data regarding physician participation in MIPS, in APMs, and QP eligibility, by specialty.

### Physician Payment Instability

Prior to the enactment of MACRA, the costs associated with running a physician practice were on the rise, and the price of medical supplies, equipment, and clinical and administrative labor remain substantial, 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.** While Congress anticipated that physicians would receive value-based incentives and differential payment updates based on their participation in either the Merit-based Incentive Payment System (MIPS) or the Alternative Payment Model (APM) tracks, many factors have led to insufficient payment updates, particularly when compared to the effort and resources physicians must devote to participate.

Instead, 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). Furthermore, as discussed below, most specialty physicians have struggled to engage in the APM track. Statistics released in the [Medicare Payment Advisory Commission \(MedPAC\) July 2022 Data Book](#) show that approximately 90,060 specialists reached Qualifying APM Participant status and earned an incentive.<sup>1</sup> Because most specialists in an APM — primarily Accountable Care Organizations (ACOs) — are participating through their employment in a hospital or health system, those incentive payments are made to that billing entity – not to the physician. Further, the bulk of incentives under MIPS have stemmed from the Exceptional Performance Bonus pool, which is set to expire after CY 2024 (based on performance in CY 2022), while the APM incentive is set to expire after CY 2025 (based on CY 2023 participation).

Beyond the challenges in physician payment created under MACRA, the Medicare Physician Fee Schedule (MPFS) is plagued by other challenges: requirements to maintain budget neutrality, and slow, irregular

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<sup>1</sup> 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.

updates to practice expense data used to set payments. In fact, physicians continue to “pay down” the significant budget neutrality adjustment prompted by CMS’ 2021 and 2023 implementation of increased relative values for office and outpatient evaluation and management (E/M) services and inpatient and other E/M services, respectively, as well as absorb CMS’ 2022 implementation of revised clinical labor prices (an update that lagged two decades). For 2024, CMS has signaled its intention to begin paying for a new E/M add-on payment that Congress previously prohibited CMS from implementing. If CMS is allowed to do this, it will prompt yet another substantial budget neutrality adjustment and concomitant reduction to the PFS conversion factor. We appreciate that Congress has intervened to temporarily mitigate the impact of these conversion factor reductions, however, 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.

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. This follows a [2020 AMA survey](#) which found that less than half of physicians are working in physician-owned practices. A consequence of 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)*

*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.

### **Ineffective Value Programs**

Implementation of MACRA’s two-track value-based payment system, the Quality Payment Program, has been ineffective and, arguably, detrimental to the delivery of most specialty medical care. Most specialists perceive the QPP as an enormous administrative hassle that simply 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 other 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.

### ***Merit-Based Incentive Payment System (MIPS)***

In contrast to the promises of MACRA, 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 that each have 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 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 to 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 through scoring policies and unreasonable requirements imposed on QCDRs;
  - QCDRs were authorized by Congress to provide a more flexible and rapid pathway for specialties to introduce more innovative and clinically relevant measures under MIPS. Instead, due to unnecessarily excessive and costly measure testing and data validation requirements imposed by CMS, many prominent specialty-sponsored registries have been given no other choice but to leave the program. This is unfortunate since clinician-led registries tend to collect more relevant and meaningful clinical outcomes data, including patient-reported outcomes data, that cannot be captured through claims. They also provide more timely and actionable feedback that is often more relevant to participating clinicians and their patient populations than what is provided by CMS under MIPS.
- **Flawed Cost Measures.** Cost measures adopted for MIPS are also extremely difficult to interpret and take meaningful action on. 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 directly with quality measures other than in title. Furthermore, 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 electronic health record (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 as it relates to 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 largely fails to align with measures used under 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 foundational flaws, which increases frustration and disillusionment among physicians at a time when worker burnout is at an historical high.

#### ***Advanced Alternative Payment Models (Advanced APMs)***

Unfortunately, the APM track of the QPP is no less challenging. Alliance organizations continue to hear from their specialty physician members that active engagement in APMs is near impossible. Specialty-focused APMs exist, but they only consider a limited number of conditions or procedures, leaving the vast majority of specialists without a dedicated model. Others, such as the Bundled Payments for Care Improvement (BPCI) program, suffer from challenges related to holding providers accountable for specific clinical episodes (versus broader clinical service lines) and fail to provide high performing practices with an incentive to stay in the program since they are held to exceedingly high cost targets that simply do not support high quality, appropriate care. Additionally, specialists that are “participants” in ACOs are usually part of large hospitals or health systems, but their role is passive; they do not meaningfully engage in quality improvement or cost containment activities specific to the ACO, as the accountability measures do not consider the conditions they treat, nor services provide. Other specialists that attempt to join ACOs are blocked from entry by the primary care physicians who lead them.

These findings are not just speculative. As highlighted in [MedPAC’s July 2022 Data Book](#), *Health Care Spending and the Medicare Program*,

*Many specialties account for a larger share of clinicians in larger ACOs. This finding may reflect smaller ACOs being more often composed of independent physician practices with relatively fewer specialists, while larger ACOs are often affiliated with hospitals or health systems that have a broader range of specialists. (p. 44)*

MedPAC also explains that,

*Specialists' participation in ACOs relative to their share of all clinicians varies by specialty. For example, cardiologists comprise about 2 percent of all clinicians participating in FFS Medicare, but a larger share of clinicians participating in ACOs. By contrast, specialties such as anesthesiology and ophthalmology are underrepresented in ACOs relative to their share of all FFS clinicians.(p. 44)*

At the outset of the QPP, the Alliance and its member organizations –independently and collectively – proactively connected with the ACO member organization to discuss opportunities for improving specialists' participation in ACOs. One approach discussed, which is contemplated in this RFI, was the development of “shadow bundles,” or as described in this RFI, “nesting of episode-based or condition-specific models in PB-TCOC models”. Further attempts to coalesce around this concept were stalled. Ultimately, we were told that specialty medical care and treatment was expensive and hurt ACOs financial performance, and – in the case of primary care-led ACOs – there was no appetite for sharing “savings” with specialists.

Despite multiple requests, both CMS and MedPAC have flat-out 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 the fact that under MACRA, the 5% Medicare incentive payment that has been offered since 2019 (based on 2017 APM participation) to clinicians who are Qualifying Participants (QP) in an Advanced APM was reduced to 3.5% and will expire after 2025 (based on 2023 performance). Those who are QPs in 2024 will only receive a nominal base conversion factor update in 2025 (0.75 percent vs. 0.25 percent for non-QPs) going forward, limiting their incentives to join APMs going forward. MACRA also prescribes specific payment and patient thresholds that clinicians must meet to become QPs. 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. There have been very limited opportunities for specialists to participate meaningfully in APMs and qualify as QPs to date. With the expiring APM 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 in its administration of 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, which results in duplicative reporting and accountability for clinicians. 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 historical knowledge 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.

This can be accomplished by acting on the aforementioned recommendations. 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.

We look forward to working with the committee to ensure specialty physician practice viability and success, and would be happy to discuss any other questions you may have going forward.