



Sound Policy. Quality Care.

June 8, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Submitted electronically to: Chiquita.Brooks-LaSure@cms.hhs.gov

Subject: Implementation of MACRA and Physician-focused Value-based Care Initiatives

Dear Administrator Brooks-LaSure:

The undersigned members of the Alliance of Specialty Medicine (Alliance) are writing to express our concerns about 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 the development of clinically relevant quality and cost measures, the operation of robust clinical data registries, and the construction of 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, CMS has declined to implement 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 with 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

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to develop and participate in more applicable models. However, as we reflect on the last five years, it is evident that implementation policies have severely limited the effectiveness of these physician-focused initiatives.

To ensure that these initiatives are coordinated and are truly improving the quality and value of physician care, we urge CMS' Center for Clinical Standards and Quality (CCSQ) to work more closely with the Center for Medicare & Medicaid Innovation (CMMI) to evaluate the impact of MACRA's value-based care programs, explore ongoing implementation challenges, and make the necessary modifications that will make these programs more meaningful to both physicians and their patients going forward. Below, we summarize our major concerns with these programs to date:

- 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 and is unnecessarily costly and time-consuming for physicians. In its current form, for many specialties, there also is no clear evidence of the value the program brings to patients, physicians or the Medicare program. Additionally, most MIPS measures do not align with those being used in APMs and even when they do (e.g., some of the Bundled Payments for Care Improvement- Advanced (BPCI-A) model measures), clinicians have to submit data twice to satisfy the requirements of both programs, which is duplicative, time-consuming, and diverts attention away from the patient. 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. For example, scoring caps applied to measures that lack benchmarks discourages the uptake of such measures and disincentivizes specialty society investment in new and better measures. Over the last few years, CMS also has adopted 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 unnecessarily burdensome measure testing and data validation requirements that exceed the standards applied to some traditional MIPS measures, as well as requiring specialty societies to “harmonize” their QCDR measure results with other disparate and non-risk stratified measures, disadvantaging specialists who care for the sickest and most complicated patients. These policies, taken together, have negated many of the opportunities initially offered through the QCDR pathway. As a result, many specialists are having a hard time identifying valid and meaningful measures to report, and many specialty societies have begun to question their future investment in measure development for purposes of MIPS. Regarding cost measures, CMS 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 — to conduct more meaningful cost analyses.
- 3. Flawed value assessments.** Regarding cost measures, the MIPS population-based, total cost measures do not help many specialists better manage resource use since they focus on treatment decisions over

which specialists lack direct control and result in performance data that is difficult for clinicians to understand. While CMS has done some work to develop more focused episode-based cost measures, many specialties and patient populations are not captured by these measures. 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. As a result of these policies, the program discourages meaningful engagement and fails to appropriately incentivize higher-value care.

- 4. Inflexible approaches to assessing value.** 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, their access and use of different technologies, their specialty, and/or their patient population.
- 5. 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 confusion and impacts the accuracy of year-to-year performance comparisons. The latest set of changes— the new participation pathway, known as the MIPS Value Pathways (MVP)— aims to reduce clinician burden, provide a more cohesive and meaningful MIPS participation experience, and better prepare clinicians for APMs. Although the Alliance fully supports these goals, we are concerned 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, the pathway does nothing to expedite the adoption of new and innovative measures, nor does it fix any of the underlying scoring or reporting rules that result in clinicians choosing the most administratively feasible participation pathway rather than the most meaningful pathway. The MVPs presented by CMS to date also have been too clinically broad to result in accurate measurement or meaningful data for patients and physicians.
- 6. Nonactionable 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. One particularly helpful piece of information would be which specialists are actually participating in Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs) since we often heard stories from our members about ACOs adopting “narrow networks” that inappropriately limit specialty physician participation. The lack of “network adequacy” standards allows this primary care-dominated model to essentially bar the participation of specialists, even when specialty physicians express interest in participating in a model. CMS has also provided little data on how different specialties are impacted by and performing on each of the MIPS 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 program’s goals are being met.

- 7. Lack of coordination within CMS.** 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 do not seem to communicate regularly with the staff administering APMs at CMMI. Additionally, CMS uses numerous different contractors (e.g., Ketchum, Acumen, MITRE) for all of its initiatives, which leads to confusion, duplication of effort, 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.

- 8. Limited ability for specialties to develop and participate in APMs.** Meaningful opportunities for specialists to participate in innovative payment and delivery models are limited due to CMS' unwillingness to test models recommended by PTAC. In the Affordable Care Act, Congress granted CMS considerable authority to test and evaluate innovative payment and delivery models by establishing the CMMI. Subsequently, MACRA established PTAC to review physician-focused payment model proposals and provide recommendations to CMS, with the expectation by stakeholders that CMMI would implement 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 currently qualify for this track. Since MACRA only authorizes these bonuses through the 2022 performance year, specialists are at a disadvantage, and most will not even have had an opportunity to qualify for this incentive before it sunsets.

The Alliance is also concerned about recent changes to quality reporting for the Medicare Shared Savings Program (MSSP) — including the requirement to implement eCQMs or MIPS CQMs in 2022 — which was finalized in the 2021 Medicare Physician Fee Schedule Final Rule. Unfortunately, the new required measures are primarily focused on a small set of primary care services. The number of patients to whom the measures would apply has also increased exponentially now that CMS requires reporting across all payers. As noted earlier, we are already concerned about ACOs adopting narrow networks that exclude specialists and negatively impact patient access to critical care. The rushed implementation of these new quality reporting mandates could cause ACOs to take additional steps to drop specialists, exacerbating a problem that already exists. Since many of the measures are broadly specified, patients who receive care from a specialist participating in an ACO will be attributed as eligible for a measure denominator for a clinical service intervention that is outside of the typical scope and practice of that clinician. For example, an ACO-assigned beneficiary has an endoscopy, and a diagnosis of diabetes is also captured in the medical record. MIPS#001 — Diabetes: Hemoglobin A1c (HbA1c) Poor Control — will be attributed to the gastroenterologist, and the ACO will be required to include this visit in the measure denominator regardless of whether the HbA1c control is outside of the focus of the visit or purview of the gastroenterologist. This could negatively impact ACO quality scores and require specialists to collect additional data and/or provide other services outside of their usual clinical work.

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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. The Alliance has simultaneously reached out to Congress to request that it continue its ongoing oversight of MACRA and collaborate with the medical community to provide CMS with more flexibility to make necessary programmatic changes to the QPP.

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

Sincerely,

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cc: Xavier Becerra, JD, Secretary, U.S. Department of Health and Human Services
Liz Fowler, JD, PhD, Deputy Administrator and Director, Center for Medicare & Medicaid Innovation, CMS
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Gene Dodaro, Comptroller General, U.S. Government Accountability Office