

**Statement of the Alliance of Specialty Medicine on MACRA Implementation
before the
Subcommittee on Health of the Committee on Energy and Commerce
of the U.S. House of Representatives
Tuesday, April 19, 2016**

The Alliance of Specialty Medicine (Alliance) is a coalition of national medical specialty societies representing more than 100,000 physicians and surgeons. We are dedicated to the development of sound health care policies that foster patient access to the highest quality specialty care. The Alliance appreciates that Congress devoted a portion of the Medicare Access and CHIP Reauthorization Act (MACRA), P.L. 114-10, to streamlining existing federal quality reporting mandates, addressing obstacles that currently prevent specialists from participating meaningfully in these programs and reducing the amount of physician payment at risk. We also appreciate that MACRA affords specialty societies the opportunity to work closely with CMS to determine how best to interpret the law.

In preparation for MACRA implementation, Alliance societies have been educating their members about the Merit-Based Incentive Payment System (MIPS) and participation in Alternative Payment Models (APMs) and gathering feedback on the most pressing policy and operational implications for specialty medicine. We look forward to sharing additional insights with Congress and the Centers for Medicare & Medicaid Services (CMS) as we continue to collect this information. In the interim, we would like to share specialty medicine's overarching recommendations and most pressing concerns.

Our specific principles and concerns about MIPS and APMs are outlined below:

Merit-based Incentive Payment System (MIPS)

- **Gradual, thoughtful implementation will be the key to success.** The Physician Quality Reporting System (PQRS), the Electronic Health Record (EHR) Incentive Program and the Value-Based Payment Modifier (VM) were all well-intentioned programs but implemented via strategies that were flawed on many levels. As a result, these programs were unnecessarily burdensome and produced largely meaningless data. There is a real fear that policymakers will maintain the flawed features of these programs and simply combine them under a dysfunctional system that differs in name only. Version 1.0 of MIPS cannot simply become Version 2.0 of the PQRS, EHR Incentive Program and the VM. MIPS represents a critical opportunity to press the reset button on current programs — to take a careful inventory of what is and what is not working for both patients and physicians, and to use those experiences to correct things that might not have been carried out appropriately in the past. However, building a new quality infrastructure will require a thoughtful and gradual approach to ensure that the initial transition to this new system is as seamless and undisruptive to clinical practice as possible. This will include balancing the need to maintain certain elements of current programs that physicians find suitable and are familiar with while abandoning the most critically flawed features and testing alternative strategies that allow physicians to demonstrate value in more innovative ways. To date, CMS has done little to evaluate whether existing federal mandates have had a meaningful effect on quality improvement across physician specialties.
- **Flexibility will ensure meaningful engagement.** When developing MIPS policies, it is critical that CMS take a flexible, rather than prescriptive, one-size-fits-all approach. Ensuring that MIPS is

relevant to all specialties will help to not only ease the transition to this new system but will also foster innovation, trust and ultimately widespread stakeholder engagement.

- **Investment in measure gaps must occur expeditiously.** For many specialties, the most significant barrier to meaningful participation in current programs is an ongoing lack of relevant measures. CMS must expeditiously support — through financial investments, technical assistance, and greater access to data — the development of high-quality, specialty-focused measures to ensure that all physicians have a fair opportunity to demonstrate quality and value for the unique conditions and populations they treat. The paucity of relevant resource use measures is especially critical. Few, if any, specialties have been able to identify resource use measures suitable for accountability. Cost profiles are difficult to create for the individual provider, requiring the development of complex risk adjustments and attribution methodologies and open access to all-payer data. While CMS and its contractors have been working for many years to develop more granular episode-based resource use measures, they are not expected to be ready in time for the initial performance year of MIPS. As a result, CMS will need to adopt a contingency plan that reflects the current state of measurement. To ensure that physicians are not inappropriately penalized, this plan should include a re-weighting of the resource use category of MIPS until these challenges are resolved. It is equally critical that CMS retire the current flawed resource use measures used under the VM, which were not developed with physician input and hold specialists accountable for care provided outside of their control, and if necessary, consider surrogate metrics in the interim, such as those that evaluate appropriate use. In general, resource use measures should not have an adverse impact on practice patterns or discourage treatments that best meet the needs of individual patients. For example, CMS' current resource use methodology is constructed in a way that disincentivizes the use of Part B drugs over Part D drugs, which can interfere with treatment decisions and patient preferences.
- **Meaningful use must be redefined.** Current strategies for incentivizing meaningful use of EHRs are impractical and unsustainable. Many of our societies' members continue to struggle to satisfy the requirements of the Electronic Health Record (EHR) Meaningful Use program because the measures are of little relevance to specialists and the unique patient populations they serve. The technology, itself, also remains cumbersome and unresponsive to specialists' needs, and interoperability persists. As a result of these ongoing challenges, specialty physicians find that the current meaningful use requirements slow down their workflow, create documentation burdens that result in minimal care improvements, and distract physicians from patient care. It is time for CMS to completely restructure incentives for meaningful use of EHRs so that physicians, as well as vendors, focus less on compliance and box checking and more on truly transforming care. Going forward, meaningful use mandates must ***not*** rely on all-or-nothing, pass-fail strategies. Instead, they should account for varying practice circumstances and varying levels of physician control over EHR choice and functionalities by rewarding incremental effort toward program goals. Physicians should not be penalized for standards that EHRs cannot yet achieve. We also believe that neither MIPS nor APMs can succeed without a more strongly enforced national mandate for genuine and widespread interoperability. We urge CMS to work closely with its federal agency counterparts on solutions that will help ensure seamless, bi-directional information exchange — across all health information technology systems and clinical data registries — without additional cost to those eligible professionals and practices that make an investment in certified electronic health record technology.
- **Continue to promote the value of clinical data registries.** We strongly support CMS' investment and promotion of qualified clinical data registries (QCDRs) to date. We support policies that continue to recognize the value of registries, that permit physicians to meet multiple components of MIPS by participating in a QCDR, that promote interoperability between registries and EHRs, and that provide registries greater access to private and payer claims data.

- **Clinical practice improvement activities.** MACRA created this new category under MIPS to recognize physicians for engaging in quality improvement activities that do not necessarily lend themselves to traditional performance measurement, such as continuing medical education, maintenance of certification, expanded office hours and the use of clinical data registries. It is critical that CMS preserve the intent of this innovative and long sought after provision by recognizing a wide variety of activities that represent the unique needs of each specialty. As part of this process, we support giving professional societies the authority to determine which activities should count for their specialty and how best to evaluate and score physician compliance with those activities. Similarly, individual physicians should have the flexibility to choose activities that are most relevant to their practice, should not be required to satisfy any specific subcategory of activities and should be able to readily attest to compliance with such activities.
- **Monitor the regulatory burden of these new programs.** A recent study in *Health Affairs* demonstrates that physicians are spending more than \$15 billion each year on quality reporting. Other research published in leading journals — including the prestigious *New England Journal of Medicine* — has shown that the focus on the way Medicare is measuring quality is off-track and is turning physicians into meaningless information box-checkers. Over both the short and long term, it is critical that policymakers carefully monitor the regulatory burden of these new policies on practicing physicians to ensure that compliance does not result in meaningless engagement, wasted resources or otherwise interfere with patient access to personalized care. The MIPS program is intended to simplify quality mandates — not make them more complicated. We remind the subcommittee that the final regulations detailing the initial implementation of MACRA policies will not be released until the fall of 2016, only months before the start of what we expect to be the first performance year. It is, therefore, critical that CMS implement policies, educational tools and other forms of support to accommodate physicians during this transition period and to ensure they are not unfairly penalized due to a lack of time to understand and comply with new rules.

APM Implementation

- **Flexibility is essential for specialties and subspecialties to develop and implement APMs for their specific patient population and practice types.** CMS' recent Request for information (RFI) on MACRA implementation seemed to suggest that the agency planned to focus on only a handful of existing models, most of which do not apply to our specialties. Similarly, we have heard that the few APMs developed to date by specialty societies are too narrow in focus because they are centered on a particular disease, condition or set of procedures. We strongly urge CMS to provide maximum flexibility in considering new models that have not previously been tested. Furthermore, the agency needs to provide the resources and technical assistance to get those models off the ground. Rather than being overly prescriptive, CMS should identify key elements that must be inherent to any APM while leaving it open to APM developers to determine how each of the key elements should be met by eligible professionals under the model. CMS' overall policy should recognize a diverse selection of APMs so that physicians can choose those that are most relevant to their patient population and most appropriate for their practice.

In addition to flexibility, policies to encourage more widespread APM participation among specialists must carry minimal administrative burden for both physicians and patients, maintain patient access to specialty care and choice of provider, and recognize patient diversity. We also continue to urge CMS to carefully consider its definition of "more-than-nominal" financial risk. Financial risk for physicians comes in many forms, including investments in human capital — clinical and administrative — technological infrastructure, clinical workflows and patient case-mix. Similarly, CMS must adopt revenue threshold policies that do not preclude specialists from becoming a "qualifying" APM participant. Several Alliance specialty organizations have developed or are developing, APMs for various procedures and conditions. However, in most instances, a specialist would not meet the revenue threshold by engaging in only one condition or procedure

specific APM developed by their specialty organization. Therefore, we encourage CMS to recognize, in the aggregate, participation in multiple APMs.

- **Ensure recognition of physician-focused payment models.** The Alliance appreciates that Congress included in MACRA a particular focus on physician-designed and developed models through expertise provided by the newly established Physician-Focused Payment Model Technical Advisory Committee (PTAC). However, specialists are concerned about the limited role of the PTAC. CMS is under no obligation to recognize models recommended by the PTAC, and the Center for Medicare and Medicaid Innovation (CMMI) has recently signaled that it will not necessarily test the physician-focused payment models that are advanced by the PTAC. These policies are concerning to the Alliance since they could significantly disadvantage specialists — most of which continue to lack relevant APMs — by leaving them with few options to participate in this track. The Alliance continues to urge CMS to give due consideration to APMs recommended by the PTAC, as well as by individual specialty societies, to provide specialists with the opportunity and incentive to participate in more transformative payment and delivery models.
- **Thoughtful consideration of APM implementation timeline to minimize physician burden and confusion.** The Alliance is concerned about the timeline carved out for the APM track. Under MACRA, the first APM payment update is scheduled for 2019. It is important that CMS administer the 2019 APM payment update in a way that allows physicians who are qualified APM participants to forego participation in MIPS in 2017. Otherwise, physicians will need to assume they must comply with the 2017 MIPS reporting requirements because they will not yet know whether they satisfied the 2019 APM payment update requirements. This timeline issue is important in the initial years of MACRA implementation, but also over the long-run.

In summary, the Alliance of Specialty Medicine supports efforts to improve the quality and overall value of health care. It is essential, however, that programs are meaningful to specialty physicians and their patients, driven by relevant clinical expertise, carefully evaluated for feasibility and provide physicians with the flexibility to choose activities that are most appropriate for their practice. Physicians should not be held accountable for increasingly challenging and clinically irrelevant federal reporting and performance mandates. We encourage policymakers to take advantage of this opportunity to construct a better, more meaningful quality infrastructure and to do so in a transparent manner that respects the MACRA mandate to engage directly with physician stakeholders.

Thank you for the opportunity to provide our views for the record. We encourage Congress to continue to exercise its oversight role as CMS implements these new Medicare payment systems.

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American College of Mohs Surgery
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American Society for Dermatologic Surgery Association
American Society of Cataract and Refractive Surgery
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