

Statement for the Record
Senate Committee on Finance
“Medicare Access and CHIP Reauthorization Act of 2015: Ensuring Successful Implementation of Physician Payment Reforms”

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Wednesday, July 13, 2016

Chairman Hatch, Ranking Member Wyden, and members of the Committee, the Alliance of Specialty Medicine (the Alliance) would like to thank the Senate Committee on Finance for the opportunity to provide feedback on implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Alliance strongly supports your involvement in ensuring that the Centers for Medicare and Medicaid Services (CMS) follows the legislative intent of MACRA as CMS undergoes rulemaking to implement its provisions. The Alliance is a coalition of medical specialty societies representing more than 100,000 physicians and surgeons from specialty and subspecialty societies dedicated to the development of sound federal health care policy that fosters patient access to the highest quality specialty care.

Member organizations of the Alliance have continuously sought out and developed robust mechanisms (including clinical decision support, clinical data registries, and other tools) aimed at improving the quality and efficiency of care specialty physicians provide. In addition, Alliance member organizations have analyzed and heavily scrutinized data related to the services they provide, looking for ways to improve how they diagnose, treat, and manage some of the most complex health care conditions in their respective specialty areas. With those sentiments in mind, the Alliance is eager to engage in programs that would further these efforts with incentives and technical assistance.

However, despite the considerable and often overwhelming effort the Alliance put into helping shape provisions in the MACRA legislation, as well as the ongoing feedback provided during the many pre-rulemaking comment and feedback opportunities, we are concerned that several of the principles we have long supported and conveyed to the agency were largely ignored. This is particularly true when it comes to proposals associated with the use of electronic health records (EHRs), the application of socioeconomic risk factors in quality and cost metrics, and most importantly, substantial disparities in Quality Payment Program (QPP) requirements that significantly disadvantage specialty care providers and the patient populations they serve. We hope that our comments herein will move CMS to address some of the most pressing issues facing specialty medicine, removing barriers that limit meaningful specialty physician engagement, and offering all specialists and non-specialists equal opportunities to demonstrate quality in a relevant manner.

Our written testimony below will detail some concerns regarding the proposals in the CMS proposed rule titled “Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models.”

As discussed in more detail below, the Alliance has the following recommendations:

- CMS should modify the initial start date of MIPS so physicians and practices have adequate time to prepare for the new program. MIPS should start no earlier than July 1, 2017, allowing CMS to establish a shorter performance period in the first year of the QPP program — such as a 6-month performance period, with an optional “look-back” to January 1 in 2017.
- CMS should minimize the reporting burden, particularly during the initial transition period, by maintaining the current PQRS reporting thresholds. Additionally, CMS should retain measures groups.
- The cost and resource use measures are completely flawed and inadequate. As such, CMS should use its authority under MACRA to re-weight this category to zero.
- There are very few activities that create a pathway for specialists to earn credit for their engagement in clinical practice improvement activities, and it is essential that CMS expand its list of recognized activities for this MIPS category.
- CMS should eliminate the “all or nothing” scoring in the electronic health record (now known as “advancing care information”) category.
- The proposed QPP largely retains the flawed siloed approach of Medicare’s current quality improvement programs and its scoring system is extremely complex. CMS should, therefore, rethink its scoring methodology and make modifications that would standardize, streamline, and maintain consistency so that MIPS eligible clinicians are able to understand and respond appropriately.
- We continue to be frustrated by the lack of APM participation options available to specialty physicians.
- CMS must establish a mechanism for distinguishing subspecialties to ensure that smaller subspecialties are not disadvantaged by the QPP and its scoring methodology.

Proposals for the Merit-Based Incentive Payment System (MIPS)

The MIPS Performance Period

Given the breadth of proposed changes to CMS’ quality and performance improvement programs, we are very concerned about the timeframe in which the agency expects to begin evaluating specialty physician performance. We are sympathetic to the administrative challenges CMS faces in operationalizing the new program. However, Alliance member organizations are concerned that specialty physicians will not be able to successfully adapt under the proposed rigorous schedule.

Even before MACRA was signed into law, specialty societies were educating their members on the anticipated changes. Unfortunately, and not unlike with other CMS programs, the challenge of educating physicians on these new programs has been difficult. We find that many of our specialty society staff are still educating members on CMS’ long-standing quality programs, including the Physician Quality Reporting System (PQRS) and Value-Based Payment Modifier (VM)/Physician Feedback Program. As you know, PQRS continues to have relatively low participation rates, and those facing adjustments under the VM do not understand exactly from where those penalties stem. As a significant portion of the MIPS is based on the PQRS, which continues to suffer from critical measure gaps in regards to specialty medicine, as well as the flawed VM and problematic Quality and Resource Use Reports (QRURs) distributed under the Physician Feedback Program, we are deeply concerned about the impact this will have on specialty physicians.

As most specialty physicians will not be ready on January 1, 2017 to begin MIPS, CMS should modify the initial start date of the MIPS program and provide a shorter reporting/performance period in 2017 — e.g. 6 months, with an optional “look-back” to January 1 in 2017. CMS should maintain this shorter reporting/performance period in future years of the program (with an optional “look-back” to January 1), in addition to any year-long reporting requirements, beginning in 2018. This shorter reporting/performance period will provide a necessary “on-ramp” for many specialty physicians who will be new to the program. And, it is consistent with approaches CMS has taken previously with the Medicare EHR Incentive Program, which currently utilizes a 90-day reporting period.

The MIPS Quality Performance Category

For the quality performance category, CMS proposes to adopt requirements similar to those under the existing Physician Quality Reporting System (PQRS). We are concerned with this approach, because, as you know, PQRS continues to have relatively low participation rates, and it has been difficult educating our members on the complexities of the PQRS. Furthermore, some of CMS’ proposals under the quality performance category would make it more difficult for specialty providers to be successful under the MIPS. Specifically:

- **The Removal of Measures Groups:** CMS proposes to no longer include Measures Groups as a data submission method for purposes of the quality performance category. In its place, CMS is proposing specialty-specific measure sets, which CMS believes will address confusion in the quality measure selection process. Some of the specialties represented in the Alliance heavily rely on Measures Groups to meet quality reporting requirements under the current PQRS program and would appreciate the opportunity to continue meeting the quality reporting requirements under the quality performance category in the same way. By proposing to do away with this reporting mechanism, CMS is severely limiting meaningful quality reporting options available to many specialists, particularly those in small practices. Similarly, in many instances, the proposed removal of measure groups will either leave no *meaningful* measures for certain specialties and subspecialties or greatly diminish the value of the measures that CMS proposes to retain as stand-alone measures.
- **Increasing the Data Completeness Threshold:** CMS also proposes to revise its data completeness thresholds such that individual MIPS eligible clinicians submitting via Part B claims would need to report on 80 percent of his/her Medicare Part B-only patients; whereas individual MIPS eligible clinicians and groups submitting via Qualified Clinical Data Registry (QCDR), qualified registry, and EHR would need to report on 90 percent of their Medicare and non-Medicare patients. We very much oppose this proposal and request that CMS lower the reporting thresholds for all reporting mechanisms to 50 percent, which is consistent with the current PQRS reporting requirements. As an alternative, CMS could consider simply requiring reporting on 20 consecutive patients, which would be consistent with CMS’ current threshold for Measures Groups under the PQRS program.

The MIPS Resource Use Performance Category

We are deeply concerned about the use of the VM measures in the MIPS program, particularly in the initial years. A CMS report on the result of the 2016 VM program (based on 2014 performance) showed that only 128 groups exceeded the program’s benchmarks in quality and cost efficiency and earned a

2016 payment incentive. In contrast, physicians in 5,418 groups that failed to meet minimum reporting requirements saw a “-2.0%” decrease in their Medicare payments in 2016 and physicians in 59 groups saw a decrease in their Medicare payments based on their performance on cost and quality measures under the VM. The disparity in groups earning an incentive or receiving a negative adjustment for the 2016 VM is great. It is clear these measures are not ready for prime time, and the need to further refine and evaluate episode-based cost measures is essential.

Furthermore, in calculating the performance under the resource use performance category, CMS proposes to include several clinical condition and treatment episode-based measures that have been reported in Supplemental Quality and Resource Use Reports (sQRURs) or were included in the list of the episode groups developed under section 1848(n)(9)(A) of the Act published on the CMS website. We are concerned about the premature application of these cost measures, which have not been adequately vetted by specialty care providers given their limited use. Most of the cost measures are new, only recently having been put forward for comment as part of CMS’ Episode Groups Request for Comment. The remaining measures may have been included in sQRURs, however, very few clinicians understood (or understand) how to access or interpret their QRURs or sQRURs.

For these reasons, we strongly urge CMS to use its authority under MACRA to re-weight this category to zero.

The MIPS Clinical Practice Improvement Activity (CPIA) Category

Despite the inclusion of 94 unique activities in the Clinical Practice Improvement Activity (CPIA) inventory, the vast majority of activities are focused on activities more appropriate for primary care providers. There are very few activities that create a pathway for specialists to earn credit for their engagement in clinical practice improvement. The list of proposed CPIAs neither includes the vast majority of activities we suggested for inclusion nor did CMS acknowledge that it had at least considered these activities for inclusion. We urge CMS to reconsider including these activities in the proposed rule. They include:

- Attendance and participation in Accreditation Council for Continuing Medical Education (ACCME)-accredited continuing medical education (CME) and non-CME events, such as the specialty and subspecialty society conferences and events, including those that are web-based, that exceed certification requirements;
- Fellowship training or other advanced clinical training completed during a performance year;
- Participation in morbidity & mortality (M&M) conferences;
- Taking emergency department (ED) call as part of Expanded Practice Access,
- Voluntary practice accreditation, such as accreditation achieved by the National Committee on Quality Assurance (NCQA), Accreditation Association for Ambulatory Health Care (AAAHC), The Joint Commission (TJC), or other recognized accreditation organizations;
- Demonstration of incorporation of evidence-based practices and appropriate use in clinician practices, using evidence-based clinical guidelines, appropriate use criteria, “*Choosing Wisely*” recommendations, etc.;
- Engagement in state and local health improvement activities, such as participation in a regional health information exchange or health information organization;
- Engagement in private quality improvement initiatives, such as those sponsored by health plans, health insurers, and health systems; and

- Participation in other federally sponsored quality reporting and improvement programs not already affiliated or considered under the MIPS program.

CMS intends, in future performance years, to begin measuring CPIA data points for all eligible clinicians and to award scores based on performance and improvement. We strongly oppose this proposal, particularly given there are no baseline or benchmark data available for comparison. In addition, we believe that requiring this diverts from the Congressional intent of including this proposal in the first place.

The MIPS Advancing Care Information Performance Category

We are sorely disappointed in the proposals included in the Advancing Care Information performance category. The implementation of programs established under MACRA afforded CMS a unique opportunity to drastically change the direction of the meaningful use program for physicians. Since the fall, CMS promised a more flexible program in response to physician concerns heard around the country. Instead, the measures that CMS has retained are every bit the same and even more difficult with the proposed removal of most exclusions. Under CMS' base scoring proposals, they must still report on at least one patient for each of the measures in the objectives that require reporting a numerator/denominator. MIPS eligible clinicians will continue to be forced to report on measures that are not meaningful to their practice and patient populations. While CMS touts these modifications as a departure from the previous "all-or-nothing" approach to the Medicare EHR Incentive Program, specialty physicians observe little change in how they can approach the new requirements and be successful.

The MIPS Composite Performance Score Methodology

We are deeply concerned about the scoring methodology for MIPS. Alliance member organizations have reviewed the proposals in great detail, yet we continue to find the proposals extremely complex and confusing. We recognize that, to provide flexibility, the scoring will be more difficult. However, if our most sophisticated and knowledgeable volunteer physician leaders are struggling to understand the scoring proposals, how does CMS expect the vast majority of physicians in practice to understand?

The proposed methodology also maintains the current silos of performance scoring, despite the fact that scoring is all rolled up into a composite performance score. To move toward a more value-driven health care system, it seems that the scoring should provide physicians with meaningful and actionable information that leads them toward that goal.

We request that CMS rethink its scoring methodology and make modifications that would standardize, streamline, and maintain consistency so that MIPS eligible clinicians are able to understand and respond appropriately.

Alternative Payment Models (APMs)

Specialty physicians are at a disadvantage as the proposed Advanced Alternative Payment Models (APMs) remain primary care-focused, leaving specialty physicians with few APM participation options. Despite its Request for Information (RFI) on Specialty Practitioner Payment Model, the Center for Medicare and Medicaid Innovation (CMMI) has not made a concerted effort to ensure specialists have a pathway toward engaging in APMs. Only two models currently cover specialty medicine – the

Oncology Care Model and the Comprehensive Care for Joint Replacement Model, the latter of which CMS did not propose to qualify as an Advanced APM.

We continue to be frustrated by the lack of APM participation options available to specialty physicians given the intent of MACRA to move physicians away from traditional fee-for-service and into payment models that better focus on cost and quality. We urge CMS to offer guidance on how APMs that did not meet the proposed Advanced APM criteria could be altered to meet the criteria. It seems as if in many cases, it is simply a lack of quality metrics or concerted use of certified electronic health record technology (CEHRT) that limit those models from Advanced APM status. If that is the case, we request that CMS work with the developers and participants of those models to make modifications that lead to Advanced APM designation.

Distinguishing Specialty Care Physicians

Finally, member organizations in the Alliance represent a broad array of specialty and subspecialty organizations. However, CMS' current proposals do not recognize the intricacies of all of these specialties and subspecialties. For example, Mohs micrographic surgeons are identified in claims and other datasets as relatively low-quality and/or high-cost providers because they are being compared to the whole of dermatology. Mohs surgeons focus their practice on skin cancer diagnosis and treatment, unlike a lot of other dermatologists who may be focused on other conditions, such as acne.

Individually, many of these subspecialty providers have urged CMS to use "Level III, Area of Specialization" codes from the Healthcare Provider Taxonomy code set to develop quality and cost benchmarks for these providers to at least somewhat level the playing field. We request that CMS begin the process for developing appropriate benchmarks for these providers using the aforementioned "third-tier" taxonomy codes. Without being able to more accurately define the role of a provider, it would be difficult for CMS to truly measure performance.

Thank you again for taking into consideration our written comments. The Alliance of Specialty Medicine looks forward to working with the Committee on addressing these issues to ensure the successful implementation of MACRA and we would be happy to discuss our concerns with you, as well as any other questions you may have going forward.