Statement for the Record

Senate Committee on Finance

"Medicare Physician Payment Reform After Two Years: Examining MACRA Implementation and the Road Ahead"

Alliance of Specialty Medicine

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The Alliance of Specialty Medicine ("Alliance") is a coalition of fifteen 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. As patient and physician advocates, the Alliance welcomes the opportunity to provide input in the formulation of healthcare and Medicare policy. This hearing is an important step toward continuing the promise of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and associated programs established under the Centers for Medicare and Medicaid Services' (CMS) Quality Payment Program (QPP) – the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (A-APMs) – as it was intended by the Congress.

The Alliance of Specialty Medicine believes:

- Congress should continue to make adjustments to the programs created under MACRA;
- Congress should maintain a viable fee-for-service option for providers under the Medicare program;
- Congress must safeguard beneficiaries' access to care by eliminating the 0% payment update applied to the Medicare conversion factor from 2020 – 2025 and replacing it with an update factor that better recognizes the Medicare Physician Fee Schedule conversion factor has failed to keep with inflation and in some instances has been reduced.
- Congress should acknowledge the slow pace of implementation of APMs by altering the timelines for bonuses embedded in statute. This includes:
    - Extending the availability of the Advanced APM 5% Incentive Payment in acknowledgement of the snail's pace of APM implementation by Medicare; and
    - Re-evaluating the qualifying participation thresholds for the A-APM incentive payment in light of the lack of implementation by CMS of qualifying APMs.

Background on Physician Engagement in MACRA

We first would like to take the opportunity to again commend Congress for enacting MACRA. This important step removed the constant threat brought to Medicare payments by the Sustainable Growth Rate (SGR). With the SGR, a destabilizing force for Medicare beneficiaries and the system overall, out of the way, Congress has provided the opportunity for all stakeholders to engage in a more meaningful discussion about how best to update Medicare payments and recognize the value of services that are provided by physicians, including specialists. We would also like to thank Congress for "technical corrections" included as part of the Balanced Budget Act of 2018, which significantly improved the ability of physicians – namely specialists – in their ability to participate in MACRA programs, and especially MIPS.

Through MACRA, Congress sought to provide flexible options for clinicians to meaningfully engage in quality improvement and value-based payment under Medicare. Members of this committee heard our concerns about legacy quality improvement programs in Medicare – the Physician Quality Reporting System (PQRS), Physician Value-Based Payment Modifier (VM) and the Medicare and Medicaid Electronic Health Record Incentive Program, or "Meaningful Use" – and in response sought to remove disparate reporting requirements, overlapping measures, and most of the "all-or-nothing" aspects of these programs and to create a streamlined system that allows physicians to focus on the measures and activities that most closely align with their practices. As a key example of that, Congress included clinical practice improvement activities under MIPS, giving physicians MIPS credit under Medicare's payment methodology for activities designed to improve care—further encouraging physician ongoing engagement in quality improvement activities. More importantly, Congressional leaders understood that a viable fee-for-service option was essential to the Medicare program for those physicians, including many specialty and subspecialty providers, that may never find a place in alternative payment and delivery models. While MIPS serves as an "on-ramp" for many clinicians, it serves as the ongoing value-based payment system for clinicians who must remain in a fee-for-service reimbursement construct. Under MIPS, specialists and subspecialists have a fair opportunity to remain in fee-for-service while continuing to measure, report, and improve performance on key areas of clinical quality that matter to their practice and their patients.

The Alliance recognizes that MIPS has challenges, although the first year of the program showed significant participation by physicians. According to CMS' 2017 Quality Payment Program Experience Report, 95 percent of eligible clinicians participated in MIPS (54 percent as groups, 12 percent as individuals, and 34 percent through MIPS APMs), exceeding the agency's goal of having 90 percent of MIPS eligible clinicians participate during the first performance year. This success can be attributed to CMS' efforts to ease clinicians into the program through a transition, which began with a "Pick Your Pace" engagement strategy and determined efforts by medical professional societies to educate physicians on successful participation. For those who participated, 93 percent earned a positive payment adjustment and 2 percent got a neutral adjustment. Of note, the majority of clinicians across all payment categories chose to report data for 90 days or longer.

Despite calls by the Alliance and other medical and healthcare professional organizations, a detailed breakdown of QPP performance by physician specialty is not available nor reporting option utilization rates by physician specialty. We contend that such data should be routinely included as part of CMS' regulatory impact analyses included in annual rulemaking for the QPP. In order for medical healthcare profession associations to better educate and motivate members, it is also important for CMS to begin sharing payment adjustment data by physician specialty.

With respect to A-APMs, engagement is more challenging, particularly for specialists. First, CMS has implemented so few APMs since the passage of MACRA that meaningful opportunities to participate in APMs for most specialists does not exist. MACRA contemplated an expansion of available models with the creation of the Physician Focused Payment Model Technical Advisory Committee (PTAC). While CMS recently announced the Primary Care First model, a single model largely focused on primary care that incorporates a few elements from several different models recommended for limited-scale testing by PTAC, CMS has otherwise failed to implement models recommended by the PTAC that have addressed a broad range of physician specialties.

Existing A-APMs, such as qualifying Medicare Accountable Care Organizations (ACOs), do not fairly measure or account for the quality and costs of specialty medical care. For example, the measure sets used by current ACO models focus on measures reported by primary care providers rather than specialty care providers, making it difficult for specialists to meaningfully engage. Without measures of specialty care, ACOs seem to struggle with specialist engagement. Perhaps more concerning, and similar to health insurers, Medicare ACOs have seemingly adopted "narrow networks" as a strategy to control costs, severely limiting the participation of specialists. Other models that have been identified as Advanced APMs, such as medical home models like Comprehensive Primary Care Plus (CPC+), are also difficult for specialty care physicians to engage in, as these models are designed for primary care physicians. CMS recently announced its Primary Cares Initiative, which again, will be largely limited to primary care providers.

While a few models focus on specialty medical conditions and engage specialty physicians, these only cover a paucity of physician specialty domains. The MACRA vision of moving clinicians from fee-for-service into alternative payment models can only materialize if those models are actually implemented by CMS for potential participation. This currently leaves MIPS as the only track of the QPP for most specialists to meaningfully engage in MACRA's reforms. More importantly, some specialists may never find an appropriate A-APM given their specialty or practice size. To that end, MIPS must be enhanced for long-term viability and the timelines contemplated under the original passage of MACRA must be re-evaluated to account for the fact that so few APMs are available and in recognition of the fact that many physicians, and specialists in particular, will continue to have payment updates based on MIPS because of this and because current APMs are not designed to account for the type of care provided by certain specialists.

MACRA and Specialists: Considerations for the Future

The Alliance appreciates the Congress' and CMS' efforts to improve the QPP and reduce the burden of participation, as well as minimize the number of clinicians subject to negative payment adjustments. Nevertheless, specialty physicians continue to face unique challenges as they attempt to engage. For example, CMS' "Meaningful Measures" initiative, which is aimed at reducing the number of measures in its quality programs, has limited the ability of specialists to meaningfully participate in MIPS as relevant measures have been eliminated. Specialty societies have made considerable investments in specialty-specific measure development, only to find CMS implementing an overly aggressive policy to eliminate what it deems are "topped out" measures. We believe that while it might be appropriate to place less of a priority on these measures from a MIPS scoring stand point, the current policy eliminates these measures when there is still measurement value, and the aggressive timeframe leaves societies with inadequate time to develop new quality measures to ensure that every specialty has a MIPS quality score based on measures meaningful to that specialty. Contrary to CMS' efforts to reduce administrative burden, this policy actualy increases the burden of MIPS on those specialties that no longer have relevant measures in the program.

The Alliance and its member organizations continue to work with the agency to improve MIPS and the availability of A-APMs. To that end, the Alliance makes the following recommendations to Congress, many of which have been previously shared with CMS:

MIPS

- Eliminate the 0% payment update applied to the Medicare conversion factor from 2020 – 2025 and replace with positive annual updates that recognize the Medicare Physician Fee Schedule conversion factor has in the past failed to keep up with inflation and in some instances has even been reduced, provides reimbursements that keep up with the escalating costs of providing care, and supports practice efforts to invest in models of care and reimbursement based on value;
- Provide participation data in MIPS, by specialty, as part of the annual notice and comment rulemaking for the QPP;
- Remove the "all-or-nothing" aspect of the Promoting Interoperability (PI) category by allowing eligible clinicians to select from a menu of measures that are most appropriate for their practice and patient population and gives full credit for this category for those practices that participate in a qualified clinical data registry (QCDR); and
- Simplify MIPS scoring so eligible clinicians and practice staff can have a more accurate understanding of how success can be achieved given various levels of participation.

A-APMs

- Provide participation data in A-APMs, by specialty, as part of the annual notice and comment rulemaking for the QPP;
- Extend the availability of the A-APM incentive payment (i.e. the 5% APM incentive payment) beyond the 2024 payment year/2022 performance year;

- Re-evaluate the qualifying participation thresholds for the A-APM incentive payment in light of the lack of implementation by CMS of qualifying APMs;
- Provide CMS with directives on implementation of physician-focused payment models (PFPMs) and, in particular, specialty-developed PFPMs; and
- For Medicare's ACO program:
  - Establish pathways for specialists to meaningfully engage in the ACO program;
  - Provide ACOs with technical assistance that would allow them to appropriately analyze clinical and administrative data, improving their understanding of the role specialists could play in addressing complex health conditions, such as preventing acute exacerbations of comorbid conditions associated with chronic disease;
  - Establish requirements that prohibit ACOs from restricting specialist participation;
  - Closely examine the referral patterns of ACOs and establish benchmarks that will foster an appropriate level of access to and care coordination with specialists, in addition to collecting feedback from beneficiaries on access to specialty care;
  - Develop an ACO quality measure that would capture the percentage of physicians reporting to specialty-focused clinical data registries; and
  - Adopt specialty designations for non-physician practitioners to ensure specialty practices are not inadvertently forced into exclusivity.

MedPAC Recommendation to Eliminate MIPS

In 2018, the Medicare Payment Advisory Commission (MedPAC) recommended the elimination of MIPS based on its conclusion that the basic design of MIPS is fundamentally flawed. The Commission contends that MIPS will not succeed in helping beneficiaries choose clinicians, in helping clinicians change practice patterns to improve value, or in helping the Medicare program reward clinicians based on the value of the care they provide. To address these concerns, MedPAC further recommended implementing a voluntary value program (VVP) that would measure large groups of physicians on population, outcome, and patient experience measures. Details about the VVP are anticipated in future Commission work; however, the concept at its broadest level ensures that most specialists will be unable to meaningfully engage as the measures MedPAC has suggested are those CMS uses in its other quality programs and focus on primary care activities and population health.

The Alliance strongly opposes MedPAC's recommendations for the reasons cited below:

- There is a significant lack of A-APMs in which specialists can meaningfully engage;
- The measures contemplated for use under a VVP will be limited in their ability to determine quality and cost of specialty medical care;
- Specialty providers have very little control over the activities that affect performance on the measures contemplated for use under a VVP; and
- MACRA very clearly intended to promote the development of clinically relevant, specialty-based quality measures. MIPS, and fee-for-service, remain a viable reimbursement structure for many specialists and subspecialists and must be maintained.

Instead of the MedPAC recommendation to scrap the progress that has been made thus far on the implementation of MACRA, in addition to the provisions suggested above, we believe the following steps, many of which can be taken by CMS, will help make the QPP a better system on which to base physician payment updates than what is suggested by MedPAC under the VVP:

- Streamline the program to avoid the siloed scoring of the current four performance categories;
- Condense the amount of time between performance and payment years in order to provide more meaningful feedback and incentives;
- Reduce the reporting periods to an amount of time that provides reliable data but reduces the administrative reporting burden placed on practices; and
- Promote the inclusion of measures that recognize the value of specialty care rather than broad primary care-focused measures that only apply to a subset of services provided in the context of the Medicare Physician Fee Schedule

Conclusion

Specialists are an essential and needed component of the healthcare system. Specialists use their deep knowledge and expertise to reach a precise medical diagnosis, present the full array of available interventions, collaborate closely with their patients to determine which treatment options are most appropriate based on their preferences and values, and coordinate and manage patients' specialty and related care until treatment is complete. No other clinician, provider or health care professional can replace the value offered by specialty physicians. At the same time, specialty physicians have had limited opportunity to engage in value-based transformation through available A-APMs that are targeted to their specialties, and the likelihood of widespread future models tailored to their expertise remain low. To that end, MIPS must continue to be improved for long-term viability since it will be the only option for many of these specialists to engage in value-based payment given they will have no other option than to remain in fee-for-service.

Finally, while we are confident that successful implementation of the idea cited above will make strides in developing a more meaningful QPP for patients, physicians, and for Medicare as a payer, we also believe that it will be important to begin having a larger conversation about the siloed payment systems in Medicare that fail to recognize the impact that specialists have on inpatient and outpatient hospital spending. Physicians have been asked to bear the brunt of Medicare spending increases with payments that are sometimes cut, certainly fail to keep pace with inflation, and fail to even measure up to the payment increases included in MACRA. For instance, in 2016, the first year that the MACRA 0.5% base payment update was implemented, the Medicare Physician Fee Schedule conversion factor actually *decreased* by -0.34% going from $35.9335 in 2015 down to $35.8043 in 2016. In no subsequent year did the actual conversion factor increase match the 0.5% contemplated in statute, and 5 years later we stand at a Medicare Physician Fee Schedule conversion factor of $36.0391, only nominally above the 2015 conversion factor. During this time, hospitals continue to get significant across-the-board Medicare payment increases based on an inflationary update in addition to their value-based purchasing program updates. CMS has proposed a general fiscal

year (FY) 2020 payment increase for inpatient hospitals of 2.7%. The inequity between these payment systems will continue to exacerbate issues in our health care delivery system, undermine the value of the services physicians provide to their patients while throwing money at brick-and-mortar investments, and fail to recognize that patients are best supported when the payment systems reflect the actual care delivery system.

The Alliance of Specialty Medicine is committed to the successful and timely implementation of the law while still providing practitioners time and opportunities to succeed. We look forward to working with the committee to ensure MACRA continues to be successful, and we would be happy to discuss any other questions you may have going forward.