Alliance of Specialty Medicine

Sound Policy. Quality Care.

November 13, 2024

The Honorable Cathy McMorris Rodgers
Chair
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Brett Guthrie
Chair, Health Subcommittee
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

**RE: Physician Payment Reform Outline**

Dear Chair Rodgers and Chair Guthrie:

The Alliance of Specialty Medicine (the "Alliance") represents more than 100,000 specialty physicians and surgeons across 16 specialty and subspecialty societies, and is deeply committed to improving access to specialty medical care through the advancement of sound health care policy. As patient and physician advocates, the undersigned organizations appreciate your efforts to address systemic issues with the Medicare physician payment system.

We also greatly appreciate your proactive engagement and willingness to collaborate with us and other stakeholders. As you know, the Alliance continues to have serious concerns about structural challenges and instability in the Medicare Physician Fee Schedule (MPFS). We write to offer comments in response to the draft physician payment reform outline circulated in September. Our comments address the major pain points our specialty organizations and their members face under the current Medicare physician payment system and value-based purchasing program.

## Bucket 1: Payment Updates

### *Baseline Update – Eliminate the positive updates built into statute and replace with an update of __% of MEI every five years.*

The Alliance strongly supports efforts to replace flat base payment updates and improve the nominal base payment updates (in calendar year (CY) 2025 and beyond) with annual payment updates to the Medicare conversion factor (CF) that are based on an appropriate inflationary index that reflects rising practice costs, such as the Medicare Economic Index (MEI). The Alliance supports **H.R. 10073, the *Medicare Patient Access and Practice Stabilization Act***, which would eliminate the upcoming 2.8% Medicare physician fee schedule cut and

provide an inflationary update set at half the MEI update for calendar year 2025. We also support **H.R. 2474, the *Strengthening Medicare for Patients and Providers Act,*** which would provide an annual inflationary update for Medicare physician payment tied to MEI. Like these bipartisan bills, we request an annual inflationary update tied to MEI. However, we are concerned that the policy included in the outline would allow Medicare physician payment to continue to fall behind inflation by tying an update to a fraction of MEI every five years rather than the full MEI annually.

Prior to the enactment of the *Medicare Access and CHIP Reauthorization Act* (MACRA), the costs associated with running a physician practice were on the rise. We continue to see substantial increases in prices for medical supplies, equipment, and clinical and administrative labor, as demonstrated by the Consumer Price Index (CPI) and the MEI.[1] Unlike other Medicare providers that receive annual payment updates based on an inflation proxy, such as increases in facility market baskets, MACRA only provided flat and nominal base updates to Medicare physician payments in the initial years and relatively modest updates thereafter. Specifically, from 2016 to 2019, physicians were slated to receive a 0.5% increase in their Medicare payments each year, 0% updates from 2020 to 2025, and based on their participation in the Quality Payment Program (QPP), an update of 0.25% or 0.75% in 2026 and beyond.

Under MACRA, Congress aimed to create a period of stable, albeit not inflation-adjusted, payment levels so physicians would have a predictable revenue stream while transitioning to more value-based care models, such as the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs), which offer additional financial incentives based on the quality and efficiency of care. The first problem was Congress' decision to undermine the onramp to value-based care by decreasing the CY 2019 base update from 0.5% to 0.25.[2] Since then, as the Centers for Medicare & Medicaid Services (CMS) began to implement MACRA (as the chart below shows), in most years, even the highest MIPS payment incentive – not including adjustments under a temporary "Exceptional Performance Bonus" – failed to close the gap between the change in the Medicare CF and practice costs. While some physicians may have benefitted from the Exceptional Performance Bonus pool, these bonuses expired following the 2022 performance year/2024 payment year.

| MIPS Payment Year | Highest Base MIPS Performance Adjustment[3] | Change from previous year in Medicare CF[4] | MEI[5] | Impact[6] |
|---|---|---|---|---|
| **2020** | 0.31 | 0.14 | 1.9 | **- 1.45** |
| **2021** | 0.00 | **- 3.3** | 1.4 | **- 4.70** |
| **2022** | 0.01 | **- 0.80** | 2.1 | **- 2.89** |
| **2023** | 0.11 | **- 2.0** | 3.8 | **- 5.69** |
| **2024** | 2.24 | **- 2.00**[7] | 4.6 | **- 4.36** |
| **2025** | 2.15[8] | **- 2.8**[9] | 3.6 | **- 4.25** |

[1] https://www.ama-assn.org/system/files/2024-medicare-updates-inflation-chart.pdf
[2] Sec. 53106 of the *Bipartisan Budget Act of 2018, Pub. L. 115–123*
[3] Represents the highest MIPS adjustment that could be earned under MIPS, not including additional payment bonuses under the Exceptional Performance Bonus, which was available in payment years 2019-2024.
[4] See the AMA History of Medicare Conversion Factors, https://www.ama-assn.org/system/files/cf-history.pdf
[5] See Actual Regulation Market Basket Updates, https://www.cms.gov/files/zip/actual-regulation-market-basket-updates.zip; 2025 MEI based on CY 2025 MPFS proposed rule, . https://www.federalregister.gov/documents/2024/07/31/2024-14828/medicare-and-medicaid-programs-cy-2025-payment-policies-under-the-physician-fee-schedule-and-other
[6] Difference between the payment rate based on the year's CF adjusted to include the base MIPS payment adjustment and the payment rate based on the CF adjusted to include an MEI update. Note that the CF for years 2021 through 2024 reflect the impact of substantial budget neutrality adjustments along with payment adjustments enacted by Congress to mitigate the impacts of the budget neutrality requirements.
[7] Estimated annualized reduction in payments relative to CY 2023 factoring in fact that Congressional intervention did not apply until claims with dates of service on or after March 9, 2024
[8] Preliminary estimate; subject to change following CMS' targeted reviews and Extreme and Uncontrollable Circumstances (EUC) Exception application decisions
[9] Preliminary estimate; subject to change following CMS' finalization of CY 2025 MPFS policies and Congressional action

## Bucket 2: Budget Neutrality

### *Rep. Murphy's Provider Reimbursement Stability Act – Updated look-back provision.*

While the Alliance generally supports **H.R.6371, the *Provider Reimbursement Stability Act***, which would update the budget neutrality threshold to allow for greater flexibility in determining pricing adjustments for physicians' services, we remain concerned about how the legislation, if enacted, would curb year-to-year conversion factor variability. The potential for harmful payment cuts under the Medicare physician payment system, even with a raised budget neutrality threshold, remain a clear and present threat.

In addition to an improved budget neutrality threshold, any legislative proposal to address systemic problems with Medicare physician payment should also:

- Exempt the following from budget-neutrality adjustments:
    - Newly covered or expanded Medicare benefits, items, and services, such as preventative services and new technologies, especially any vision, hearing, or dental services;
    - Items and services that are delivered in response to a public health emergency (PHE); and
    - Changes in relative values due to increased practice costs (e.g., clinical labor, professional liability).
- Authorize the Secretary of Health and Human Services (HHS) the flexibility to waive or modify budget neutrality requirements in other circumstances, as appropriate.
- Require the HHS Secretary to update the direct inputs used to calculate practice expense relative value units at least every five years.

Beyond the challenges in physician payment created under MACRA, the MPFS is plagued by other challenges, including requirements to maintain budget neutrality and irregularly timed 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 commenced paying for a new E/M add-on payment that Congress previously prohibited CMS from implementing, prompting yet another substantial budget neutrality adjustment and concomitant reduction to the MPFS CF. We appreciate congressional efforts to reduce CF cuts temporarily, however, Congress has still allowed year after year of cuts to the MPFS CF, and this pattern is unsustainable. In addition to congressionally mandated stabilization of the MPFS CF, 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, Medicare reimbursement volatility has system-wide impacts. One such consequence is that the increasing downward financial pressure on physicians continues to result in many having to sell or merge their practices with hospitals, health systems, and private equity groups. This is reflected in an April 2022 report[10] 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 American Medical Association (AMA) survey,[11] which found that less than half of physicians are working in physician-owned practices. Another recent survey found that between 2019 and 2022, there was a 9% increase in the number of hospital-owned physician practices, but in the same time frame, there was an 86% increase in the number of corporate-owned physician

[10] http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI Avalere Physician Employment Trends Study 2019-21 Final.pdf?ver=ksWkgjKXB_yZfImFdXlvGg%3d%3d

[11] https://www.ama-assn.org/press-center/press-releases/ama-analysis-shows-most-physicians-work-outside-private-practice

practices.[12] 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,[13] the Medicare Payment Advisory Commission (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)*

Consolidation remains a concern due to its impact on program spending. For example, research shows that hospital outpatient department charges can be more than double for the same service in the office setting.[14] Potential Medicare savings resulting from payment parity between the two settings have been predicted by the Congressional Budget Office (CBO).[15]

Medicare's reimbursement instability results in a domino effect for physicians and their patients: fewer physicians participate in the program, more physicians are forced to sell their practices, and, as noted above, costs for both the program and beneficiaries increase due to consolidation. This dynamic directly impacts access to care, especially for low-income beneficiaries and those living in rural or underserved areas. To extent to which the MPFS contributes to rising health care costs because it encourages consolidation is something that warrants thorough examination and correction by Congress.

## Bucket 3: Alternative Payment Models (APMs)

- *APM Bonus – 1-year clean extension.*
- *Reducing Fraud – Allow ACOs to flag adherent billing behavior without holding risk.*
- *Reforming CMMI – Overarching goal of increasing transparency and improving accountability, considering: Rep. Adrian Smith's bill, and Rep. Burgess draft to reform the stakeholder input process and CMMI funding, including sunsetting funding so Congressional reauthorization would be necessary for each subsequent decade.*
- *Reforming PTAC – Rep. Burgess draft to establish PTAC as a more independent body from CMMI with a more clearly defined statutory mission, more direct path to implementing models, and its own budget to ensure execution.*

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[12] https://www.modernhealthcare.com/providers/physician-compensation-private-equity-stipends-tuition-reimbursement?utm_source=modern-healthcare-am&utm_medium=email&utm_campaign=20241004&utm_content=article2-headline

[13] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar20_medpac_ch15_sec.pdf

[14] EBRI Issue Brief No. 525: "Location, Location, Location: Cost Differences in Health Care Services by Site of Treatment — A Closer Look at Lab, Imaging, and Specialty Medications" by Paul Fronstin, Ph.D., Employee Benefit Research Institute, and M. Christopher Roebuck, Ph.D., RxEconomics, LLC (Feb. 18, 2021).

[15] See, *e.g.*, CBO cost estimate for H.R. 5378, the *Lower Costs, More Transparency Act*, section 203 ("Parity in Medicare Payments for Hospital Outpatient Department Services Furnished Off-Campus")

The Alliance urges Congress to:

- Require CMS to release more granular and timely data regarding specialty participation in CMMI-tested models and other CMS APMs; the impact of those models on quality, value, and access to specialty care; and eligibility for the Advanced APM track of the QPP by specialty.
- Improve the APM pipeline to provide specialists more opportunities to participate meaningfully in APMs and qualify for the Advanced APM track of the QPP.
- Provide more guidance to specialists and their societies on how to get more APMs approved.
- Ensure that CMMI and PTAC employ more transparent processes and are accountable to Congress and the public in a manner that builds trust in these processes but is not so cumbersome as to stifle progress and innovation.
- Restore and extend the full 5% APM incentive payment, which expired following the 2022 performance year/2024 payment year, and maintain current QP thresholds to facilitate specialty physician movement into Advanced APMs, including new and more relevant models that have not yet materialized.

The specialty community has faced substantial challenges in terms of gaining access to data that will help it to better understand specialty engagement in, and barriers to, APM participation. Despite multiple requests, both CMS and MedPAC have been reluctant to provide data on the number and type of specialists in APMs to help us better understand and overcome these challenges. Although in recent years, MedPAC has begun to release some basic data on the participation rates of select specialties in MSSP ACOs,[16] the data are limited to a single model, do not cover all specialties, and do not provide insight on the rates at which different specialties qualify as Qualifying Participants (QP) in Advanced APMs. Similarly, CMS recently released its 2022 QPP Experience Report,[17] but it only includes aggregate national data on the number of clinicians that were QPs in an Advanced APM. It does not provide any insight into specialty-specific trends, nor does CMS make such data available through the QPP Public Use File (PUF).[18]

From what we have gathered from our members, most specialty physicians have struggled to meaningfully engage in the Advanced APM track of the QPP, as there are only a few APMs that are applicable to specialty care. Through discussions with Alliance member organizations and the physicians they represent, we have found that accountable care organizations (ACOs) are often the only option for APM engagement and usually the result of specialists' hospital or health system employment. Specialists often have little control over their decision to participate in these ACOs, and the current set of metrics used to measure the quality of care provided under the ACO do not reflect the more focused care provided by specialists.

Alliance organizations continue to hear from their specialty physician members that active and meaningful 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 Initiative–Advanced (BPCI-A) program, which CMS plans to sunset after 2025, do not align with other physician quality reporting requirements under MIPS and fail to provide high-performing practices with an incentive to stay in the program since they are held to exceedingly challenging spending targets that simply do not support high quality, appropriate care. Additionally, as discussed earlier, specialists who 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 the services they provide. At the same time, CMS policies adopted under the QPP and the Shared Savings Program have largely discouraged APM Entities from including specialists on their Participation Lists to date.

[16] https://www.medpac.gov/wp-content/uploads/2024/07/July2024_MedPAC_DataBook_SEC.pdf
[17] https://qpp-cm-prod-content.s3.amazonaws.com/uploads/2817/2022ExperienceReport.pdf
[18] https://data.cms.gov/quality-of-care/quality-payment-program-experience

These findings are not just speculative. As highlighted in MedPAC's July 2022 Data Book,[19] *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 fee-for-service (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 a recent Health Affairs blog post by senior CMS Innovation Center (CMMI) officials,[20] was the development of "shadow bundles." This concept of nesting more specific episode-based or condition-specific models in population-based total cost of care (PB-TCOC) models was also discussed in the PTAC's 2023 Request for Information (RFI) on Integrating Specialty Care in Population-Based Models[21] and its follow-up 2024 RFI on Implementing Performance Measures for PB-TCOC.[22] At the time, further attempts to coalesce around this concept with the ACO community were stalled. Ultimately, we were told that specialty medical care and treatment were expensive and hurt ACOs' financial performance, and — in the case of primary care-led ACOs — there was no appetite for sharing "savings" with specialists.

The Alliance appreciates the CMMI's recent recognition that a comprehensive approach to accountable care must account for both primary care and specialty care and that it is exploring opportunities to build on the shadow bundle concept. However, Alliance members still have not yet seen any meaningful progress. Some Alliance member organizations have already invested in this type of work, yet they continue to face challenges in terms of getting CMS to adopt these models. The American Society of Cataract and Refractive Surgery (ASCRS), for example, developed the Bundled Payment for Same-Day Bilateral Cataract Surgery (BPBCS), which aims to promote same-day bilateral cataract surgery to appropriate patients at a lower cost for both patients and Medicare. Under this model, the Cataract Surgery Team (the surgeon, facility and anesthesiologist) would receive a single bundled payment — rather than separate payments — for all services associated with the surgery. Importantly, the patient would also have a single cost-sharing amount for those services, and there would be fewer trips needed to the surgery center and to the physician for follow-up visits, which would reduce out-of-pocket expenses for the patient and family. This model supports a team-based approach to care that promotes efficiencies that will result in the best outcomes at the lowest possible cost. Despite multiple encouraging meetings where CMS leadership expressed support for the model, the agency has yet to take any action. As a result, ASCRS has begun to explore alternative pathways, including working with Medicare Advantage plans to test the model. The BPBCS is an example of a thoughtfully developed framework that could work in tandem with CMS PB-TCOC models — such as ACOs — as a separate voluntary agreement with a cataract surgery team without requiring specialists to be part of an ACO. The Alliance continues to urge CMS

[19] https://www.medpac.gov/wp-content/uploads/2022/07/July2022_MedPAC_DataBook_SEC_v2.pdf
[20] https://www.healthaffairs.org/content/forefront/cms-innovation-center-s-strategy-support-person-centered-value-based-specialty-care
[21] https://aspe.hhs.gov/sites/default/files/documents/2cd91b29eac2742fbc9babaf8f3b7962/PTAC-Specialty-Integration-RFI.pdf
[22] https://aspe.hhs.gov/sites/default/files/documents/823f7133bbde9de118d693a4330d2645/PTAC-Perf-Meas-RFI.pdf

and CMMI to work more closely with the specialty community and to take advantage of investments that have already been made in this space.

Overall, we are disappointed by the ongoing lack of models that are relevant to specialists. PTAC was created in 2015 to evaluate physician-focused models and to help guide CMS in selecting such models for testing. Although PTAC has considered more than three dozen models and recommended several, not a single one has been adopted by CMMI to date. The Alliance urges Congress to ensure that CMMI and PTAC are held to higher standards of transparency and accountability related to the consideration and inclusion of specialists in models. As a starting point, Congress could direct the U.S. Government Accountability Office (GAO) to conduct a study on APMs that documents gaps in current availability of APMs for specialists, identifies current barriers to specialist participation in APMs, collects insights from specialists and other physicians on how they would like to see APMs designed, and evaluates more specifically the reasons why models that were proposed to the PTAC and recommended to CMMI were never tested. The Alliance looks forward to working with Congress to address ongoing impediments to meaningful specialty engagement in APMs, but to also ensure that any standards adopted to address these gaps do not inadvertently stymie innovation and progress.

Specialists are further disadvantaged by 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 QPs in an Advanced APM is no longer available. Set to expire after the 2022 performance/2024 payment year, Congress subsequently extended this incentive payment an additional year, but at a reduced rate of 3.5%, and then again, for the 2024 performance/2026 payment year, but at a further reduced rate of 1.88%. Moving forward, as mandated under MACRA, physicians who qualify as QPs will only receive a nominal base CF update starting in 2025 (0.75% vs. 0.25% for non-QPs, including MIPS participants who are also eligible for upward performance-based payment adjustments), limiting their incentives to join APMs going forward.

MACRA also prescribes specific Medicare payment and patient thresholds that clinicians must meet to become QPs. Beginning with the 2023 performance year, the Medicare QP thresholds were supposed to 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. While Congress froze these thresholds at the lower levels for 2023 and 2024, they are scheduled to increase in 2025 without Congressional action, which will make it even more challenging for specialists to qualify for this track of the QPP.

While the Alliance appreciates the steps Congress has taken to date in an attempt to continue to support the movement of physicians into APMs, it is still 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 successfully in an APM. Similarly, higher QP thresholds will result in even fewer specialists qualifying for this track. The Alliance is concerned that these and other shifting policies will create a situation where MIPS incentive payments exceed APM incentive payments, causing reverse movement away from APMs and back into MIPS, contrary to Congress' vision of the QPP. We urge CMS to extend APM incentive payments and to maintain or reduce current QP thresholds.

## Bucket 4: Merit based Incentive Payment System (MIPS)

- *Late Submission – Allow for eligible clinicians to submit their data late with a [1%] penalty for submission [1 month] after the deadline, a [3%] penalty for [2-3] months after the deadline, and a [6%] penalty [3-6] months after the deadline, with o penalty exceeding a maximum 10%. Also, add an additional [ ]% penalty for complete non-participation.*
- *Clinical Data Registries and MVPs – Allow clinical data registries to count as MIPS participation and direct HHS to continue to add MVP pathways.*
- *Paperwork Reduction – Eliminate clinical practice improvement activities, allow for that portion of MIPS scoring to be split evenly by the other categories.*
- *Helping Small and Rural Practices – Revive the Technical Assistance to Small Practices and Practices in Health Professional Shortage Areas, adding [$20 million] for fiscal years 2026-2030.*

The Alliance urges Congress to:

- Give CMS the authority to move beyond the four siloed performance categories of MIPS and instead recognize more comprehensive and innovative investments in high value care.
- Better recognize the value of clinical data registries and their role in the QPP by, for example, allowing clinicians to receive credit across all four MIPS categories for registry participation that meets minimum standards and recognizing similar participation pathways that are more meaningful to specialists.
- Require CMS to better incentivize the development and use of specialty-focused metrics through technical assistance, less resource-intensive measure testing policies, and revised MIPS scoring policies.
- Allow physicians to meet Promoting Interoperability requirements via "yes/no" attestation of using CEHRT or technology that interacts with CEHRT, such as participation in a clinical data registry.
- Allow CMS to modify the MIPS Cost category by:
    - Removing the primary care-based total per capita costs measure mandate that continues to hold physician practices — including specialties that are explicitly excluded from the measure — 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 simultaneously account for any changes in quality indicators meaningfully tied to cost performance among the same patient population to ensure cost-containment efforts do not result in poorer quality care or negatively impact access to care.
- Enforce MACRA's requirement that CMS provide access to Medicare claims data to assist specialties and their registries with a better understanding of existing gaps in care and support the development of quality and cost measures.
- Require CMS to release more granular and timely data regarding physician participation in MIPS.

Implementation of MACRA's two-track value-based payment system, the QPP, has been ineffective and, arguably, detrimental to the delivery of most specialty medical care. Many 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, many 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 have demonstrably improved as a result of the MACRA-established quality programs.

In contrast to the promises of MACRA, MIPS has evolved into an overly complex, disjointed, burdensome, and clinically irrelevant program for many specialists. Even the U.S. Government Accountability Office (GAO),[23] 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. In its March 2024 environmental scan of value-based payment models,[24] discussed earlier, PTAC notes: "Overall, there is little evidence that pay-for-performance and public reporting of quality measures have improved overall quality of care in the United States." 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 and complex reporting requirements and scoring rules, making program compliance extremely resource intensive with little to no evidence of value. Additionally, for many specialties, 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 comprehensive value-based activities, such as reporting and regularly tracking performance through a clinical data registry, which would minimize duplicative and misguided reporting mandates while rewarding more meaningful investments in value-based care. 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 for many specialties, it does not meaningfully reflect the overall value of care.
- **Constantly Shifting Goalposts**. Each year, CMS changes MIPS participation rules, including rules around eligibility, reporting requirements, and available measures. CMS also has the authority to update performance thresholds, which it has done many times since the program launched. 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 analyze the overall impact of the program over time accurately.
- **Lack of Incentives for Specialty Measures**. Many specialties have also faced challenges developing more specialty-focused quality measures and getting members to report on those measures as a result of MIPS scoring policies and other challenging requirements associated with maintaining a QCDR.
    - 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.
    - CMS quality measures scoring policies also disincentivize the development and use of more focused, specialty-specific measures — especially measures such as patient-reported outcomes measures, which are more time-consuming to collect but more meaningful to patients and physicians.
- **Barriers to Accessing Claims Data.** Specialty societies and QCDRs have also faced major challenges in accessing claims data. Claims data acquisition is costly and time-consuming, and specialty societies continue to face delays in trying to access such data. Specialty societies are willing to assist CMS with more robust quality and cost analyses but cannot do this without reasonable access to timely Medicare claims data.

[23] https://www.gao.gov/assets/gao-22-104667.pdf
[24] https://aspe.hhs.gov/sites/default/files/documents/dae3de25b874112a649445d6381f527e/PTAC-Mar-25-Escan.pdf

- **Flawed Cost Measures**. Cost measures adopted for MIPS are also extremely difficult to interpret and take meaningful action on, and efforts to implement cost measures under MIPS to date have uncovered a variety of complex issues that make physician-level accountability an ongoing challenge. They often reflect care decisions and costs that are outside of a specialist's direct control and rarely align directly with quality measures other than in the title. For example, autoimmune diseases such as rheumatoid arthritis and Crohn's disease are managed with highly complex medications, including biologics and biosimilars, that physicians have little control over. Depending on the patient's unique biology, disease progression, and other clinical factors, one therapy may be clinically indicated, recommended and prescribed over another. Additionally, regardless of the condition or disease, 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 to care. However, there is no meaningful way to align cost performance with applicable quality measures. This is even true under CMS' MIPS Value Pathways (MVP) Framework, which was intended to align performance assessment across the four MIPS performance categories. Unfortunately, MVPs too often include a cost measure addressing a specific condition, but no corresponding quality measures addressing the same condition. Therefore, it is not clear if the MIPS participant achieved good cost performance by improving value, or by simply stinting care.
- **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 promoting innovative use cases of health information technology, such as clinical data registries, clinical decision support tools, and tracking data from wearables and other digital devices that are more common among specialty patients. EHR adoption and federal policies supporting interoperability have advanced significantly since the enactment of MACRA. There is much more widespread use of certified EHR technology (CEHRT) among clinicians, and CEHRT requirements have evolved to a point where users of CEHRT are inherently satisfying the actions that the current set of MIPS Promoting Interoperability measures originally set out to capture and incentivize (e.g., secure data exchange). As a result, this category of MIPS has become outdated and should be revised to represent the current landscape better and minimize unnecessary reporting burden.
- **Lack of Alignment Across CMS Programs**. MIPS physician-level reporting requirements and measures largely fail to align with other CMS value-based incentive programs, including payment and delivery models, that apply to other providers and settings of care. For example, specialty practices submitting quality measure data for the BPCI-A model cannot simultaneously receive credit for the same measures under MIPS and must submit data for the two programs separately. 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 — even as recently revised through the MIPS Value Pathways (MVP) Framework — 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 earlier.
- **Misguided Efforts to Improve MIPS**. Although CMS' recently introduced 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 physician burnout is at an historical high.

## Bucket 5: Quality Measures

- *Digital Quality Measures – Adding to C) Additional measures, "Emphasizing digital measures under the quality performance category In applying subparagraph (B)(i), the Secretary shall, as feasible, emphasize the application of digital measures, including by allowing for voluntary demonstration projects to test new digital measures."*
- *Rep. Blake Moore's bill on sunsetting quality measures.*

The Alliance strongly supports recent efforts by CMS and the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health IT (ASTP/ONC) to advance interoperability and minimize the burden associated with data collection and reporting since compliance with MIPS costs, on average, $12,800 per physician per year, with physicians spending 53 hours per year on MIPS-related tasks.[25] We believe that digital quality measures can improve data quality; allow for the use of more robust measures (e.g., patient-reported outcome measures); optimize data aggregation, including improved alignment of measures across multiple agencies and payers; allow for more advanced analytics that support a learning health system that continually raises the bar on care; and reduce provider measurement burden overall. At the same time, we are concerned that the infrastructure needed to support these objectives is still lacking and that health IT vendors will pass the costs of complying with new federal certification standards on to physicians or implement other potentially coercive contractual clauses related to new functionalities that lessen their value or even make them inaccessible. Technology that supports digital quality measures must be affordable and accessible to all practice types and sizes, user friendly, secure, and seamlessly integrated into clinical practice. The Alliance supports voluntary demonstration projects to test new digital measures so long as they keep these principles in mind. We also oppose mandating the use of digital quality measures given ongoing challenges related to EHR adoption and use—particularly EHR interoperability with other data sources, such as registries.

In regard to sunsetting quality measures, we support greater transparency and providing the public with greater opportunity to weigh in on these decisions. We also urge Congress to hold CMS accountable for its decisions by requiring that the Agency provide more substantive feedback on how they reached a decision to remove a measure, particularly when members of the public do not agree with such a decision. At the same time, we remind Congress of ongoing critical gaps in specialty measures. Specialty measures are often more nuanced and robust (e.g., patient-reported outcome measures) and thus more challenging to develop, test, and administer. Even where specialty-focused measures exist, CMS scoring policies often disincentivize their use. It is critical that CMS consider the availability of measures to each specialty as part of its measure removal criteria.

## Closing Remarks

While Congress has sought to provide flexible options for clinicians to engage in meaningful quality improvement and value-based care in the Medicare program, the implementation of these statutory quality programs has resulted in a rigid system that holds physicians accountable for metrics and models that often 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.

[25] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2779947

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"[26] and urge you to incorporate these principles in any physician payment reform solution.

Thank you for considering our feedback as you work to stabilize the Medicare physician payment system while ensuring successful value-based care incentives are available for specialty physicians. Please contact us at info@specialtydocs.org if you have any questions or would like to discuss these issues in greater detail.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Otolaryngology – Head and Neck Surgery
American Association of Neurological Surgeons
American College of Mohs Surgery
American Gastroenterological Association
American Society of Cataract and Refractive Surgery
American Society for Dermatologic Surgery Association
American Society of Echocardiography
American Society of Plastic Surgeons
American Society of Retina Specialists
American Urological Association
Congress of Neurological Surgeons
Coalition of State Rheumatology Organizations
National Association of Spine Specialists
Society of Interventional Radiology

[26] https://www.ama-assn.org/system/files/characteristics-rational-medicare-payment-principles-signatories.pdf