Testimony from the Alliance of Specialty Medicine by Parag D. Parekh, MD, MPA

American Society of Cataract & Refractive Surgery (ASCRS)

Before the House Energy and Commerce Committee

Subcommittee on Health

"MACRA and MIPS: An Update on the Merit-based Incentive Payment System"

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Chairman Burgess, Ranking Member Green, and members of the Health Subcommittee, thank you for the opportunity to provide feedback on implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). My name is Dr. Parag Parekh. I am a private practicing ophthalmologist in rural Western Pennsylvania, and the only board-certified, fellowship-trained ophthalmologist specializing in cataract and refractive surgery, as well as cornea and glaucoma surgery, in that geographic area and the entire 5th district. I am an active member in multiple professional medical societies. Notably, I am the Chair of the American Society of Cataract & Refractive Surgery (ASCRS) Government Relations Committee where I have served as a member for the past 10 years. I also serve on relevant technical expert panels (TEP) formed by the Centers for Medicare and Medicaid Services (CMS) to address the programs established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and implemented under CMS' Quality Payment Program (QPP).

I am here today on behalf of the Alliance of Specialty Medicine ("Alliance"). 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. As patient and physician advocates, the Alliance welcomes the opportunity to provide input in the formulation of health and Medicare policy.

Today's hearing is an important step to ensuring the Congressional intent of MACRA in providing flexible options for clinicians to meaningfully engage in the program. The Alliance has worked closely with policymakers and CMS to ensure that implementation of the law is consistent with Congress' intent. For this reason, we greatly appreciate that Congress included "technical corrections," as part of the February 9, 2018 Continuing Resolution (CR). Not only will these adjustments strengthen the law and continue progress made to date, it will significantly improve the ability of physicians, particularly specialists, to engage in quality improvement activities, and specifically in the Merit-based Incentive Payment System (MIPS) track of MACRA.

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 option is most appropriate based on their preferences and values, and coordinate and manage their specialty and related care until treatment is complete. No other clinician, provider or health care professional can replace the value offered by specialty physicians. To that end, MIPS must be implemented successfully and set up for long-term viability since it will be the only option for many of these specialists to engage in pay-for-performance given they will have no other option than to remain in fee-for-service.

Moving to Value-Based Payment in Medicare

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. For example, the American Association of Neurological Surgeons (AANS) and Congress of Neurological Surgeons (CNS) support multiple registries that promote national quality research efforts, including comparative effectiveness research, practice data collection requirements for board certification, and robust data for structured quality improvement studies in the areas of spine surgery, cerebrovascular, stereotactic radiosurgery and brain tumors. In addition, AANS/CNS is working on other clinical decision support tools, including predictive risk calculators to counsel patients and assess their risks and potential outcomes from spine surgery. Another example is the American Gastroenterological Association's (AGA) "My IBD Manager" patient app and the "Ask AGA: IBD" clinical platform. These tools work together to improve the physician/patient relationship and to simplify access to clinical evidence and clinical guidelines, while providing patients a one-stop-shop to learn about their disease, monitor symptoms and share information with their health care team.

Members of this committee will recall Congress' 17 interventions over 11 years, which were necessary to prevent steep reductions in Medicare physician payment under the Sustainable Growth Rate (SGR) formula – in some cases up to 24%. Without your help, physician practices would have been financially devastated and access to care would have been severely restricted for America's frailest, and most vulnerable population. Congress also established quality improvement programs on top of the flawed SGR reimbursement mechanism, including 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." While the goals of these programs were laudable, they had disparate reporting requirements that included overlapping measures. Physicians and practices were at

a loss to keep up with the various deadlines and would face stiff penalties if they made even minor clerical errors due to the "all-or-nothing" nature of the programs. Congress listened to the concerns about these legacy quality reporting programs raised by physicians and created the MIPS program, which streamlined the existing programs and allowed physicians to focus on the measures and activities that most closely align with their practices. As a key example of that, the addition of the clinical practice improvement activities gives physicians MIPS credit for activities designed to improve care—many of which physicians were already doing.

Now, with the looming threat of yearly cuts in Medicare reimbursement due to the flawed SGR removed, thanks to Congress, and members of this committee in particular, Alliance member organizations can further efforts to improve specialty care with incentives and technical assistance provided under MACRA.

Importantly, the Alliance appreciates the approach Congress took, and in particular, this committee, when drafting MACRA, which established two value-based reimbursement tracks for physicians under Medicare. Under one track, physicians can opt to remain in fee-for-service and participate in MIPS. Through the MIPS program, physicians report and are measured on their performance on: (1) relevant, self-selected quality measures, typically developed by and for their specialty; (2) meaningfully use certified electronic health technology (CEHRT), reporting their performance on objectives and measures that generally align with how their practice uses EHRs and other health information technologies; (3) demonstrating clinical practice improvement through various activities, such as using data from a qualified clinical data registry to tailor care management plans for discrete patient populations within their practice or collect and follow-up on patient experience and satisfaction data related to beneficiary engagement; and finally, (4) cost of care provided to certain beneficiaries in

key clinical areas, although considerable work remains before physicians, and specialists in particular, should be held accountable for efficient resource use. Specifically, CMS should continue efforts to develop episode-based cost measures and remove flawed population health measures that potentially hold physicians accountable for the cost of care they did not provide. In the second track, physicians can significantly participate in Advanced Alternative Payment Models (APMs) and potentially earn incentives and increased reimbursement under Medicare. Both tracks are built on Medicare's current fee-for-service payment system, and both entail financial risk and reward. Both tracks also measure quality of care, and to a certain extent, hold participants accountable for financial efficiencies.

For many specialists, including ophthalmologists like me, MIPS is the only meaningful and viable pathway for participating in programs established under MACRA. In fact, many specialists have no opportunities to participate in Advanced APMs, at all. A review of CMS' MIPS exclusion tables from the 2017 Quality Payment Program Final Rule shows that family medicine, internal medicine, obstetrics/gynecology, and nurse practitioners, are the primary specialties that will make up the vast majority of Advanced APM qualifying participants (QPs), based on 2017 estimates. By comparison, CMS projected that specialists, such as ophthalmologists, neurosurgeons and rheumatologists, would be less likely to engage in APMs, with only 153 (0.7 percent), 46 (0.8 percent) and 79 (1.4 percent) of these specialty physicians, respectively, expected to reach QP status based on 2017 performance.

As this committee is aware, only a handful of Advanced APMs have been designed for a narrow subset of specialty physicians and complex health conditions they are best equipped to diagnose, treat and lead teams in managing patient care. The vast majority of Advanced APMs, including the various Medicare Accountable Care Organizations (ACOs) and the Medical Home Model, were designed with a focus on delivering primary and preventive care and to address broad population health goals, led by

teams of primary care providers. Specialty physicians have attempted engagement in Medicare ACOs but have faced significant challenges. For example, small, primary-care led ACOs maintain closed or "narrow networks," excluding some or all specialty physicians. While specialists have had more success participating in large, hospital- or health system-centered ACOs, their engagement has been passive. In fact, specialists that participate in large ACOs tell us they have no meaningful role in improving the quality or cost of care for the ACO's assigned population because there are no metrics focused on the conditions they cover or the care they deliver. The Alliance has recommended a number of changes in Medicare's Shared Savings Program regulations that would address these and other challenges with ACO participation by specialists, and we will continue those efforts.

Even before passage of MACRA, several Alliance organizations were working diligently to foster alternative payment and delivery models for their specialty through existing agency channels. Despite a multitude of meetings with CMS' Innovation Center, these models were dismissed – even those that addressed services representing a high proportion of Medicare expenditures and had been successfully tested in the private insurance market. Candidly, Innovation Center officials told some of our organizations that models centered on primary care were the agency's priority. Now, as evidenced by the multiple letters of intent and proposed models submitted for review and deliberation by the Physician Focused Payment Model Technical Advisory Committee (PTAC), it should be clear that specialists are eager to contribute to responsible stewardship of federal health programs. It is frustrating to be viewed as a costly part of the Medicare program, while simultaneously being turned away when we present proactive, innovative solutions and proposals.

While there is more work to be done to encourage value-driven health care, and several disease states and procedures are prime for quality and resource use improvements, many specialists have made

significant strides to engage in activities that deliver high-quality, efficient care. In fact, some have already refined key conditions and procedures through medical advancement and technological innovation. For example, some specialists have moved services and procedures from expensive inpatient settings to lower-cost outpatient settings; some perform all aspects of a surgical service in the physician office-setting, ensuring high-quality and reducing inefficiencies, while lowering government and beneficiary costs; and, others have eliminated variations in cost, quality and access to their procedures through long-term performance improvement, which is documented in the literature.

A key example is my own specialty of cataract surgery. Cataract surgery is performed in either an Ambulatory Surgery Center (ASC) or Hospital Outpatient Department (HOPD). When complications, but also variations in outcome occur, it is often due to patient co-morbidities, such as diabetes, glaucoma, macular degeneration or retinal disorders, or other significant pre-existing health issues. There have not been demonstrated gaps in the quality, cost, or access to care based on the site of service. In the last 50 years, since the advent of phacoemulsification, ophthalmologists have made tremendous strides in improving cataract surgery so that complications are relatively rare. While still an intensive procedure requiring the special skill of ophthalmologists, the medical innovation of the last half-century means that patients will have a reliable assurance that the outcome of their surgery will contribute positively to their overall quality of life. There are very few opportunities for further improvements to quality or efficiency in cataract surgery, which makes developing or participating in an Advanced APM difficult.

For me and certain other specialists, engagement in the MIPS track, which relies on a fee-for-service reimbursement structure, remains the most appropriate mechanism. More specifically, the MIPS track allows specialists – those without suitable Advanced APMs options – 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. It is critically important that Congress maintain a viable fee-for-service option in Medicare Part B, along with the MIPS program, to ensure specialists can continue to meaningfully engage in federal quality improvement initiatives, and more importantly, continue to deliver high-quality care to America's senior and disabled population.

Importance of Technical Corrections Approved by the Congress

We greatly appreciate that Congress included provisions in the Bipartisan Budget Act of 2018 (Public Law No. 115-123), to ease the ramp up of the MIPS Program and to allow those committed to value-based care improvement to remain in this track of the QPP. We are particularly supportive of the provision that would give CMS three additional years of flexibility to determine the appropriate weight of the MIPS cost category based on the availability of relevant measures. Given the state of readiness of cost measures, this flexibility is essential. A significant amount of work remains to be done to ensure that new episode-based cost measures are developed and integrated in a way that accurately reflects the complexities of cost measurement and does not inadvertently discourage clinicians from caring for high-risk and medically complex patients.

I have been participating in efforts to develop episode-based cost measures. I served on two CMS-appointed technical expert panels related to these measures, including the ophthalmic clinical committee that developed the cataract surgery measure. Throughout this process, my fellow committee members and I have worked to ensure that physicians are not penalized for the cost of care outside their control, unlike the current flawed measures held over from the Value-based Payment Modifier—Medicare Spending per Beneficiary and Total per Capita Cost of Care that are meaningless to specialists. We have looked at every aspect of care related to cataract surgery, including pre-, intra-, and post-operative costs. We accounted for difference in cost related to the differing facility payments for procedures performed

in ASCs versus HOPDs, and risk -adjusted for costs related to significant ocular co-morbidities. My colleagues serving on other subcommittees also grappled with cost drivers relevant to their own conditions and procedures. It is a painstaking process that requires analysis tailored to each unique procedure or condition.

While CMS is proposing to include the cataract surgery episode measure and seven other procedure and condition-based episodes in MIPS for 2019, it will be several years before a significant number of measures can be developed. The additional time provided by the technical corrections will allow further refinement and development of these measures.

In addition, we appreciate provisions that allow CMS to more gradually increase the MIPS performance threshold year-over-year before reaching the "mean or median" standard. For 2019, CMS has proposed to increase the performance threshold to 30 points, up from the 2018 performance threshold, which was set at 15 points, and the 2017 performance threshold, which was set at 3 points. Gradually increasing the performance threshold gives physicians the opportunity to implement necessary practice changes as they gain experience. It also ensures that the performance threshold is not set too high, which could discourage participation or negatively impact practices with fewer resources. Data on physician participation and performance collected by CMS will best determine clinician readiness and should guide the agency as it works with the physician community on increasing program requirements. CMS reports that 91% of eligible physicians participated in the first year of MIPS, which should provide ample data for the agency to evaluate and determine how to proceed in coming years.

We also appreciate the technical correction that ensures Medicare Part B drugs and other items and services outside the physician fee schedule are not included in the application of MIPS payment

adjustments and determination of MIPS eligibility. Without the correction, CMS would have been authorized to penalize and reward clinicians based on the volume of medicines they administer in their offices. Not only would these adjustments potentially hinder access to care for beneficiaries whose physicians are penalized, but positive adjustments to practices that administer Part B drugs would unfairly reduce the incentive pool for all other clinicians.

Alliance member organizations, such as my own, ASCRS, have developed extensive training materials to help physicians understand and thrive in the program. Efforts include the development of guides tailored to each specialty, in-person training programs for physicians and their practice administrators, webinars and other online education, infographics and visual aids, among other resources. These extensive education efforts have already started to pay off as many specialists are participating in MIPS and are active members of the quality improvement community. Additional time and flexibility will ensure that all specialists are prepared and can be successful as the performance thresholds increase each year.

Additional Refinements to MIPS Still Needed

While the Alliance greatly appreciates the added flexibilities included in the Bipartisan Budget Act of 2018, we believe that additional modifications are needed to make MIPS less administratively burdensome and costly for physicians; more meaningful, relevant and actionable to both physicians and patients; and more transparent. A more simplistic and applicable approach will ensure not just greater clinician engagement, but more purposeful engagement, which is the only way to effect real change. The Alliance supports practical solutions that would lessen the complexity of MIPS scoring, including additional opportunities for clinicians to get credit across multiple MIPS categories for engaging in a single set of

actions. Members of the Alliance have been working with its colleagues to flesh out these proposals and would be happy to have a more detailed follow-up discussion with members of the subcommittee.

To that end, we greatly appreciate proposals put forward by CMS in its recent Year 3 Quality Payment Program proposed rule that would address key challenges physicians have faced with the MIPS program, and particularly the Promoting Interoperability performance category, formerly known as the Advancing Care Information performance category. CMS is proposing to reduce the number of objectives and measures that physicians would report to be meaningful users of certified electronic health record technology, eliminate the convoluted scoring construct, and to focus exclusively on a clinician's performance on a more limited set of measures. If finalized, these modifications will make a meaningful difference in the ability of many specialists to engage in the MIPS promoting interoperability performance category. We look forward to working with CMS, Congress, and members of this committee on additional refinements that will further interoperability across electronic health records and other health information technologies, including qualified clinical data registries (QCDRs). I'll discuss more about this in a moment.

There is also an ongoing need to support measures and reporting mechanisms that recognize patient and clinician diversity. Most specialties still lack a robust set of meaningful measures due to the complexity of their care, nuanced variations in their patient population, and ongoing barriers to data collection. Nevertheless, members of the Alliance continue to invest in efforts to better track the performance of their care. Specialty societies in the Alliance continue to invest heavily in the development of quality measures, including outcomes and those reported by patients, and have established robust clinical data registries, that have been qualified for use in the MIPS program. These QCDRs are especially important for specialty physicians looking to deepen their understanding of quality and performance for

relevant episodes of care. Not only do the data collected and resultant information fuel important improvements in practice-level outcomes, it also helps specialty societies engage in education at the national level, benefiting their respective professions at the broadest level. In my own specialty of ophthalmology, the IRIS registry serves as a key tool in not only reporting MIPS data, but tracking outcomes for ophthalmic surgery and the care of patients with chronic eye disease. Despite the advantages physicians gain through their use, QCDRs face ongoing challenges connecting to certified electronic health record technology (CEHRT), which is prevented by vendors blocking the bidirectional exchange of this important health information. The Alliance hopes to work with this Committee to ensure this challenge is addressed by the Secretary as required under the 21st Century Cures Act. This is a huge impediment to our success and we strongly encourage you to address this obstacle.

Measure implementation is another ongoing challenge. Specialty societies often find themselves in a catch-22 in that newly implemented measures need to be reported by a sufficient number of physicians to produce reliable benchmarks that can be used for performance scoring. Our member societies continue to confront situations where they invest heavily in the development of new, specialty-focused measures, but when they do not immediately produce enough data to set reliable performance benchmarks, CMS threatens to remove them from the program. The Alliance asks for more flexibility, especially for smaller specialties, to support physician participation in MIPS and to incentivize the collection of data needed for benchmarks over time. We appreciate that CMS has proposed an "opt-in policy" that would allow previously exempted physicians to participate in the program. This policy, if finalized, will significantly assist with data collection and the establishment of benchmarks that are desperately needed for new specialty-focused quality measures. Additional incentives, such as assigning "high priority" status to new quality measures, would also help support the reporting of new measures.

MedPAC Recommendation

The Alliance would also like to express our concerns with the Medicare Payment Advisory Commission's (MedPAC) recommendation to eliminate the MIPS program and replace it with a new Voluntary Value Program (VVP). MedPAC's recommendation, coupled with forthcoming recommendations to "rebalance" the Medicare physician fee schedule (MPFS) toward primary care, undercuts and devalues the role of specialists in providing thorough examinations, rendering accurate diagnoses, offering a complete range of treatment options, to include performing surgery, and delivering comprehensive and effective management of complex health conditions.

MedPAC has specifically called for the *Congress to eliminate the current Merit-based Incentive Payment System and establish a new voluntary value program in fee-for-service Medicare in which clinicians can elect to be measured as part of a voluntary group and qualify for a value payment based on their group's performance on a set of population-based measures.* According to MedPAC staff, spending implications include distributing the $500 million MIPS exceptional performance bonus pool to improve payment for primary care or encourage engagement in Advanced APMs.

We again reiterate that the MIPS program provides the only mechanism for many specialists and subspecialists to engage in federally-sponsored quality improvement activities and demonstrate their commitment to delivering high-value care. Specialty care is often targeted as being high cost and of variable quality. These claims cannot be validated nor addressed by adding yet another program that relies on a set of population-based measures more geared toward primary care and eliminating the one program that specialists can actually use to demonstrate and improve their quality and overall value. Eliminating MIPS in favor of MedPAC's proposed new quality program would discourage specialty physicians from developing robust quality and outcomes measures that are most relevant to their patient

populations, disincentivize the use of high-value clinical data registries to track patterns of care, and thwart efforts to collect and report performance data, overall.

It would also exacerbate the whiplash and confusion that physicians are already experiencing as they transition from multiple pay-for-reporting and pay-for performance programs that have evolved since the Physician Voluntary Reporting Program (PVRP) commenced in 2006. The types of changes we are all hoping for take time—time for policymakers and regulators to work with stakeholders to develop and establish the policies, and time for physicians to implement the programs and adapt their practices to the changes. It took 15 years to solve the SGR conundrum and develop MACRA; scrapping the MIPS program as a failure when it has barely launched is grossly inappropriate and unfair, particularly given the support the medical community demonstrated in helping the Congress and this committee establish the program under MACRA.

We disagree with MedPAC that the reporting requirements under MIPS are ineffective at improving care because physicians can choose the quality measures to be graded on. In contrast, this is one of the most important aspects of the MIPS program, which was recognized by the drafters of the MACRA law. Had Congress intended for the Medicare agency to select quality measures for physicians to report, it wouldn't have emphasized the development of quality measures by medical specialty societies and provided requisite funding. Physicians know which measures are most applicable to their practice based on their clinical specialty or subspecialty area, the services and treatment options they provide, and the patient population they serve. Holding physicians, and particularly specialists, accountable for measures that are not applicable to their practice or patients would pose an undue regulatory burden and result in meaningless data of little value to both specialists trying to improve the quality of care and patients trying to make well-informed medical decisions about the quality of care provided by specialists.

While we understand CMS' interest in pursuing a more parsimonious set of measures through initiatives such as "Meaningful Measures" and "Patients Over Paperwork," it is critical that CMS maintain a diverse enough set of measures to appropriately capture the quality of care provided across specialties and practice settings.

We also disagree with MedPAC that quality measures do not focus on clinical outcomes. Out of the 271 MIPS quality measures, more than 168 are 'high priority' measures, which include more than 70 outcomes measures. This does not include outcomes measures that are exclusive to the multiple specialty-focused QCDRs. In ophthalmology, including cataract surgery, the vast majority of clinical quality measures are outcomes-based. Specialty societies continue to develop outcomes-based clinical quality measures where appropriate and feasible.

The Alliance has shared its concerns with MedPAC about the adverse impact the Commission's recommendation would have on specialty physicians and the beneficiaries they serve. Specifically, we called to their attention the lack of Advanced APMs in which specialists can meaningfully engage, the limitations of population-based measures in determining quality and cost of specialty medical care, and MACRA's intent to promote the development of clinically relevant, specialty-based quality measures. Moreover, we explained that fee-for-service remains the only viable reimbursement structure for many specialists and subspecialists.

Similar to the discussion above regarding the VM cost measures, population-based quality measures, such as those used in Medicare's ACO program or reported by Medicare Advantage Organizations (MAOs) under the "Star Ratings" program, are not reflective of specialty medical care. As such, these measures cannot help specialists improve or change behavior, and will not help CMS differentiate between high and low-value specialists, nor yield meaningful information that drives

beneficiaries toward high-value specialty providers. In fact, one of the concerns specialty physicians have raised with CMS is that the quality measures in the Medicare ACO program and Medicare Advantage hinder specialty participation because their value cannot be demonstrated. Both Medicare ACOs and Medicare Advantage plans have "narrow networks" that exclude specialist participation because few of the quality measures they are held to account for specialty medical care. Rather, these models are focused on broad population-health measures that are generally under the purview of primary care providers. This is one reason why small, physician-led ACOs, are dominated by primary care physicians, and why larger, hospital- or health system-led ACOs only passively engage specialists.

We urge the Congress, and members of this committee, to disregard MedPAC's recommendation and instead work toward ongoing improvements to the MIPS program as it continues to mature.

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 subcommittee to ensure the implementation of MACRA continues to be successful, and we would be happy to discuss any other questions you may have going forward.