Alliance of Specialty Medicine

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Alliance of Specialty Medicine
Statement for the Record
Senate Finance Committee Hearing
"Bolstering Chronic Care through Medicare Physician Payment"
Thursday, April 11, 2024

The Alliance of Specialty Medicine ("Alliance"), a coalition of 16 medical specialty organizations representing more than 100,000 specialty physicians, is deeply committed to improving access to specialty medical care through the advancement of sound health policy. We thank the Committee for convening a hearing to examine how changes to Medicare physician payment can bolster chronic care. Today, we outline suggested actions that Congress should take to stabilize the Medicare physician payment system while ensuring successful value-based care incentives are available for specialty physicians. We continue to have serious concerns about structural challenges and instability in Medicare payments to physicians and request your assistance to begin the process of stabilizing and improving Medicare physician reimbursement and performance programs through legislative reforms.

Our statement addresses the major pain points our specialty organizations and their members have been facing under the current Medicare physician payment system and quality improvement programs. **We urge Congress to take the following actions to address many of the challenges patients and doctors face:**

- Replace flat base payment updates and improve nominal base payment updates (in CY 2026 and beyond) with annual payment updates to the Medicare conversion factor that are based on an appropriate inflationary index that reflects rising practice costs, such as the Medicare Economic Index (MEI).
- Exempt the following from budget-neutrality adjustments:
    - Newly-covered or expanded Medicare benefits, items, and services, such as preventative services and new technologies,
    - 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 the flexibility to waive or modify budget neutrality requirements in other circumstances, as appropriate.

- Require ongoing and consistent updates of key data inputs used to set Medicare payments to physicians (e.g., practice expense and liability insurance) and hold physicians harmless from these updates, which are outside their control,
- Perform more granular and timely evaluations of the impact of the Quality Payment Program (QPP) and Physician-Focused Payment Model Technical Advisory Committee (PTAC) on health care quality and value, as well as access to care— particularly as it relates to specialty care. While PTAC recently released an environmental scan of value-based payment models,[1] which includes a table listing the percentage of physicians participating in Advanced Alternative Payment Models (APMs) by specialty, it is missing specialties and only reflects trends from 2017-2019. Such outdated information is of little value to our members. Similarly, the QPP Experience Report data set, which provides aggregate participation and performance information related to each year of the Merit-based Incentive Payment System (MIPS), is also outdated. As of April 2024, the most current data set available to the public relates to the 2021 performance year. Given how frequently CMS changes MIPS rules, performance thresholds, and measure sets, CMS' more than two-year lag in reporting participation and performance trends makes it nearly impossible for the public to meaningfully assess the impact of the program and to comment on the feasibility of newly proposed policies. Additionally, the QPP Experience Report data set, which is slightly more current than the recently released PTAC data and includes much more granular, individual clinician-level and specialty-specific data, includes no information about APM participation through the QPP.
- Make technical improvements to MACRA to strengthen the QPP, including:
    - Providing CMS with the authority to truly dismantle the silos that currently prevent more accurate and efficient assessments of value. At the very least, Congress should provide CMS with the authority to make MIPS more streamlined and flexible, allowing physicians to earn credit across the four performance categories of MIPS for certain robust activities, such as reporting to and using data from a clinical data registry to improve care.
    - Providing CMS with the authority to move away from the current one-size-fits-all approach to measurement and permit more flexibility in regard to measure adoption, participation pathways, scoring, and performance thresholds to better reflect the diversity of clinical practice in terms of settings, specialties, and/or patient populations. This should include:
        - Providing CMS with the flexibility to adjust the weights of the MIPS performance categories over time to reflect the current state of the health care landscape, shifting gaps in care, and the availability of relevant measures.
        - Allowing CMS to set the MIPS performance threshold (i.e., the minimum points needed to avoid a penalty) at an appropriate level each year based on performance trends and stakeholder input, rather than setting it at the mean or median score of all MIPS eligible clinicians during a previous performance period, as mandated by MACRA. Given the program's frequently changing polices and unpredictable disruptions to our healthcare system that impact participation and performance scores, CMS should not be locked into using historic averages as a barometer of success.
        - Allowing CMS to set multiple performance thresholds, such as a separate threshold for small and rural practices.

[1] https://aspe.hhs.gov/sites/default/files/documents/6d9f300bb4b45d16485d2a2c013a4151/PTAC-Sep-18-Escan.pdf

        - Providing CMS with the flexibility to provide MIPS credit for more innovative and comprehensive investments in quality and value, such as ongoing data collection and performance feedback for purposes of Board certification, performance measurement taking place under other CMS programs, and quality and cost analyses under APMs, so long as minimum standards of reliability and validity are met.
    - Require CMS to better support and encourage the use of specialty-focused Qualified Clinical Data Registries (QCDRs), the development and use of specialty-specific measures, and participation pathways that are more meaningful to specialists.
    - Enforce MACRA's requirement that CMS provide access to Medicare claims data to assist specialties and their registries with better understanding existing gaps in care and supporting the development of quality and cost measures.
    - 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 among the same patient population to ensure cost-containment efforts do not result in poorer quality care or negatively impact access to care.
    - Improve the APM pipeline to provide specialists more opportunities to participate meaningfully in APMs and qualify for the APM track of the QPP.
    - 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 APMs, including new and more relevant models that have not yet materialized.
- Require CMS to release more granular and timely data regarding physician participation in MIPS, eligibility for the APM track of the QPP, and participation in APMs in general, by specialty.
- Reduce administrative burdens and ensure safe, timely, and affordable access to care for patients by streamlining prior authorization in the Medicare Advantage program.

Physician Payment Instability

Prior to the enactment of MACRA, the costs associated with running a physician practice were on the rise, and the price of medical supplies, equipment, and clinical and administrative labor remain substantial, as demonstrated by the Consumer Price Index (CPI) and MEI (*see* American Medical Association (AMA) Medicare Updates Compared to Inflation (2001-2024)[2]). Unlike other Medicare providers that receive annual payment updates based on an inflation proxy, such as the CPI, MACRA established physician payments to include flat and nominal base updates in the initial years, transitioning to a system that emphasizes performance-based adjustments. 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 QPP, an update of 0.25% or 0.75% in 2026 and beyond.

[2] https://www.ama-assn.org/system/files/2024-medicare-updates-inflation-chart.pdf

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 MIPS and APMs, which offer additional financial incentives based on the quality and efficiency of care. The first problem was the decision to undermine the onramp to value-based care by decreasing the CY 2019 base update from 0.5% to 0.25.[3] Then as the CMS implementation of MACRA began to unfold (as the chart below shows), in most years since MACRA's implementation, the "budget neutral" MIPS payment incentive failed to close the gap between the change in the Medicare conversion factor and practice costs. While some physicians may have benefitted from additional incentives provided through an "Exceptional Performance Bonus" pool, these bonuses were short-term and expired with the 2022 performance year.

MIPS Payment Year	Budget Neutral MIPS Adjustment[4]	Change from previous year in Medicare Conversion Factor[5]	Actual Medicare Economic Index (MEI)[6]	Impact[7]
2019	0.29	0.11	1.5	**- 1.10**
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	2.23	**- 2.00**[8]	4.6	**- 4.37**

Beyond the challenges in physician payment created under MACRA, the Medicare Physician Fee Schedule (MPFS) is plagued by other challenges, including requirements to maintain budget neutrality, and slow, irregular 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 PFS conversion factor. We appreciate congressional efforts to temporarily reduce conversion factor cuts, however, Congress has still allowed year after year of cuts to the MPFS conversion factor, and this pattern is unsustainable. In addition to congressionally-mandated stabilization of the MPFS conversion factor, 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, the increasing downward financial pressure on physicians is forcing many to sell or merge their practices with hospitals, health systems, and private equity groups, which is reflected

[3] Sec. 53106 of the *Bipartisan Budget Act of 2018, Pub. L. 115–123*

[4] Represents the budget-neutral MIPS adjustment for those earning a MIPS final score at the performance threshold; excludes additional payment bonuses under the Exceptional Performance Bonus

[5] See the AMA History of Medicare Conversion Factors, https://www.ama-assn.org/system/files/cf-history.pdf

[6] See Actual Regulation Market Basket Updates, https://www.cms.gov/files/zip/actual-regulation-market-basket-updates.zip

[7] Difference in the payment rate between a conversion factor based on the budget-neutral MIPS payment adjustment and the payment rate adjusted for increases in practice costs as measured by inflation (e.g., MEI-adjusted conversion factor).

[8] 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.

in an April 2022 report[9] 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 AMA survey[10] which found that less than half of physicians are working in physician-owned practices. 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[11], 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)*

To what extent the MPFS contributes to rising health care costs because it encourages consolidation is something that warrants thorough examination and correction by Congress.

Ineffective Value Programs

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 has demonstrably improved as a result of the MACRA-established quality programs.

As discussed below, most specialty physicians have also struggled to meaningfully engage in the 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, where any APM incentives are directed. Specialists often have little control over their decision to participate in these ACOs and the current set of metrics used to measure quality of care provided under the ACO do not reflect the more focused care provided by specialists.

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9 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

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

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

Merit-Based Incentive Payment System (MIPS)

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)[12], 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,[13] 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 reporting requirements and scoring rules. 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 robust value-based activities, such as reporting to a clinical data registry, which would minimize duplicative reporting and reward more innovative activities. 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 accurately reflect the overall value of care.
- **Constantly Shifting Goalposts**. Each year, CMS changes not only the MIPS eligibility rules and reporting requirements, but also the performance thresholds. 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 accurately analyze the overall impact of the program over time.
- **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.
- **Flawed Cost Measures**. Cost measures adopted for MIPS are also extremely difficult to interpret and take meaningful action on. They often reflect care decisions and costs that are outside of a

[12] https://www.gao.gov/assets/gao-22-104667.pdf

[13] https://aspe.hhs.gov/sites/default/files/documents/dae3de25b874112a649445d6381f527e/PTAC-Mar-25-Escan.pdf

specialist's direct control and rarely align directly with quality measures other than in title. For example, autoimmune diseases such as rheumatoid arthritis and Crohn's disease are managed with highly complex medications, including biologics and biosimilars. Depending on the patient's unique biology, disease progression, and other clinical factors, one therapy may be clinically-indicated, recommended and prescribed over another. 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.

- **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 promote innovative use cases of health information technology, such as clinical data registries, clinical decision supports tools, and tracking data from wearables and other digital devices that are more common among specialty patients.
- **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 Bundled Payments for Care Initiative—Advanced (BPCI-A) 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 below.
- **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 worker burnout is at an historical high.

Advanced Alternative Payment Models (Advanced APMs)

Unfortunately, the APM track of the QPP is no less challenging. Alliance organizations continue to hear from their specialty physician members that active 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 BPCI-A program, 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 high cost targets that simply do not support high quality, appropriate care. Additionally, as discussed earlier, specialists that 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 services provide. Other specialists that attempt to join ACOs are blocked from entry by the primary care physicians who lead them.

These findings are not just speculative. As highlighted in MedPAC's July 2022 Data Book,[14] *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 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 officials,[15] 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 PTAC's 2023 Request for Information (RFI) on Integrating Specialty Care in Population-Based Models[16] and its follow-up 2024 RFI on Implementing Performance Measures for PB-TCOC.[17] 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 was 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 CMS Innovation Center'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. 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

[14] https://www.medpac.gov/wp-content/uploads/2022/07/July2022_MedPAC_DataBook_SEC_v2.pdf

[15] https://www.healthaffairs.org/content/forefront/cms-innovation-center-s-strategy-support-person-centered-value-based-specialty-care

[16] https://aspe.hhs.gov/sites/default/files/documents/2cd91b29eac2742fbc9babaf8f3b7962/PTAC-Specialty-Integration-RFI.pdf

[17] https://aspe.hhs.gov/sites/default/files/documents/823f7133bbde9de118d693a4330d2645/PTAC-Perf-Meas-RFI.pdf

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 population-based, total-cost-of-care 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 and the Innovation Center to work more closely with the specialty community and to take advantage of investments that have already been made in this space.

The specialty community has also faced challenges in terms of accessing data that will help it to better understand specialty engagement in, and barriers to, APM participation. Despite multiple requests, both CMS and MedPAC have flat-out refused to provide data on the number and type of specialists in APMs to help us better understand and overcome these challenges. As noted earlier, just last month, PTAC finally released some basic data on the participation rates of select specialties in Advanced APMs; however, the data are over five years old and provide no insight on more current trends.

Making matters worse is 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 Qualifying Participants (QP) in an Advanced APM was 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 1.75%. Moving forward, as mandated under MACRA, physicians who qualify as QPs will only receive a nominal base conversion factor update starting in 2025 (0.75 percent vs. 0.25 percent 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.

While the Alliance appreciates the steps Congress has taken to date in an attempt to continue to support 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 meaningfully in an APM. Similarly, higher QP thresholds will result in even fewer specialists qualifying for this track.

Finally, as mentioned earlier in the context of MIPS, CMS suffers from internal disorganization in its administration of Medicare value-based initiatives. Multiple offices within CMS are responsible for managing similar, but separate, value-focused initiatives authorized by MACRA, with little apparent coordination. For example, the staff responsible for administering the QPP seem disconnected from the CMMI staff administering APMs, despite the intrinsic link between the two, which results in duplicative

reporting and accountability for clinicians. Additionally, to carry out these initiatives, CMS relies on numerous contractors who are not aligned or coordinated with one another, which leads to confusion, inefficiencies, and situations where individuals with no institutional historical knowledge and very little understanding of the clinical implications of their recommendations and actions are making important decisions.

Recommendations to Improve MACRA

Congress sought to provide flexible options for clinicians to engage in meaningful quality improvement and value-based care in the Medicare program. However, 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.

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

We look forward to working with the committee to ensure specialty physician practice viability and success and will be happy to discuss any other questions you may have going forward.

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