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October 31, 2022

The Honorable Ami Bera, MD
U.S. House of Representatives
172 Cannon House Office Building
Washington, DC 20515

The Honorable Larry Bucshon, MD
U.S. House of Representatives
2313 Rayburn House Office Building
Washington, DC 20515

Dear Representatives Bera and Bucshon,

On behalf of the 7,700 members of the American College of Rheumatology (ACR), I write to provide comments in response to your Request for Information on the Medicare Access and CHIP Reauthorization Act (MACRA), dated September 8, 2022. The ACR appreciates the opportunity to provide our feedback on the MACRA program and areas for improvement.

Effectiveness of MACRA

The ACR recognizes the complexities of Medicare payment and value-based care. We appreciate Congress' efforts to reform how quality and reimbursement are connected. The Center for Medicaid & Medicare Services (CMS) Quality Payment Program (QPP) is a reasonable first step towards the larger goals. However, essential factors must be considered in any updated legislation or regulation to move value-based payment forward. In particular, we note that the QPP began with far more incentives to participate than now. The next iteration of the program must include funds to revive incentive payments.

Under the current QPP program, providers must perform exceptionally to earn even a neutral payment adjustment. This encourages them to select the best-performing measures, which are often the easiest-to-collect-data measures and may not relate to the actual quality of care they offer patients or to even their specialty. For example, vaccination rates among patients are simple to collect. Patients are given a "yes or no" question, and EHRs provide a discrete field for collection. In most cases, providers do not even collect the data – a medical assistant requests and records the data, and a nurse likely administers the vaccine.

However, in a typical encounter for a patient living with rheumatoid arthritis, the data collection processes in a rheumatologist's office are more complex and many EHR systems are not readily equipped to capture specialty-specific data. For example, two options for more relevant rheumatology-specific MIPS measures ask providers to collect information on the disease activity (reversible manifestations of the disease) and functional status (patient's ability to complete the tasks of their daily life) for RA patients. In order to accomplish this, the provider and patient work together to complete detailed questionnaires to assess these items. Even before the provider reaches the point of treating the patient, far more extensive data has been collected than required for the easiest-to-collect-data measures, and most EHRs do not offer discrete fields to house this critical rheumatology-specific data. Instead, the provider or practice must outline a template, pay the EHR for the creation of the template, and share complex data mapping details with their registry vendor, all to be able to report on relevant and important specialty measures.

We share this example not to suggest the necessity of complicated measures, but to ensure that Congress knows something of what doctors experience in practice every day as they attempt to collect all the relevant information to determine the best treatment plan for each patient.

The most common complaint we receive from providers and practice managers about the current QPP pathways is the amount of time and effort required to reach a neutral payment threshold. Of course, data collection is critical, but in many cases, especially for specialty providers, it requires extensive effort and time, which they do not see returned in their reimbursement. At the outset of the program, the bonus incentives made these substantial efforts feel more worthwhile, but now the program is primarily centered around avoiding a penalty. Avoiding penalties and incentivizing high-quality care are two entirely different approaches, and we support any movement toward the latter.

Regulatory, statutory, and implementation barriers that need to be addressed for MACRA to fulfill its purpose of increasing value in the U.S. healthcare system

Electronic Health Record (EHR) Software Systems

The ACR strongly supports data standardization and interoperability efforts. However, the realities of the current EHR landscape are often not appropriately addressed in legislation or regulation. Therefore, we strongly encourage a detailed environmental assessment of EHR software capabilities and, perhaps most importantly, consider the *procedures* focusing on EHRs used primarily by small and rural practices.

The rheumatology practices we serve regularly encounter issues with their EHR vendors in key areas to success in the QPP: the creation of adequate data collection templates, ease of data collection during encounters, data sharing with the QCDR/QR of the practice's choice, and data transfer during a transition from one EHR to another. Unfortunately, in cases where this functionality is available, many practices cannot afford the fees set by the EHR to remedy these issues.

This assessment should be made now and following the ONC's deadline for updating technology to meet the new certification criteria. We do not share the same optimism as CMS that EHR vendors will complete all requirements in the allotted timeline, which would help facilitate many of CMS' proposals in recent proposed and finalized rules. Therefore, we remain concerned with recommendations (e.g., – digital quality measures, P.I. measures to Provide Patients with Electronic Access to Their Health Information, proposed Screening for Social Drivers of Health quality measure) that require providers to meet interoperability standards their EHR may or may not fully support. Any new legislation should address EHR vendor compliance with regulations and the costs passed to the providers to meet those requirements.

We agree that standardizing data and making the data available to patients are essential and worthwhile efforts. Our concern is CMS is holding practices or clinicians accountable for factors over which they often do not have control. The environmental scan should consider costs to the

practice for access, specialty-specific templates and reports, registry participation, patient portal access, and more for the EHR implementation.

Considering the costs of all necessary features to perform well in the evolving MIPS/MVP program in relation to practice income may be particularly worthwhile. We encourage you also to consider the staff resources needed to implement CMS' vision of EHR functionality within a practice. We understand the need to require practices to use the technology available through the EHR, but the requirement can burden practices' finances and staff time to implement. The landscape assessment should consider which elements of interoperability are genuinely and solely under the purview of the clinician and either not make requirements beyond those limits or update the appropriate exemption policies to allow clinicians and practices to advocate for themselves on a case-by-case basis.

Digital Quality Measures

The ACR strongly supports CMS' efforts to include quality measurement in its work to push data standardization and interoperability forward. We see these efforts as a significant step forward in reducing healthcare providers' data collection and reporting burden. We are excited to see the shift toward digital quality measures (dQMs) and believe the work to build dQMs that interface with FHIR-based APIs is very promising.

While we would like to see this work move forward, we believe the success of such an effort will rely on ensuring all stakeholders have the resources required to support dQMs, including CMS. As previously noted, an essential requirement to successfully modernize the quality measurement enterprise is ensuring that EHR systems have incorporated the new FHIR standards required to facilitate the calculation and reporting of dQMs. We hear from our providers regularly about their struggles in finding an EHR system that accommodates the specific needs of rheumatology providers for a reasonable price. Many times, practices must make additional investments – beyond obtaining an EHR system – to access specialty-specific templates or to develop custom forms to facilitate the collection of specialty-specific data. We urge following these steps to evaluate the readiness of CMS, its measure stewards, EHR systems, and the medical community to move to dQMs:

- Evaluate the success of a wide variety of EHR systems in adopting and incorporating FHIR and interoperability standards as laid out by ONC and CMS and the cost to providers to access all relevant functionality
- Review the data elements required to support each of CMS' measures against available FHIR resources and identify factors where no FHIR resources currently exist to support the calculation of dQMs
- Define the role that CMS will play in the development of new FHIR resources to support the transition to and development of new dQMs
- Determine the role that measure stewards and measure developers, including organizations with QCDR measures, will play in supporting the transition to dQMs

We believe that organizations with established QCDRs are uniquely positioned to partner with CMS in helping guide the transition to and management of dQMs. Organizations like the ACR have been integral to the success of MIPS thus far. QCDRs spend significant time and resources to help providers understand and successfully navigate the world of quality measurement and federal reporting. We are also intimately familiar with measure development and implementation processes and the common pitfalls of translating quality measures into computer software and accurately feeding back performance information to providers. Through such a partnership, organizations with QCDRs could not only serve as a source of valuable information while transitioning to dQMS, but they could also serve as a direct line to providers to ensure that the entire medical community is moving forward together. In addition, we believe that QCDRs, particularly those maintained by specialty organizations, have much to offer in the push toward data standards, interoperability, and dQMs. Given this, any changes to MACRA legislation should continue to encourage the involvement of QCDRs in supporting and furthering the adoption of a federal value-based care model.

Performance Thresholds

The ACR encourages Congress to remove the performance threshold requirement (set at the mean or median of all scores). Selecting the appropriate score thresholds should be the purview of CMS. CMS rule-making process offers the opportunity for input from critical stakeholders, such as QCDRs and QRs, patients, and providers. These voices must be heard, and CMS must have the flexibility to respond.

For example, the transition to the current performance threshold continued amidst the international COVID-19 pandemic because MACRA required it, not because CMS or any stakeholder thought it appropriate. The best way to gain provider interest and participation is to incorporate their ideas and address their concerns in updates to the program intentionally and regularly. This is likely best accomplished at the regulatory agency rather than through federal legislation.

Additional Payment Mechanisms- Evaluation and Management

Rheumatologists are considered cognitive specialists and provide evaluation and management (E/M) services to care for individuals with complex medical conditions. A large portion of a rheumatology practice bills evaluation and management services. These face-to-face services require a high level of expertise and often lead to the specialist coordinating both specialized and primary care for patients with chronic conditions. The main component of E/M services is face-to-face time spent with patients, which is important for care management and is valued by patients. In the process of setting payment rates for thousands of physician fee schedule services, Medicare underprices certain services, such as E/M office visits, relative to other services, such as procedures. This imbalance contributes to significantly higher incomes for physicians in procedural specialties relative to those who rely more extensively on E/M type visits.

Each year the relative valuation of E/M is eroded due to budget neutrality requirements, which negatively impacts the conversion factor. While this impacts other services, procedural-oriented specialties often have other factors that can help offset these impacts, such as relying on a wider range of services thereby increasing their opportunities for positive updates and gaining efficiencies in their procedures through technology advancements. These options are not possible for E/M services, which are largely time-based. ACR is concerned with this passive devaluation of E/M services that accumulate over time and are limited by the structural process by which the relative values of code sets are updated.

The 2020 revaluation of E/M outpatient services provided a much-needed boost to these codes, the result was long overdue and only modestly improved reimbursements. It took more than 20 years to be re-evaluated and it only occurred after a problematic proposal to do so was put forward unilaterally by the previous administration. While the 2020 E/M changes were historic, we cannot afford to wait another two decades or longer for a future revaluation considering the structural challenges that exist that erode E&M's value over time.

We ask that Congress ensure that E/M codes be re-evaluated on a regular basis. We believe this change will help ensure that these codes, which provide the fundamental underpinnings of primary and complex chronic care, remain financially viable and competitive with non-E&M procedures and other services. Without this change, history will likely repeat itself through the slow and steady devaluation of E/M services, creating a new significant challenge for patients, clinicians, and Congress.

How to increase provider participation in value-based payment models

Small and Rural Community Practices

Small and rural practices play a vital role in the national healthcare landscape. This is particularly true for specialties such as rheumatology, where patients increasingly must travel long distances to reach a specialist – because small practices are becoming less and less sustainable for providers to manage. Under MIPS, CMS currently makes allowances for small practices through minimum points for quality measures. All current policies to provide burden relief to small practices should be maintained, and CMS should be unconstrained in providing further relief opportunities to small and rural practices.

The current nominal risk criterion makes it difficult for small practices to attempt the APM track. Small practices engaged in Physician-focused APMs should not be held to the same degree of negligible risk as large organizations such as ACOs. We also recommend lowering the payment and patient count thresholds for Physician-focused APMs to allow "qualifying participant" status to be more achievable for small practices and those providers who use disease-specific models. We feel this would encourage more small practices to pursue Physician-focused APMs. We also continue to urge CMS to allow the set-up cost of physician-focused APMs to serve as the financial risk, at least on an interim basis.

Bonus Points

The ACR urges adding back into the QPP incentives as bonus points for all reporting pathways. For example, these could include end-to-end electronic reporting bonus points appropriately rewarded to practices participating in the program as CMS desires by capturing data electronically. The high-priority measure bonus encouraged providers to track and improve on more measures, which benefits patients. The high-priority bonus is also key to QCDRs' ability to introduce new QCDR measures. Providers are often willing to submit new measures with bonus points in addition to – but not instead of – other benchmarked measures.

Additionally, maintaining bonus point opportunities helps to combat issues with obtaining appropriate differentiation among practice performance due to clinical quality measure selection bias. The bonus points encourage providers to report on a wider variety of measures, even if a measure is not a top-scoring measure for the clinician or practice. Further, maintaining bonus points helps to incentivize a broader range of practices to take time to implement new measures. As a result, providers have been more willing to implement new measures, especially those with data elements where no current standard exists to identify them readily or where documentation practices vary widely among providers. Providers are willing to implement these measures if they know they provide an opportunity to positively impact their MIPS score, not just lessen the negative impact.

Recommendations to improve MIPS and APM programs

Role of QCDRs & QRs

Qualified Clinical Data Registries (QCDRs) and Qualified Registries (QRs) are lynchpins executing CMS' QPP. Most, if not all, QCDR/QR entities employ staff members solely to assist registry users in understanding, participating, and submitting data to the QPP. As a result, registry staff are more easily accessible to providers and practices, have detailed knowledge of the ins and outs of the specialty, and walk step-by-step with the provider or practice to complete the MIPS data submission process.

CMS relies heavily on QCDRs and QRs to implement the QPP appropriately and benefits significantly from our commitment to understanding and communicating the program's subtle details to providers. QCDRs and QRs are the bridge between regulation and the providers. Furthermore, QCDRs and their quality measures help fill measurement gaps for specialties and disease areas that are not significant enough to garner investment in measure development efforts from larger organizations. Therefore, any updates to MACRA or downstream changes to the QPP must protect the work of QCDRs and QRs to maintain program integrity.

Additionally, the availability of performance data shared back to QCDRs/QRs must be addressed. QCDRs and QRs should receive access to CMS' final calculated scores for the providers and practices who participated in the QPP through registries. Accessing and understanding the calculation of final scores for providers and practices can only make QCDRs

and QRs more effective in assisting CMS with program execution, setting appropriate expectations among providers, and evaluating the success of the QPP.

Cost Measures

The ACR recognizes the priority the MACRA legislation has assigned to assessing the cost of care as an essential function of evaluating a provider's quality of care. However, while we understand the importance of considering cost, we firmly feel there is not yet a fair cost measure for rheumatologists or many other cognitive specialties. The generally applicable measures of Total Per Capita Cost and Medicare Spending Per Beneficiary are the only two measures that might apply to our providers. But unfortunately, we know these cannot give an accurate picture of the cost of care from our providers.

CMS contractor is currently working with a group of rheumatology experts to address the lack of appropriate cost measures for rheumatology providers. At the moment, we are optimistic that the resulting cost measure will be suitable. However, our providers have been evaluated on inappropriate cost measures for years. Given this, we highly suggest any changes to MACRA legislation provide more flexibility around how cost measures are assigned to providers to avoid forcing inappropriate cost evaluations on providers and practices.

Access to Medicare Data

To identify ways to measure cost, the ACR has taken steps to conduct evaluations of the expenses among rheumatology providers. However, there are significant barriers to completing this work. Even established programs providing access to claims data have failed to offer clinician-led clinical data registries with meaningful access to claims data. Therefore, we strongly encourage Congress to advance the Meaningful Access to Federal Health Plan Claims Data Act (H.R. 5394). The bill will provide clinician-led clinical data registries timely, broad, and continuous access to claims data for research purposes, linking such data with clinical outcomes data and performing risk-adjusted, scientifically valid analyses and research.

A new data access program would make it easier for organizations to develop cost measures specific to the providers they support and submit those measures for CMS approval and use across the QPP. It would also further CMS' goals of moving towards dQMs that use data from various data sources, including claims information, to provide a more holistic assessment of the quality of care. Finally, such access would allow those organizations to further support necessary research within their fields and perhaps even provide a new avenue to bring in the resources required to continue to support CMS programs.

Transparency and Timeliness in Scoring

The Cost and Quality Categories are now equally important to a provider's or practice's final score, per the timeline laid out in MACRA. In addition, CMS requires QCDRs and QRs to provide "feedback" reports to participants four times per year at minimum. These reports aim to

ensure providers and practices know how they are currently performing, identify opportunities for improvement, and act to improve their patient care throughout the year. Many QCDRs/QRs far exceed this requirement and provide an online dashboard that is available 24/7 and shows updated performance monthly.

While CMS created stringent requirements for how often and what exactly constitutes appropriate feedback for QCDRs/QRs, there has not been feedback given to providers on the Cost measures, nor for the Population Health measures currently identified for the MVP pathway that is set to begin in 2023. Providers, practices, QCDRs, and QRs cannot even estimate a Cost or Population Health measure score at this point. The first and only time a provider or practice is notified of the scores on these measures is when CMS releases final scores in July. A provider or method cannot be expected to improve if they do not understand how the score was calculated and if they are denied access to a regular calculation of the score.

New Measure Creation & Testing

To further the development of meaningful specialty-specific measures, Congress and CMS should support the protection of QCDR-developed measures as intellectual property of the creating organization. Given the extensive resources required for measure development, especially for QCDR measures, the ownership and all decisions regarding using these measures must be left to the creating organization.

To develop meaningful and relevant measures, an organization goes through the rigorous and resource-intensive process of development, collaboration with relevant external stakeholders, and approval/endorsement. Therefore, the ACR strongly believes that organizations will not be able to continue to invest in advancing meaningful quality measures if their measure concepts are appropriated with superficial changes and then supported by CMS.

The ACR appreciates the opportunity to provide feedback and areas of opportunity to improve MACRA. We also understand Congress' attention to the broad reforms needed in the Medicare physician payment system. The current system for reimbursing care of Medicare patients by physicians is unsustainable, and reforms are necessary to secure a medical workforce and protect patient access to quality, evidence-based care. As Congress considers systemic reforms to Medicare payment to maintain our workforce and adequately incentivize high-quality care, we ask that these themes and recommendations be considered:

- Review office evaluation and management (E/M) codes as often as procedure codes are reviewed (every 5-7 years) to ensure appropriate reimbursement and maintain the workforce.
- Reward the value of care provided to patients rather than administrative burdens such as data entry, which may not be relevant to the service or patient receiving care.
- Ask CMS to fairly weigh practice expense and malpractice work components across the board to reimburse providers equitably.
- Provide timely, actionable claims data so physicians can identify and reduce avoidable costs.

- Offer a variety of voluntary payment models and incentives tailored to different specialties and practice settings while ensuring fee-for-service models remain financially viable.
- Recognize the value of clinical data registries to improve the quality of care.

We look forward to partnering with Congress and CMS as program improvements are developed and implemented. Please contact Amanda Grimm Wiegrefe, MScHSRA, Director of Regulatory Affairs, at awiegrefe@rheumatology.org should you have any questions.

Sincerely,

Kenneth G. Saag, MD, MSc
President, American College of Rheumatology