House Energy & Commerce Subcommittee on Health
Hearing: "Medicare Access and CHIP Reauthorization Act of 2015: Examining Implementation of Medicare Payment Reforms."

March 17, 2016

American Academy of Dermatology Association

Statement for the Record

Chairman Pitts and Ranking Member Green, the American Academy of Dermatology Association (Academy), which represents more than 13,500 dermatologists nationwide, commends you for holding a hearing regarding the Medicare Access and CHIP Reauthorization Act of 2016 (MACRA), especially as all stakeholders work towards a successful implementation over the coming years. The Academy is committed to excellence in medical and surgical treatment of skin disease; advocating high standards in clinical practice, education, and research in dermatology and dermatopathology; and supporting and enhancing patient care to reduce the burden of disease. We applaud you for continuing to monitor the implementation of MACRA and ensuring that the needs of physicians and other healthcare providers, as well as those of our patients, are taken into account as the requirements are developed.

The Academy is actively working to develop tools to help our members prepare for MACRA and its implementation. Most recently, the Academy launched DataDerm™, a robust clinical data registry developed by dermatologists for the specialty of dermatology. This registry platform includes 35 dermatology-specific and applicable measures with a focus on measuring and improving quality. DataDerm™ interfaces with electronic health records (EHRs) and will facilitate reporting of a number of Physician Quality Reporting System (PQRS) approved measures to allow dermatologists to meet current Medicare quality program requirements. Additionally, DataDerm anticipates the data needed for MACRA reports of quality, resource use and clinical practice improvement. DataDerm includes dermatology-specific non-PQRS measures that will provide a profile of care across important dermatological care issues such as skin cancer, psoriasis and biopsies. With secure data drawn from thousands of dermatologists and millions of patients, dermatologists will receive a comparative report of the quality of care they are delivering. Participating dermatologists will easily access reports that compare their performance with the national average and allow continuous monitoring of patient care through dashboards, driving a deeper analysis of their practice to proactively provide the best quality of care possible.

DataDerm™ will also prepare dermatology for the changing payment environment. It will allow the Academy to further measure development with a focus on more dermatology-specific measures and provide dermatologists with more clinically relevant and meaningful data. As a result, the specialty will be better suited to identify individual provider and specialty level measure gaps; and ultimately, DataDerm™ will provide guidance on the development of severity scales to allow for variations in patient populations.

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The Academy has also been seeking to maintain an active, strategic approach to engaging innovations in payment and delivery system reform, recognizing the importance of converging and interrelating work streams to achieve success. Dermatologists understand the importance of participating in alternative payment models (APMs), and we have begun exploring bundled care, coordinated care, and other models for select dermatologic conditions. As the Centers for Medicare and Medicaid Services (CMS) moves forward with MACRA implementation, the Academy has urged the agency to remain mindful of the importance of incorporating a broad variety of physicians into the new framework and providing the flexibility and support necessary to encourage the participation of specialists. This includes both solo and small group practitioners, whose care remains critically important to many of our patients.

A gradual, phased-in approach to the Merit-Based Incentive Payment System (MIPS) and APM provisions in MACRA, that recognizes the unique challenges of specialty care, including the practice of dermatology, will bring the new physician payment framework closer to its intended goals of rewarding quality care, ensuring patient access, and creating an efficient healthcare system. Additionally, while there are common themes between MIPS and the APM program, implementation should not conflate the pathways and erode important distinctions that might overcomplicate or confuse physician participation.

Likewise, rapid, hurried implementation of approaches to APM adoption may overlook opportunities to improve care delivery, and the Academy encourages MACRA implementation to provide on-ramps for physician participation in such models. APMs should seek to maximize the value of appropriate care, which will require a transition to APMs with specific attention to the unique context of specialists. The Academy has been engaging on such opportunities to ensure that our patients and the health system more broadly, can appropriately benefit from specialty care. Appropriate visits to dermatologists, for example, can improve accurate diagnosis and avoid unnecessary treatments and spending, a benefit from care coordination not currently captured in existing quality or resource use metrics. Central to designing APMs that closely encourage such value and enable participation in this new payment paradigm is specialty society access to all payer claims data, and to that end we encourage CMS to explore how it can encourage qualified entities (QEs) to share data more readily.

Even as the design of and move toward APMs continues, the Academy continues to support preserving the viability of fee-for-service as a payment model. The Academy has prioritized educating members about the potential risks and opportunities that APMs present due to CMS implementation of a mandated transition of health care reimbursement methods. The Academy encourage the development and implementation of APMs that incorporate efficaciousness, minimize adverse effects, promote flexibility of decision-making for providers and patients, are cost sensitive while encouraging high quality dermatologic care, are not onerous for participating physicians, and are financially feasible for patients and physicians. Through notice and comment, the Academy has encouraged CMS to ensure that specialists such as dermatologists will be able to participate in MIPS and APMs in a meaningful manner, and that the systems developed incorporate valid and meaningful quality metrics, are implemented with a reasonable timeline, and are financially viable for patients and physicians.

Additionally, the Academy is advocating for a more meaningful and less unduly burdensome Meaningful Use (MU) program. However, challenges such as barriers to interoperability and minimal flexibility of the program are a cause for concern. Many dermatology offices have had to reduce the number of patients they can see in a day by more than 30% at a time when demand for physician care is reaching an all-time high. In the Academy's annual survey of its members, it was found that 65% of respondents close to retirement age found "pressures to implement EHR" to be a significant factor in their decision to retire. For these physicians in particular, the program requirements are simply too costly and time-consuming to implement given the providers' brief period in which they would need to meet the EHR program requirements.

When Congress passed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and replaced the sustainable growth rate (SGR) with the MIPS, the intention was to move toward value-based healthcare that focuses on high-quality, efficient, and coordinated patient care. In doing so, it phases out MU.

Given this significant new direction in the regulation of EHR use, there should be a focus on ushering in a new era of rewarding the provision of high-quality patient care and redesigning how MU will function within the new MIPS framework. The Academy believes that regulations governing physicians' use of EHRs must be revised to foster technological innovation, enable interoperability, and enhance usability. Only with significant changes can the use of EHRs ultimately improve patient care and streamline physicians' workflow. The Academy believes that this work includes providing for flexibility in measuring MU, including permitting PQRS reporting to count for the clinical quality measures in MU, as well as allowing physician use of a clinical data registry to count for full MU participation. In light of the imminent regulatory changes, the Academy does not believe it would be the best use of Centers for Medicare & Medicaid Services (CMS) and physician resources to make the substantial effort that moving forward with Stage 3 of MU would require.

As physicians prepare for the changes in how they must report on and track quality and performance measures, it makes sense for CMS to take this opportunity to put a hold on new or heightened Stage 3 requirements. A longer-term, gradual approach will give providers time to catch up to the Stage 2 MU requirements and better serve the purpose of making meaningful use of EHR technology. Although physicians are adopting and using EHR programs, many are still not able to meet the MU attestation requirements. In fact, less than ten percent of physicians were able to meet MU Stage 2 requirements in 2014. If the program continues to adopt more complex standards with higher thresholds, the Academy expects to see more physicians decide the effort is not worth it and drop out of the program. Therefore, the Academy recommends that the current Stage 2 modified standards for meaningful use continue through the early implementation of MIPS. In short, we urge CMS to "pause" Stage 3 of MU.

Additionally, with the implementation of MACRA, flexibility in reporting requirements is necessary for physicians to comply with the meaningful use requirements in 2016. The Academy supports the continued use of a 90-day reporting period for physicians. More flexibility in reporting will contribute to a successful implementation of MACRA especially in 2017 when meaningful use will still be required under MIPS.

The program has also failed to focus on interoperability and has instead created new barriers to easily exchanging data and information across care settings. The Academy encourages the subcommittee to renew their focus on interoperability of EHRs by urging vendors to respond to the demands of physicians rather than the current system where vendors must meet the ill-informed check-the-box requirements of the MU program. The Academy also strongly encourages the Subcommittee to recognize the value that clinical data registries bring to healthcare, and encourage their use by supporting measures that recognize physicians utilizing an EHR to participate in a clinical data registry as satisfactorily achieving all stages of MU.

The Academy appreciates your continued leadership on this issue and look forward to working with you to ensure that physician practices are ready for MACRA implementation. The Academy would like to serve as a resource for you and your Subcommittee, as you continue to address this important issue. If you have questions, or if the Academy can provide any additional information, please contact Christine O'Connor, Associate Director, Congressional Policy at (202) 609-6330 or coconnor@aad.org