



U.S. House of Representatives
Committee on Energy and Commerce
Subcommittee on Health
Hearing on “MACRA & MIPS: An Update on the Merit-Based Incentive Payment System”
Thursday, July 26, 2018
American Academy of Dermatology Association
Statement for the Record

Chairman Burgess and Ranking Member Green, on behalf of the American Academy of Dermatology Association (Academy), which represents more than 13,800 dermatologists nationwide, thank you for your leadership in convening the hearing on “MACRA & MIPS: An Update on the Merit-Based Incentive Payment System.” The Academy is pleased to submit the following statement for your consideration.

The Academy is committed to excellence in the medical and surgical treatment of skin disease; advocating high standards in clinical practice, education, and research in dermatology; and supporting and enhancing patient care to reduce the burden of disease. We applaud you for continuing to monitor the implementation of Medicare Access & CHIP Reauthorization Act (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 of the Quality Payment Program (QPP), and the Merit-Based Incentive Payment System (MIPS) specifically, are developed.

We greatly appreciate the substantive progress that was made in 2017 to implement the Quality Payment Program (QPP) under MACRA in a manner that provides regulatory relief to physicians. The Centers for Medicare and Medicaid Services (CMS) increased the threshold for individual Merit-Based Incentive Payment System (MIPS) eligible clinicians or groups to be considered exempt, excluding from the new system those with up to \$90,000 in Medicare Part B allowed charges or up to 200 Part B beneficiaries. CMS added a new hardship exception for clinicians in small practices (15 or fewer clinicians) under the Advancing Care Information (ACI) performance category, and CMS also provided relief to physicians who faced disasters such as the California wildfires and the devastating hurricanes of 2017. Finally, as MACRA requires 25 percent of the MIPS final score be based on performance in the ACI performance category, CMS made an important modification to the performance score changes to give 10 points for participating in a specialized registry such as the Academy’s Qualified Clinical Data Registry (QCDR), DataDerm. Rewarding physicians for participating in a QCDR not only allows physicians to report on performance measures that are approved by CMS, but it also promotes QCDRs’ development of quality measures that are relevant and meaningful to practicing physicians.

As the Subcommittee convenes this hearing today, there are four issues that the Academy would bring to the Subcommittee’s attention.

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Cost Performance

First, the Academy is concerned that it is premature for physician payment to be based on cost performance given the flaws in the current patient attribution methods. For 2018, CMS finalized a 10 percent weight for the cost performance category in the final MIPS score. This is intended to ease the transition to a 30 percent weight for the cost performance category in the 2021 MIPS payment year. For the 2018 MIPS performance period, CMS is adopting the total per capita costs for all attributed beneficiaries measure and the Medicare Spending per Beneficiary (MSPB) measure, both of which were adopted for the 2017 MIPS performance period.

However, many physicians have reported problems with the current attribution methods. For instance, a dermatologist provided the most Evaluation and Management services to a patient during the reporting period. That patient suffered from recurring mental health problems that resulted in admission to an inpatient facility. The costs for hospitalization and other care associated with the mental illness were attributed to the dermatologist. This indicates that the attribution method is clearly flawed, and we understand that the appeals process does not seem to be functional. Until CMS corrects the attribution method to ensure that costs of care not associated with the condition being treated are not attributed to the specialist caring for the patient, the cost performance should not be given a weight.

Additionally, it is very difficult for physicians to look-up their cost score prior to their reporting cycle. Physicians are not aware of what this score will be nor what they can do to positively affect cost performance. CMS needs to make this scoring process more transparent and not grade physicians on their performance without providing details on how they can actually improve their cost scores.

QCDR Measure Approval Process

Second, improvements to the QCDR measures approval process are needed to achieve efficiency, transparency, and connection to clinical evidence. The current process is characterized by unreasonable deadlines, unexplained rejection or consolidation of measures, an inconsistent review process, and disjointed review. Consideration of time to gather data and provide evidence of measure and performance gaps during the review process would allow for continued meaningful measures for specialists. Further, the Academy opposes applying the MIPS Call for Measures process to QCDR measures. The MIPS process is slow (6 months between measure submission and publication of the final list), cumbersome, and ill-suited to specialty care. The Measurement Application Partnership (MAP) process hinges on National Quality Forum (NQF) endorsement, a separate lengthy process with few standing committees that include Dermatology topics. Historically, the Measures Advisory Panel lacks the expertise to review the clinical importance and evidence for specialty measures. The measure approval process must be based on specialty-relevant clinical expertise and rationale. Instead of applying the MAP process to QCDR measures, we have urged CMS to improve the current QCDR measure review by implementing a transparent review process with clear criteria about the acceptability of measures and clear timelines for CMS review. Harmonization is a worthy goal that should be addressed

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outside the measure approval process. We appreciate that CMS has met with us a number of times to hear our concerns on this important issue and hope that needed improvements can be made.

Data Blocking

The ability of QCDRs to access patient information from electronic health record (EHR) vendors is crucial for such registries to not only achieve their missions of improving quality of care, but also to foster the development of quality measures that are relevant and meaningful to practicing physicians. The passage of provisions in the 21st Century Cures Act (Pub. L. 114-146) (the “Cures Act”) was instrumental to prevent EHR vendors from blocking the transmission of clinical outcomes data to third parties, such as QCDRs.

While we understand that the OIG and Office of the National Coordinator for Health Information Technology (“ONC”) are developing rulemaking to implement such information blocking requirements, some EHR vendors are creating barriers to access patient information within their systems. For example, some EHR vendors require providers to pay a large annual fee to send their data from the EHR to the clinical data registry or their software vendor, or require purchasing intermediary software systems owned by the EHR. Cost-prohibitive interoperability deters physician participation in QCDRs. EHRs also refuse to provide full measure calculations to clinical data registries and only provide partial data on various measures. Much of this is also due to various EHRs having a stake in their own MIPS reporting modules, which provide incentives to their bottom line. Such barriers interfere with and materially discourage access to such information by clinical data registries. These obstructive tactics also create inefficiencies for physicians to report their data for MIPS. We look forward to working with the OIG and ONC to address these data blocking concerns to unlock QCDRs’ potential to develop meaningful measures for the QPP.

Administrative Burden

MACRA also has increased physician burden through complex scoring and reporting requirements. Though much has been done to reduce reporting burdens on physicians who participate in MACRA, there is still more to do to ensure our health care system is able to address the needs of a growing and diversifying patient population. We believe QCDRs hold the key for data-driven policy changes and streamlined physician reporting, and would like to collaborate with you in strengthening the reliance on QCDRs as part of the Quality Payment Program. We are pleased that CMS has indicated further reduction in physician reporting will come through increased credit for the use of QCDRs. We encourage you to further strengthen QCDRs by ensuring that participation in QCDR reporting is sufficient for meeting threshold status for MIPS providers. This would reduce overall administrative burden on physicians and provide one outlet for them to report all of their measures through MIPS. We are pleased that many of the physicians we represent were able to avoid the penalty for MIPS in 2017 by reporting through a QCDR, with a significant percentage of them being recognized as high performers due to their having reported additional measures. This score adjustment would stimulate increased participation in QCDRs and accelerate QCDRs’ development of quality measures that are relevant and meaningful to practicing physicians and their patients. Additionally, this could encourage EHR vendors to more readily share patient data, since MIPS credit is a significant selling point for EHRs.

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Again, the Academy appreciates the Subcommittee holding this hearing today, and the Academy appreciates the Subcommittee's efforts to address the clinician burdens in implementation of this important payment system changes under MACRA. Please feel free to contact Christine O'Connor, the Academy's Associate Director, Congressional Policy, at coconnor@aad.org or (202) 609-6330 if you have any questions or if we can provide additional information.