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October 28, 2022

The Honorable Ami Bera, M.D.
United States House of Representatives
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The Honorable Earl Blumenauer
U.S. House of Representatives
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The Honorable Larry Bucshon, M.D.
U.S. House of Representatives
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The Honorable Brad R. Wenstrup, D.P.M.
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The Honorable Bradley Schneider
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The Honorable Michael C. Burgess, M.D.
United States House of Representatives
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The Honorable Mariannette Miller-Meeks
M.D.
United States House of Representatives
1716 Longworth House Office Building
Washington, DC 20515

Submitted to: macra.rfi@mail.house.gov

Re: Request for Information: Medicare Access and CHIP Reauthorization Act (MACRA)

Dear Representatives Bera, Bucshon, Schrier, Burgess, Blumenauer, Wenstrup, Schneider, and Miller-Meeks:

On behalf of the American Academy of Otolaryngology—Head and Neck Surgery (AAO-HNS), I am pleased to submit the following comments on the Medicare Access and CHIP Reauthorization Act (MACRA) Request for Information dated September 8, 2022. The AAO-HNS is the national medical association of physicians dedicated to the care of patients with disorders of the ears, nose, and throat, as well as related structures of the head and neck. The Academy has approximately 13,000 members who provide clinical, surgical, and hospital care in rural, urban, and suburban communities. Our membership spans academic, private independent practices, and employed physicians across all practice sizes from solo to large single-specialty and multi-specialty groups, reaching into the hundreds.

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Otolaryngologist–head and neck surgeons diagnose and treat patients from conception to end of life, providing complete diagnostic, medical and surgical treatment for a wide range of medical conditions, including allergic and sinus disease, hearing and balance disorders, head and neck cancer, sleep disorders, speech and swallowing problems, cosmetic reconstructive surgery of the face and neck, acute trauma to the head and neck, and pediatric and geriatric care.

Healthcare reform is a complex problem, and there is no one-size-fits-all solution. The AAO-HNS shares your desire to work toward a more affordable, sustainable, and patient-centered healthcare system and applauds your efforts to seek input from healthcare providers to develop solutions. We believe our specialty is in a unique position to see the challenges and varied and complex interactions that lay ahead; we are proud to be a resource and a willing participant in this undertaking, given our relatively even split of medical and surgical management of diseases affecting the entire lifespan of patients.

Our specialty is actively involved in the transition of care, when safe and effective, from the inpatient setting to the hospital outpatient and ASC settings and ultimately, the office setting, to increase flexibility and access to care while saving the overall healthcare system significant expense. Our specialty is engaged in defining quality for diagnosis and treatment of otolaryngologic disease using Clinical Practice Guidelines and a Clinical Data Registry that also works to improve outcomes, eliminate unnecessary care, and decrease costs. Otolaryngologist-head and neck surgeons around the country are participating in various types of value-based care networks, including specialty-run clinically integrated networks and other shared savings models. In future discussions surrounding the re-imagining of more equitable, value-based systems, we feel it will be essential to allow some flexibility through pilot studies to gather data on the value of each of these pilots before committing to one particular solution. As we have learned through MACRA, there may not be one system that equitably fits all.

MACRA’s Merit-based Incentive Payment System (MIPS) program was felt to have great promise when introduced, but the program has failed in most ways to deliver either savings or improved care. The majority of quality measures used in MIPS do not follow standard practice patterns of specialist physicians and have not shown any tracking toward improved patient outcomes, the final measuring stick. The only consistent quality of the MIPS program is that it gets more difficult and expensive by the year for physicians, especially those in independent practice, to comply with the cadre of rules promulgated annually. These rules have failed to progress toward the true measurement of patient outcomes. It is also disappointing that the advertised positive updates for those physicians who comply have evolved into at most a 1.8% increase while physicians are still subject to the -9% cut if they do not comply.

This year’s update fails to offset the costs expended by Medicare practitioners to participate. The fixed bonus pool and budget-neutral funding rules as they currently exist simulate the same problems with Medicare Part B that has kept physician reimbursement at a level less than that in the 1990s. That is not sustainable under current situations especially given the recent tremendous inflationary pressures and staffing shortages and rapidly increasing costs. Through positive payment adjustments, providers are rewarded for exceeding certain performance targets (quality, cost, and promoting interoperability).

Additionally, the agency responsible for overseeing and implementing MIPS has not established true cost markers. Providers who fall short of these targets are penalized and receive negative payment adjustments. To date, the highest incentive payment has been +2.33%, an insignificant amount when factoring in the administrative cost associated with participating in the MIPS program. The successor to MIPS, the MIPS Value Pathway (MVP) is saddled with the same faults that its predecessor MIPS contains. Specialists, particularly surgeons, have not been able to date to identify APM programs that they can successfully participate in to earn the 5% bonus. It is important to maintain Qualified Clinical Data Registries (QCDRs) as an anchor to the current MIPS and any forthcoming Medicare quality improvement program. These registries, such as the AAO-HNS' Reg-ent registry, can adequately recognize and incentivize high-quality care as well as identify areas for clinical improvement and cost savings.

A true value-based, quality program under Medicare should relate to the day-to-day practice of medicine and measure outcomes that are important to both physicians and their patients by measuring outcomes they are trying to achieve, not administrative markers. To increase participation in MACRA or a successor program, one must also consider economic principles. Providers must be compensated appropriately, and the administrative costs and complexity must not dissuade participation. In terms of appropriate compensation, physicians must be treated equally to other Medicare providers and, at a minimum, receive annual payment updates based on an inflation proxy such as the Consumer Price Index (CPI).

Increased participation in MACRA will not lead to improved quality of care or cost savings unless the metrics of assessment transition from administrative to clinical measuring and work towards patient outcomes using validated instruments developed by medical specialties using data-driven solutions. Only then can Medicare beneficiaries use this as a tool to accurately measure the quality of the provider to inform their decision-making.

In developing new measures of value-based care, CMS should work with each medical specialty society to develop best-care paradigms for the most common diseases/problems seen by each specialty. These paradigms will serve as the underlying foundation for value-based care and allow for well-defined cost and quality alignment modeling. Performance feedback based on these best care paradigms will enable physicians to compare themselves to their peer group and help facilitate care improvement solutions. In addition, value-based care measures should not be limited to claims data but should incorporate patient-reported outcomes. The data is there, and it should be incorporated.

Currently, a reliable cost-reduction strategy available to CMS is to transition care from high to low-cost facilities when clinically appropriate. As previously mentioned, our specialty can shift specific care away from hospital outpatient departments and into lower-cost Ambulatory Surgical Centers (or other non-facility settings). However, CMS has failed to properly update the Medicare payment schedules to allow for this transition. To enable care in lower-cost facilities, CMS must provide appropriate reimbursement on both the physician work and practice expense portion for these services. This includes accounting for the overhead costs incurred by the provider. While this initially increases rates to the provider, it creates much greater savings to Medicare by avoiding the higher hospital outpatient fees. Accomplishing this will require Medicare Part B to have a similar funding mechanism

as Medicare Part A that allows the agency flexibility to move away from the budget-neutral requirement that has created the current situation. Such a change would allow Congress more time to work on solutions to MACRA, rather than introducing annual legislation to ensure physicians receive appropriate reimbursement for providing care to Medicare patients.

The AAO-HNS greatly appreciates the opportunity to provide comments and recommendations toward the development of a more affordable, sustainable, and patient-centered healthcare system. The comments provided in this letter are that of a larger subset that the Academy has to offer. We look forward to working together in the 118th Congress on this shared goal and offer ourselves as a resource for further discussions.

Sincerely,

James C. Denny III

James C. Denny III, MD
Executive Vice President and CEO