Society of Gynecologic Oncology

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October 31, 2022

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

The Honorable Kim Schrier, M.D.
U.S. House of Representatives
1123 Longworth House Office Building
Washington, DC 20515

The Honorable Earl Blumenauer
U.S. House of Representatives
1111 Longworth House Office Building
Washington, DC 20515

The Honorable Bradley Scott Schneider
U.S. House of Representatives
300 Cannon House Office Building
Washington, DC 20515

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

The Honorable Michael C. Burgess, M.D.
U.S. House of Representatives
2161 Rayburn House Office Building
Washington, DC 20515

The Honorable Brad R. Wenstrup, D.P.M
U.S. House of Representatives
2419 Rayburn House Office Building
Washington, DC 20515

The Honorable Marianette Miller-Meeks, M.D.
U.S. House of Representatives
1716 Longworth House Office Building
Washington, DC 20515
SUBMITTED ELECTRONICALLY VIA macra.rfi@mail.house.gov

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

The Society of Gynecologic Oncology (SGO) appreciates the opportunity to provide feedback on this request for information (RFI) to inform legislative efforts to stabilize the Medicare payment system, which would provide certainty for beneficiaries dependent on the program for their health care and providers.

The SGO is the premier medical specialty society for health care professionals trained in the comprehensive management of gynecologic cancers. The SGO contributes to the advancement of women's cancer care by encouraging research, providing education, raising standards of practice, advocating for patients and members and collaborating with other domestic and international organizations.

The Effectiveness of MACRA

The Medicare Access and CHIP Reauthorization Act (MACRA), signed into law on April 16, 2015, authorized the Centers for Medicare and Medicaid Services (CMS) Quality Payment Program (QPP) that (1) repealed the Sustainable Growth Rate (SGR) formula; (2) changed the way that Medicare rewards clinicians for value over volume; (3) streamlined the agency's quality programs under the new Merit Based Incentive Payments System (MIPS); and (4) authorized bonus payments for participation in eligible alternative payment models (APMs).[1]

MACRA eliminated the SGR's volume-based targets, which annually required cuts to the conversion factor that Congress stepped in to avert. However, it replaced the SGR with modest annual updates of 0.5 percent to the conversion factor from 2016 through 2018 and the final update of 0.25 percent was applied in 2019. The legislation did not include statutory updates to the conversion factor for 2020 through 2025 and retained the Medicare Physician Fee Schedule's budget neutrality requirement. Medicare physician payment has stagnated for the last two decades as a result of the SGR experience coupled with MACRA's limited updates and retention of budget neutrality. Physicians have struggled to keep pace as practice costs, the consumer price index, and inpatient and outpatient hospital reimbursement have all increased.

Regulatory, Statutory, and Implementation Barriers That Need to be Addressed for MACRA to Fulfill its Purpose of Increasing Value in the U.S. Health Care System

The SGO recognizes that Congress does not wish to increase Medicare Physician Fee Schedule spending. However, we do not believe that MACRA can be fixed without eliminating or adjusting the budget neutrality requirement. While Congress and CMS wish to transition to value-based payment, maintaining the current investment in physician services is not reasonable when the costs of practicing medicine, including the electronic health records and staff needed to meet CMS' reporting requirements, are increasing.

Outside of the budget neutrality requirement, the compliance requirements of the Quality Payment Program (QPP) are incredibly complex despite Congress' intention to simplify CMS' quality reporting

[1] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs

requirements in MACRA. The QPP includes two tracks—MIPS and advanced APMs; however, MIPS is not significantly more streamlined than the programs it was intended to replace. Congress must strive to revise the QPP such that its requirements support the delivery of value-based care and improved quality and do not create new "check the box" exercises or administrative burden. On that account, the QPP has failed as some practices devote staff just to meeting the program's reporting requirements.

Additionally, MACRA's statutory requirements have impeded Congress' goals for the program. For instance, MACRA dictated the weights of the different MIPS categories—quality, cost, promoting interoperability, and improvement activities. While the cost category now comprises 30 percent of the physician's MIPS score, many do not feel that CMS' cost measures accurately reflect a physician's performance. In some ways, the statute got ahead of CMS' measurement tools, potentially penalizing participating physicians.

To accurately measure quality and value, physicians must be able to report on measures and metrics relevant to their practice. CMS is moving in the correct direction with the establishment of the MIPS Value Pathways, yet there is still a long way to go until all physicians, including gynecologic oncologists can meaningfully report. Additionally, these programs must do a better job accounting for a patient's social determinants of health and risk. Physicians who treat these complex patients should not be penalized for doing so.

Increasing Provider Participation in Value-based Payment Models

The purpose of value-based care programs is to drive down health care costs and improve patient outcomes, but those goals cannot be achieved without robust physician participation in these models. Unfortunately, there are challenges for physicians, such as financial risk and administrative burden. Physician practices vary by size, specialty, and location; therefore, it is important that APMs are developed in a way that is feasible and makes sense for different practices and patient populations. To start, there are significant financial investments required to develop and implement an APM putting this option out of reach for many specialties or health systems. CMS should be provided with the resources to support measure and APM development allowing them to partner with interested stakeholders.

To address measurement challenges to improve physician participation in value-based payment models, SGO members recommend improvements be made to attribution and risk adjustment methods. Specifically, attribution methodology should consider multiple patients at a single site of care or more than one site of care (i.e., a patient who has surgery for cancer at one site and then chemotherapy for cancer at another site). Additionally, during an episode of care, care is often delivered across multiple providers who are part of the care team; however, such providers may be in different care settings. Therefore, in defining episodes of care, Congress and CMS should consider establishing different categories of care (i.e., surgery, adjuvant treatment, maintenance phase, etc.).

Risk adjustment is also a significant concern for physicians who treat high-risk patients, based on the disease they have, the social determinants of health affecting their care, or a combination of both. We urge CMS to ensure that risk adjustment methodologies account for all of these factors to ensure that the physicians treating these patients are not unfairly penalized for doing so. In MIPS, physicians may be eligible for a complex patient bonus in recognition of this issue. However, more must be done to recognize the challenges delivering care to certain patients poses in APMs as well as MIPS.

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Further, small patient populations create barriers to APM development. For specialists, like gynecologic oncologists, Congress, CMS, and the Innovation Center must determine how to develop APMs for those physicians who treat diseases that are relatively rare but still represent significant burden to the U.S. population due to the intensive therapies used for treatment, high rates of recurrence, and high mortality.

Recommendations to Improve MIPS and APM Programs

The SGO believes value-based care delivery is critical in maximizing quality and cost effectiveness. SGO members are interested in the significant opportunities APMs could provide for physicians to improve the quality and outcomes of their patients' care using clinical interventions that are currently not reimbursed under the Medicare program, but that could lower the overall health care spending for the treatment of gynecologic cancers. However, it is critical that physicians, like SGO members, are involved in designing APMs to ensure that alternative ways of delivering services are appropriate, not overly burdensome, and support the needs of our patients. As such, we have the following recommendations for improving these programs:

1. Physician participation in APMs should remain voluntary as CMS continues to develop and test new models suitable for a wide range of practices of different sizes and specialties.
2. In developing APMs, the Innovation Center should take maximum advantage of opportunities to lessen administrative burdens on physicians, including the use of certified electronic health records by waiving unnecessary requirements in existing payment systems. Additionally, the Innovation Center must provide the resources physicians need to deliver new types of services, including increased payments and incentives, to support clinical transformations.
3. The Innovation Center's highest priority should be expanding the availability of APMs in which specialists can successfully participate. Instead of the Innovation Center defining such payment models itself, the agency should commit to implementing condition-specific APMs that have been developed by physicians and medical specialty societies. Additionally, they should collaborate with societies like SGO, providing them with technical assistance during the APM design process. These changes could accelerate the adoption of APMs and provide specialties with needed support, including access to Medicare claims data and commit to implementing approved APMs.

Thank you again for the opportunity to provide feedback. The SGO would welcome the opportunity to meet with you at your convenience to discuss our comments. Should you have any questions or require further expertise, please don't hesitate to contact Stephanie Blank, MD at stephanie.blank@sgo.org.

Sincerely,

Stephanie V. Blank, MD

2022-2023 SGO President

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