

December 1, 2017

Chairman Francis J. Crosson, MD  
Medicare Payment Advisory Commission  
425 I Street, Suite 701  
Washington, DC 20001

RE: Registries and the Quality Payment Program

Dear Chairman Crosson,

On behalf of the undersigned organizations, we are writing to highlight the significant benefits of clinical data registries and the role they should play in achieving the goals of the Quality Payment Program (QPP). While MedPAC is considering a recommendation to eliminate the Merit-Based Incentive Payment System (MIPS), Congress recognized that it was essential to preserve a fee for service option under the Medicare Access and CHIP Reauthorization Act (MACRA), primarily because many specialties do not have a path to alternative payment models (APMS). In addition, MedPAC's June 2017 report pointed out that fee-for-service is the best low-cost option over APMs in some markets. We agree that improvements should be made to MIPS to ensure the overall goals of the QPP are achieved. Congress has also highlighted the benefits of clinical data registries in recent legislation. Registries have evolved substantially and are being utilized to improve care delivery and patient outcomes.

Rather than repealing MIPS, rewarding clinicians and increasing MIPS incentives to participate in a clinician-led qualified clinical data registry (QCDR) would significantly increase the performance and value of MIPS. Specifically, we recommend full credit for the Advancing Care Information category of MIPS to clinicians utilizing a certified electronic health record system to participate in a clinician-led QCDR. In addition, based on the overall positive impact registries have on patient care and the healthcare system, we would suggest, similar to the credit provided for participation in Patient-Centered Medical Homes under Advanced APMs (A-APMs), the consideration of an additional pathway to APMs and an exemption from MIPS for participants in clinical data registries.

### **Background**

Congress created the Quality Payment Program to achieve a transparent and simplified Medicare quality incentive program. While an improvement over legacy programs, MIPS falls short of congressional intent due to its complexity and lack of timely feedback. Many specialties, however, will never fit under an Advanced Alternative Payment Model program. Several obstacles prevent qualification, including the requirement for 50 percent and eventually 75 percent of the doctor's patients or revenues to come under the A-APM. In addition, A-APM quality measurement is focused on primary care, leaving most specialty care (provided by 50 percent of physicians) unmeasured.

Congress made it clear in MACRA that it believed in the power of QCDRs and other clinician-led clinical data registries. Registries drive improvements in the value of health care, including by providing feedback on quality and appropriate use metrics and patient outcomes, highlighting variations in care, identifying best practices to improve care and outcomes, and analyzing aggregate data sets to uncover and advance scientific insights. Clinical data registries were envisioned by Congress to be a meaningful solution to achieving the QPP's goals. Currently, under MIPS, clinical data registries exist simply as an alternative reporting mechanism. Physicians should be more strongly encouraged to participate in clinical data registries so that they can take a proactive approach to improving value. Specific steps include providing full credit for the advancing care information (ACI) category of MIPS to providers who utilize a certified EHR to participate in a clinician-led QCDR.

Congress intended to incentivize participation in this proactive, quality improvement, feedback tool, and as such, we are disappointed in the limited recognition for QCDR participation under MIPS. We believe that increasing the credit physicians receive under the QPP for participating in QCDRs does the following:

- Facilitates high-value care;
- Simplifies the program;
- Encourages the transition to certified EHR technology (CEHRT);
- Improves transparency; and
- Reduces clinician burden.

### **High-Value Care**

QCDRs help physicians monitor and manage patient populations, facilitating early interventions and preventive care, which can lead to more successful and less expensive care. The dynamic feedback provided by QCDRs allows physicians to identify weaknesses and implement changes that create high-value care, and track improvements over time. Clinician-led QCDRs collect specialty-specific meta-data that can be used to analyze treatment effectiveness in specific demographics at specific stages in the disease process and account for variables in a way that was not previously possible. Clinician-led registries can evaluate practitioners' cost and resource use, and can also provide feedback on performance on appropriate use measures, such as *Choosing Wisely*<sup>®</sup> measures. Early data from the clinical data registry movement demonstrates the impact they are already having on improving best practices, care and outcomes for patients.

### **Drives EHR Use for Practice Improvement**

QCDRs drive the use of CEHRT by enabling electronic measurement on meaningful metrics and reducing reporting burden. Electronically-enabled QCDRs, or those that use data collected by clinicians in their EHR, encourage the use of EHRs for care improvement.

### **Improved Transparency and Feedback**

Specialty registries provide real-time, actionable feedback to participants. Data that is extracted from participating physicians' EHR systems provide a timely and accurate picture of what is taking place in the physician's practice and patients' care. These qualified clinical data registries allow physicians to compare their performance against colleagues, national averages, and CMS benchmarks and pinpoint areas for improvement. Registries provide actionable data, whereas the one- to two-year-old feedback from CMS under MIPS is too late to drive real-time action or improvement.

### **Meaningful, Specialty-Specific Measures**

Clinician-led qualified clinical data registries are uniquely poised to develop and test measures that are meaningful to the specialty and important to patients. These registries provide information to clinicians on individual patient outcomes and enable specialty societies to introduce new meaningful measures to address gaps in care quickly.

### **Decreases Burdens on Clinicians and CMS**

Clinicians spend an average of 15.1 hours per week reporting quality measures.<sup>1</sup> Using CEHRT to participate in QCDRs provides real-time quality monitoring, and eliminates reporting burden. QCDRs monitor, score, and provide feedback on measure performance meaningful to the physician and physicians' patient population, relieving burden on CMS.

At least 25 medical and surgical specialties have now initiated an electronic-based clinical data registry, and others are using data collected in EHRs to populate clinical data registries. Investments from

participants include the need to purchase and upgrade to a certified EHR. Many of these registries also include a registration cost. MIPS has the opportunity to have a dramatic impact on the future of high-value care by increasing the incentives for physicians to join these specialty-led registries.

### **Conclusion**

Scrapping MIPS while it is in its infancy is the wrong direction in the movement towards value-based care. Rather than opting for this option, MedPAC should embrace improvements for the program. Recommending an expanded role and credit for participating in clinician-led clinical data registries is an essential move in the right direction.

Thank you for considering our comments.

Sincerely,

American Academy of Dermatology Association  
American Academy of Ophthalmology  
American Association of Neurological Surgeons  
American Academy of Physical Medicine and Rehabilitation  
American College of Emergency Physicians  
American College of Rheumatology  
American Joint Replacement Registry  
American Society of Cataract and Refractive Surgery  
American Society of Plastic Surgeons  
American Urological Association  
Society of Interventional Radiology  
Society of Thoracic Surgeons

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<sup>1</sup> Casalino LP, Gans D, Weber R , et al. *US Physician Practices spend more than \$15.4 Billion annually to Report Quality measures. Health Aff* 2016;35:401–6.[doi:10.1377/hlthaff.2015.1258](https://doi.org/10.1377/hlthaff.2015.1258)