



Sound Policy. Quality Care.

January 9, 2018

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

RE: Chairman's Recommendation to Eliminate the Merit-based Incentive Payment System (MIPS) and Implement a Voluntary Value Program (VVP)

Dear Chairman Crosson,

On behalf of more than 100,000 specialty physicians from 13 specialty and subspecialty societies, and dedicated to the development of sound federal health care policy that fosters patient access to the highest quality specialty care, the undersigned members of the Alliance of Specialty Medicine (the "Alliance") write to express concerns with your recommendation to eliminate the Merit-based Incentive Payment System (MIPS) program and to replace it with a new, Voluntary Value Program (VVP).

Your recommendation, coupled with forthcoming recommendations to "rebalance" the Medicare physician fee schedule toward primary care, undercuts and devalues the role of specialists in providing thorough examinations, rendering accurate diagnoses, offering a complete range of treatment options, and delivering comprehensive and effective management of complex health conditions.

Recommendation to Eliminate MIPS, Implement a VVP

At the December 2017 meeting of the Medicare Payment Advisory Commission (MedPAC), your draft recommendation called for the following:

The Congress should eliminate the current Merit-based Incentive Payment System and establish a new voluntary value program in fee-for-service Medicare in which clinicians can elect to be measured as part of a voluntary group and clinicians in voluntary groups can qualify for a value payment based on their group's performance on a set of population-based measures.

According to MedPAC staff, spending implications include distributing the \$500 million MIPS exceptional performance bonus pool to improve payment for primary care or encourage engagement in Advanced Alternative Payment Models (A-APMs).

Prior to formalizing this recommendation, the Alliance shared concerns with you, the Commission, and the MedPAC staff, about the impact on specialty physicians and the beneficiaries they serve. Specifically, we shared that:

There is a lack of A-APMs in which specialists can meaningfully engage. While a handful of specialty-focused A-APMs are available for a narrow range of specialists, most A-APMs are geared toward primary care providers (e.g., Accountable Care Organizations, Comprehensive Primary Care Plus), evidenced by the quality measures reported by these entities, which focus on preventive care and population health. Most specialty physicians have found that participation in small, primary-care led ACOs is difficult, if not impossible, while those participating in large, hospital- or health system-centered ACOs have no meaningful engagement and are generally unaware they are even participants. Specialists are working to improve their relationships with ACOs to understand how they might fit in and where they can deliver value to an ACOs beneficiary population and earn a portion of the shared savings.

We refute Commissioner Thomas' comment that people "*are not organizing because they don't want to, not that they don't have the opportunity to.*" A simple assessment of the [letters of intent and proposed models submitted for review and deliberation by the Physician Focused Payment Model Technical Advisory Committee \(PTAC\)](#) demonstrates that specialists are moving, as Commissioner Thomas wants, "*in the right direction of being proactive and working together as a group,*" motivated by their desire to improve beneficiary quality-of-life and health outcomes, while reducing the overall Medicare spend, in areas where they have expertise and control. Moreover, some Alliance organizations attempted to collaborate on models with the Centers for Medicare and Medicaid Services (CMS) Innovation Center prior to enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) but were told that the administration was focused on models that promoted primary care, not specialty care.

Population-based measures are limited in their ability to determine quality and cost of specialty medical care. Despite specialty physicians concern about the overall health and well-being of their beneficiary population and routine collaboration with disparate specialties to coordinate care for multi-morbid patients, they remain limited in their ability to control quality and resource use outside the clinical area in which they deliver services. As we observed in the Value-Based Payment Modifier (VM), application of the Medicare Spending Per Beneficiary (MSPB) and Total Per Capita Costs (TPCC) measures provided no useful data or actionable information that allowed specialists to meaningfully change behavior. In fact, specialty physicians continue to oppose CMS' attribution methodology that erroneously assigns beneficiaries to them, a sentiment we have even heard from some who earned substantial bonuses under the VM. The VVP would continue reliance on the same and similar measures, which will do little to inform the Medicare program on the quality and resource use of specialty physicians or in steering beneficiaries to high-value specialists.

MACRA very clearly intended to promote the development of clinically relevant, specialty-based quality measures. Even before passage of MACRA, specialty societies were expending tremendous effort to develop quality, resource use, and appropriateness measures, as well as establish qualified clinical data registries (QCDRs), to raise the bar on performance and improve outcomes. Specialists are active participants in the quality arena and remain committed to ongoing engagement.

While you clarified during the December meeting that "*in no way should [the recommendation] be read as [the Commission doesn't] believe in the value of process measures,*" eliminating MIPS in favor of VVP contradicts that. MIPS relies on a variety of measures, including process. Measuring the frequency at which providers complete a specific action or adhere to a certain process can help identify where a breakdown is occurring and education on best practices is warranted, which will improve patient outcomes and overall health. Specialty societies have also developed, or are developing, outcomes measures, including those that are patient-reported.

The data and information produced by the broad array of specialty-society developed measures and complementary QCDRs assist specialists with longitudinal performance improvement, provide a rich dataset for clinical research, and are frequently used to personalize treatment interventions and in shared decision-making. Your recommendation to eliminate MIPS in favor of a new VVP would end these activities given funding to support specialty physician engagement would stop.

Fee-for-service remains a viable reimbursement structure for many specialists and subspecialists.

Under your proposal, those who remain in fee-for-service (i.e., they do not participate in an APM or join a “voluntary” group for large-scale measurement) will be subject to a financial withhold (e.g., 2-3%). Some specialty and subspecialty providers have already refined key conditions and procedures through medical advancement and technological innovation (e.g., moving services and procedures from expensive inpatient settings to lower-cost outpatient settings, reducing clinical gaps in care through long-term performance improvement). Where variations in cost and clinical quality have been eliminated for key conditions and procedures, and it is well-documented in the literature, fee-for-service remains the most appropriate reimbursement structure. It is unreasonable to penalize providers who have reached a point of excellence in the delivery of certain healthcare services, particularly when there may be no appropriate alternative mechanism available for them.

Additional Concerns

CMS recently established the Virtual Group model, which will allow small practices to voluntarily join and be measured in large groups under MIPS. The specialty physician community has raised concerns with this model, primarily because a mechanism for specialty practices to identify and partner with other like-minded entities has not been established. In addition, it is unclear if or how specialists in multi-specialty clinics would be able to break-off into a “subgroup” and join or form a virtual group (i.e., a virtual group of subgroups).

Under the VVP, the challenge of identifying other groups to join and be measured with would intensify as practices would need to consider data for a broader array of providers, a larger patient population, and health conditions outside the scope of their expertise. Essentially, you are asking small practices to operate as insurance companies, determining which entities to merge with and collectively share risk, but without providing the requisite resources (i.e., tools, staffing, and other technical assistance) to do so.

Conclusion

For the reasons above, ***we continue to oppose your recommendation to eliminate MIPS and to replace it with the new VVP.*** Specialists use their deep knowledge and expertise to reach a precise medical diagnosis, present the full array of available interventions, working with them to determine which option is most appropriate based on their preferences and values, and coordinate and manage their specialty and related care until treatment is complete and the patient is ready to return to their primary care provider, if one is available. ***No other clinician, provider-type or health care professional can replace the value offered by specialty physicians. Specialists are an essential and needed component of the healthcare system.***

Our efforts to work with CMS and Congressional leaders to improve MIPS and allow for more meaningful and robust engagement are ongoing. ***We urge you to withdraw your forthcoming recommendation, which diminishes the important role of specialty medicine in Medicare. Instead, the Commission and staff, under your leadership, should work toward a new recommendation that would***

improve aspects of the MIPS program that remain a challenge for all clinicians. For example, the Commission might use its expertise and resources to weigh-in on the inappropriate MIPS adjustment to Part B drugs, which will penalize and reward clinicians based on the volume of medicines they prescribe. A recent study by Avalere found that *“the magnitude of risk for certain types of specialists would continue to increase as the MIPS program reaches full implementation. In performance year 2020, the payment adjustments could reach as high as +/- 29% for rheumatologists and oncologists.”*¹ Not only would these adjustments potentially hinder access to care for beneficiaries whose physicians are penalized, but positive adjustments to practices that administer Part B drugs would unfairly reduce the incentive pool for all other clinicians.

We appreciate the opportunity to share our concerns. Should you have any questions, please contact us at info@specialtydocs.org.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
American Association of Neurological Surgeons
American College of Mohs Surgery
American College of Osteopathic Surgeons
American Gastroenterological Association
American Society of Cataract and Refractive Surgery
American Society for Dermatologic Surgery Association
American Society of Echocardiography
American Society of Plastic Surgeons
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
North American Spine Society

¹ <http://avalere.com/expertise/life-sciences/insights/cms-proposal-for-new-medicare-payment-system-could-lead-to-large-payment-va>