



Sound Policy. Quality Care.

October 24, 2017

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

RE: Next steps for the Merit-Based Incentive Payment System (MIPS)

Dear Chairman Crosson,

The undersigned members of the Alliance of Specialty Medicine (the “Alliance”) are writing to provide our perspectives on several policy considerations discussed at recent meetings of the Medicare Payment Advisory Commission (MedPAC).

The Alliance represents more than 100,000 specialty physicians from 13 specialty and subspecialty societies. We are dedicated to the development of sound federal health care policy that fosters patient access to the highest quality specialty care.

Policy Consideration to Address Commission Concerns with MIPS

At its October meeting, staff presented a policy option aimed at moving physicians toward Advanced Alternative Payment Models (A-APMs) by eliminating the Merit-based Incentive Payment System (MIPS) program and replacing it with a Voluntary Value Program (VVP), which ***requires*** participation in A-APMs or engagement in population-based measurement via “large” entities to avoid financial penalties.

We appreciate that the Commission recognizes the challenges physicians face with participation in the MIPS program, including the complexity of reporting requirements and tremendous cost burden. We also appreciate the difficulty beneficiaries may experience when using quality and performance measures and their resultant scores to make informed choices about their care. Physicians have been working closely with the Centers for Medicare & Medicaid Services (CMS) and Congress to address some of these issues so as to improve the program for physicians and beneficiaries alike. Because the MIPS program is new, and many of its components currently retain elements of Medicare’s quality legacy programs (e.g., Physician Quality Reporting System, Electronic Health Record (EHR) Incentive Program or “Meaningful Use”, and the Value-Based Payment Modifier), physicians anticipated fine-tuning of program requirements — especially during the transition years.

Nevertheless, **we strongly oppose the aforementioned policy option and forthcoming recommendation for several reasons. First, a lack of A-APMs for specialists to meaningfully engage exists. Second, the limitations of population-based measures in determining quality and cost of specialty medical care will hinder specialists' performance in "large" entities. Third, the Medicare Access and CHIP Reauthorization Act (MACRA) very clearly intended to promote the development of clinically relevant, specialty-based quality measures. Fourth, most physicians do not practice in "large" entities; thus impeding these individuals or groups from successful participation. And, finally, fee-for-service remains a viable reimbursement structure for many specialists and subspecialists where alternative models of care and payment have already addressed the value equation for the vast majority of their services.**

Significant Void of A-APMs

According to a new report issued by Leavitt Partners, not every provider has a path forward under the A-APM track of the Centers for Medicare and Medicaid Services (CMS) Quality Payment Program (QPP).¹ In fact, some specialists have no opportunities to participate in A-APMs, at all. According to CMS, between 70,000 to 120,000 eligible clinicians are estimated to be qualifying participants (QPs) for payment year 2019 based on A-APM participation in performance year 2017. CMS estimates that approximately 180,000 to 245,000 eligible clinicians may become QPs for payment year 2020 based on A-APM participation in performance year 2018, given the addition of new A-APMs. Moreover, a review of CMS' MIPS exclusion tables in its 2017 QPP final rule, show that family medicine, internal medicine, obstetrics/gynecology, and nurse practitioners, are the primary specialties that will make up the vast majority of QPs, based on 2017 data. Specialists, such as ophthalmologists, neurosurgeons and rheumatologists, will see 153 (0.7 percent), 46 (0.8 percent) and 79 (1.4 percent) of their respective specialty physicians in Medicare qualify for an incentive under the APM track, whereas the remaining will participate in the MIPS program.

In previous correspondence with the Commission, the Alliance has raised concerns about the inability of specialty physicians to engage in Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs), specifically noting that MSSP ACOs use "narrow networks" as a strategy to control costs, which hinder specialty physician participation. Other models that have been identified as A-APMs, such as Patient Centered Medical Homes, are also difficult for specialty care physicians to engage, as these models are designed for primary care providers. Most other models that have been identified as A-APMs are focused on primary care providers, not specialists.

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) continues to review models that are focused on specialty-driven care; however, most of these models have not been recommended or the Secretary has chosen not to test them. We anxiously await how the Centers for Medicare and Medicaid Innovation (CMMI) will redirect its resources in a way that will foster new models for a variety of specialists, enabling them to engage as meaningfully in alternative models of care and delivery as their colleagues in primary care.

¹ <https://leavittpartners.com/wp-content/uploads/2017/09/CMS-Initiatives-White-Paper-9.7.2017-1.pdf>

Population-Based Measurement in Specialty Medicine

Most population-based quality and cost measures are designed around chronic, comorbid conditions that are largely under the management of primary care providers, leaving the vast majority of specialty physicians without opportunities to demonstrate a direct and positive impact on the value of care they deliver.

A review of the population-based quality measures reported by Medicare ACOs are not reflective of specialty medical care, particularly for subspecialty providers. It would be difficult for most specialists to prove their value under currently available quality measures used in most A-APMs.

Regarding claims-based cost measurement, the majority of specialty physicians subject to CMS' 2015 Value-Based Payment Modifier (VM) program received neutral payment adjustments in CY 2017, while a scarce few received *significant* financial incentives, much to their surprise. After reviewing their feedback reports, many discovered the incentives were paid because Medicare patients they saw only once or twice during the performance period for a specific condition affecting one body system, were attributed to them. While these specialists delivered high-value care, they were perplexed as to how their limited interaction with attributed beneficiaries was enough to hold them accountable for a given beneficiary's total per capita costs of care or justify such tremendous pay-outs. Moreover, they were unable to discern from the reports how they might replicate the behavior to continue earning incentives, or, more importantly, avoid a financial penalty in the future. Broad issues with resource use measurement are being addressed by CMS with input from the physician community, including specialists, as CMS moves closer to holding physicians accountable for costs under the current MIPS program.

Clinically Relevant Specialty Measurement

MACRA specifically emphasized the development and prioritization of specialty-focused quality measures. As such, CMS has implemented a Measures Development Plan (MDP) that operationalizes this work, which will significantly enhance the agency's measure portfolio.² Members of the Alliance are heavily invested in this work, producing quality measures that improve clinical care, patient experience, and ultimately, beneficiary understanding of the care they can expect to receive by qualified providers. MedPAC's policy direction would dismantle these efforts, which are broadly supported by government, providers, patients, and payers.

In addition, MACRA emphasized the use of qualified clinical data registries (QCDRs). QCDRs are especially important for specialty physicians looking to deepen their understanding of quality and performance for relevant episodes of care, particularly when they identify a gap in care and seek ways to address it. As with quality measure development, specialty societies have invested

² <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Final-MDP.pdf>

significant resources to establish QCDRs with the goal of raising the bar in specialty medical care, as well as assist specialists with quality reporting activities. The data collected, and resultant information, has fueled important improvements in quality and resource use across many specialties, not to mention assisted some specialty societies with improving the content of their scientific conferences through the use of aggregate back-end data, benefiting their respective professions at the broadest level. Again, MedPAC's policy considerations diminish these activities as meritless and wasteful.

Preservation of a Plurality of Medical Practices, Reimbursement Structures

A recent *Policy Research Perspectives* from the American Medical Association (AMA) shows that most physicians in the United States continue to work in small practices. In fact, single specialty practice was the most common practice type, with 42% of physicians in single specialty practices in 2014. As a result, a significant proportion of beneficiaries receive healthcare from physicians in small practices. This is a viable model of healthcare delivery that must be preserved; **not all physicians should join or form large entities.**

Moreover, while there is significant promise in value-driven health care and several disease states and procedures are prime for quality and resource use improvements, **fee-for-service should not be eliminated as a reimbursement structure.** While many specialists are making significant strides to engage in activities that deliver on that promise, some have already refined key conditions and procedures through medical advancement and technological innovation. For example, some specialists have moved services and procedures from expensive inpatient settings to lower-cost outpatient settings, and reduced clinical gaps in care through long-term performance improvement. In some cases, these specialists have eliminated variation in cost and clinical quality across geographic regions, which is documented in the literature. For these specialists, fee-for-service remains the most appropriate reimbursement structure. Their performance can and should be measured to maintain excellence in care and treatment delivery, and most will continue to engage in federally-sponsored quality improvement programs, including MIPS, to demonstrate their commitment to delivering high-value care to beneficiaries.

Conclusion

The MIPS program provides the only mechanism for many specialists and subspecialists to engage in federally-sponsored quality improvement activities and demonstrate to beneficiaries their commitment to delivering high-value care. Eliminating MIPS in favor of MedPAC's proposed new quality program would discourage specialty physicians from developing robust quality and outcomes measures, including the establishment of high-value clinical data registries, and would thwart efforts to collect and report performance data.

Specialty physicians are working with CMS and Congress to improve MIPS and allow for more meaningful and robust engagement. We are encouraged by the dialogue and positive trajectory. MedPAC's proposal would be a significant step backwards and will be opposed by the vast majority of physicians, including the Alliance.

We appreciate the opportunity to provide comments on the aforementioned issues of importance to the Alliance. Should you have any questions, please contact us at info@specialtydocs.org.

Sincerely,

American Association of Neurological Surgeons
American College of Mohs Surgery
American College of Osteopathic Surgeons
American Gastroenterological Association
American Society for Dermatologic Surgery Association
American Society of Cataract and Refractive Surgery
American Society of Plastic Surgeons
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons