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September 8, 2015

Andy Slavitt, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1631-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016

Dear Mr. Slavitt,

The Alliance of Specialty Medicine (the "Alliance") represents more than 100,000 specialty physicians from 14 specialty and subspecialty societies. Our mission is to advocate for sound federal health care policy that fosters patient access to the highest quality specialty care. In line with our mission, we provide the following comments on the CY2016 Medicare Physician Fee Schedule Proposed Rule.

Determination of Malpractice Relative Value Units

The Alliance is concerned that the impact of CMS changes regarding professional liability insurance (PLI) is estimated by CMS to have a negative impact on some specialties. We understand that CMS has said that the decrease "relates to a technical improvement that refines the MP RVU methodology, which we are proposing to make as part of our annual update of malpractice RVUs. This technical improvement will result in small negative impacts to the portion of PFS payments attributable to malpractice for gastroenterology, colon and rectal surgery, and neurosurgery." However, we would like to see more details on how the specialty impacts were determined. We appreciate the assertion that it may be difficult to obtain premium data for some specialties, however, we believe the agency must thoroughly vet the methodology used by the contractor. We urge CMS to review the data, continue to try to obtain updated premium data in as many states as possible, and to share the data in the final rule in order for the agency and the specialty to determine its accuracy.

Potentially Misvalued Services Under the PFS

The Alliance continues to have concerns about CMS' implementation of the potentially misvalued code initiative. Most notably, we are concerned that many of CMS' screens are based simply on utilization, and that CMS does not consider the quality and value of these services. We urge CMS to seek advice from the American Medical Association (AMA) Relative Value Scale Update Committee (RUC) to refine its potentially misvalued code initiative.

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National Association of Spine Specialists • Society for Cardiovascular Angiography and Interventions • Society for Excellence in Evicare

Review of High Expenditure Services across Specialties with Medicare Allowed Charges of \$10,000,000 or More

We continue to believe that the application of the “high expenditure by specialty” screen, which identifies codes that account for greater than \$10M in Medicare expenditures within a specialty, is arbitrary and flawed. As the agency is aware, the \$10M threshold does not take into account the value of services being provided, nor does it consider other circumstances for why expenditures have reached this level of spending. In many instances, increased levels of utilization and higher spending are directly attributed to a specialty’s response to evolving practice guidelines, appropriate use criteria, and current medical literature, not to mention the sharp increases in the number of beneficiaries becoming eligible for Medicare each year. Furthermore, CMS has consistently failed to take into account local and national coverage decisions and other payment and coverage policies that may lead to services reaching the \$10M threshold. Finally, we request that CMS remove ZZZ codes from the screen as they are add-on codes to 10- and 90-day global procedure codes that have been excluded from the review. We urge CMS to revise this screen under the statutory category, “codes that account for the majority of spending under the PFS.”

Valuing Services That Include Moderate Sedation as an Inherent Part of Furnishing the Procedure

As Appendix G procedure values are adjusted to no longer include moderate sedation, CMS must ensure the value and subsequent reimbursement are fair and accurate. This will require CMS to work closely with the AMA RUC and medical specialty societies, and may require this to be done on a specialty-by-specialty, family-by-family, or even code-by-code, basis. We would oppose any methodology that takes a “blanket approach” to addressing this issue; for example, simply removing the standard packages for the direct PE inputs associated with moderate sedation. Members of the Alliance that will be impacted by this proposal stand ready to assist the agency with this work.

Improving the Valuation and Coding of the Global Package

The Alliance urges CMS to be thoughtful as it considers the best way to improve the value and coding of the global surgical package, and that any modifications are phased-in over time, given the various issues that will result from attempting to dissect global surgery codes into discrete components. Members of the Alliance that provide global surgical services stand ready to assist the agency with this endeavor, and we encourage CMS to provide multiple opportunities to engage with the medical community as it considers options for addressing global codes.

Refinement Panel

The Alliance is deeply concerned about CMS’ proposal to eliminate the Refinement Panel, especially since the process by which stakeholders may “appeal” an RVU determination outside of this process is unclear. Rather than eliminate the Refinement Panel, we urge CMS to work with stakeholders to address shortcomings in the Refinement Panel process to ensure it is effective and purposeful, particularly since the need for this process is relatively infrequent and requires little in the way of resources, yet is viewed by the medical societies as tremendously valuable given the time and expense the societies have expended toward developing relative values.

Should CMS disagree with our request and finalize its proposal to eliminate the Refinement Panel, the agency must provide detailed guidance on how stakeholders may seek a change in previously finalized RVUs, including the process to initiate a meeting with CMS staff to share and discuss new information or clarify previously shared information, as well as any key timelines or dates that may impact CMS’ ability to initiate a change in previously finalized RVUs.

Improvement Payment Accuracy for Primary Care and Care Management Services

CMS continues to emphasize its commitment to supporting primary care services, and for prioritizing the development and implementation of initiatives designed to improve the accuracy of payment for, and encourage long-term investment in, care management services.

In the rule, CMS proposes options for improving primary care and care management services, including (a) the development of an add-on code to describe the professional time in excess of 30 minutes and/or a certain set of furnished services, per one calendar month for a single patient to coordinate care, provide patient or caregiver education, reconcile and manage medications, assess and integrate data, or develop and modify care plans; (b) payment for collaborative care in which separate payment could be made for robust interprofessional telephone/internet consultative services; (c) payment for other services finished through collaborative care models; and, (d) revisions to the requirements for the complex care management (CCM) and transitional care management (TCM) to make these services more accessible to Medicare beneficiaries.

CMS' proposals for improving payment accuracy for primary care and care management services are thoughtful toward addressing challenges in providing primary care and care management services, however, we urge CMS to ensure these new codes are not limited in their use to traditional primary care specialties. Specialty physicians routinely provide the same types of services described, particularly for their patients that have multiple chronic health conditions, whether they have a primary care provider or not.

In addition, we urge CMS to consider additional proposals for new and add-on codes that address unique circumstances where specialty physicians are providing primary care and care management services. As the comment window is too narrow for us to elaborate on the types of collaborative care models that our specialties would like to offer, we urge CMS to issue a Request for Information (RFI) to solicit additional proposals and public comment on this topic in advance of making any more formalized proposals in next year's rule.

Target for RVU Adjustments for Misvalued Services

As required by statute, CMS proposes methodology for achieving a target for relative value adjustments for misvalued services. CMS has considered in its calculation of the target the values for codes newly proposed for payment in CY 2016, the Advance Care Planning (ACP) service codes. We urge CMS to exclude these codes from its calculation of the target as these codes are only this year being proposed for payment, therefore, they are not and have never been, identified as potentially misvalued.

Regarding the phase-in of significant RVU reductions, we urge CMS to reconsider its proposal to adopt a 19% reduction as the maximum 1-year reduction and to phase-in any remaining reduction in the second year of the phase-in, and instead adopt a 50 percent phase-in approach, which will be much cleaner and understandable to those paid under the MPFS.

Incident To Proposals Billing Physician as the Supervising Physician and Ancillary Personnel Requirements

CMS' proposed modifications to its incident-to requirements could be particularly problematic for many specialty physician practices that provide treatment over long durations, such as chemotherapy. We urge CMS to clarify whether it is now requiring that the physician upon whose professional services the incident-to service is based must always supervise the services, or if it would consider physicians in the same group practice to be the same physician for purposes of applying the clarified incident-to supervision requirement. If the former, we strongly oppose the proposed change.

Imaging Appropriate Use Criteria

Appropriate Use Criteria (AUC) are well-intended efforts on the part of physicians to make sure the profession is doing the right things for the right reasons. We believe the best approach to implementing AUC is one that is diligent, maximizes the opportunity for public comment and stakeholder engagement, and allows for adequate advance notice to physicians and practitioners, beneficiaries, AUC developers, and clinical decision support mechanism developers (i.e., Apps, other). It is for these reasons that the Agency should proceed using a stepwise approach, adopted through rulemaking, to first define and lay out the process for the Medicare AUC program.

The Alliance appreciates CMS' effort to lay out a foundation for this complex new requirement. As a first step in the implementation of a provision in the Protecting Access to Medicare Act of 2014 (PAMA) that will require physicians to consult AUC prior to ordering certain services, CMS has laid out the ground rules it will use to choose which AUC sets could be used to meet the requirement. CMS has considerable latitude in determining what conditions and for which modalities consultation will be required. The proposed rule suggests that the Agency will take a flexible approach to choose between competing sets of AUC and clinical decision support mechanisms. The specific criteria, clinical decision support mechanisms that incorporate the criteria, and the rules surrounding how physicians choose, document, and use AUC products will be taken up in the 2017 rulemaking process. However, only a narrow list of AUC would be approved for the purpose of identifying outlier physicians who would be required to get prior authorization effective January 1, 2020. CMS intends to base outlier identification on a narrow set of conditions where there is wide agreement on clinically appropriate treatments.

The Alliance strongly opposes using AUC for withholding payment for services provided. AUC are designed to help ensure that the best information is available for clinical decision making and to help support appropriate choices by physicians and their patients, in the context of good clinical judgment and patient preferences. AUC are developed to identify common clinical scenarios but they cannot possibly include every patient presentation, clinical scenario, or set of patient preferences.

The Alliance supports the intent to define a "provider-led entity" as these are organizations that have the opportunity to become qualified to develop, modify, or endorse specified AUC. The proposed definition would include national professional medical societies or an organization that is comprised primarily of providers and is actively engaged in the practice and delivery of healthcare (e.g., hospitals and healthcare systems). **We urge CMS to explicitly define a provider-led entity as an organization consisting of practicing physicians in the field to which the AUC will apply.** This would help resolve the concern that insurers would not qualify as a provider-led entity.

The Alliance supports the proposal to qualify AUC developers and endorsers rather than qualifying each individual AUC set. Provider-led organizations that use processes meeting certain requirements and want to be recognized as qualified provider-led entities may apply to CMS. A provider-led entity is not considered qualified until CMS makes a determination via the qualification process discussed in the proposed rule.

The Alliance believes that the qualification process to select an AUC developer is an important opportunity by the public to address concerns about an AUC developer's methodology. An AUC developer's methodology needs to be transparent in how it assures wide agreement on clinically appropriate treatments by all participating societies, including a process when one or more participating medical societies do not endorse AUC. In specific circumstances, one or more of the participating medical societies may choose, after full review of the process, to not endorse AUC for a particular condition for a number of valid reasons. The AUC process could have an overly broad scope, too few panel members with sufficient expertise, perceived bias of the selected panelists, and unnecessary restrictions on full peer review and adequate consideration of all external

comments by known experts of the proposed AUC as part of their methodology. As a result, non-endorsers may continue to support previously endorsed AUC. **We recommends that any qualified AUC developer be required to name participating medical societies that didn't endorse and their reasons as a matter of transparency. This information would be used in assessing a qualified AUC developer at a future date.**

The proposed rule states that applications to be a qualified provider entity include the following:

“AUC development led by at least one multidisciplinary team with autonomous governance. At a minimum, the team must be composed of three members including one with expertise in the clinical topic related to the criterion and one with expertise in imaging studies related to the criterion. CMS encourages such teams to be larger, and include experts in each of the following domains: statistical analysis (such as biostatistics, epidemiology, and applied mathematics); clinical trial design; medical informatics; and quality improvement. A given team member may be the team's expert in more than one domain. These experts should contribute substantial work to the development of the criterion, not simply review the team's work.”

The Alliance cannot support the proposed application criteria to qualify as an AUC developer. We believe that a minimum panel of three physicians does not offer the required diversity of opinions to debate the evidence and develop AUC. Criteria should explicitly state that only experts qualified in the field should provide voting input and that while oversight and comment may be appropriate for those who don't provide the services regularly, final decisions regarding appropriateness should be made by active practitioners. For example, a panel should include physicians that rely on those imaging studies to make their clinical decisions on appropriateness for their procedures. Those physicians would understand when imaging studies are not available (e.g., on weekends or at night) or patient preferences to significant radiation exposure or lengthy procedures despite marginally better outcomes to alternative options. These perspectives are vital in assessing the evidence to determine AUC. We do not believe that patients or consumers should be on a panel since the technical aspects of assessing evidence would inevitably result in “simply reviewing the team's work.”

The Alliance also urge the Agency to require an annual requalification of AUC developers instead of every six years (as stated in the proposed rule) as Medicare patients rely on robust monitoring of qualified entities. Future proposed rules can elongate the requalification timeframe.

Physician Self-Referral Updates

As discussed above, specialty physicians routinely provide primary care and care management services to their patients, and particularly those who are multimorbid. As such, we urge CMS to broaden its definition of primary care services to include those primary care services provided by specialty physicians. Moreover, to relax certain Stark Law provisions for certain physician specialties, and not others would be wholly inappropriate and an abuse of CMS' authority.

Private Contracting/Opt-Out

The Alliance thanks CMS for implementing this important provision of MACRA. Once finalized, we urge CMS to provide education about the change in the opt-out process via its usual educational channels, such as MedLearn Matters articles and other newsletters.

Physician Compare

The Alliance reiterates its concerns about CMS' goal of reporting performance data across ALL reporting mechanisms (including QCDRs) and for ALL size groups and individual practitioners by late 2016 based on 2015 data. We believe this timeline is overly ambitious given the ongoing lack of specialty-focused measures. While QCDR measure data will help to fill some of these gaps, this reporting mechanism is less than two years old. Data errors including missing or incorrect performance rates, missing or invalid numerator data, missing or

invalid denominator data, and calculation errors are current challenges that the Agency has not fully addressed with QCDR vendors at this time. Furthermore, not all specialties have had the time or resources to become a qualified entity and even among those who have, most have had little time to test and set accurate benchmarks for new measures.

Given our concerns, we do appreciate that CMS at least plans to only make available to the public measures that prove to be valid, reliable, and accurate upon analysis; are deemed to be statistically comparable; meet a minimum sample size of patients; and are not first year measures. However, we do take issue with the 20 patient threshold that CMS will use to determine if a measure is appropriate for public reporting. A sample size this low could compromise the validity of the data, provide little information of value for patient decision-making, and result in inaccurate judgments that could harm the reputation of physicians.

We also appreciate that CMS will conduct consumer testing to determine whether the information presented is relevant and useful to the public. It is critical that CMS conduct these evaluations in a transparent manner and with the ongoing input of professional societies and their clinical expert members. As part of this process, CMS should also carefully consider to what extent consumers are actually using information presented on the site for better informed healthcare decision-making.

CMS indicates that it will only deem select data appropriate for Physician Compare physician profile pages and that the remainder of publicly reported data will be available through a downloadable data file. While we respect CMS' effort to balance transparency with the need to ensure data is ready for public consumption, we do not agree with this proposal. Data that CMS determines is not yet ready to be showcased on profile pages should not be posted in a raw data file that could be easily misinterpreted or misused by a range of stakeholders purporting to be arbiters of quality. If CMS feels the need to make these raw data files available to the public, it should make them available only to professional societies, which can then determine the most appropriate uses for the data.

As early as late 2017 based on 2016 data, CMS proposes to include a green check mark on individual and group practice profile pages who received an upward adjustment as a result of the Value Modifier (VM). CMS also proposes to add to the Physician Compare downloadable database the 2018 VM quality tiers for cost and quality, based on historic and outdated 2016 data, for group practices and individual eligible professionals (EPs). The Alliance strongly objects to both of these proposals given our ongoing concerns with the underlying measures and methodologies that comprise the VM. We continue to believe that the quality and cost measures, taken together, are a poor proxy for physician value. Furthermore, CMS has increasingly needed to rely on automatic "average" designations in situations where it is unable to incorporate performance data either due to reporting errors or an insufficient population of attributed patients. These designations, which are common among specialty physicians, are not necessarily an accurate reflection of overall value, but rather an indication that the VM program, in its current form, does not accurately capture specialty physician value. In fact, in certain instances, the automatic "average" designation might even result in a lower overall value rating (and penalty) than if the physician were held accountable for more relevant measures. Given these serious ongoing flaws, the Alliance does not believe that current VM quality tiering and payment adjustment data would provide anything of value to consumers and if anything, would simply mislead and confuse them. The Alliance opposes the addition of a green checkmark for the above reasons.

In this section of the rule, CMS also proposes to apply a measure-level benchmarking methodology known as the Achievable Benchmark of Care (ABC™) to publicly reported PQRS measures. CMS claims this is a well-tested, data driven model that evaluates who the top performers are, and then uses that to set a point of comparison for all of those groups or individual EPs who report the same measure. However, we remind CMS that testing of this methodology has primarily been conducted in primary care settings and only applied to substantially

smaller projects. Our concerns with this methodology center on its apparent lack of adjustments to ensure that physicians with similar patient populations and practice settings are compared to each other. CMS' recent decision to drastically increase the PQRS reporting requirements to 9 measures across 3 domains, including one cross-cutting measure, means that most specialists must report on at least some broadly focused measures, on which primary care and other physicians also rely. When setting benchmarks for a measure, CMS should not pool performance across a range of diverse providers reporting the same measure. If CMS is unable to incorporate specialty and/or site of service adjustments at this time (or otherwise stratify performance data) then it should refrain from setting benchmarks at this time or else focus only on finite measures that target a very specific and homogenous population. We also warn against the risk of oversimplifying performance data by relying on a 5 star rating system. If the underlying data is not appropriately adjusted, a five star tiering system could result in arbitrary cutoffs between physicians whose performance is not statistically different.

Finally, we would like to express our concern about CMS' potential future proposal to include "Open Payments" data on individual EP profile pages on Physician Compare. We strongly oppose this proposal. These data are already available to the public. The primary intent of the Physician Compare website is to provide the public with information about physician quality. We do not believe it is appropriate to post financial disclosure data alongside information about clinical quality since the former is not an indicator of the latter.

Physician Quality Reporting System

Proposed Changes Related to Qualified Clinical Data Registries (QCDRs)

In this rule, CMS proposes multiple modifications to the requirements for becoming a QCDR in 2016, including opening the self-nomination a month earlier (i.e., December 1 through January 31), but moving up the self-nomination deadline (i.e., from March 31 to January 31). While the former proposal is helpful, the latter could cause challenges for entities self-nominating for the first time and existing QCDRs that have substantially changed their measures. Each year, CMS only adds to the documentation requirements of becoming a QCDR so lessening the time that an entity has to understand and comply with these requirements seems unreasonable.

The Alliance thanks CMS for proposing to comply with the Medicare and CHIP Reauthorization Act (MACRA) by making the QCDR reporting mechanism available to those electing to participate in the PQRS via the Group Practice Reporting Option (GPRO). This will ensure that a greater number of specialists can take advantage of more meaningful and relevant measures offered through QCDRs.

While CMS is not proposing any changes to the reporting criterion for EPs using QCDRs in 2016 (i.e., 9 measures, including 2 outcomes measures, for at least 50% of all applicable Medicare and non-Medicare patients), the Alliance requests that CMS consider allowing QCDRs to make their own determinations about the sample size needed to achieve a valid and reliable result. The requirement to collect data on 50% of ALL patients is often more than is needed for many measures and imposes a greater reporting burden on physicians than traditional PQRS measures, which require reporting on 50% of applicable Medicare patients only. This substantially larger reporting requirement also might discourage QCDRs from more granularly specifying measures to enhance accuracy, since any added data elements would add further to what is already a considerable reporting burden.

The Consumer Assessment of Healthcare Providers Survey (CAHPS) for PQRS

Currently, group practices of 100 or more participating in GPRO under *any* reporting mechanisms must also use *and bear the cost of* a CMS-certified survey vendor to report the CAHPS for PQRS survey to CMS. For the 2016 reporting year, groups with 25 or more that register for the *GPRO Web Interface only* would also have to report CAHPS for PQRS measures. The Alliance opposes CMS mandating the use of CAHPS for PQRS, as well as the expense of contracting with a CMS-certified vendor to administer the survey, given the inapplicability of the survey to most of specialty medicine. We support giving all physicians the flexibility to choose the patient experience measure(s) that are most relevant to their practice. Barring such a policy, we at least appreciate that

CMS recognizes in this rule that group practices selecting other non-Web Interface GPRO reporting mechanism (e.g., registries, EHRs) are more likely to be highly specialized and therefore should be excluded from this requirement.

Potential Future Policies

CMS seeks comments on its intention to require the collection of quality data, stratified by race, ethnicity, sex, primary language and disability status, within each of the PQRS reporting mechanisms. The Alliance supports adjustments to data that make them more meaningful and actionable for both consumers and physicians. However, we are concerned that the underlying foundation of PQRS data is not yet robust enough to stratify by all of these factors. Furthermore, we ask CMS keep in mind the unique limitations of each PQRS reporting mechanism, which may make it difficult to collect this information. For example, claims data might not adequately capture the breadth of socio-demographic factors that need to be accounted for. While a clinical data registry has more flexibility to customize its data points, doing so could create an additional data collection burden on registry participants if the registry cannot easily extract this additional information from an EHR or other source due to lack of interoperability or uniformity of data definitions.

Value-Based Payment Modifier (VM)

The Alliance appreciates that CMS is not proposing to raise the ceiling on potential penalties under this program for 2018 and that, consistent with other years, it is relying on a phased rollout where EPs in their first year of the program are held harmless from downward payment adjustments. However, due to our ongoing concerns regarding the program's reliance on questionable measures and methodologies, we request that CMS continue to hold smaller group practices and solo practitioners harmless from downward performance-based payment adjustments in 2018. The current set of quality and cost measures, and the methods those measures rely on to attribute patients to physicians, are often of little relevance to smaller group practices and solo practitioners, who tend to be more specialized and/or focus on a single specialty. In many instances, CMS cannot even apply these measures to smaller groups and individuals because of an insufficient sample size of applicable patients, which, as discussed earlier, results in what may be an inaccurate "average" determination. Until CMS has adopted a mechanism to incorporate quality data that is more relevant to specialists, as well as more accurate and clinically specific cost measures, we believe it should hold smaller practices and solo practitioners harmless from downward performance-based payment adjustments under the VM. CMS should also hold harmless from any downward payment adjustments, any EP or group practice to which CMS automatically applies an "average designation" due to its inability to calculate a quality or cost measure.

Quality Measures

CMS proposes to continue to base the VM largely on PQRS measures, as well as other acute and chronic care prevention measures that have very little to do with specialty medicine. As the PQRS offers enhanced opportunities for specialty physicians to report on more relevant measures through QCDRs, we request that CMS consider discontinuing its use of the acute and chronic care prevention measures.

Cost Measures

The Alliance has long criticized the current set of cost measures that CMS uses to calculate the VM since they assess the total amount billed per patient and not the treatment of the individual provider. While tracking costs (and quality) across the care continuum is important for developing policies to improve our care delivery system, these general assessments are not appropriate for physician-level accountability since they incorrectly assume that physicians have control over the care plan and treatment decisions of other physicians who also treated the patient over the reporting year.

Furthermore, the current set of cost measures have absolutely no connection to the quality measures used to calculate the VM. CMS cannot purport to make determinations about overall value if these measures focus on different elements of care.

We remain very interested in CMS' work to develop and test more focused episode-based cost measures. Many of our member societies have been assisting CMS with this work to date and those that have stand ready to help. Episode-based cost measures that focus on a specific medical condition or procedure would more accurately evaluate care over which a physician has control and allow for more equal comparisons of physicians. As such, we request that CMS devote as much time and resources to this process as possible so that it can replace the current set of cost measures as soon as possible. We have been eagerly awaiting the results of this work for many years now.

In the interim, we request that CMS at least adopt policies that will minimize the inappropriate application of existing cost measures. For example, CMS proposes to increase the minimum number of episodes required for the Medicare Spending Per Beneficiary (MSPB) measure to be included under the cost composite from 20 to 100 episodes. The Alliance supports raising this threshold, but requests that CMS consider increasing the case minimum even higher, to 200 cases, so that it is consistent with the methodology previously adopted by CMS for the All-Cause Hospital Readmissions quality measure included in the quality composite beginning with the 2017 payment adjustment year. As we noted earlier, the Alliance recommends that CMS hold harmless from downward payment adjustments EPs and groups for which CMS cannot calculate a quality or cost score due to an insufficient sample or data submission error.

CMS also seeks comment on potential future approaches to risk adjusting the Total Per Capita Cost Measures used under the VM. The Alliance agrees that the CMS-hierarchical condition categories (HCC) Risk Adjustment methodology currently applied to these measures does not accurately capture the additional costs associated with treating the sickest beneficiaries. We support potentially stratifying cost measure benchmarks by beneficiary risk score in the future so that groups and solo practitioners are compared to other groups and individual practitioners treating beneficiaries with similar risk profiles. We urge CMS to work closely with specialty societies to ensure that relevant clinical experts have an opportunity to provide guidance on the most accurate mechanisms to achieve these adjustments. We also urge CMS to reconsider the specialty adjustments it currently applies to cost measures. While we support these adjustments, there are situations where CMS might need to further account for subspecialties or even settings of care.

Finally, we strongly urge CMS to apply socioeconomic status adjustments to cost measures under the VM. A large body of evidence demonstrates that sociodemographic factors such as income and insurance status affect many patient outcomes, including readmissions and costs. Failing to adjust measures for these factors can lead to substantial unintended consequences, including harm to patients and heightened health care disparities by diverting resources away from providers treating large proportions of disadvantaged patients. It also can mislead patients, payers and policymakers by blinding them to important community factors that contribute to worse outcomes.

Quality and Resource Use Reports (QRURs)

The Alliance cannot overemphasize the need to ensure that these reports are easy to understand and easy to access. This is especially critical as CMS increases the amount of data included in these reports (e.g., more specific episode-based cost measure data) and the frequency by which it issues these reports. Many of our members continue to find it challenging to access their reports (either because of technical issues or because they work in larger groups or systems that do not provide easy access to the reports). Those who do eventually access their reports find them extremely confusing to navigate and find that they provide very little, if any, meaningful or actionable information to improve care. While updates to the format of the reports are helpful, the real problem is the underlying measures and methodologies. If CMS is unable to make substantial changes to the data calculated in this report, then it should at least strive to provide clearer explanations about the measures and methodologies and their ongoing decision to rely on such.

Provisions Related to the Medicare Access and CHIP Reauthorization Act (MACRA)

For both the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models, we strongly encourage CMS to maintain as much flexibility as possible by recognizing a diverse range of activities and models that reflect the practice settings and patient populations of a wide variety of physicians, including specialists. Both programs offer specialty medicine a unique and much needed opportunity to be recognized for more relevant aspects of care. For MIPS, in particular, we request that CMS adopt a minimally burdensome attestation process by which physicians can document their participation in qualified Clinical Practice Improvement Activities. We also remind CMS that MACRA gives the agency the authority to adjust weights for each performance category if there are not a sufficient number of measures/activities applicable to each type of physician involved. CMS should consider demonstrating this authority to recognize the ongoing lack of meaningful use metrics related to specialty medicine and other ongoing challenges related to EHR selection and implementation. In addition, the Alliance urges CMS to delay Stage 3 meaningful use and work with specialty societies to reduce the thresholds required in Stage 3 to more reasonable levels. The proposal for Stage 3 meaningful use would prohibit our members from not only successfully satisfying the current EHR Incentive Program, but also being able to successfully participate in the MIPS program, if it is included.

In regards to low volume thresholds, the Alliance recommends that CMS further analyze practice patterns by subspecialty and practice setting to determine if there is a limit that separates high from low volume. Any established threshold should be reevaluated periodically to account for variations in practice patterns. The low volume threshold exemption should also be optional so that all EPs are provided with the opportunity to participate in MIPS if they believe they can provide CMS with meaningful data to qualify for an incentive.

We appreciate the opportunity to provide comments on the aforementioned issues of importance to the Alliance. Should you have any questions, please contact Rachel Groman, MPH, at rgroman@hhs.com, or Emily L. Graham, RHIA, CCS-P, at egramham@hhs.com.

Sincerely,

American Academy of Facial Plastic & Reconstructive Surgery
American Association of Neurological Surgeons
American College of Mohs Surgery
American Gastroenterological Association
American Society of Echocardiography
American Society of Cataract and Refractive Surgery
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