Alliance of Specialty Medicine

Sound Policy. Quality Care.

October 16, 2018

Seema Verma, MPH
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1701-P, Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations-Pathways to Success

Dear Ms. Verma,

On behalf of more than 100,000 specialty physicians from 15 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 in response to proposals aimed at redesigning and providing a new direction for the Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs).

General Concerns

Specialist Participation in ACOs

Despite a recent Medicare Payment Advisory Commission (MedPAC) analysis that found sixty percent (60%) of ACO-participating physicians are specialists[1], the Alliance remains concerned that many ACOs have adopted "narrow networks" to inappropriately limit specialty physician participation. The lack of "network adequacy" standards allows this primary care-dominated model to essentially "bar" the participation of specialists, even when specialty physicians express an interest in joining the model.

Some ACOs have told specialists that the items and services related to the care they deliver is "expensive" and would be difficult to control, potentially having a negative impact on cost and resource use. In addition, the quality measures ACOs are held to are primary-care focused, leaving specialists with little opportunity to improve care and quality scores. Specialists that are participants report their engagement as limited, if at all. In fact, the vast majority of specialists have been unaware of their ACO participation status until they received notification through CMS' Quality Payment Program (QPP).

Specialty physicians are an essential and needed component of the health care system, and especially in the Medicare program. Specialists use their deep knowledge and expertise to reach a precise medical diagnosis, present the full array of available interventions, collaborate closely with their patients to determine which option is most appropriate based on their preferences and values, and coordinate and

[1] http://www.medpac.gov/docs/default-source/reports/jun18_ch8_medpacreport_sec.pdf?sfvrsn=0

manage their specialty and related care until treatment is controlled and/or complete. As such, ***it is essential that CMS establish pathways for specialists to meaningfully engage in the ACO program***, especially as the program grows and as beneficiaries can opt-in to this model of care. In addition, ***we urge CMS to provide ACOs with technical assistance that would allow them to appropriately analyze clinicial and administrative data, improving their understanding of the role specialists could play in addressing complex health conditions, such as preventing acute exacerbations of comorbid conditions associated with chornic disease.*** Further, ***we urge CMS to establish requirements that prohibit ACOs from restricting specialist participation.*** Finally, as the agency continues to implement the QPP, ***we ask that CMS publicly release data on the participation rates of specialists in ACOs (by percentage and specialty type).***

Access to Specialists

CMS monitors access to specialty care providers through its requirement that ACOs report data collected from beneficiaries via the "Access to Specialists" module of the CG-CAHPS Survey; however, we are concerned that this measure will not be enough to demonstrate whether beneficiaries are being referred to specialists at the most clinically appropriate point in their care. In fact, data collected through the survey could be unreliable as beneficiaries may be unaware that specialty medical care is necessary in order to properly manage a diagnosed health condition.

Early intervention and referral to specialists, when appropriate, drastically reduces the progression of certain chronic illnesses, such as rheumatoid arthritis or certain types of spine conditions resulting in neurological symptoms. To ensure beneficiaries receive important specialty care at the most clinically appropriate time, ***we urge CMS to closely examine the referral patterns of ACOs and establish benchmarks that will foster an appropriate level of access to and care coordination with specialists, in addition to collecting feeback from beneficiaries on access to specialty care.***

Emphasis on Clinical Data Registries

As part of its "Meaningful Measures" initiative and in the spirit of reducing regulatory burden, CMS recently proposed to limit the number of quality measures reported by ACOs. We recognize the importance of addressing administrative burden, however, by relying on only a handful of broad-based primary care-focused measures, specialists are unable to demonstrate the value they bring to care epsiodes and end up being held accountable for aspects of care outside of their control and clinical focus. Thus, it is imperative that measures reflective of specialty care are included in the ACO program, which would incentivize ACOs to meaningfully engage specialists in their networks. To balance these priorities, ***CMS should develop a measure (to be reported by ACOs) that would capture the percentage of physicians reporting to specialty-focused clinical data registries.*** Such a measure would emphasize reporting to registries, as well as help ACOs assess the quality of specialty medical care provided by specialists in its network.

Specialty Designation for Non-Physician Practitioners

Specialty physician practices frequently retain non-physician practitioners, such as nurse practitioners (NPs) and physician assistants (PAs), to enhance and improve care delivery and care coordination activities. However, these mid-level providers are generally viewed as "primary care providers" by the Medicare program and considered in the claims-based assignment methodology. As a result, an entire group of specialists not otherwise considered in the assignment methodology could be forced into exclusivity with a single ACO if one of its mid-level providers under the same Tax Identification Number (TIN) is considered in the claims-based assignment methodology. To address this challenge, ***CMS should adopt specialty designations for non-physician practitioners. That is, when NPs and PAs enroll in***

Medicare, they should self-designate a primary specialty in which they practice. Specialty designation for non-physician practitioners would also ensure appropriate attribution of care, as well as more objective quality and cost evaulations and comparisons across provider types.

Provisions of the Proposed Rule

Structual Changes to the ACO Program

CMS proposes to significantly restructure participation options for ACOs, to include discontinuing Track 1 (one-sided shared savings-only model) and offering a new BASIC track to facilitate the transition to incrementally higher performance-based risk. As we understand, specialists that have been able to engage in ACOs are participating in Track 1 ACOs. Therefore, CMS' elimination of this track will further hinder specialists from moving into alternative delivery and payment models.

While many specialists will continue to participate in the Merit-based Incentive Payment System (MIPS) track of the QPP, it is essential that pathways for specialist participation in the ACO program increase. Therefore, ***we urge CMS to maintain the current one-sided shared savings-only model (i.e., Track 1), particularly as ACOs increase their engagement of specialists in the model.***

Revisions to Policies on Voluntary Alignment

The Bipartisan Budget Act of 2018 requires the Secretary to *permit* a Medicare FFS beneficiary to *voluntarily* identify an ACO professional as their primary care provider for purposes of assignment to an ACO. To meet the statute, CMS proposes to modify its current voluntary alignment policies to provide that it will assign a beneficiary to an ACO based upon his/her selection of any ACO professional, *regardless of specialty*, as their primary clinician. Specifically, a beneficiary may select a practitioner with *any specialty designation*, for example, a specialty of surgery, as their primary care provider and be eligible for assignment to the ACO in which the practitioner is an ACO professional. To accomplish this, CMS proposes to revise §425.402(e)(2)(iii) to remove the requirement that the ACO professional designated by the beneficiary be a primary care physician as defined at §425.20, a physician with a specialty designation included at § 425.402(c), or a nurse practitioner, physician assistant, or clinical nurse specialist.

By removing this requirement, we are concerned that physicians with a specialty designation <u>*not*</u> listed at § 425.402(c) would be subject to CMS' "exclusivity" requirements, and therefore, limit their participation to a single ACO. For the vast majority of specialists and subspecialits, particularly in areas where multiple ACOs have formed, the ability to participate in multiple ACOs is essential. ***We oppose any policy that would limit specialty physicians (i.e., those with primary specialty designations <u>not</u> included in § 425.402(c)) from participating in multiple ACOs.***

Beneficiary Opt-in Based Assignment Methodology

CMS solicits comment on whether it should offer ACOs an opportunity to voluntarily choose an alternative beneficiary assignment methodology under which an ACO could elect to have beneficiaries assigned to the ACO based on a beneficiary opt-in methodology supplemented by voluntary alignment and a modified claims-based assignment methodology.

Similar to the above, we are concerned about the impact of an "opt-in" based or modified claims-based assignment methodology to the extent it would hinder specialists and subspecialists from participating in more than one ACO. ***We would oppose any proposal that would force specialty physicians (i.e., those***

with primary specialty designations not included in § 425.402(c)) into exclusive arrangements with a single ACO.

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We appreciate the opportunity to share our concerns. 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 of Cataract and Refractive Surgery
American Society for Dermatologic Surgery Association
American Society of Plastic Surgeons
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons