



Sound Policy. Quality Care.

---

September 10, 2018

Ms. Seema Verma, MPH  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1694-P  
P.O. Box 8011  
Baltimore, MD 21244-1850  
Submitted online via regulations.gov

**Re: CMS-1693-P – Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program**

Dear Administrator 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 outlined in the 2019 Medicare Physician Fee Schedule (MPFS) and Year 3 Quality Payment Program (QPP) proposed rule.

#### [Medicare Physician Fee Schedule](#)

##### *Evaluation and Management (E/M) Proposals*

We are deeply concerned with CMS' E/M proposals, which are detrimental to the stability and relativity of the entire Medicare physician fee schedule and the specialty medicine physicians reimbursed under this payment system. Despite the worthwhile and laudable goal of reducing E/M documentation requirements on clinicians, a single, blended payment rate for E/M services (Level 2-5) particularly undercuts and devalues specialists and subspecialists providing thorough examinations, rendering accurate diagnoses, offering a complete range of treatment options, and delivering comprehensive and effective management of complex health conditions. This is especially true for those specialists and subspecialists that provide a high volume of Level 4-5 E/M services. The lower payment rates will result in fewer resources to support providing the high quality care these practices already struggle to provide under the

current E/M payment construct. And, while CMS proposes add-on codes to boost the new blended rate for certain specialties, these additional funds would not bring the new blended rate to a sustainable level for any of these specialties to continue delivering high quality specialty care and treatment. More importantly, the add-on codes are inappropriately funded by a multiple procedure payment reduction (MPPR) that would arbitrarily reduce payment for key services provided in conjunction with an E/M service. The additional services provided already take into account efficiencies that are expected when performed in conjunction with E/M services.

We also note the impact of the E/M proposal on indirect practice expense indices (IPICs), which is significant and detrimental on several Alliance specialties. In fact, CMS refined direct practice expense inputs in an attempt to more accurately value medical overhead employed during medical services. However, as a direct consequence of the E/M proposals, several specialties' indirect practice expense will now be dramatically and inappropriately decreased. Moreover, given the E/M proposal is not resource-based, it threatens the relativity of the entire PFS.

We note that most electronic health record (EHR) vendors will not be able to update their systems in time to address this proposal, and the likely upgrades will come at a heavy cost to physicians that have purchased certified EHR technology. We also note that private payers are unlikely to be able to implement this policy in a similar timeframe or fashion, meaning physician practices will be faced with a significant administrative burden in managing two separate E/M documentation systems.

As a result, the Alliance opposes CMS' E/M proposals and asks the agency not to finalize these proposals as currently drafted. We urge CMS to work with the medical community through the AMA CPT/RUC process over the next year on a solution that achieves reduced administrative burden for both physicians and the agency, which could be first implemented in FY 2020.

#### *"Communication Technology-Based Services"*

Generally, the Alliance appreciates CMS' efforts to provide reimbursement for "virtual care" using communication technology-based services. While we urge CMS to finalize these proposals to pay for "virtual check-ins," remote evaluation of pre-recorded patient information, and interprofessional internet consultations, we strongly urge CMS to review the individual comments of Alliance member organizations given nuanced issues that surround some of these emerging services that are unique to each specialty. For example, retina specialists are concerned that a patient-transmitted image would be inadequate to diagnosis diabetic retinopathy and other ophthalmic pathology. In addition, we encourage CMS to work with physicians to outline appropriate parameters to ensure patient care is not stunted and that patients continue to receive the right care in the right location in order for clinicians to make the most accurate diagnosis. Further, CMS should proceed with caution given potential redistributive effects that may occur if this proposal is finalized.

### *Part B Drugs*

The Alliance opposes CMS' proposed cut to WAC-based drug payment. This proposal is a simple cut to reimbursement for physicians, who have no control over the setting of drug prices, and will do nothing to bring down the underlying prices of these products. We urge CMS not to finalize this policy. We are eager to work with the Administration to pursue meaningful reforms to drug pricing.

### *Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging*

We continue to believe the AUC reporting program, which was authorized prior to the passage of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, is inherent within the QPP, which holds clinicians accountable for the quality and cost of patient care. As the agency looks to reduce regulatory and administrative burden on clinicians, and until a long-term solution can be identified, we urge the agency to deem clinicians participating in either MIPS or an Advanced APM as fully satisfying the AUC program requirements.

## Quality Payment Program

### *General Comments*

We are pleased that CMS is considering, for future years, to further reduce reporting burden by linking or otherwise bundling performance categories (e.g., creating sets of multi-category measures that would cut across difference performance categories; allowing clinicians to report once for credit in all three categories) and/or creating public health priority measure sets. In this vein, we would encourage CMS to emphasize the use of clinical data registries, allowing clinicians to fully satisfy Merit-based Incentive Payment System (MIPS) requirements when they participate in a robust clinical data registry.

### *Low-Volume Threshold and "Opt-In" Policy*

The Alliance supports CMS' proposal to add a third criterion (i.e. the provision of 200 or fewer covered professional services to Medicare Part B-enrolled individuals) for the determination of low-volume status. We also support CMS' proposal to allow eligible clinicians and groups the option to "opt-in" to MIPS and receive either a positive, neutral, or negative payment adjustment based on their performance. We urge CMS to finalize these proposals.

### *Quality Performance Category*

We continue to oppose the elimination of "topped out" measures. As we have stated in prior comments, quality measures that CMS deems topped out may not accurately reflect a state where clinicians have adopted practices aimed to be achieved by so-called topped out measures. Until a substantial number of clinicians are participating in the MIPS program or until the measure steward has determined that appropriate quality of care thresholds have been met, CMS should not remove topped out measures.

In addition, we are disappointed that CMS is maintaining yearlong reporting despite the promise of reduced administrative burden and our long-standing request for 90-day reporting, consistent with the reporting timeframes for the PI and IA performance categories. Physicians

should spend more time delivering quality care, rather than focusing on reporting measures of quality. We urge CMS to adopt 90-day reporting for the Quality performance category.

#### *Promoting Interoperability (PI) Performance Category*

The Alliance supports CMS' efforts to align the PI program across provider types, simplify PI performance category scoring, and substantially reduce the PI performance category reporting burden. These modifications are a welcome relief for physicians, particularly specialists that face unique challenges with the PI performance category over their colleagues in primary care. Unfortunately, however, the agency has yet to address the "all-or-nothing" construct of the PI performance category scoring. We have urged CMS to allow clinicians to "pick and choose" measures from a "menu" of objectives and measures, rather than require certain objectives and measures to be met. While we urge CMS to finalize its proposed policies, we request further revision to eliminate the all-or-nothing scoring approach to this performance category.

In addition, we have concerns about CMS' intent to remove the Public Health and Clinical Data Exchange objective and measures no later than 2022. While we believe many clinicians will continue to share data with public health entities and report data to clinical data registries, it remains a significant policy lever for those who have yet to engage in this aspect of promoting the exchange of important health information. We note that the Medicare Access and CHIP Reauthorization Act (MACRA) emphasized the use of Qualified Clinical Data Registries, thus we see no rationale for CMS to propose its removal in a future year from this category of MIPS. In fact, as noted above, we encourage CMS to count participation in a robust QCDR as a means for fully satisfying MIPS.

#### *Scoring Methodology*

Despite the significant improvement to the PI performance category scoring, the overall MIPS scoring methodology remains complex and cumbersome for clinicians to understand. Indeed, the scoring section of the proposed rule was just over 100 pages long, evidence that the policies are needlessly complicated. We urge CMS to simplify scoring so that clinicians can better understand their performance and needed achievement/improvement to be successful year over year.

#### *Submission Types*

We oppose CMS' proposal that reporting via Medicare Part B claims would only be available to MIPS eligible clinicians in small practices beginning in 2019. We understand that CMS believes that approximately 69 percent of the Medicare Part B claims measures are topped out; however, as noted above, we disagree with this contention. Further, we still believe the claims-based option is necessary for those who are unable to use or afford other reporting options.

#### *Qualified Clinical Data Registries (QCDR)*

The Alliance opposes CMS' proposal to require QCDRs to enter into a license agreement that would permit all other QCDRs to use specialty-society developed measures. Specialty societies that have developed "home-grown" quality measures expend tremendous resources to engage

in this activity. We disagree that CMS has the authority to demand our copyrighted material is now “open” for use by other public and private organizations without any agreement or contract with the QCDR measure stewards. We urge CMS to withdraw this proposed policy.

#### *Advanced Alternative Payment Models (AAPMs)*

A handful of specialty-focused AAPMs are available for a narrow range of specialists, but most AAPMs are geared toward primary care providers (e.g., Accountable Care Organizations, Comprehensive Primary Care Plus). This is evidenced by the quality measures reported by these entities, which focus on preventive care and population health, and the number of specialty physicians that are *meaningfully* engaged. Specialists are working to improve their ability to participate in ACOs, learning how they might fit in and where they can deliver value to the assigned beneficiary population, but this has proven challenging. We urge CMS to establish more AAPMs for specialists and to create additional pathways for specialists to engage in existing ACOs.

#### *Specialty Impact Tables*

We are disappointed that CMS has eliminated specialty impact tables from the QPP section of the proposed rule. Alliance member organizations appreciate CMS’ data on the number and type of specialists that are participating in MIPS and in Advanced APMs. We urge CMS to provide the same data it provides in the inaugural QPP proposal and final regulations, in addition to other data to show how participation has changed year-over-year since the inception of the program.

\*\*\*\*\*

We appreciate the opportunity to share our feedback on the 2019 MPFS and Year 3 QPP proposed rule. Should you have any questions, please contact us at [info@specialtydocs.org](mailto: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 Society of Retina Specialists  
American Urological Association  
Coalition of State Rheumatology Organizations  
Congress of Neurological Surgeons  
North American Spine Society  
Society for Cardiovascular Angiography and Interventions

