



Sound Policy. Quality Care.

September 11, 2023

Ms. Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1784-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via www.regulations.gov

RE: Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program

Dear Administrator Brooks-LaSure,

The Alliance of Specialty Medicine (the “Alliance”) represents more than 100,000 specialty physicians across 16 specialty and subspecialty societies. The Alliance is deeply committed to improving access to specialty medical care by advancing sound health policy. On behalf of the undersigned members, we write in response to proposals outlined in the CY 2024 Medicare physician fee schedule (PFS).

CY 2024 Conversion Factor Update

In this CY 2024 PFS rulemaking, CMS proposes another sharp reduction in Medicare payments to physicians, estimated at -3.4% (or a \$1.14 cut to the conversion factor), due to the implementation of statutory requirements and regulatory changes discussed in the rule. In contrast, most other Medicare providers anticipate sizeable increases in their 2024 payments (e.g., inpatient hospitals (3.1%); inpatient rehabilitation facilities (3.4%); hospices (3.1%); hospital outpatient departments (2.8%); and Medicare Advantage plans (3.32%)).

The price of skilled labor, medical equipment and supplies, and rent have increased considerably over the past several years, particularly during the COVID-19 public health emergency (PHE). These increases impact physician practices — particularly those that are small, rural, and treating underserved beneficiaries — just as much as they impact other Medicare providers. Yet, our updates do not consider growing rates of inflation.

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Congress of Neurological Surgeons • National Association of Spine Specialists • Society of Interventional Radiology

In its March 2023 *Report to the Congress*, the Medicare Payment Advisory Commission (MedPAC) highlights that:

Clinicians' input costs—as measured by the Medicare Economic Index (MEI)—grew by 2.6 percent in 2021 and are estimated to have grown 4.7 percent in 2022, substantially higher than the recent historical norm of 1 percent to 2 percent per year. Growth in clinicians' input costs is projected to remain high in 2023 (3.9 percent) and 2024 (2.9 percent), though these projections are subject to change.¹

The Commission also stated that “Given the recent growth in inflation, cost increases could be difficult for clinicians to absorb” and “recommends that Congress update the 2023 Medicare base payment rate for physician and other health professional services by 50 percent of the projected increase in the MEI.” According to CMS’ Market Basket data, the MEI forecasts are at all-time highs — the Q3 CY 2023 forecast currently sits at 4.3%, and the Q1 CY 2024 forecast is 3.6.²

The increasing downward financial pressure on physicians is forcing many to sell their practices to consolidate with hospitals and health systems or sell to private equity groups. Consolidation remains a growing concern of policymakers and their advisors. In fact, in its March 2020 *Report to the Congress*, MedPAC stated:

Physician–hospital integration, specifically hospital acquisition of physician practices, has caused an increase in Medicare spending and beneficiary cost sharing due to the introduction of hospital facility fees for physician office services that are provided in hospital outpatient departments. Taxpayer and beneficiary costs can double when certain services are provided in a physician office that is deemed part of a hospital outpatient department.³

MedPAC further notes that “[G]overnment policies have played a role in encouraging hospital acquisition of physician practices” and highlights how “[t]he potential for facility fees from Medicare and higher commercial prices encourages hospitals to acquire physician practices and have physicians become hospital employees.”³

While CMS cannot update physician payments using an inflation proxy, such as the MEI, it can be more cautious when proposing and finalizing policies that adversely impact the conversion factor. This includes policies that prompt significant, negative budget-neutrality adjustments that CMS suggests it cannot mitigate under its existing authority. For example, in this proposed rule, CMS:

- Intends to implement a new Healthcare Common Procedure Coding System (HCPCS) add-on code, G2211, that would provide payment for certain care provided to patients with complex health needs;
- Proposes new codes and payment for a series of new services that aim to address health-related social needs; and
- Continues to phase in clinical labor pricing updates, which continues to cut key Medicare services provided by specialists, such as drug administration services, among other things.

¹ https://www.medpac.gov/wp-content/uploads/2023/03/Ch4_Mar23_MedPAC_Report_To_Congress_SEC.pdf

² <https://www.cms.gov/files/zip/market-basket-history-and-forecasts.zip>

³ https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar20_medpac_ch15_sec.pdf

These policies — particularly the implementation of a new add-on code that is responsible for most of the budget-neutral adjustment — further impair physicians’ ability to receive fair and reasonable payment updates under the current payment system. ***We urge CMS to take steps to mitigate the budget-neutral payment adjustment proposed for CY 2024 and work with Congress on a long-term solution to the remaining challenges facing the PFS, including the lack of a meaningful payment update based on their costs.***

Practice Expense Data Collection

Now that the American Medical Association (AMA) effort to collect cost data from physician practices is underway, CMS has agreed to pause using other cost data sources in the physician payment system until those are complete. The Alliance agrees with this approach, as using the most current and appropriate data set, particularly for the MEI, is critical.

We also reiterate our prior comment that ***CMS should work toward a more consistent and regular approach to updating all direct and indirect practice expenses.*** CMS is in its third year of a 4-year phase-in of clinical labor price updates, a policy that has created significant reimbursement challenges for many specialties due to the budget-neutral nature of the PFS. In fact, some Alliance specialties could be cut by as much as 22.04% for critical services they deliver due to this policy. These reductions were exacerbated by the fact that CMS had not updated these inputs in 20 years. As a result, many physicians are being paid *less* for services that cost them *more* to deliver.

Evaluation and Management Services

Regular and Comprehensive Reviews

The Alliance reminds CMS that most of its member organizations invest considerable time and resources to participate in the AMA/Specialty Society RVS Update Committee (RUC) and develop work and practice expense relative values for the services they deliver, a process that is generally recognized as open and transparent, and where CMS staff have an active role. We have concerns about CMS establishing a separate process that would focus exclusively on establishing E/M service values, particularly when the existing process has led to recommended improvements for these services. A second process would be duplicative, potentially creating more administrative and policy challenges for CMS.

Other Concerns

In addition, we continue to be concerned about CMS’ increasing use of alternative approaches to derive different — and usually lower — relative values for physician services. This is true across many services, including the global surgery services, where some Alliance members have expressed concern that CMS has failed to apply updated values for office and outpatient E/M and hospital and discharge day management services to the post-surgery visits included in the global surgery packages.

CMS is already engaged in the AMA RUC process, and we ask that staff who attend be forthright about concerns with physician service values as they are being evaluated during the RUC meetings rather than using separate processes established by the agency.

Telehealth

Generally, the Alliance appreciates CMS’ implementation of provisions outlined in the *Consolidated Appropriations Act, 2023*. ***CMS should continue working with Congressional lawmakers to extend further and make permanent many of the flexibilities provided during the COVID-19 PHE, including removing originating site requirements and geographic restrictions.***

The Alliance continues to support the availability of audio-only telehealth services, which enable patients who are unable or unwilling to utilize audio-visual telecommunications technology to continue to receive essential specialty medical care, as clinically appropriate, regardless of whether such patients have the financial resources, local broadband infrastructure, or technological wherewithal to utilize more traditional telehealth modalities. We appreciate that CMS has deemed the telephone E/M services (CPT codes 99441-99443) “telehealth services” and will remain actively priced through CY 2024. ***We urge CMS to make audio-only healthcare a permanent feature of the PFS in CY 2025 and beyond.***

The Alliance also appreciates CMS’ proposal to streamline the process used to add services to the Medicare Telehealth Services List, which will prevent confusion, and ***urges the agency to finalize this process.***

Merit-Based Incentive Payment System (MIPS)

MIPS Performance Threshold

Section 1848(q)(6)(D)(i) of the Social Security Act requires that CMS compute the performance threshold such that it is the mean or median of the final scores for all MIPS eligible clinicians with respect to a “prior period” specified by the Secretary. It also provides that the Secretary may reassess the selection of the mean or median every three years. In the CY 2022 PFS final rule, CMS established that for the CY 2022 performance period/2024 MIPS payment year through the CY 2024 performance period/2026 MIPS payment year, the performance threshold would be the mean of the final scores for all MIPS eligible clinicians from a prior period. For CY 2022 through CY 2023 performance periods/2024 through 2025 MIPS payment years, CMS selected a single performance period as the prior period to compute the mean of the final scores and establish the performance threshold. However, in this rule, CMS changes course and proposes to revise its policy for identifying the “prior period” on which to base the threshold beginning with the CY 2024 performance period/2026 MIPS payment year so that it is three performance periods (i.e., the mean of the final scores for the CY 2017 through CY 2019 MIPS performance periods). As a result, CMS proposes increasing the MIPS performance threshold from 75 points to 82 points for the CY 2024 performance period/CY 2026 payment year.

The Alliance strongly opposes CMS’ proposal to increase the MIPS performance threshold next year and believes this is an inappropriate time to adopt a new methodology for calculating the threshold. While we appreciate the use of a three-year average to account for year-to-year fluctuations in the performance threshold specific to a shorter time frame and to mitigate the potential impact of outliers, we also believe that CMS must treat the CY 2024 performance year as a transition year to account for extenuating circumstances.

MIPS-eligible clinicians will face multiple, unique issues going into the CY 2024 performance period. For example, physicians continue to be paid under a deeply flawed Medicare PFS that fails to keep up with inflation and results in significant cuts in payments to physicians each year. Considering inflation, Medicare physician payment rates fell 26% from 2001 to 2023, while practice costs rose by 47% over the same period.⁴ Physicians also face multiple payment sequesters that further reduce their Medicare reimbursements. The Medicare Access and CHIP Reauthorization Act (MACRA) established flat base payment updates for physicians, assuming physicians could fill that gap with value-based incentive payments under MIPS. However, CMS estimates that if it finalizes an 82-point threshold for the 2024

⁴ <https://www.ama-assn.org/about/leadership/congress-must-act-now-medicare-physician-payment-reform#:~:text=Adjusted%20for%20inflation%2C%20Medicare%20physician,analysis%20of%20Medicare%20Trustees%20data>

performance year, 54% of clinicians could receive a MIPS penalty in 2026, with the average penalty being 2.4%. Subjecting physicians to these additional cuts is simply unconscionable when their payments have already declined in inflation-adjusted terms, and payment rates to all other Medicare providers continue to increase. Raising the MIPS performance threshold will make it harder for physicians to care for Medicare patients while doing nothing to improve quality, which is the presumed goal of the Quality Payment Program.

Additionally, although the PHE has officially ended, volume and care patterns are still disrupted due to ongoing staffing shortages and other residual effects of the pandemic. CMS' proposal fails to account for this reality, which continues to cause disruptions in clinical care and makes it challenging to invest further in administrative activities, including regulatory compliance.

We also urge CMS to consider the fact that next year will presumably be the first year since 2019 that CMS will not offer a COVID-19 hardship exception. Clinicians exempted under this provision over the last few years will re-enter a program in 2024 that is starkly different from when they last participated in terms of reporting and scoring rules, measure inventories, and, most notably, the performance threshold (which was at 30 points in 2019 and 15 points in 2018). These practices, which have struggled the most with the cost and burden of MIPS compliance, will be hardest hit if CMS finalizes its proposal to increase the performance threshold. CMS should instead aim to adopt policies supporting their transition into the program.

Finally, we refer CMS to its discussion in the third-party intermediary section of this rule, which proposes eliminating the "health IT vendor" category due to experiences with these vendors submitting inaccurate and unusable data. CMS notes that this is largely due to the absence of data validation requirements that have been applied to health IT vendors. This proposal clearly indicates that at least a portion of the data that CMS has used to calculate MIPS performance thresholds to date is flawed and not a reliable representation of real-world performance. This is yet another reason why we believe increasing the performance threshold at this time is inappropriate.

Overall, the Alliance requests that CMS select the lowest MIPS performance threshold value possible under statute and work with Congress to find a better solution that provides the agency with more flexibility to set the threshold at the most appropriate level in light of current circumstances. We also request that CMS release specialty-specific data regarding mean and median MIPS performance. This will help CMS determine if there are significant differences across specialties that may warrant a more thorough evaluation and guide consideration of performance thresholds adjusted for specialty or other clinician characteristics.

MIPS Value Pathways (MVPs)

As we stated last year, MVPs should remain a voluntary pathway for clinicians, alongside traditional MIPS, providing clinicians with a choice that best reflects their patient populations and practice needs. Many of our member organizations currently do not have an MVP that applies to their specialty. Given ongoing gaps in the underlying MIPS measure inventory, they will likely not have one in the near future. Rather than focus on this single new pathway, we urge CMS to continue working with stakeholders and Congress to fundamentally reform the program.

The Alliance appreciates CMS' desire to streamline MIPS reporting, reduce clinician burden, focus on metrics that are valuable to clinicians and patients, and provide clinicians with a glide path to alternative payment model (APM) participation. ***However, we remain very concerned that the MVP framework is not enough of a departure from traditional MIPS and that it fails to resolve foundational issues with***

the program that some Alliance member specialties believe has limited clinician engagement and hampered meaningful progress towards higher quality care. MVPs preserve the siloed nature of the four MIPS performance categories and fail to provide cross-category credit or recognize more comprehensive investments in quality improvement. MVPs also continue to rely on problematic MIPS participation options, scoring rules, and qualified clinical data registry (QCDR) policies that often disincentivize developing and using more clinically-focused measures and participation pathways that better align with clinical practice. Furthermore, MVPs that cut across an entire specialty are useless for highly subspecialized fields like ophthalmology. When developing MVPs, CMS must also accommodate those focused on subspecialties and the care they provide.

As CMS implements the MVP framework, particularly as it considers adopting a sub-group reporting mechanism, it is critical to incentivize the ongoing development and use of a diverse inventory of specialty- and sub-specialty-specific measures that are truly meaningful to both physicians and their patients. Current program policies encourage large multispecialty groups and institutions to report on broad measures that are not relevant or meaningful to all specialists in those groups or the patients they treat. At the same time, specialty societies that have invested in developing better measures, including through QCDRs, have faced increasingly challenging regulatory requirements that have made it difficult to justify the investment, and their members have faced evolving MIPS scoring rules that disincentivize the reporting of such measures. As a result, many specialists lack MIPS results that can lead to data-driven improvements in quality. At the same time, their patients are denied the granularity of data needed to make informed health care decisions. While some specialties, such as retina specialists, have the resources to develop and submit new measures, most specialties do not and find it labor and resource-intensive to invest in when compared to other competing priorities.

While we believe that subgroup reporting has the potential to produce more clinically relevant, actionable and valuable data, it can only do so if paired with policies that simultaneously incentivize the development and use of more meaningful measures and more focused reporting mechanisms. Otherwise, subgroup reporting will only add another layer of complexity and administrative burden to an already unworkable program.

Quality Category

Data Completeness Threshold

CMS proposes to maintain the data completeness criteria threshold to at least 75% through the CY 2026 performance period/2028 MIPS payment year and to increase it to at least 80% for the CY 2027 performance period/2029 MIPS payment year.

Similar to last year, when CMS proposed to increase the data completeness criteria from 70% to 75%, we continue to oppose any increases in the data completeness threshold until reporting is more seamlessly integrated across providers and settings. Specialists often do not have direct control over EHR systems, particularly when a single Taxpayer Identification Number includes multiple geographic locations and practice settings (e.g., various hospitals), and revisions to accommodate new measure requirements may take time to design and implement. Additionally, sub-regulatory guidance is usually unavailable until late in the performance year, which could result in a change in reporting strategy that makes it challenging to satisfy data completeness requirements. We also remind CMS that no other federal quality programs at the hospital or health plan level rely on sample sizes as high as MIPS. Finally, as discussed above, we do not believe that the CY 2024 performance year is an appropriate time to make additional changes to reporting and scoring rules, given the ongoing strains on practices as a result of the pandemic and the number of practices that will be transitioning back into the program after numerous years of non-participation.

As we have requested in the past, the Alliance also urges CMS to consider setting different data completeness thresholds depending on the type of measure. For example, clinicians may find it challenging to satisfy a 50% data completeness threshold for patient-reported outcome measures. Setting a lower threshold for these types of measures could incentivize the development and use of such measures.

Cost Category

RFI: Publicly Reporting Cost Measures

For several years, CMS provided cost measure scores to clinicians for informational purposes only and did not publicly report clinicians' performance in this category. However, given the number of cost measures CMS has adopted in MIPS for at least two years and with the PHE ending, it is seeking feedback from the public on ways to publicly report performance on cost measures, beginning with data from the 2024 performance period being publicly reported in 2026. Although Alliance member societies have been involved in the development of many of the MIPS cost measures, we continue to believe they are flawed in terms of their strict reliance on claims data; their failure to simultaneously account for changes in quality that result from cost savings or spending; and their complex nature, which results in performance data that even physicians find challenging to interpret. ***As such, the Alliance opposes the public reporting of cost performance data. We do not believe that data on these measures will be of value to patients at this time and, if anything, may lead to further confusion.***

Targeted Reviews

CMS proposes to amend the timeline by which MIPS-eligible clinicians, groups, virtual groups, subgroups, and APM entities may request a targeted review of their MIPS payment adjustment factor(s) calculation. Specifically, CMS proposes to permit the submission of a request for targeted review beginning the day it makes the MIPS final score available and ending 30 days after publication of the MIPS payment adjustment factors for the MIPS payment year. This proposal would modify the current time period to submit a request for targeted review, which is 60 days beginning the day CMS makes the MIPS payment adjustment factors available for the MIPS payment year. CMS clarifies that its proposal would allow for a total of approximately 60 days for the targeted review submission period (about 30 days before publication of the MIPS payment adjustments factors and 30 days thereafter). CMS also explains that the current timeline presents challenges related to CMS' requirement to apply a differentially higher PFS conversion factor to Qualifying APM Participants (QPs) beginning with the CY 2024 QP Performance period/2026 payment year. CMS must submit the final list of QPs to its Medicare Administrative Contractors no later than October 1st of the preceding year to ensure the application of the alternative conversion factor to QPs. However, under its current targeted review timeline, which takes place in August and ends sometime in November, this information would not be available until the first week of December.

The Alliance is concerned about unintended consequences that could be associated with moving up this timeline. ***If CMS does decide to alter this timeline, clinicians must have access to a complete set of performance and payment adjustment information, including any facility-based scores, at the opening of the targeted review period so that they can make a well-informed determination about whether a targeted review submission is necessary.*** We also request that CMS clarify what other changes it intends to make to the timeline. CMS refers to "permit[ting] submission of a request for targeted review beginning on the day it makes available the MIPS final score" and estimates this will give clinicians about 30 days to submit a request prior to the publication of the MIPS payment adjustment factor. However, this year, CMS released final performance feedback and payment adjustments at the same time in mid-August. If this proposal is finalized, does CMS plan to release final scores prior to releasing payment

adjustment factors? Or is CMS referring to the current earlier MIPS final score preview period, which occurs in mid-June? We would appreciate it if CMS could clarify these timelines.

CMS also proposes to shorten the timeline for clinicians to respond to a CMS request for additional information under the targeted review process to 15 days compared to the current 30 days. ***While we understand that CMS needs to prepare to apply a differentially higher PFS conversion factor to QPs, the proposed shortened timeline is inadequate for such a consequential process. We urge CMS to preserve the 30-day requirement instead.*** Targeted reviews are a critical tool for clinicians. Gathering the information to defend a review request is a time-consuming and resource-intensive process that often relies on records and other data held by other stakeholders, such as third-party intermediaries. Clinicians have little direct control over the pace at which these stakeholders make such data available. They should not face an erroneous score and payment adjustment simply because of an accelerated timeline that deprives them of the opportunity to defend their case.

Public Reporting on Compare Tools

Publicly Reporting Utilization Data on Profile Pages

Section 104(a) of MACRA provides that, beginning with 2015, the Secretary shall make publicly available on an annual basis, in an easily understandable format, information with respect to physicians and, as appropriate, other eligible professionals on items and services furnished to Medicare beneficiaries. CMS previously finalized a policy to report the most recently available utilization data in downloadable format beginning in late 2017. This information continues to be available today in the Medicare Provider Data Catalog (PDC) and is a subset of the most commonly performed procedures in the Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use File (PUF).

CMS later established a policy for publicly reporting procedure information on Care Compare clinician profile pages, beginning no earlier than CY 2023. The agency finalized that these data would be based on a 12-month lookback period and would not initially prioritize complex, rare procedures. CMS also noted at that time that the utilization data shown on profile pages would only reflect Medicare Fee-for-Service (FFS) claims data and not include procedures performed for patients with other types of insurance. According to CMS, although consumer testing since that time has shown that publicly reported utilization data on patient-facing clinician profile pages using plain language is helpful for patients and caregivers, consumers would like the procedure volume also to reflect patients with other insurance, if possible.

To meaningfully categorize procedures, CMS also previously finalized using the Restructured Berenson-Eggers Type of Service (BETOS) Codes Classification System to collapse HCPCS data into procedural categories, and when no Restructured BETOS categories are available, procedure code sources used in MIPS, such as the procedure categories already defined for MIPS cost or quality measures. According to CMS, Restructured BETOS is a taxonomy that allows for the grouping of procedure codes into clinically meaningful categories and subcategories, which allows CMS to publicly report procedural utilization data in a meaningful way to patients and caregivers rather than showing thousands of rows of individual HCPCS data, as it does for the research community in the PDC.

In the CY 2024 PFS proposed rule, CMS proposes to publicly report aggregated counts of procedures performed by providers based on MA encounter data in addition to Medicare FFS utilization data to provide a more accurate representation of procedure volumes. CMS also proposes to modify its existing policy to use alternate sources (i.e., in addition to the Restructured BETOS categorization system and code sources used in MIPS) to create clinically meaningful and appropriate procedural categories, particularly when no relevant grouping exists. If CMS develops new procedure categories for publicly

reporting utilization data on clinician profile pages, it proposes to engage subject matter experts (e.g., clinicians) and interested parties through periodic requests for feedback and focus groups to solicit feedback on such procedure categories planned for future releases of utilization data.

As we have stated in the past, the Alliance opposes including utilization data on the Care Compare clinician and group profile pages and opposes any expansion of such efforts. We appreciate the need to provide patients and their caregivers with meaningful information to support medical decision-making. However, utilization is not a clear or consistent indicator of quality, particularly since claims data do not accurately capture the presence or absence of appropriate clinical indications for a service. Additionally, this proposal would fail to provide patients with a complete or accurate assessment of a practice's performance since it is limited to procedure and Medicare claims data, potentially misleading and confusing the public. Sometimes, a clinician improves quality for the patient by minimizing unnecessary tests or services, and avoiding unnecessary services cannot be assessed through claims data.

We have also expressed concerns about collapsing HCPCS codes using the BETOS Codes Classification System. The BETOS system is outdated and includes no standard or systematic way to group procedures by CPT/HCPCS code beyond very broad categories. In fact, some of our members' specialty codes are not even captured by this system. As a result, we are concerned that this effort to collapse and simplify procedure codes will result in inaccuracies and generalizations about specialists that will further mislead patients.

While we oppose public reporting of utilization data in its entirety, if CMS opts to continue to move forward with it, it is critical that the agency also finalize its proposal to use alternate sources to create clinically meaningful and appropriate procedural categories with the input of relevant clinical stakeholders. We also strongly urge the agency to first conduct comprehensive testing with both clinicians and patients to ensure these data are appropriate, useful, and accurately reflective of clinical practice. Clinicians should also be able to review and correct data before it is publicly reported. Finally, we again strongly urge CMS to include an additional disclaimer to remind the public that utilization does not necessarily equate to quality and that many factors besides utilization may contribute to a clinician's overall performance.

Qualifying Participants in Advanced APMs

Under the statute, CMS must increase the thresholds for becoming a QP, which makes a clinician eligible for an incentive payment and exempt from MIPS. In general, the threshold percentages will increase beginning with the 2024 performance year/2026 payment year as follows:

- Medicare payments: QP threshold increasing from 50% to 75%
- Medicare patients: QP threshold increasing from 35% to 50%

Under the statute, eligible clinicians who are QPs for the 2023 performance year will receive a 3.5% APM Incentive Payment in the 2025 payment year (down from 5%). Beginning with the 2024 performance year/2026 payment year, QPs will receive a higher PFS payment rate (calculated using a higher "qualifying APM conversion factor") of 0.75% versus non-QPs who will receive 0.25%. QPs will continue to be excluded from MIPS reporting and payment adjustments for the applicable year.

The Alliance is very concerned about the negative impact these shifting policies will have on specialty eligibility for the QP track and the general movement of specialists toward APMs. To date, there have been very limited opportunities for specialists to participate meaningfully in Advanced

APMs and to qualify as QPs. Most existing models are primary care or population-focused and provide no material role for specialists. Alliance member organizations have a long history of attempting to work with the CMS Innovation Center and the Physician-Focused Payment Model Technical Advisory Committee to establish specialty-specific APMs. Despite these heavy investments of time and financial resources, few specialty-focused models have been tested by CMS to date.

In this rule, CMS proposes multiple policies to ensure that specialists are not excluded from Advanced APM participant lists and, thus, ineligible for QP status. First, CMS proposes making QP determinations at the individual eligible clinician level instead of at the APM Entity level. CMS also proposes to change the definition of “attribution-eligible beneficiary” to include any beneficiary who has received a covered professional service furnished by the eligible clinician for whom CMS is making the QP determination. Under current policy, E/M services are the default basis for attribution for purposes of QP determinations.

The Alliance appreciates that together, these policies would address challenges that specialists have faced in terms of qualifying as a QP. The first proposal addresses a current problem where eligible clinicians who are fully engaged in an Advanced APM may still be unable to earn QP status. The second proposal would address failing to capture an attribution-eligible beneficiary if none of the services provided are E/M services. At the same time, we are concerned that if CMS begins making individual-level QP determinations while increasing the QP thresholds, it could result in the opposite of the intended effect despite mitigating some of the current perverse incentives. QP thresholds will be so high next year that it will be extremely challenging for individual specialists to qualify on their own, or worse yet, it could dissuade specialists from participating in APMs. ***As such, we recommend that going forward, CMS instead apply both individual-level and APM Entity-level QP determinations and use the more favorable determination. We also urge CMS to provide more data and modeling on the impact of simultaneously adopting policies to improve specialty eligibility for QP status and higher QP thresholds since CMS does not include such an analysis in the rule comparing these scenarios. As part of ongoing analyses, it should also monitor the impact of these policies on specific types of practices and patient populations.***

Again, while appreciated, these new policies would go into effect at a time when the QP thresholds are increasing and when the APM incentive payment is no longer available. This means that specialists will not only face greater challenges becoming a QP, but they will have already missed out on the opportunity to earn critical resources needed to invest in APMs. ***The Alliance requests that CMS take more direct steps to effectively engage more specialists in APMs, such as by testing and implementing more specialty-focused APMs developed by physician specialty organizations. We also urge CMS to work with Congress to make technical updates to MACRA that extend the 5% incentive payment for QPs in Advanced APMs to provide physicians with more substantive resources needed to support new and truly innovative methods of delivering care and maintain the current QP threshold levels.*** As discussed earlier, physicians are already facing staggering Medicare payment reductions compared to other Medicare providers. Even if CMS provided opportunities for specialists to participate in more meaningful payment and delivery models, specialists would still need the APM incentive payment to offset the financial risk and additional administrative costs associated with implementing those models.

Finally, it is critical that CMS maintain fee-for-service as an option for physicians who do not believe that APMs are appropriate for their practice or in the best interest of their patients.

Medicare Shared Savings Program

RFI on MVP Reporting for Specialists in Shared Savings Program ACOs

CMS previously adopted a policy that Shared Savings Program ACOs would be assessed on a MIPS APM Performance Pathway (APP) for Shared Savings Program ACOs measure set. Since then, it has heard concerns about the challenges and applicability of the APP measures to specialists who are part of their ACOs. In response, CMS is soliciting comments on scoring incentives that would be applied to an ACO's quality performance score beginning in performance year 2025 when specialists who participate in the ACO report quality MVPs. Under this potential future policy, ACOs could receive up to a maximum of 10 additional points added to their quality performance score if they meet the data completeness requirement and receive a MIPS Quality performance category score, in addition to administering the CAHPS for MIPS survey. In addition to specialists participating in the ACO reporting quality MVPs, an ACO would be required to report all measures in the APP measure set to be eligible for bonus points.

While the Alliance appreciates CMS' attempt to address concerns about the inapplicability of the APP measure set to specialists, we have numerous concerns about how it envisions addressing this issue in the future. As expressed in comments earlier in this letter, we do not believe that MVPs adequately address foundational issues with MIPS that have limited specialty engagement in MIPS. MVPs, for example, are limited to the traditional MIPS measure inventory and do nothing to integrate the four performance categories of MIPS. While some specialties might have access to a more specialty-focused participation pathway through MVPs, many still do not and may never have that opportunity based on the current inventory of measures. We are also concerned that since an ACO would still be required to report all APP measures to be eligible for these MVP-related bonus points, this could impose an even greater reporting burden on specialists, whose patients could presumably contribute to both the MVP measures and the APP measures, and potentially subject specialists to double accountability. ***As CMS thinks through more thorough ways to recognize the unique contributions of specialists within the context of ACOs, we urge it to consider policies that provide distinct, alternative participation pathways that do not increase the reporting burden or expose specialists to undue levels of accountability.***

Rather than providing a bonus for specialists to attempt to fit into quality measurement paradigms that do not account for the nuances of their specialized care, we encourage CMS to provide direct financial incentives for specialists to craft alternative and focused quality measurement programs that can inform them and their patients of current performance, to guide improvement.

Appropriate Use Criteria for Advanced Diagnostic Imaging Program

CMS proposes to pause efforts to implement the Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging program and to rescind the current AUC program regulations. This program was established under the Protecting Access to Medicare Act of 2014. CMS has used rulemaking over the ensuing years to set up the program in phases. However, the program has been plagued with operational issues that have resulted in perpetual delays. At this time, CMS has determined that it has exhausted all reasonable options for fully operationalizing the program consistent with the statutory provisions that direct the agency to require real-time claims-based reporting to collect information on AUC consultation and imaging patterns for advanced diagnostic imaging services, which would ultimately inform outlier identification and prior authorization. CMS expects this to be a hard pause to facilitate thorough program reevaluation, and, as such, it is not proposing a time frame within which implementation efforts may recommence. However, CMS states that it will continue to identify a workable implementation approach and proposes to adopt any such approach through subsequent rulemaking.

The Alliance applauds CMS for proposing a hard pause to the AUC program and rescinding the current program regulations. The AUC Program has been fraught with implementation challenges since its enactment and, in the intervening time, has grown outdated — particularly with the subsequent enactment of MACRA and the rise of new health care payment and delivery models that hold clinicians responsible for health care resource use, such as APMs and MIPS. We are pleased that CMS recognizes this and look forward to collaborating with CMS to further the goals of this program in an alternative manner.

We appreciate the opportunity to comment on these important issues and welcome the opportunity to meet with you to discuss them in more detail. Should you have any questions or wish to schedule a meeting, please contact us at info@specialtydocs.org.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
American Association of Neurological Surgeons
American Gastroenterological Association
American Society of Cataract and Refractive Surgery
American Society of Plastic Surgeons
American Society of Retina Specialists
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
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