November 03, 2017

Francis J. Crosson, MD
Medicare Payment Advisory Commission
425 I Street, NW, Suite 701
Washington, D.C. 20001

Re: MedPAC MIPS Policy Proposal

Dear Chairman Crosson,

The Cognitive Specialty Coalition (CSC) represents more than 115,000 physicians with extensive training in specific medical specialties and subspecialties necessary to appropriately diagnose, treat and manage individuals with the most complex, and often the costliest, health conditions. Cognitive specialty physicians provide timely, effective and appropriate evaluation and therapy – services that require a high level of expertise and often lead to the specialist coordinating both specialized and primary care. As a result, patients avoid costly or unnecessary procedures and realize improved outcomes at a lower overall cost.

Examples of cognitive specialists include rheumatologists who manage complex chronic conditions such as rheumatoid arthritis, lupus and other rheumatic diseases; neurologists who manage multiple sclerosis, Alzheimer's disease, Parkinson's disease, and epilepsy; endocrinologists who manage diabetes; infectious diseases specialists who treat the most complex and difficult to treat infections, including HIV/AIDS; neuro-ophthalmologists who manage the most complex visual disorders affecting both the eye and brain; and, psychiatrists who specialize in assessing and treating psychiatric disorders including depression, bipolar disorder, schizophrenia, dementia and substance use disorders.

Recently, the Medicare Payment Advisory Commission (MedPAC) has discussed policy options to eliminate the Merit-based Incentive Payment System (MIPS), replacing it with a new voluntary value program. While we agree that improvements to MIPS are needed, we have concerns about the approach currently under discussion by the Commission. We urge the Commission to consider the shared priorities discussed below while refining the proposed approach before the December public meeting.

This new policy proposal suggests a 2% withhold from all physicians with the option of participating in the voluntary value program to earn it back. We believe that a mandatory 2% withhold is unfair due to the barriers to entering an Alternative Payment Model (APM) that most physicians encounter. We therefore recommend against a mandatory penalty. Additionally, among the many unknown or as-of-yet poorly defined elements of the proposal is a lack of clarity around the method used to calculate the 2% withhold. This requires clarification, as does whether the program would maintain bonuses in the value program.

Furthermore, insofar as the program evaluates physician performance on cost issues based solely on total cost data in Medicare claims; this raises particular concerns for our professions. Such data is disconnected from quality of care, incentivizes physicians to prioritize economics above the needs of their patients, and reverses progress to date in shifting the priority for health care reimbursement from quantity to value. Moreover, cognitive physicians have no

control over the cost of drugs or ancillary services, nor over the severity of other illnesses and co-morbidities that drive the need for such services. Our physicians should not be penalized for rampant inflation in these sectors. In addition, the value provided by cognitive physicians who take care of patients with chronic needs is not accurately represented in claims data. Early and appropriate treatment of these complex and vulnerable patients by specialized medical professionals can prevent or slow disease progression and decrease the likelihood of long-term disability and the costs associated with it. Along these lines, we also recommend that health care policies be designed to allow patients early access to cognitive specialty care.

Regarding the value program proposal, should the commission move forward with it, we suggest that if a group is actively participating in a Qualified Clinical Data Registry (QCDR) then they should automatically be protected against the negative payment adjustment. Participation in a QCDR demonstrates sophisticated application of an electronic health record by a provider to improve, collect and analyze data about patient care, outcomes and practice efficiency and such participation should be compensated.

Finally, we understand that the long-term goal of these proposals is to incentivize physicians to join APMs, but such a shift would require several policy changes to facilitate widespread physician participation. We question whether the Commission fully understands the pragmatic barriers to specialty physicians contemplating participation in an APM. In order to move physicians into APMs, the financial risk and patient thresholds must be reduced. We strongly suggest a proposal to reduce the requirements to qualify for APM track status from 25% to a lower number, such as 15%, and to reduce the crescendo in the coming years. We also recommend lowering the payment and patient count thresholds for Physician-Focused APMs to make "qualifying participant" status achievable for smaller practices. This would encourage more small practices to pursue Physician-Focused APMs. Finally, we suggest allowing the set-up cost of Physician-Focused APMs to count toward the financial risk, at least on an interim basis.

The CSC is dedicated to ensuring that physicians have the resources they need to provide patients with high-quality care. We believe that the Commission should make policy proposals designed to reflect the needs of complex care patients, reduce administrative burdens and increase access to care. The undersigned organizations appreciate the opportunity to provide Commission our views regarding the current policy proposal. We look forward to being a resource to you and we would like to request a meeting with the Commission staff to discuss these priorities in more detail. Please contact Kayla L. Amodeo, Ph.D., Director of Regulatory Affairs at the American College of Rheumatology, at kamodeo@rheumatology.org or (202) 210-1797, to schedule such a meeting, if you have questions, or if we can be of further assistance.

Sincerely,

American Academy of Allergy, Asthma, and Immunology (AAAAI)
American Academy of Neurology (AAN)
American Association of Clinical Endocrinologists (AACE)
American College of Rheumatology (ACR)
American Psychiatric Association (APA)
Coalition of State Rheumatology Organizations (CSRO)
Infectious Diseases Society of America (IDSA)
North American Neuro-Ophthalmology Society (NANOS)