



Sound Policy. Quality Care.

April 7, 2023

Miranda Lynch-Smith
Deputy Assistance Secretary, Office of Human Services Policy (HSP)
Assistant Secretary for Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201
Submitted electronically via: PTAC@HHS.gov

**RE: Improving Care Delivery and Integrating Specialty Care in Population-Based Models
Request for Input (RFI)**

Dear Ms. Lynch-Smith,

The Alliance of Specialty Medicine (the “Alliance”), representing more than 100,000 specialty physicians from sixteen specialty and subspecialty societies, is deeply committed to improving access to specialty medical care by advancing sound health policy. On behalf of the undersigned members, we write to provide feedback on the aforementioned request for input.

Background

Members of the Alliance have a long history of engaging the Physician-Focused Payment Model Technical Advisory Committee (PTAC) on the establishment of specialty-specific alternative payment models (APMs) that address recognized challenges in the delivery and cost of care for certain conditions and procedures. Unfortunately, none of the PTAC-recommended models from Alliance members have been approved by the Centers for Medicare and Medicaid Innovation (CMMI) as Advanced APMs for purposes of the Quality Payment Program (QPP).

In addition, Alliance members have also recommended that the Centers for Medicare and Medicaid Services (CMS) revise its regulations for Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs), and other ACO and population-based payment models, to enable more robust and meaningful participation by a broader range of specialists and subspecialists. Part of our recommendations included a request that CMS make data and information on specialty participation in ACOs publicly available. To date, the Agency has declined to adopt our recommendations (or consider them as part of annual rulemaking) to make specialty participation data and information available in the public domain. As a result, specialty societies do not have a full or clear understanding of the manner in which specialists currently engage in these models and the challenges they face.

www.specialtydocs.org

info@specialtydocs.org

American Academy of Facial Plastic and Reconstructive Surgery • American Academy of Otolaryngology-Head and Neck Surgery
American Association of Neurological Surgeons • American College of Mohs Surgery • American College of Osteopathic Surgeons
American Gastroenterological Association • American Society for Dermatologic Surgery Association
American Society of Cataract & Refractive Surgery • American Society of Echocardiography • American Society of Plastic Surgeons
American Society of Retina Specialists • American Urological Association • Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons • National Association of Spine Specialists • Society of Interventional Radiology

Given the context in which the PTAC is making this request and the questions it poses, the Alliance urges this Committee to include our recommendations and our request for publicly available data on specialty engagement in APMs, as part of its report to the Secretary of Health and Human Services (HHS).

Value of Specialists

Specialty medical care is an essential and needed component of the health care system, and increasingly so as chronic, complex diseases become more prevalent. Unlike primary care physicians (PCPs), specialty physicians have advanced expertise, knowledge and skills that allow them to provide more thorough examinations, render more precise diagnoses, offer more targeted and clinically appropriate treatment options, and provide comprehensive and effective management of acute and chronic health conditions. For example:

- Rheumatologists are best positioned to render an accurate diagnosis, establish a plan of care, and manage life-long rheumatologic conditions such as rheumatoid arthritis, systemic lupus erythematosus, and other debilitating inflammatory diseases. Because these conditions are systemic and side effects from the necessary medications can affect various organ systems, such as renal or hematologic there is overlap with many primary care issues. Weight, blood pressure, blood sugar, bone density, kidney and bone marrow function are just a few of the areas that are monitored on a regular basis by rheumatologists in the care of their patients.
- Patients with diabetes often suffer from ocular comorbidities, such as diabetic retinopathy or diabetic macular edema. Primary care practices are not equipped to offer treatment for these diseases, which includes advanced imaging and often regular intravitreal injections. Retina specialists are an integral part of managing diabetic patients.
- Interventional radiologists (IRs) utilize cutting-edge, targeted, minimally invasive image-guided procedures to diagnose and treat diseases in nearly every organ system, particularly in difficult or challenging situations where a collaborative approach may provide the best outcome. IRs treat patients who suffer from a wide variety of conditions including arterial conditions (aneurysm and dissection, arteriovenous malformations (AVM), hereditary hemorrhagic telangiectasia (HHT), peripheral arterial disease), venous conditions (deep vein thrombosis (DVT), pulmonary embolism (PE), venous and lymphatic malformations), liver and biliary conditions (ascites, encephalopathy, liver cancer-hepatocellular carcinoma, liver cancer - metastatic, portal hypertension, variceal bleeding, biliary obstruction, biliary leak) gastrointestinal conditions (malnutrition, obstruction, gastrointestinal bleeding, gastrointestinal ischemia) male conditions (benign prostatic hyperplasia (BPH), varicocele), female conditions (uterine fibroids, pelvic congestion syndrome), osteoarthritis of the knee and vertebral fractures.

Physicians across our member organizations have found that primary care physicians routinely refer patients for specialty intervention very late in disease progression. Worse, some primary care physicians misdiagnose complex conditions or rely on outdated treatments or therapies given their limited experience in managing these diseases. Once these patients finally reach a specialist – often on their own volition – their disease state is heightened and more difficult to control, leading to diminished outcomes and increased costs. CMS' primary care-led APMs, such as ACOs, exacerbate this problem with misaligned financial incentives that fail to account for the role of the specialist, few quality measures reflecting specialized conditions, and a lack of requirements for the ACO to ensure specialists are included in the model, which can lead to situations similar to health plan narrow networks and resulting patient access issues.

Specialists' Role in Alternative Payment Models

Alliance organizations continue to hear from their specialty physician members that active engagement in APMs is extremely challenging. Specialty-focused APMs do exist, but they only consider a limited number of conditions or procedures, leaving the vast majority of specialists without a dedicated model. Others, such as the Bundled Payments for Care Improvement (BPCI) program, suffer from challenges related to holding providers accountable for specific clinical episodes (versus broader clinical service lines and fail to provide high performing practices with an incentive to stay in the program since they are held to exceedingly challenging cost targets that simply do not support high quality, appropriate care. Additionally, specialists that are “participants” in ACOs are usually part of large hospitals or health systems, but their role is passive; they do not meaningfully engage in quality improvement or cost containment activities specific to the ACO, as the accountability measures do not consider the conditions they treat or services provided. Other specialists attempt to join ACOs, but are blocked from entry by the primary care physicians who lead them.

These findings are not just speculative. As highlighted in the Medicare Payment Advisory Commission (MedPAC) July 2022 Data Book, [*Health Care Spending and the Medicare Program*](#),

Many specialties account for a larger share of clinicians in larger ACOs. This finding may reflect smaller ACOs being more often composed of independent physician practices with relatively fewer specialists, while larger ACOs are often affiliated with hospitals or health systems that have a broader range of specialists.

MedPAC also explains that,

Specialists' participation in ACOs relative to their share of all clinicians varies by specialty. For example, cardiologists comprise about 2 percent of all clinicians participating in FFS Medicare, but a larger share of clinicians participating in ACOs. By contrast, specialties such as anesthesiology and ophthalmology are underrepresented in ACOs relative to their share of all FFS clinicians.

At the outset of the Quality Payment Program (QPP), the Alliance and its member organizations – independently and collectively – proactively connected with the ACO member organization to discuss opportunities for improving specialists' participation in ACOs. One approach discussed, which is contemplated in this RFI, was the development of “shadow bundles,” or as described in this RFI, “nesting of episode-based or condition-specific models in PB-TCOC models”. Further attempts to coalesce around this concept were stalled. Ultimately, we were told that specialty medical care and treatment was expensive and hurt ACOs financial performance, and – in the case of primary care-led ACOs – there was no appetite for sharing “savings” with specialists.

We recognize that one-size-does-not-fit-all and there will be obstacles to establishing alternative payment and delivery models for specialists – whether stand-alone or “nested” in population-based total cost of care models. Each specialty, and subspecialty, is unique in how care is diagnosed, treated, and managed. Some methodologies will work for a broader range of conditions and services, while others will be exclusive to a single condition or procedure.

Recommendations

Members of the Alliance are beyond frustrated, especially those who have invested significant resources in the development of impactful specialty-focused models and provided their expertise on ways that APMs, including ACOs, could integrate specialists to address high-impact conditions while improving quality of care. This not only discourages the development of more innovative models but significantly limits the movement of specialists into value-based models. As you will recall, the first PTAC recommended payment model was Project Sonar, which focused on a high-impact condition in gastroenterology – inflammatory bowel disease (IBD). Despite the fact that HHS did not proceed with this model, it has been a success in the commercial space. Several thousands of patients have been managed under this accountable care model. It has consistently [demonstrated](#) the ability to lower emergency department visits and inpatient admissions and has returned savings of 7.5% to 15% on total cost of care.

In addition, the cataract surgeons developed a bundled payment model that would enable appropriate patients to receive same-day, bilateral cataract surgery at a lower cost, while maintaining and improving outcomes for patients. This model, which would reduce spending and improve the quality of care for a large population of patients, would be appropriate for “nesting” into an ACO or other PB-TCOC model. Despite extensive review and positive discussions about the proposed model by senior staff and leadership of the Center for Medicare (CM) and CMMI, agency officials have taken no action, nor communicated further with the model developers.

Moreover, although outside the purview of the PTAC, the burden of participating in the Merit-based Incentive Payment System (MIPS) – where incentives have evaporated and penalties are steep – continues to increase as many specialists find it increasingly challenging to participate in a meaningful manner. This is the result of CMS’ removal of meaningful, specialty-focused measures, constantly shifting goal-posts, and unnecessarily burdensome requirements for qualified clinical data registries (QCDR).

As a result, the vast majority of specialists are at a gross disadvantage in the QPP compared to their primary care counterparts, a disparity that has persisted for far too long and must be addressed swiftly.

We urge PTAC to include the below recommendations in its report to the Secretary:

- Adopt PTAC’s previously recommended APMs for specialists and continue to prioritize the development of specialty-focused models;
- Leverage CMS’ administrative data and analytics capabilities to:
 - Identify opportunities for specialists to engage in existing APMs, including ACOs and other population-based total cost of care models.
 - Establish episode-based and condition-specific models that appropriately reward specialists for care they can control within existing APMs, including ACOs and other PB-TCOC models.
- In considering embedded ACO or other PB-TOCC models, it is important that CMS:
 - Not simply carry over the methodologies of existing episode-based models, some of which are flawed and pose challenges to specialists in terms of long-term participation.
 - Keep in mind that one size will not fit all when it comes to specialty integration into population-based models.
 - Ensure that specialists can achieve QP status if participating in a nested model and be exempt from MIPS.

- Ensure that more specialty-specific quality and cost measures in any new nested model are aligned with MIPS so that even if a specialist does not achieve QP status, they can still receive credit simultaneously under both initiatives.
- Closely examine the referral patterns of existing APMs, including ACOs, and establish benchmarks that will foster an appropriate level of access to and care coordination with specialists, in addition to collecting feedback from beneficiaries on access to specialty care;
- Examine how the calculation of qualifying APM participant (QPs) thresholds creates incentives or barriers to specialty engagement, and adjust as necessary to ensure that APM entities are not penalized for engaging specialists and that specialists can qualify as QPs;
- Require APMs and ACOs to maintain and publicly-post a list of specialty physician participants on their websites, including their specialty and subspecialty designation;
- Adopt specialty designations for non-physician practitioners to ensure specialty practices are not limited to participation in a single ACO; and
- Release granular data on specialty participation in existing APMs, including ACOs.

We appreciate the opportunity to provide feedback on the proposals in this rule that aim to improve access to specialty and subspecialty care. Should you have any questions or would like to meet with the Alliance to discuss these recommendations further, please contact us at info@specialtydocs.org.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
 American Academy of Otolaryngology-Head and Neck Surgery
 American Association of Neurological Surgeons
 American College of Mohs Surgery
 American College of Osteopathic Surgeons
 American Gastroenterological Association
 American Society for Dermatologic Surgery Association
 American Society of Cataract and Refractive Surgery
 American Society of Echocardiography
 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 of Interventional Radiology