June 24, 2016

Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed Rule (CMS-5517-P)

Dear Acting Administrator Slavitt:

On behalf of the undersigned organizations, thank you for the opportunity to comment on the notice of proposed rulemaking (NPRM) regarding the implementation of MIPS and APMs under the Medicare Access and Chip Reauthorization Act (MACRA). The undersigned state, national, and specialty medical societies represent the vast majority of practicing and future physicians who provide medical services every day for millions of patients. We appreciate the administration's outreach to the physician community during the comment period on this important proposed rule, including listening sessions, briefings, and meetings with our organizations. We are especially thankful for the statements from the Centers for Medicare & Medicaid Services (CMS) about the importance of identifying NPRM policies that need to be modified to avoid adopting perverse incentives or creating barriers to successful participation. We remain hopeful that this ongoing dialogue with medicine will promote the effective implementation of MACRA. While some progress has been made in the regulation, the physician community remains very concerned about a number of the proposed rule provisions.

As you know, the physician community was deeply engaged with Congress as it drafted the MACRA legislation. With the potential for significant improvements over the incentive programs in prior law, including reduced penalties, more support for positive incentive payments, simpler requirements, and fewer administrative burdens, our organizations are strongly committed to a successful MACRA launch. If properly implemented, the new MIPS and APM framework will promote improvements in the delivery of care for Medicare patients. The following comments seek to:

- simplify the proposed MIPS program to ensure that it facilitates meaningful opportunities for performance improvement while decreasing administrative and compliance burdens;
- provide a more robust APM pathway that can support physicians who want to make the transition to new delivery and payment models; and
- accommodate the needs of physicians in rural, solo, or small practices in order to enhance their opportunities for success and avoid unintended consequences.

MIPS

The overall goal in MIPS should be to create a more unified reporting program with greater choice and fewer requirements. While we see several positive changes in the proposed rule, our main concern is that CMS continues to view the four components as separate programs, each with distinct measures, scoring

methodologies, and requirements. This has created significant complexity in the program as a whole, leading us to be very concerned that physicians will not be able to understand the complete MIPS program. To remedy this problem, we believe CMS should adopt the following in the final rule:

MIPS Proposals that Should Be Finalized

- **Allow physicians to report through a variety of methods.** The proposed rule provides flexibility by permitting reporting through claims, electronic health record (EHR), clinical registry, qualified clinical data registry (QCDR) or group practice reporting Web-interface as well as reporting as either an individual or group. CMS should finalize all of these options to ensure flexibility for physicians.

- **Reduce reporting burden.** CMS should finalize proposals that reduce reporting burden, including removing advancing care information (ACI) measures that impacted EHR usability and redundant electronic clinical quality measures.

- **Offer choice.** CMS should finalize its proposal to allow physicians to select from any Clinical Practice Improvement Activities (CPIAs) without specific requirements related to categories or subcategories.

- **Promote medical homes and APMs.** Throughout the MIPS program, CMS should finalize or further enhance proposals that provide credit for and promote medical homes and APMs.

MIPS Proposals that Need to Be Modified

- **Improve chances of success by creating more opportunities for partial credit and fewer required measures within MIPS**. Where possible, CMS should see if it can further simplify the reporting burdens on physicians, specifically by reducing the complexity of the overall MIPS composite score.

- **Take into account differences in practice sizes, specialties, and availability of measures.** Throughout MIPS, CMS should identify exceptions or greater flexibility to address the unique concerns of small, rural, and other practices. For example, under the proposed quality scoring, physicians with no outcome or "high priority" measures are at a disadvantage. To resolve this problem, CMS should only provide bonus points instead of requiring these measures to achieve the maximum quality score. The final rule should also consistently define "small" practices across the different MIPS categories to avoid confusion.

- **Reduce the threshold and number of quality measures.** The proposed rule dramatically increases the threshold for reporting on quality measures from 50 percent of Medicare Part B patients to 90 percent of all patients through a registry, QCDR, and EHR, or 80 percent of Medicare Part B beneficiaries if reporting via claims. This greatly increases administrative burden and may dissuade physicians from using electronic reporting tools. CMS should maintain the existing 50 percent reporting threshold and further reduce the number of required quality measures.

- **Eliminate administrative claims population health measures.** CMS proposes to use administrative claims population health measures that were previously part of the value-based

modifier and developed for use at the community or hospital level. These measures tend to have low statistical reliability when applied at the individual physician level and at times at the group level. Instead, CMS should make the measures optional under the CPIA component or exempt small practices from all of the administrative claims quality measures.

- **Eliminate costs measures developed for other settings.** Replace measures like total cost of care and Medicare Spending per Beneficiary (MSPB) that were developed for use in hospitals and other settings with measures that have been developed for and tested for use in physician offices.

- **Focus on methodological improvements.** Making resource use workable requires CMS to focus on various methodological improvements, including more sophisticated risk-adjustment, more granular specialty comparison groups, and improved attribution methods. CMS should direct special effort at eliminating flaws that have made practices with the most high-risk patients more susceptible to penalties than other physicians.

- **Adopt virtual groups.** The MACRA statute included the concept of virtual groups to help assist small practices; however, CMS proposes not to implement such groups until the 2018 performance period. We strongly urge CMS to act on forming these groups as soon as possible. Without this assistance, we believe small practices may face even greater challenges when attempting to move into the MIPS program structure.

- **Grant credit for each reported ACI measure.** The proposed rule retains a pass-fail element in the base ACI score. Instead of keeping this approach, CMS should provide credit for each measure reported, even when it is a simple yes/no or attestation measure. The final rule should also maintain all existing Meaningful Use (MU) program exclusions and hardships, including for physicians who do not refer patients and have insufficient broadband availability.

- **Encourage alternative ACI measures.** Rather than maintaining the current MU Stage 3 measures, CMS should allow proposals for more relevant measures. This would ensure that practices can select tools in innovative ways and not be limited by existing technology barriers. Further flexibility can be provided by allowing physicians to utilize both 2014 and 2015 edition technologies in 2018 and subsequent years.

- **Expand high-weighted CPIAs.** The proposed rule identifies few high-weight CPIAs and lists key patient quality activities as only medium weight. Given the patient benefit associated with these activities, CMS should provide more credit for these important care activities.

- **Reduce the number of required CPIAs.** Under the proposed rule, physicians could be required to report on as many as six different activities in order to receive the full CPIA score. While the activities vary, six different requirements may quickly become overly burdensome, especially given the low-weight of this performance category compared to others. CMS should reduce the total number of required CPIAs to avoid additional burden on practices.

- **Work with affected physicians and medical societies to determine how to reweight performance categories**. CMS should not over emphasize the quality category when determining how to reweight a missing MIPS component. Rather, the rule should allow for flexibility in how to redistribute the different performance weights, and CMS should work with affected physicians and medical societies to determine a more appropriate approach.

APMs

MACRA specifies that physicians who reach defined levels of revenues coming through an APM qualify for five percent payments and are exempt from MIPS. Eligible APM entities must tie payments to MIPS-comparable quality measures, require certified EHR technology, and assume more than nominal financial risk. The NPRM defines those APMs that enable physicians to qualify for the five percent payments as "Advanced APMs" and other APMs that help improve physicians' MIPS scores as "MIPS APMs."

APM Proposals that Should Be Finalized

- **Quality measure requirements for Advanced APMs.** The flexibility proposed for Advanced APMs to choose their own approach to measuring quality, consistent with the goals of the APM, should be confirmed in the final rule. Advanced APMs would need to choose one quality measure from among several categories of MIPS-comparable measures.

- **EHR requirements for Advanced APMs.** The proposal that Advanced APMs require 50 percent of participating clinicians to use certified EHRs to document and/or communicate clinical care to their patients or other health care providers should be finalized and not increased in subsequent years.

- **Patient thresholds.** Advanced APM revenue thresholds start at 25 percent for 2019 payments and increase to 75 percent for 2023. CMS should finalize its flexible alternative approach to qualify for the bonus payments by having 20 percent of patients receiving care through the APM for 2019, increasing to 50 percent by 2023.

- **Scoring participation in MIPS APMs.** CMS should finalize several proposals for modifying the way MIPS components are reported and weighted for physicians participating in MIPS APMs. These proposals aim to prevent physicians from having to fulfill redundant or conflicting requirements for an APM and for MIPS.

APM Proposals that Need to Be Modified

- **Definition of "more than nominal" financial risk.** Five key modifications are needed in the financial risk criteria that CMS has proposed:
  1. Simplify the definition. With multiple components that include total risk, marginal risk and minimum loss rate, it would be difficult for physicians contemplating participation in Advanced APMs to understand their financial risks and avoid losses.
  2. Base risk requirements on physician professional services revenues, not expenditures under the APM. Physician Fee Schedule services are just 19 percent of total Medicare Part A and B expenditures and physicians should not have to take risks for expenses outside their control.
  3. Reduce the amount of losses defined as "more than nominal." The Regulatory Impact Analysis notes that CMS has long defined "significant" impact as 3 percent of physician revenue. Defining "more than nominal" as 4 percent of total costs would set "more than nominal" far above "significant."
  4. Count physicians' uncompensated costs as potential financial losses. APMs may incur substantial costs including care coordinators, patient educators, data analysis, and other non-billable services.

5. Count loss of guaranteed payments as losses for all APMs, not just medical homes, as all APM participants should be able to treat repayment of performance-based payments as financial risk.

- **Increase medical home flexibility.** The NPRM proposes more realistic financial risk standards for medical homes than other APMs, but CMS should: eliminate the 50-clinician cap on medical homes eligible for this standard, expand eligibility to specialty medical homes, and maintain the initial risk standard instead of increasing it to five percent. CMS should also prevent the risk requirements from being extended to primary care medical homes serving vulnerable populations, such as children with Medicaid coverage.

- **Provide more APM opportunities.** MACRA provided two pathways for physician participation, MIPS or APMs, but the NPRM limits the opportunities for participation in Advanced and MIPS APMs to just a handful of physicians. Several proposed policies need to be changed to provide a more robust APM pathway:
  1. Although MACRA defined nearly all Medicare Shared Savings Program and Center for Medicare and Medicaid Innovation models as APMs, very few existing models qualify as APMs under the NPRM. A process needs to be established to allow other models to be modified so that they can qualify.
  2. Final regulations should establish a timely and predictable CMS review process for stakeholder APM proposals, including models for specialists and those recommended by the Physician-Focused Payment Model Technical Advisory Committee, in order to increase MACRA APM opportunities. Physicians are especially concerned by comments from some CMS officials that stakeholder models proposed by the independent advisory committee established by Congress will then have to go through the entire CMS model review process, which suggests it will be years before any physician-focused APMs are available.

Low-Volume Threshold

The undersigned organizations strongly recommend that the low-volume threshold be raised significantly in the final rule. Since the release of the MACRA NPRM, many concerns have been voiced about the potential impact of MIPS on solo and small physician practices. To help mitigate adverse effects on small practices, CMS has proposed a low-volume threshold that would exempt physicians with less than $10,000 in Medicare allowed charges AND fewer than 100 unique Medicare patients per year from MIPS. The proposed threshold, however, would help very few physicians and other clinicians. An AMA analysis of the 2014 "Medicare Provider Utilization and Payment Data: Physician and Other Supplier" file found that just 10 percent of physicians and 16 percent of all MIPS eligible clinicians would be exempt under the $10,000/100 beneficiary proposal, and that these clinicians account for less than one percent of total Medicare allowed charges for Physician Fee Schedule services. As one example, by raising the threshold to $30,000 in Medicare allowed charges OR fewer than 100 unique Medicare patients seen by the physician, CMS would provide a better safety net for small providers. This would exclude less than 30 percent of physicians while still subjecting more than 93 percent of allowed spending to MIPS.

Performance and Reporting Periods

The NPRM requires that APM and MIPS participation be measured starting January 1, 2017, with the first MIPS payment adjustments being made in January 2019, and the first incentive payments to Advanced APM participants being made in mid-2019. Collectively, we believe the start date should be moved back so that physicians have time to prepare, have adequate notice of final program requirements and thresholds, a final list of qualified APMs is available, and the performance period is closer to when incentive payments will be made. We believe this extra time will also be helpful for vendors, registries, and others to update their systems to accommodate the new program requirements.

In addition, we urge CMS to allow more suitable reporting periods for both the MIPS and APM programs. A full calendar year requirement can create significant administrative burden for practices and limit innovation while not improving the validity of the data, particularly in categories where measures are not automatically calculated by CMS. Instead, physicians should be able to select a shorter reporting period or use the full calendar year (with an optional look-back to January 1 in 2017) if they believe it is more appropriate for their practice.

We thank you for your consideration of our recommendations. We are committed to working collaboratively and constructively with CMS and others as final regulations are prepared and the agency works to implement these MACRA reforms.

Sincerely,

American Medical Association
Advocacy Council of the American College of Allergy, Asthma and Immunology
AMDA – The Society for Post-Acute and Long-Term Care Medicine
American Academy of Allergy, Asthma and Immunology
American Academy of Dermatology Association
American Academy of Emergency Medicine
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Family Physicians
American Academy of Home Care Medicine
American Academy of Neurology
American Academy of Neuromuscular and Electrodiagnostic Medicine
American Academy of Ophthalmology
American Academy of Orthopaedic Surgeons
American Academy of Otolaryngology-Head and Neck Surgery
American Academy of Pain Medicine
American Academy of Physical Medicine and Rehabilitation
American Academy of Otolaryngic Allergy
American Association for Geriatric Psychiatry
American Association of Clinical Urologists
American Association of Hip & Knee Surgeons
American Association of Neurological Surgeons
American College of Cardiology
American College of Emergency Physicians
American College of Medical Genetics and Genomics
American College of Mohs Surgery

American College of Phlebology
American College of Radiology
American College of Rheumatology
American Congress of Obstetricians and Gynecologists
American Gastroenterological Association
American Geriatrics Society
American Psychiatric Association
American Society for Clinical Pathology
American Society for Dermatologic Surgery Association
American Society for Gastrointestinal Endoscopy
American Society for Radiation Oncology
American Society of Addiction Medicine
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Clinical Oncologists
American Society of Dermatopathology
American Society of Echocardiography
American Society of Hematology
American Society of Interventional Pain Physicians
American Society of Nuclear Cardiology
American Society of Plastic Surgeons
American Society of Retina Specialists
American Society of Transplant Surgeons
American Thoracic Society
American Urogynecologic Society
American Urological Association
Association of American Medical Colleges
College of American Pathologists
Congress of Neurological Surgeons
Heart Rhythm Society
Infectious Diseases Society of America
International Society for the Advancement of Spine Surgery
Medical Group Management Association
National Association of Medical Examiners
North American Neuromodulation Society
North American Neuro-Ophthalmology Society
Obesity Medicine Association
Renal Physicians Association
Society for Cardiovascular Angiography and Interventions
Society for Vascular Surgery
Society of Gynecologic Oncology
Spine Intervention Society
The Society of Thoracic Surgeons

Medical Association of the State of Alabama
Alaska State Medical Association
Arkansas Medical Society
California Medical Association

Colorado Medical Society
Connecticut State Medical Society
Medical Society of Delaware
Medical Society of the District of Columbia
Medical Association of Georgia
Hawaii Medical Association
Idaho Medical Association
Illinois State Medical Society
Indiana State Medical Association
Iowa Medical Society
Kansas Medical Society
Kentucky Medical Association
Louisiana State Medical Society
Maine Medical Association
MedChi, The Maryland State Medical Society
Massachusetts Medical Society
Michigan State Medical Society
Minnesota Medical Association
Mississippi State Medical Association
Missouri State Medical Association
Montana Medical Association
Nebraska Medical Association
Nevada State Medical Association
New Hampshire Medical Society
Medical Society of New Jersey
New Mexico Medical Society
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North Carolina Medical Society
North Dakota Medical Association
Ohio State Medical Association
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Oregon Medical Association
Pennsylvania Medical Society
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Tennessee Medical Association
Vermont Medical Society
Medical Society of Virginia
Washington State Medical Association
West Virginia State Medical Association
Wisconsin Medical Society
Wyoming Medical Society