CMSS

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June 27, 2016

Andy 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

Subject: Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models (CMS-5517-P)

Dear Administrator Slavitt:

The Council of Medical Specialty Societies (CMSS), with 43 member societies representing 790,000 physician members in the US, is pleased to comment on the proposed rule for MIPS and APMs. We will comment in several categories. Should you have any questions, please do not hesitate to contact us.

Timeline for Implementation

We hope that CMS already recognizes that an implementation timeline of January 1, 2017 is too aggressive. We suggest that the performance period start on July 1, 2017 to allow time for adequate physician education and preparation for the transition to this fundamentally new payment system.

Moreover, the 2-year data lag between performance measurement and payment adjustments seems to be more of a reward and punishment system than a value-based payment system. Without rapid cycle feedback and an ability to connect behavior to payments, physician practices are challenged to improve their delivery of value-based care.

MIPS Eligible Clinicians

CMSS supports CMS' proposal to include telehealth services in the definition of patient-facing encounters for the Quality Payment Program. Telemedicine has a potential to significantly impact health care delivery and may help address the anticipated shortage of specialists in the near future.

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Low Volume Threshold

The burden to implement MIPS for low volume providers is considerable. The reporting, HIT and structural changes required for practices with a small percentage of Medicare patients will require considerable resources, for which no incentives could reasonably cover the costs for these practices. We recommend increasing the thresholds for exemption to at least $30,000 and 150 Medicare beneficiaries.

Data Threshold

CMS is proposing to increase the reporting threshold in the quality category to require that clinicians report on 80% of their Medicare patients (if using claims) or 90% of all patients (if using registry, QCDR, or EHR). These proposed thresholds for claims, qualified registry and QCDR in particular appear to be too high, as these clinicians are now required to only report on 50%. In addition, qualified registry and claims reporters now only report on Medicare patients. Many physicians have chosen not to utilize the QCDR option because of the all-payer requirement. To include all patients means that the data on which one would have to report would be much higher, and the reporting burden would be significantly increased.

Another option for reporting, if CMS maintains the all-payer approach for registries, is for physicians to submit data on twenty consecutive patients (the number of patients needed for validating a quality measure). This would reduce the reporting burden as it is consistent with how physicians report data to their certifying boards for Maintenance of Certification (MOC).

Requiring physicians to report on such a high percentage of their patients limits the types of measures physicians will be able to report. For example, patient reported outcomes and patient satisfaction/experience are important aspects of care in almost all specialties, and reflect information sought by consumers and other stakeholders. It is unreasonable, however, to expect providers to report these labor intensive outcome measures for such a large percentage of their patients. This requirement may very well have the unintended consequence of resulting in providers avoiding these types of measures. CMS should therefore lower the threshold to 50%, as is currently required under PQRS for registry reporting. Additionally, since only Medicare data is used for resource use evaluation, CMS should limit required reporting to Medicare patients. As an alternative, CMS could give partial credit if thresholds are not met.

We appreciate the clarification that CMS will be submitting new measures for publication in applicable specialty appropriate, peer-reviewed journals before including such measures in the final list of measures annually. While we agree the publication requirement will help to ensure measures are both meaningful and comprehensive, CMSS requests that CMS ensure a more collaborative approach to the submission of measures to peer-reviewed journals. Many societies have a robust Clinical Practice Guideline development methodology and routinely publish guidelines in their peer-reviewed journals. Given what is required to undertake developing measures at the specialty and sub-specialty level, as well as the investment in resources by societies, we feel publication of a finished measure set detailing the methodological background and other components outlined by

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CMS would be most appropriate in society specific journals. We therefore request CMS allow measure developers the right to first submit measures to specialty specific, peer-reviewed journals of their choice.

Measure Groups

CMS should reinstate measure groups for reporting. Measures groups are designed as composite measures to provide an overall picture of patient care for a particular condition or set of services. For example, one measure group addresses complication rates, clinical outcomes, patient-reported outcomes, and patient satisfaction to provide a comprehensive picture of care. The measures that are included in a measures group undergo a deliberative process with the intent of the measure group in mind. Allowing clinicians to report on a measures group for a smaller sampling of their patients is a less burdensome yet meaningful way for clinicians to meet their quality reporting requirements and encourages use of the harder outcomes measures. This reporting option allows smaller practices and individual physicians without an EHR to participate. It seems particularly unfair that CMS proposes to allow large groups to report on a sampling of their patients (via GPRO Web Interface), yet proposes to do away with the measures group reporting for individual physicians and small practices, which represent the majority of physicians.

Cross-Cutting Measures for 2017 and Beyond

Under MIPS, CMS proposes to remove thirteen cross-cutting measures from the 2017 reporting period, leaving only eight remaining cross-cutting measures available for submission. If CMS requires submission of cross-cutting measures, we request that CMS provide a broader selection of measures to choose from.

With regards to QCDRs, the proposal requiring submission of cross-cutting measures creates additional barriers for use of QCDRs and should not be finalized. CMS proposes that providers submitting data through a QCDR must report on at least six measures, including one cross-cutting measure (if patient-facing) and at least one outcome measure, if available. The requirement for QCDRs to report on cross-cutting measures may not be relevant or applicable to the data that some QCDRs were designed to collect, since many QCDRs are specialty-specific. Collecting data on a cross-cutting measure is likely to force QCDRs to focus on health care areas that are outside of their specialty-specific scope.

Topped out Measures

For measures that reach the "topped out" threshold during the performance period, we urge CMS to hold harmless the physicians who report on these measures from any downside adjustment in the maximum points that the measure is worth by maintaining the 10-point maximum value of the measure for that performance period. In addition, we ask that CMS provide for a transition period before removing any "topped out" measures from the program in future years. This would give

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affected specialties an opportunity to adjust, and may help bridge any divide among the CMSS members.

CMSS agrees with CMS' conclusion that removing all potentially topped out measures from MIPS would be inappropriate at this time, and shares CMS' concern that removing a large volume of measures could complicate specialist's ability to successfully report under MIPS**.** Furthermore, CMS notes that because not all MIPS ECs are required to report these potentially topped out measures, it's nearly impossible to determine when a measure is truly topped out, or rather is reported on only by high quality providers. CMSS requests CMS not remove any potentially topped out measures until a methodology is developed to reliably differentiate between a measure that is "topped out" and a measure for which performance is high because it is solely reported by high quality providers. CMSS also suggests CMS consider the breadth of applicable measures by clinician type, only removing topped out measures in scenarios where sufficient numbers of applicable measures remain for specialist providers to successfully report.

CMS proposes a scoring methodology which will not permit physicians to earn the maximum quality score through reporting on measures that have already demonstrated high performance. CMS has identified that 50% of the measures are thus "topped out." Prohibiting reporting on successful measures would particularly disadvantage specialties that have fewer measures to choose from. CMS should eliminate its proposed scoring methodology for "topped out" measures, and use the same methodology for all measures.

Additionally, we recommend that CMS publicly disclose any measures that are "topped out" prior to a performance period. This can be done as part of the publication of the final quality measures each year, which must be published by November 1 of the year prior to the performance period. Along with this information, CMS should also publish the statistics of any measures that are nearing the topped out status prior to the performance period. Because physicians often select the same measures to report year-after-year, it will be important for them to know in advance which measures are close to topping out in advance of the performance period so that they have the opportunity to select alternate measures. Since credit can be given for improving on performance from year-to-year, information on "topped out" measures as well as those nearing "topped out" status is important as physicians select which measures to report on.

ACI/MU

CMS proposes to evaluate physicians on a base score as well as a performance score. As proposed, the base score calculation carries over the problematic pass/fail structure of the current Meaningful Use program. If a physician fails to report even one requirement which is not relevant to his or her patients, the physician will be scored zero on ACI, regardless of whether that physician scores 100% on every other requirement.

CMS bases the performance score on the problematic Stage 3 list of measures opposed by the majority of physician societies. Many of these measures are out of the control of the physician, such as patient electronic access, or patient engagement and health information exchange. A physician's

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performance should not be judged on an action required by the patient, such as viewing their information online, sending self-generated health information (i.e. Fitbit® data) to the physician, asking the physician to send their information to their favorite app, or sending a secure message to the physician. We recommend the advancing care information performance category allow greater bonus points for participating in a specialized registry and allow clinicians to give attestations.

Table 64

Most practices with fewer than 25 physicians are predicted to receive cuts, with only the largest of practices succeeding in this budget neutral system. Thus, too many practices are projected to receive cuts in reimbursement.

APMs

CMS has only proposed six models to be recognized as advanced APMs. Moreover, the thresholds providers must meet in order to be a "qualified provider" under an Advanced APM will be difficult for many clinician practices to meet. CMS needs to develop more pathways for APMs to meet advanced criteria and establish more flexibility for physicians to qualify as "qualified providers" under an Advanced APM.

One could conceivably tweak the aggregating approach such that if a clinician works at an APM model site, he or she should get credit for all those patients at that site, particularly if the model holds that clinician accountable for all spending (i.e. BPCI). The model makes demands that go toward the success of the ACO, without formally allowing for the individual clinician's participation.

APM Scoring Standard for MIPS Eligible Clinicians Participating in MIPS APMS

CMS notes that eliminating duplicate reporting requirements was a key consideration in drafting the proposed rule for implementation of MIPS and APMs. CMS further acknowledges that most APMs require participants to report data that may be similar to what MIPS requires. To prevent eligible clinicians from having to submit duplicate data for both their respective APM and MIPS, CMS is proposing to use a scoring standard to allow for use of APM data to generate a composite performance score under MIPS.

CMS' attempt to create a scoring standard that will allow MIPS eligible clinicians participating in non-advanced APMs to receive credit for their reporting efforts is much appreciated. We support an alternative approach to re-weight and assess performance that is not redundant, given that most physicians will be subject to MIPS until more advanced APMs become available. As such, we support the proposals for Medicare Shared Savings Program and Next Generation ACO participants. The proposal for other MIPS APM participants should be modified so that the advancing care information performance category is not 75 percent of the physician's MIPS score. CMS also needs to develop a pathway to help MIPS APM participants' transition to Advanced APMs.

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Application of Criteria to Current and Recently Announced APMs

There needs to be a straightforward means of modifying existing APMs so that they can qualify as Advanced APMs. The statute authorizing the Center for Medicare & Medicaid Innovation (CMMI) directs the Secretary of Health and Human Services (HHS) to focus on models expected to reduce program costs while preserving or enhancing the quality of care. This makes it difficult to understand how the Bundled Payments for Care Initiative (BPCI) and several other CMMI models listed in Table 32 of the proposed rule could have been implemented as an alternative payment model, but yet do not qualify as Advanced APMs. There should be an expeditious means of modifying the agreements between existing APM entities and CMS to allow more APMs to qualify as Advanced APMs.

***Nominal Risk* (P. 28305 – 28309)**: **Financial Risk for Monetary Losses**

The third criterion that an APM must meet to be an Advanced APM is that it must either be a Medical Home Model, or bear financial risk for monetary losses in excess of a nominal amount. In general, we find the criteria for nominal risk for Advanced APMs to be complex and confusing. We request that CMS provide straightforward information about financial risk for monetary losses so that MIPS eligible clinicians contemplating participation in an Advanced APM can easily interpret it and make informed decisions.

MACRA does not set specific risk thresholds for more than "nominal" risk. CMS proposes to define the amount of risk required to be eligible as total risk of at least four percent of the APM spending target, marginal risk of at least 30 percent, and minimum loss rate not greater than four percent. For many clinicians, the risk is much greater than expected and would not include a number of models in which clinicians already participate. This makes it difficult for physicians contemplating participation in Advanced APMs to understand their financial risks or know how much to set aside to cover potential repayments. It is not appropriate for CMS to tie nominal risk requirements to the total cost of care for patients as the proposed rule does by linking it to expenditures under the APM. Our concern is that the four percent of total expenditures standard outlined in the proposed rule could potentially equate to 20 percent or more of a physician practice's revenue. CMS should set "more than nominal risk" at a small percentage of an organization's revenue, not APM expenditures, as these include costs beyond physicians' control. If CMS maintains its current approach to defining more than nominal financial risk, it may potentially preclude many promising APMs that are under development from qualifying as Advanced APMs.

The definition of how one meets nominal risk needs to be set at a level that is more realistic and attainable. With multiple components including total risk, marginal risk and minimum loss rate, it would be difficult for physicians contemplating participation in Advanced APMs to understand their financial risks. Most physician offices, especially smaller offices, do not have actuaries to calculate their risk, the data on which to calculate risk, the IT infrastructure to support such calculations, nor the number of lives under their care to facilitate spreading the risk. We would recommend that for the first two years, there be no penalties if the APM falls short of anticipated revenues, as not receiving a bonus should be sufficient incentive for improving the ability to calculate risk.

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Clinical Practice Improvement Activities (CPIA)

Incorporation of more diverse activities will drive success of the new clinical practice improvement activities performance category for MIPS eligible specialists. CMS should incentivize physician participation in robust clinical data registries that provide feedback to participating clinicians, share best practices related to, and drive improvement in quality of care. Registries function as tools for quality and performance measurement, reporting and improvement. Registries offer a sufficient number of activities to support participating clinicians starting in the first year of MIPS. As such, registries support high value clinical practice improvement.

As registries support high value clinical practice improvement, they should therefore earn physicians the highest amount of CPIA credit. As it stands, physicians in practices with more than 15 physicians would have to report on 6 CPIA activities weighted as medium in order to reach 60 points, which would be unnecessarily burdensome for physicians to perform and report, and would be equally as challenging for registries to offer in the first year. Increasing the point value of registry related activities to 20 points would reduce this burden on physicians and registries. Therefore, the activities related to registries should be reweighted from "medium" (10 points) to "high" (20 points). We encourage CMS to assign all registry-related CPIAs a high weight to incentivize increased participation in registries.

The CPIA table is inconsistent when giving credit for registries. In some areas credit is given only for QCDRs and in others all registries (e.g., public health, QCDR, FDA and other outcomes registries) are included. CMS should be consistent - credit should not be limited to QCDR registries.

In light of the narrow door that CMS has provided for APMs to be eligible as Advanced APMs, MIPS APM participants should receive a higher score than half the CPIA score. We recommend that physicians participating in MIPS APMs receive the highest potential CPIA score. In addition, we note that CMS has proposed that primary care medical homes receive the highest potential CPIA score, but has made no provisions for comparable specialty medical home programs.

We ask CMS to consider establishing more activities that would allow specialists to play a proactive role in improving their clinical practice, such as the following:

- Fellowship training or other advanced clinical training completed during a performance year
- Voluntary practice accreditation, such as accreditation achieved by the National Committee on Quality Assurance (NQCA), Accreditation Association for Ambulatory Health Care (AAAHC), The Joint Commission (TJC), or other recognized accreditation organizations
- Engagement in state and local health improvement activities, such as participation in a regional health information exchange or health information organization
- Engagement in private quality improvement initiatives, such as those sponsored by health plans, health insurers, and health systems
- Participation in other federally sponsored quality reporting and improvement programs not already affiliated or considered under the MIPS program

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We recommend that CMS accept participation in a certifying board's MOC program as meeting the CPIA requirement. Regardless of the types of activities accepted by the different boards, they all require demonstration of lifelong learning/self-assessment and practice improvement. Physicians are already feeling burdened by the MOC requirements so having those same criteria work for CPIA would be highly beneficial and would address the apparent goals of this requirement.

While we appreciate CMS' recognition of Maintenance of Certification (MOC) Part IV, we strongly urge CMS to specifically recognize accredited continuing medical education (CME) as another means to satisfy CPIA requirements. CME encourages physicians to develop and maintain the knowledge, skills, and practice performance that leads to improved performance with optimal patient outcomes. Practice improvement multi-dimensional interventions, including participation in professional development activities like CME, are a necessary component of the change process that results in meaningful, sustained clinical performance improvement. Without this professional development, the measurement of adherence to quality metrics and use of health information technology are insufficient to produce clinical performance improvement. As patients will continue to need health care professionals that engage in lifelong learning, assessment, and improvement in practice, it is important for these activities to be recognized and rewarded in value-based payment programs promulgated by CMS and private payers.

Accredited CME providers design and evaluate the impact of activities that promote new practice strategies, performance change for individuals and teams, and patient outcomes. Accredited CME activities engage learners in closing professional practice gaps inclusive of each of the domains described in the MIPS pathway.

We urge CMS to recognize credit for certain defined CME activities:

- Accredited CME activities that involve assessment and improvement of patient outcomes or care quality, as demonstrated by clinical data or patient experience of care data.
- Accredited CME that teaches the principles of quality improvement and the basic tenets of MACRA implementation, including application of the "three aims," the National Quality Strategy, and the CMS Quality Strategy, with these goals being incorporated into practice.

One issue potentially complicating CMS's recognition of accredited CME pertains to the 90 day rule. According to the Proposed Rule, MIPS eligible clinicians or groups must perform CPIAs for at least 90 days during the performance period to earn CPIA credit. To allow for accredited CME to count toward CPIA, we urge CMS to allow approved CME activities that incorporate a 90-day survey or evaluation period into the program as having met the 90 day requirements.

Resource Use

MACRA requires that no more than 10 percent of the MIPS Score be based on resource use performance. Although CMS has the authority to limit the weight to a value less than 10 percent, CMS proposes that resource use count for 10 percent. Given the problems with the measures in the

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resource use category, including but not limited to attribution methodologies and inadequate risk adjustment, a significantly lower percentage would be more appropriate. It should be noted that it will be difficult for the physician-patient relationship codes to be finalized in the final rule. We would recommend that CMS consider weighting resource use as zero for the initial performance period (at least). Each of the other performance categories should be reweighted evenly.

The Council of Medical Specialty Societies (CMSS), with 43 member societies representing 790,000 physician members in the US, is pleased to have had the opportunity to comment on the proposed rule for MIPS and APMs. Should you have any questions, please do not hesitate to contact us.

Sincerely,

Norman Kahn, MD, CPE
Executive Vice President and CEO