K.8

MEDICAL SOCIETY OF THE STATE OF NEW YORK
EXECUTIVE HEADQUARTERS

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

Dear Acting Administrator Slavitt:

On behalf of the over 20,000 physician, resident and student members of the Medical Society of the State of New York, we are writing to you to express our strong concerns with CMS' proposal to implement the MIPS and APM value-based payment proposals that were created under the MACRA legislation passed by Congress last year. We are concerned that the proposal is far too complex for many physicians who are already drowning in required paperwork from public and private payers, and are concerned that it could drive many physicians away from the Medicare program.

We appreciate the administration's outreach to the physician community during the comment period on this proposed rule, including listening sessions, briefings, and meetings with several physician advocacy organizations. We remain hopeful that this ongoing dialogue with the physician community will promote the effective implementation of MACRA.

That being said, while there are some improvements in the proposed regulation over existing reporting requirements, we are very concerned with a number of the proposed rule provisions. To begin with, let us note that as MACRA was being passed by Congress last year, MSSNY expressed concerns to our Congressional delegation that the MIPS and APM value-based payment programs contained in the legislation could very likely exacerbate adverse practice conditions that already are forcing countless physicians out of private practice and into employed relationships with hospitals. It has been reported over and over again that this dynamic is driving up the cost of care and, in some cases, impacting continuity of care for our patients. We again assert our strong concern that the complexity associated with complying with the various components of the Merit Based Incentive Payment system (MIPS) and Alternative Payment Models (APMs) could be greater than complying with the existing PQRS, Meaningful Use and Value-Based modifier programs it is replacing. We do not believe that effect was intended by Congress.

865 Merrick Avenue, Westbury, NY 11590 Phone: (516) 488-6100 FAX: (516) 281-3096

In particular, we raised concerns that small physician practices already unable to sustain any cuts in Medicare and other payments would be most at risk since many did not have the infrastructure in place to be successful in complying with these programs. Our worst fears were confirmed when we read Table 64 contained on p.676 of the proposed regulation noting that nearly 90% of solo practice physicians and 70% of physicians practicing in small groups would see negative Medicare payment adjustments. While we appreciate that CMS has since sought to assuage concerns from smaller practice physicians about the potential negative impact of this program, it has caused many physicians to re-consider participation in the Medicare program given the potential significant cuts they could face.

As you seek to finalize the rule, we urge CMS to assure that its proposed reporting systems seamlessly fit into physician practice and care delivery models, and are less costly than those that are currently required under the existing PQRS, Meaningful Use and Value-Based modifier program. The focus should be on improving care for all Medicare patients, not simply creating "winners" and "losers". Physicians who want to shift to value-based care should have sufficient time to make this transition in a way that actually benefits the care they deliver to their patients and does not cause undue collateral damage to their practices.

Needed Changes to the MIPS program

We note that there are some positive changes from the existing incentive/penalty programs, including reducing from 9 to 6 the number of measures needed to be reported under the updated PQRS program, and added flexibility to demonstrating meaningful use in the new "Advancing Clinical Care information" MIPS category. Moreover, we appreciate that the regulation would achieve the following:

- **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.

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

- **Offer choice,** by permitting physicians to select from any Clinical Practice Improvement Activities (CPIAs) without specific requirements related to categories or subcategories.

However, far more needs to be done to better assure that this program does not create a substantial disincentive for practicing physicians to continue to participate in the Medicare program, and reduce the supply of physicians to provide care to our seniors. Therefore, we are urging that CMS make the following revisions to the proposal:

- **Significantly raise the MIPS participation "exemption" threshold** from the proposed 100 Medicare patients and $10,000 in Medicare revenue. The low-volume threshold is an important tool for preventing adverse impacts from the MIPS program on patients' access to care. The proposed rule estimates significant costs of participating in MIPS. Physicians with small Medicare fee-for-service patient populations will have little likelihood of recovering these investments. And physicians who have no possibility of earning more than it costs them to report data should not be forced into unacceptably risky payment models and should be exempted.

- **Create a shorter reporting period.** With such a short time for practices to be ready to comply with the regulations which will not be finalized until this fall, we urge CMS to postpone the implementation start date to at least several months after January 1, 2017

- **Need for periodic feedback.** We urge CMS to create a mechanism for physicians to receive comprehensive periodic feedback from CMS as to how they are performing in each of the 4 categories before each performance period ends. It is unfair that a physician or practice may not find out how their "performance" compares against their peers until after the performance year.

- **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. Perhaps most importantly, we urge CMS to appropriately stratify physicians for determining Medicare bonus payments or penalties so that the MIPS program compares "apples to apples" rather than "apples to oranges". A physician's "performance" should be compared against other physicians practicing in similar specialties, and practice size rather than all being "lumped together" into one big pool.

- **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 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.

- **Grant credit for each reported ACI measure.** One of our greatest concerns with the existing Meaningful Use (MU) program is its pass/fail aspect that causes many physicians attempting to participate to still be penalized if their performance is not perfect. Unfortunately, the proposed rule retains this pass-fail element in the base Advancing Care Information (ACI) score. Instead, 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.

- **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 Clinical Practice Improvement Activity (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. We urge CMS to 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.

Needed Changes to the APM Program

We are very concerned that the CMS definition of "more than nominal risk" within the definition of an Alternative Payment Model (APM) will enable only a relatively small number of physicians and physician groups to be able to participate in this track. In particular, we are concerned that this definition will exclude physicians participating in a Level 1 Accountable Care Organization. For ACO in Track 1, excluding them from the APM disregards the huge effort and financial risks involved in running an ACO, estimated to be around $1 million a year for an 8,000 member ACO. In addition, we suggest the following:

- **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.

- **Base risk requirements on physician professional services revenues, not expenditures under the APM.** Physician Fee Schedule services account for just 19% of total Medicare Part A and B expenditures. Physicians should not have to take risks for expenses outside their control.

- **Reduce the amount of losses defined as "more than nominal."** The Regulatory Impact Analysis notes that CMS has long defined "significant" impact as 3% of physician revenue. However, it defines "more than nominal" as 4% of total costs. Since the definitions of "more than nominal" and "significant" would seem to be similar, "more than nominal" should be reduced to 3%.

- **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. These costs should be part of the calculation as potential financial losses.

- **Increase medical home flexibility.** The proposed regulation 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.** The 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.

Thank you for your attention to these comments. Again, we urge CMS to implement this law in a way that will encourage physicians to continue to treat Medicare patients rather than imposing difficult to implement rules and reporting mechanisms that will only have the effect of driving physicians away from the program.

Sincerely,

Malcolm D. Reid MD MPP

MALCOLM D. REID, MD

865 Merrick Avenue, Westbury, NY 11590 Phone: (516) 488-6100 FAX: (516) 281-3096