

June 27, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS-5517-P
P.O. Box 8013
Baltimore, MD 21244-8013
Submitted electronically via <http://www.regulations.gov>

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

Dear Acting Administrator Slavitt:

The Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) made important strides when it removed the Sustainable Growth Rate formula for determining Medicare payments for health care providers' services. However, the MACRA Quality Payment Program is a complete overhaul of our current payment model and requires careful, precise, and intelligent implementation. MedChi, the Maryland State Medical Society, supports the position of the American Medical Association and offers our additional comments regarding the notice of proposed rulemaking on the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs).

Maryland Waiver

We ask that CMS consider how Maryland's unique Medicare Waiver will affect the implementation of MACRA. Maryland physicians, with the Health Services Cost Review Commission, have worked with stakeholders for over two years on several gainsharing programs that are currently under consideration of CMS. The MACRA legislation presents a unique opportunity to continue the alignment of physicians and hospitals by linking payment to both quality and costs. However, several innovative payment models have not been allowed in Maryland as a result of the waiver. For example, CMS excluded Maryland from participating in Comprehensive Care for Joint Replacement (CJR) model. Maryland physicians are concerned that they will be penalized significantly (at least 5% in Medicare Payments) if CMS does not provide alternative Maryland-specific models to qualify as APMs.

Alternative Payment Models

To qualify for payments under APM provisions, the alternative payment entity must require use of certified electronic health record technology (CEHRT), have quality measures in place, and bear “more than nominal financial risk.” The proposed rule is unclear of how physician practices can meet the requirement for “more than nominal financial risk.” The proposed rule implies that “nominal financial risk” would be 4% of APM’s spending benchmark, which could account for 25% of the physician services. The AMA suggests, and we agree, that the definition of nominal financial risk should be modified to “4% of professional services revenues or an equivalent dollar amount,” which would put the risk of losses in an APM equivalent to the penalty risk in MIPS during the first performance year. Because this risk is more identifiable, physicians can more aptly prepare those funds, in the event they need to be repaid. According to the Impact Analysis, HHS has used 3% of physicians’ revenues as a standard for “significant impact.” Therefore, anything more than that cannot reasonably be considered “nominal.” Additionally, the “financial risk” requirement should be adjusted for Maryland physicians to account for the inherent risk that Maryland physicians face due to the unique Medicare Waiver.

Resource Use

The MIPS Rule proposes to add 41 episode-based measures to account for differences among specialties. While episode groups are a more effective method of assessing resource use, not all of the measures that CMS proposed are ready to be used. Additionally, the use of problematic cost measures renders it difficult to accurately compare costs of physician practices. CMS should replace hospital-intended cost measures with those that prevent practices with higher-risk patients from being more susceptible to penalties than practices with lower-risk patients and more precisely compare of factors relevant to all specialties. These measures should also align with any measures required under Maryland’s unique Medicare Waiver.

Small, “Fragile,” or Specialized Practices

The proposed MIPS rule includes an impact table that shows the MIPS rule could unfairly penalize small practices and put specialists and physicians who work in Health Professional Shortage Areas at a disadvantage. According to the Regulatory Impact Analysis, physician practices of fewer than ten clinicians would account for an estimated 70 percent of MIPS penalties in 2019. CMS has maintained that it will ensure additional flexibility for smaller practices, and that the impact table was based on old and incomplete data. These flexibilities should include lower reporting burdens, measures that compare these smaller practices with themselves, rather than larger, more sophisticated entities, an expanded low-volume threshold, and education, training, and technical assistance so that these practices do not face unnecessary administrative burdens as it tries to participate in MIPS or APMs.

The low-volume threshold exempts physicians with less than \$10,000 in Medicare allowed charges and fewer than 100 unique Medicare patients per year. MedChi strongly supports a

significant increase in the low-volume threshold to better safeguard solo physicians and small practices from adverse consequences, such as a restriction on patients' access to care. If low-volume physicians, those who are not considered "low-volume" under MACRA, are not exempted from MIPS, they may decide to opt out of Medicare or limit the number of Medicare patients they treat, which would reduce the number of physicians accessible to Medicare patients. Changing the low-volume threshold would allow physicians, especially those who provide high-cost treatments to a small number of Medicare patients, to continue serving the Medicare population.

Additionally, CMS has stated that under MIPS, clinicians will have the option to be assessed as part of a "virtual group" across four MIPS performance categories. How these virtual groups will be constructed has yet to be determined. The idea of virtual groups is good in theory, but small practices and solo practitioners are small for a reason. To link the performance of a "virtual group" to how the individual members get paid, individual members who have not worked together prior to the formation of this virtual group, is unfair and pushes the small practices to essentially merge. Flexibility, physician choice, and a later implementation date will allow small practices sufficient time to learn how virtual groups can help their practice succeed in this new payment structure. If the "virtual group" program is going to be implemented, CMS should significantly increase the low volume threshold to expand the exemption for small practices until the virtual group program is ready.

CMS also intends to use claims based on population health measures that were developed for use at a hospital and community level. These hospital-intended measures are not reliable measures of performance when applied to individual physicians or small group practices. Specialists also have reason to be concerned if they do not have outcome measures or measures in "high priority," as not having either measure would produce a lower score.

Advancing Care Information

The proposed rule replaced Meaningful Use with Advancing Care Information, which combines a Base Score and a Performance score that allows physicians to receive partial credit on measures. While CMS reduced the number of measures included in the scoring, CMS did not change the measures themselves to include additional patient engagement and health information exchange measures. CMS should use measures proven to demonstrate quality patient care. Additionally, because the Base Performance score is still pass-fail, and the base performance score makes up 50% of the total score, the Protecting Patient Information measure requires physicians to conduct security risk analysis, which physicians are not appropriately equipped to do and provides an additional administrative burden on the physician. The proposed rule also eliminated any possible exclusion from participation and requires new participants to begin reporting in less than a full calendar year. This provision should be changed to allow new participants who previously qualified for an exclusion additional time to transition to the new reporting system.

Timeline of MACRA Implementation

The start date of January 1, 2017 does not provide sufficient time for testing the physicians' ability to participate in MIPS or APMs. Additionally, because incentive payments would not begin until 2019, payments would be based on performance starting in 2017, which would prevent physicians from receiving timely feedback. If CMS were to push the start date to January 1, 2018, physicians would need to continue reporting Meaningful Use Stage 3, which would be an inefficient use of physician resources, whether the physician chooses to comply with a transient program or pay the penalty for noncompliance. A transition period and a later start date would allow physicians to collaborate with CMS on an appropriate performance period and additional flexibilities for diverse practices.

MedChi urges CMS to consider the waiver's specific impact on the implementation of MACRA in Maryland and how Maryland physicians could face additional penalties for simply practicing in Maryland.

Sincerely,

Gene M. Ransom, III
Chief Executive Officer