

August 21, 2017

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Re: CY 2018 Updates to the Quality Payment Program (CMS-5522-P)

Dear Administrator Verma:

On behalf of the largest physician organization in Maryland, MedChi, The Maryland State Medical Society, I am pleased to offer our comments to the Centers for Medicare & Medicaid Services (CMS) on the 2018 Quality Payment Program (QPP) proposed rule. MedChi supports many of CMS' proposals and appreciates that the agency is working to create a new program that reduces burden while promoting innovative approaches to improving quality. MedChi also strongly supports the comments. In particular, we appreciate that CMS listened to the recommendations of physicians and other stakeholders and is proposing another transition year for the Merit-Based Incentive Payment System (MIPS). CMS was also responsive to our concerns with the need for greater assistance to small and rural practices, as well as several improvements to Advanced Alternative Payment Models (APMs).

We recognize that beginning a new payment program requires a significant learning curve and that experience from these early years will help guide changes in the future program. Accordingly, we are committed to working with CMS to provide feedback on the QPP and highlight ways to improve successful participation. With respect to the 2018 program year, while we believe CMS has included many improvements, we continue to urge the agency to seek ways to simplify and further streamline the program. We would also ask that CMS put appropriate language in the rules that doesn't disadvantage physicians in Maryland given the unique Maryland All Payer Hospital Model.

The following outlines the American Medical Association's (AMA) and MedChi's principle recommendations on the 2018 QPP proposed rule:

MIPS:

- MedChi supports the expansion of the low-volume threshold, and urges CMS to notify individuals and groups as soon as possible that they qualify for the low-volume threshold exemption.

- MedChi opposes including items or services beyond the physician fee schedule, especially Part B drugs, when determining MIPS eligibility, applying the MIPS payment adjustment, and in cost score calculations.
- MedChi supports the AMA recommendations to simplify the overall MIPS scoring methodology, including setting a low performance threshold, maintaining the 70 point additional performance threshold, eliminating bonus points from the calculation of future performance thresholds, maintaining stability in program requirements in future years, and increasing the reliability threshold.
- CMS should continue to seek feedback and analyze data before adopting an approach to measure and score improvement, which may add complexity to the program and, once implemented, may be difficult to change.
- MedChi is supportive of the CMS proposal to allow physicians to select a facility-based measurement option; however, CMS should reduce the thirty percent floor in the quality category for physicians electing to use facility-based measurement to better align program requirements for both facility and non-facility physicians.
- MedChi strongly supports the ability for small groups and solo practitioners to form virtual groups and believes physicians should have maximum flexibility in the formation of virtual groups.
- MedChi strongly supports many of CMS's proposals that will create stability within the quality performance category for physicians, including not increasing the number of quality measures a physician is required to report, setting the data completeness threshold at 50 percent, eliminating cross-cutting measures from many of the specialty measure sets, and keeping the minimum point floor at three points for physicians who report on quality measures that meet the data completeness threshold. There are a number of modifications needed within the quality performance category, however, including the elimination of the outcome / high priority measure requirement, the removal of the requirement to report on all-payer data, the elimination of administrative claims measures, the topped-out measure removal process, and the proposed benchmarking methodology.
- MedChi strongly supports the CMS proposal to maintain the cost category weight at zero for the 2018 performance period. MedChi believes CMS needs additional time to develop, test, and refine new episode-based cost measures prior to including them in the MIPS program in future years.

- MedChi supports CMS’s proposal within the Advancing Care Information (ACI) category to extend certified electronic health record (CEHRT) flexibility for performance year 2018 and the proposed hardship exemption for small practices. We recommend improvements to the ACI category, including adding flexibility within the base score, reducing information blocking attestation requirements, , and creating a pathway for physicians to achieve ACI credit by using CEHRT to participate in a Qualified Clinical Data Registry (QCDR).
- MedChi supports CMS’s proposal to maintain the reporting and performance requirements within the Improvement Activities (IA) category to provide stability within the MIPS program. We urge CMS to continue to avoid adding complexity to the IA category by maintaining reporting through attestation, not removing any IA activities, and not requiring a future minimum participation threshold. In addition, MedChi encourages CMS to continue to increase opportunities to promote health information technology and increase the participation credit to APM participants within the IA category.

APMs:

- MedChi appreciates the proposals to: extend the eight percent revenue-based nominal amount standard for APMs for an additional two years; allow Other Payer APMs to use the revenue-based standard; and allow the Physician-focused Payment Model Technical Advisory Committee (PTAC) to recommend Medicaid APMs.
- We agree strongly with the AMA recommendation that the revenue-based nominal risk standard not be increased above eight percent in years 2021 and beyond. We also recommend that CMS: phase-in the eight percent standard for Advanced APMs; extend the medical home nominal risk standard to small and rural practices participating in all Advanced APM models, specialty medical homes, Other Payer medical homes, and medical home organizations with 50 or more clinicians; base the revenue standard for nominal risk on the revenues of the individual APM entity participating in the APM that is responsible for repayment of any losses; exclude reimbursement for Part B drug costs from the nominal amount definition; and modify the requirement to base the revenue standard on both Part A and Part B revenues. I have attached a list of Maryland practices that could be adversely affected if this rule is not changed.
- CMS should allow participation in Medicare Advantage APMs to be included under the beneficiary count test for Qualified Participant (QP) status determinations affecting 2019 and 2020 payment adjustments.
- Physicians who begin participating in an Advanced APM should be exempt from MIPS and have access to the five percent bonus payment during the year immediately following their first year of Advanced APM participation.

- MedChi strongly supports the AMA recommendation to provide technical assistance and data to facilitate development of physician-focused APM proposals, and urges the Secretary to respond to the recommendations of the PTAC within 60 days. We also think a Maryland model thru the progression plan under the new Medicare Waiver would be a logical addition.

We thank you for the opportunity to provide input on this proposed rule and look forward to continuing to work with CMS to ensure that MIPS and APMs realize their potential to support the ongoing transformation of health care delivery. If you have any questions regarding this letter, please contact me at 410-539-0872.

Sincerely,

Gene M. Ransom, III
Chief Executive Officer

Attachment

ATTACHMENT 1

According to the Maryland Health Care Commission (MHCC) the following Maryland Primary Care Program Organizations With Greater than 50 Providers That May Qualify for Program As of August 7, 2017:

Number of Primary Care Providers	Parent Organization
175	Johns Hopkins Community
126	Johns Hopkins University
126	MedStar Medical Group II LLC
102	Medical Faculty Associates, Inc.
81	Greater Baltimore Medical Center, Inc.
74	Patient First Maryland Medical Group PLLC
71	Sinai Hospital of Baltimore Inc.
69	Privia Medical Group LLC
64	Maryland Primary Care Physicians LLC
63	Anne Arundel Physician Group LLC
59	Maryland Family Care Inc.
56	Kaiser Foundation Health Plan of the Mid-Atlantic States Inc.
52	MedStar Franklin Square Physicians LLC