



Wisconsin Medical Society

June, 23, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS– 5517–P
P.O. Box 8013
Baltimore, MD 21244–8013

Re: Comments on 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:

The Wisconsin Medical Society (Society) appreciates the opportunity to offer comments to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) rule. We believe this proposed rule has very important implications for physicians, as well as for patients.

Comprised of more than 12,500 member physicians, residents and medical students, the Society is committed to value-based health care and supports efforts to create a sustainable Medicare system through incentivizing high-value care. We are the largest association of medical doctors in Wisconsin; nearly 65 percent of licensed physicians in the state are Society members.

Overall, the Society supports the conceptual development of the value initiatives at CMS. We believe that properly structured incentives to provide high-value care (i.e., high-quality, low-cost care) will result in better care for patients at a lower cost for payers. We also believe value-based payment policies can drive better quality, lower the cost of care and reduce overall costs for the Medicare program.

Below we provide specific comments on several provisions included in the MACRA proposed rule.

MACRA OVERVIEW

The Society and organized medicine strongly supported the MACRA, which repealed Medicare's deeply flawed Sustainable Growth Rate (SGR) formula. An aspect of the Society's support was the anticipated consolidation and administrative simplification in relation to current frameworks. In many important and significant ways, MACRA is better than the SGR. That said, many more improvements can be made, and the proposed rule's implementation of MACRA should be seen as a work in progress.

MACRA was designed to offer physicians two payment model pathways: 1) a modified fee-for-service model Merit-based Incentive Payment System (MIPS), 2) new payment models that reduce costs of care

and/or support high-value services not typically covered under the Medicare fee schedule included in Alternative Payment Models (APMs).

One goal in the Society's support of MACRA was simplification of administrative processes for physicians. Compared to the recent past/current framework, the proposed regulations include significant improvements. The Society's continued goal is to work to significantly reduce net regulatory burdens and complexities while creating flexibility and choice. We believe CMS shares our overarching aims in shaping regulations in that the proposed MACRA rule should provide more choice, flexibility, simplicity, feasibility and clinical relevance to physicians in the Medicare system. It is our expectation that CMS will listen earnestly to clinicians' feedback and improve upon the rule, as this will be key to the success and implementation of the law.

The proposed rule highlights many welcome areas of alignment across Quality Payment Program options. However, the program still seems like individual components with nuanced requirements that neither contribute to value nor a glide path to becoming Qualifying Participant (QP) APMs. Organizations and eligible clinicians (ECs) could spend considerable resources concurrently to meet old Physician Quality Reporting System (PQRS), Meaningful Use (MU) and Value Modifier requirements that are not aligned with the 2017 MIPS reporting period definitions. In addition, the MIPS reporting requirements are not necessarily aligned with achieving the QP APM incentives. The glide path to QP APM status must build upon streamlining existing standardized definitions for performance measures, units of analysis, measurement periods, benchmark periods, patient and eligible clinician attribution, risk adjustment, data sources and scoring. Quality Payment Program algorithms that are not aligned to help ECs transition from volume to value through successive levels of evidence-based, value-added patient care are wasteful.

We appreciate that CMS has tried to incorporate flexibility in this significant undertaking to pay eligible clinicians in a manner that rewards and motivates them to practice medicine in the most efficient, patient-centric way. Yet, the complexity related to this flexibility is not acceptable. We strongly encourage the individuals at CMS who are responsible for the Quality Payment Program proposed rules to begin meeting regularly to further align the requirements towards a glide path to QP APM status. This will require a system perspective rather than programs that are developed individually.

Lastly, while this is not an issue for this proposed rule as the statute prevents CMS from addressing the issue of budget neutrality, the Society believes one of the flaws of MACRA is that it continues the rigid budget neutrality provision for the MIPS program. The Society, given the opportunity, will work with Congress to ease this limitation.

A) MIPS OVERVIEW

The Society appreciates CMS's effort in the proposed rule to streamline the three independent and overlapping programs, and for providing more flexibility and choice of measures. CMS also provided a robust set of measures to choose from in the new Clinical Practice Improvement Activities (CPIA) component, which we believe will help to promote improvement and innovation.

Timeline

The proposed rule would implement an entirely new Medicare payment system on January 1, 2017. Under the proposed rule, 60 days after the final rule is published, physicians would begin to be rated/report on their performance with no testing to ensure their ability to participate and with no assurance that CMS has the capability to validate accuracy of scores or ratings within each compartment of the MIPS compartment score. The MACRA law calls for measurement and adjustments to occur within the shortest

timeframe possible, yet there are several areas where the proposed rule falls quite short of the spirit of the MACRA law.

The Society has several concerns regarding the implementation timeline, including the short lead time for physicians to learn the rules and the inadequate time to make practice adjustments. Simply put, the implementation timeline needs to be adjusted! The Society has had a longstanding position that movement toward a new payment system should be preceded by a period of payment stability for physicians and their practices. CMS should work to preserve a period of stability during its implementation of MACRA by providing for a period of transition and testing in the first three to six months of 2017.

This stable transition period should include assurances that CMS has conducted appropriate testing, including physicians' ability to participate and validation and accuracy of scores or ratings, and that CMS has the necessary resources to implement provisions regarding MIPS and APMs. The ICD-10 testing process is an excellent example of how to do this the right way to ensure success for nearly everyone; the last thing we want is another healthcare.gov rollout.

Table 64

Wisconsin is a state with highly integrated health systems, with 70 percent of physicians practicing in a large group setting. We believe our physicians, who provide high quality and efficient care to Medicare patients as documented by the Agency for Healthcare Research and Quality (AHRQ) and Dartmouth Atlas, are well positioned to thrive in a value-based care system.

However, the Society is worried about the potential negative impacts on small practices. CMS needs to address Table 64 and its implied inequitable impact on small practices given that 70 percent of MIPS penalties will be in groups of 10 EPs or less. CMS does exempt them from the all-cause hospital readmission measure and physicians in practices of 15 or less have a lower CPIA threshold, but more needs to be done.

The Society believes that while the data assumptions used to determine the percentage of certain eligible clinicians who would be penalized were flawed, we are still concerned about the inequitable impact. The Society encourages CMS to make methodological changes that ease the impact, like raising the low-volume threshold above the proposed \$10,000. For example, raising the low-volume threshold for the first year to \$30,000 would provide relief for nearly 20 percent of physicians from MIPS and provide a transition for them into the new payment system.

Quality Reporting vs. PQRS

In the proposed rule, CMS decreased the overall number of measures from nine to six, proposed to largely remove the pass/fail approach and allow for partial credit, moved from requiring that the measures must fall across specific quality domain to allow for flexibility and choice in the measures physicians choose, and eliminated many thresholds. The proposal to allow individual MIPS-eligible clinicians and groups the flexibility to determine the most meaningful measures and reporting mechanisms for their practice should encourage meaningful measurement. Also, CMS's elimination of overlapping quality measurement across separate programs should make data submission less burdensome and confusing.

The Society believes CMS has made good progress streamlining quality reporting programs and in laying the groundwork for an improved quality reporting program with more weight on outcomes-focused quality measures. We hope this work continues.

The Society does have concerns that the aggregate administrative burden for practices is still too high and some measures, like the full score thresholds, have increased from 50% to 80%-90%. Also, the Society is concerned that there continues to be full-year reporting for most components and that there are scoring methods that put at a disadvantage specialties without measures in “high priority” areas. Lastly, methodological issues remain, and the Society believes CMS should work to improve all of the mentioned above in the final rule.

Resource Use

In the proposed rule, CMS removes the double penalty for failing to report PQRS measures under the current payment system, improves upon the risk adjustment methodologies that produced penalties for treating the sickest patients by introducing 41 episode-based measures, and plans to improve attribution methods in 2018 (for 2020 payments). The Society appreciates CMS’s efforts in this area.

In implementing the resource use domain of MIPS, CMS continues to use the Value-Based Modifier (VBM) cost measures (Medicare spending per beneficiary and total per capita cost) that were developed for hospital-level measurement. We believe that given the current lack of other measures to determine resource use, continuing VBM in the initial year of the MIPS program makes sense as those measures will have been in place for many years in 2019, and doing so provides a transition physicians should be familiar with.

The Society does have concerns given that the cost measures and episode groups will still need to be improved and matured. Also, there are issues with risk adjustment, attribution methodologies, and sample sizes. Additionally, physicians may be subject to attributable measures for which they have no choice. Lastly, timely and actionable feedback is needed to enable improvement, and more readily available information remains elusive.

Resource Use Attribution

In the proposed rule, CMS largely delays for one year any changes to attribution methodologies. The Society encourages CMS to continue to explore alternative risk-adjusted methodologies and suggests CMS continue to work with specialty societies that can utilize their robust clinical data registries for comparison with claims data to test if there are better risk-adjustment methodology options.

We believe CMS’s attribution methodology must take into consideration when a physician first begins to care for a patient and reward physicians for keeping patients healthy. Physicians should not be penalized for seeing patients with high-risk scores. Under current CMS models, the primary care physician could be attributed the prior costs associated with that patient’s care, even though that physician was not involved with patient’s care at the time. This is particularly true for practitioners who provide primary care services. Many physicians will continue to look worse than they actually are on the average cost per patient unless CMS corrects this attribution methodology. If a provider has a record or patients declare that a provider is their primary care physician, Medicare should extract that data and count it in the physician’s score even if a beneficiary doesn’t use services for a given time period.

Also, CMS should reward and not penalize—as it does under some schemes—physicians for taking a larger role in coordinating care for a difficult patient and should not be concerned if they take on a larger role in coordinating care for the patient. If not done right, physicians will be dis-incentivized from coordinating care for fear that spending from other physicians and the costs associated with them could be attributed to their own cost score if they get more involved to a level where they would meet the current CMS threshold for attribution to that patient. In addition, healthy patients who need limited or no services

during a performance period also should be attributed to physicians. Successful physicians who keep their patients well should be attributed and rewarded for that care, otherwise only their sickest and highest cost patients will be attributed to the physician.

Undoubtedly, a new attribution methodology is needed to assign spending and responsibility, and it must focus on the services and spending a physician can influence. Under such a scheme, all portions for every patient would be assigned to some physician and/or provider, which is better than assigning total spending to a single physician. We recognize that the group TIN attribution methodology addresses this to some degree. That said, CMS needs to be able to better identify physicians who are able to reduce costs and/or unneeded care, and maintain or improve the quality of care they deliver. Whatever approach CMS takes, it is important that improvements are made to ensure that every physician will have spending that is attributed to him/her that is under her/his control. This will allow for physicians to do performance improvement and change their delivery and payment models based on an assessment of the information provided to them regarding the care they actually can control or influence.

Resource Use - Increase weight of resource use domain

Under the MACRA law, if 75 percent of EPs are successful, the weight of the Advancing Care Information (ACI) domain may be reduced to 15 percent. *The Society believes that if and when the ACI domain is decreased from 25 percent to 15 percent, that the 10 percent weighting removed from ACI should be moved into the resource use domain. This would increase the resource use weight from 30 percent in 2021 and beyond to 40 percent.*

Advancing Care Information

In the proposed rule, CMS moved away from the Meaningful Use (MU) program's 5 percent penalty for failing to get 100% score on all measures and replaced the pass-fail program with a base and performance scoring scheme. In the performance score, CMS proposed eliminating thresholds and allowing physicians to receive partial credit on measures. CMS also proposed removing redundant measures and problematic Computerized Physician Order Entry (CPOE) and Clinical Decision Support (CDS) quality measures. In addition, CMS proposed allowing for reporting as a group to ease the reporting process. Lastly, CMS proposed reducing the public health registry reporting required. The Society believes such changes will allow physicians and other clinicians to select measures to better reflect how information technology best suits their day-to-day practice, will help improve keeping the focus on patient care, and appreciates CMS's efforts.

The Society is concerned that the new 50 point base score threshold still requires 100% security attestation, that full-year reporting is required and, most importantly, it appears that the remaining MU measures are largely unchanged and simply reorganized. *It appears that the proposed rule primarily changes the scoring without changing the actual measures. The Society encourages CMS to dramatically rethink its approach to the way it measures electronic health records (EHR) interoperability to provide the needed greater flexibility, and to include regulations that focus on the goal versus the process.* Also, the Society believes CMS should return to previous year's requirements where physicians have been able to satisfy the MU requirements of the EHR Incentive Program by reporting over any 90-day period. The proposed rule requires full-year reporting, which is a significant leap from the current 90-day timeframe and we ask CMS to finalize and maintain a consistent reporting time period.

CMS should get rid of measures that focus on quantity of records and focus more on achieving interoperability and care coordination goals. Currently, most EHR vendor products simply exchange static

documents that really only satisfy the minimum meaningful use requirements. The lack of interoperability is one of the major reasons why the promise of electronic health records has not been fulfilled. Vendors have been incentivized to meet the flawed benchmarks under the meaningful use program. We need to replace those benchmarks with ones that focus on better coordinated care. MACRA offers that opportunity, and we need to take advantage of it.

Rather than using data exchange as the metric for measuring interoperability, CMS should focus on usefulness, timeliness, correctness and completeness of data, as well as the ease and cost of information access. Those metrics would benefit patients more than counting how many times voluminous documents are sent back and forth. There is no reason to carry over the flawed measures from meaningful use. MACRA gives us a chance to start fresh and produce metrics that enhance the wellness of patients. Organized medicine looks forward to working with CMS to get there.

Clinical Practice Improvement Activities (CPIA)

The Society appreciates that CMS included multiple options in the 90 plus activities offered. We also appreciate that CMS did not require physicians to have activities in each of the eight activity categories laid out.

The Society believes that the CPIA categories included in the high priority activities reflect the important facilitated performance improvement work that physicians are engaging in. Many physician organizations like the Society are well positioned to support physicians' efforts to reach the measures included by CMS via learning platforms already being operationalized. In fact, the Society's performance improvement continuing medical education (PI CME) activities are well represented in the CPIA and the quality measures.

The Society thinks that CMS could improve upon the CPIA domain by expanding the high weight activities that qualify for the higher 20-point weighted activities. Specifically, the Society believes the activity "Participation in MOC Part IV for improving professional practice including participation in a local, regional or national outcomes registry or quality assessment program. Performance of activities across practice to regularly assess performance in practice, by reviewing outcomes of addressing identified areas for improvement and evaluating results" should be moved into the high weight category and eligible for 20 points.

The Society also believes that physicians who are unable to report for other MIPS categories should have the option to increase the weight of CPIA scoring.

Proposed Data Submission

The Society appreciates the proposed rule that encourages the use of Qualified Clinical Data Registries (QCDRs) and creates opportunities for QCDRs to report new and innovative quality measures. Specifically, CMS is allowing for QCDRs to report data on all MIPS performance categories that require data submission. The Society hopes that this becomes a viable option for MIPS-eligible clinicians and believes these flexible options will allow MIPS-eligible clinicians to more easily meet MIPS submission criteria which, in turn, will positively affect their composite performance score. The Society believes QCDRs have the potential to be a central platform and can help to unify quality programs by validating data and testing measure results. The Society appreciates that CMS has opened the door to leverage the potential of QCDRs and their ability to connect efforts to improve outcomes.

MIPS Scoring

The MIPS Scoring seems overly complex with the varying points, bonus points and weights for each of

the four performance categories. Up to 90 points can be earned through a combination of performance measures and bonus points for “high priority” measures in the quality category, 40 points for the top box resource use score, 60 points for the CPIA top box score, and 100 points for the ACI category. Within each category there are special requirements and higher priority activities that are more heavily weighted. This “flexibility” at the expense of significant scoring complexity is an opportunity for improvement. At a minimum, CMS should consider having the total number of points for each performance category be the category weight. The overall MIPS score should be based on 100 points that would be attributed across the four performance categories based on the weight of each category. For example, in the 2017 reporting period, the quality category would count for 50 points for ECs in the top decile, 10 points for ECs in the top Resource Use decile, 15 points for ECs meeting all of the CPIA requirements, and 25 points for the top performers in ACI activities. Fewer than the maximum points could be allocated within each category for less than optimum performance. This would simplify the complex scoring algorithm where weighting is applied a variable “top” performance score for each category, resulting in a weighted score for each category that is summed.

At the beginning of the reporting period or when the benchmark data are available, a table for each MIPS category would show how the maximum points possible are distributed across each category. For instance, if an EC earns only 50 out of 60 points for the CPIA category, he/she can easily convert that to the MIPS score (a number less than 25) for that category through a simple look-up table. This concept should be applied across the performance categories to make the scoring more transparent.

MIPS APMS

Under the MIPS APM model, providers can improve their MIPS scores if they don’t meet Advance APM thresholds. The Society seeks further clarification as to why CMS proposed a zero weight to resource use for the first year of the MIPS APMS. The Society believes CMS may have done this because arrangements like MSSP ACOs in the VPM are being assigned as “average” for cost purposes. Presumably this is because the MSSP ACO structure has a different cost measure built in (against their historical benchmark) rather than a comparison to a national average.

The Society worries that if providers in a MIPS APM have a known cost measure or resource use below or above the national average—which they would be able to get from their QRURs—that those whose costs are below the national average would be disadvantaged by zeroing out the resource use. The Society wants to ensure that the zeroing out is not memorialized, particularly as the program is matured and the resource use category is increased to 30 percent. The proposed policy encourages high quality MIPS APMS to be scored on quality metrics only and would result in unfair higher scoring. If such were the case, it would encourage inefficient high quality APMS to continue to be inefficient, and the Society worries that the system could be gamed if CMS allows that to happen. This is especially true given that nearly 95 percent of ACOs in MSSP are in track one, which involves upside financial risk only.

The Society suggests a compromise for the first year that would allow resource use scores for MIPS APMS that turn out to be better than the national median the opportunity to achieve credit for the resource use/efficiency category, which would help their scores and recognize their investments in an APM.

B) APMS OVERVIEW

The Society appreciates that CMS’s approach to quality measure requirements under APMS are generally reasonable, including an initial EHR use proposal of 50 percent, which seems flexible although the threshold increases quickly, allowing performance to be judged on a group basis, and include reasonable

criteria for judging physician-focused payment models. CMS has aligned—and the Society encourages CMS to continue wherever possible—standards between the MIPS and APM tracks so clinicians can readily move between them.

Limitations on Who Can Participate

The Society is disappointed that in the proposed rule CMS has greatly restricted the types of entities that would qualify as an Advanced APM in 2017. MACRA intended to encourage broad APM participation and, to live up to the spirit of the law, CMS needs to provide more models that will be Advanced APM entity eligible. Yet under the rule, as little as 4.5 percent or 30,658 of eligible clinicians are anticipated to qualify as a participant in an Advanced APM. That could be as little as \$146 million in bonus payments in the first year.

Timeline

Also, the timeline for developing new models is long, the risk requirements are unrealistic in that the risk for cost versus revenues doesn't add up, and the risk requirements are far too complicated. Unfortunately, for a group of clinicians thinking about making the decision to become an advanced APM, they would have to make that decision essentially right now in the summer of 2016 in order to be eligible for the 5 percent bonus payment in 2019. The small window of opportunity to join in time for the 2017 performance year / 2019 payment year virtually ensures very little uptake by those not already in an APM.

APM Nominal Risk

Physician spending is roughly 16 percent of total Medicare spending, yet the 4 percent risk as defined in the proposed rule could be on average 25 percent of the physician's professional services. In addition, physicians often have incomplete information on their patients and the spending that occurs in other settings or with pharmaceuticals. The Society believes that the 4 percent risk included in the Advanced APM should be limited to physician or professional services.

Lastly, there is no credit for investments like data analysis and hiring of staff which are needed to start up an APM. Those start-up costs should be captured and counted in the calculation of the amount of money physicians put at risk.

APM Thresholds

While the Society understands that the established APM revenue thresholds are statutorily bounded, we are concerned the thresholds are too high and prescriptive for most clinicians and systems to develop and implement sustainable APMs. We ask CMS to be willing to work with clinicians and take this into consideration to the extent possible under statute in developing rules. Exploring way to be more flexible in meeting the requirements to participate as an APM may be one way to help alleviate the high threshold burden.

CONCLUSION

The Society appreciates the opportunity to comment on this important proposed rule and support the goals set forth in MACRA. We look forward to continuing to provide feedback on this important initiative. Please contact us if we may be of any assistance as CMS further refines the proposed rule.

Sincerely,

Rick Abrams, JD
CEO, Wisconsin Medical Society