August 21, 2017

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-5522-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CY 2018 Updates to the Quality Payment Program

Dear Administrator Verma:

The Wisconsin Medical Society (Society) appreciates the opportunity to offer comments to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed rule CMS-5522-P which proposes changes to the Quality Payment Program (QPP). We believe this proposed rule has very important implications for physicians, as well as for patients. The Society wishes to reaffirm its commitment to value-based payment while limiting the administrative burden that is placed on physicians.

Comprised of more than 12,500 physicians, residents and medical students, the Society supports efforts to create a sustainable healthcare 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.

The proposed rule modifying the QPP will impact more than a third of physicians nationwide. We respect and appreciate CMS’s efforts to reduce the regulatory burden on physicians especially since 90 percent of physicians feel that requirements for the Merit-based Incentive Payment System (MIPS) are burdensome. The Society believes improvements can be made to the rule to help it work more effectively for the physicians in the program. Specifically, improvements to the QPP can be made regarding the scoring mechanisms for both the MIPS and Alternative Payment Models (APMs), along with modifications to the virtual group parameters and low-volume thresholds.

Attached to this comment letter are the Society’s “Health System Reform Objectives” which state that any changes to the Affordable Care Act (ACA) and health care reform in general -- should not cause individuals to lose existing coverage, place undue burdens on patients or physicians, restrict access or adversely affect affordability. With these core principles in mind the Society has the following comments on CMS file code CMS-5529-P, document number: 2017-03010.

MIPS Scoring

The Society believes that the overall scoring methodology for the MIPS program should be simplified to reduce administrative burden on physicians. If physicians do not comprehend the scoring, they are likely to view the program as unfair and may be subject to financial penalties solely due to confusion rather than their actual performance. Broadly speaking, the Society has concerns with regards to the multiple types of bonus points available to physicians under the QPP. To simplify MIPS scoring and to avoid arbitrarily awarding points, The

1 “Are physicians ready for MACRA/QPP?: Results from a KPMG-AMA Survey.”
Accessed June 28, 201.
Society recommends that additional bonus points be equal to one another. To avoid confusion the Society urges CMS to make all bonus points permanent. We also believe that the bonus points should not be factored into setting future performance thresholds.

**Quality Reporting-Data Completeness and Topped-out Measures**
In the 2018 update CMS is recommending that physicians who do not satisfy the data completeness threshold for the 2019 MIPS performance period get 1 point instead of 3 as in calendar year 2017. The Society suggests that CMS keep the 3-point threshold so long as the physician makes a substantive effort to submit data, or provide a sliding scale for physicians who make a good faith effort to achieve data completeness thresholds. In doing so CMS would reward physicians submitting data in a timely manner. Then in later years as data submission becomes more ubiquitous CMS can adjust the thresholds. CMS also should consider easing the data completeness requirements for small practices. Small practices, particularly in rural areas of Wisconsin, are often the most adversely affected by the QPP data requirements and may not have robust electronic health record (EHR) systems. Given the financial and temporal requirements necessary to administer an EHR those small practices that do have robust EHRs should be rewarded under the QPP with either a small practice-specific bonus or a bump to their overall data completeness score. Doing so may incentivize other small practices to incorporate EHRs into their practices.

In addition, CMS should reevaluate the removal of “topped-out” measures from the MIPS program. The Society acknowledges that easily achievable targets may not contribute to improved quality or value over the long term. However, the Society is concerned that with almost half of the MIPS quality measures close to topped-out status high-performing physicians may not be adequately rewarded for their outcomes. The Society urges CMS to consider that any topped-out process-oriented measures be replaced with outcome-oriented measures so physicians are correctly rewarded for providing high quality care. We also support CMS’ phased-in approach for removing topped out measures from MIPS, however, we do not support CMS’ proposed timeline for classifying measures as “topped out” or its proposal to cap achievement points. Prior to removing any “topped out” measures, CMS should review measures to determine if they are tied to our nation’s most important “Vital Signs” as described by the National Academy of Medicine in its report with the same name. Further, CMS should exercise caution when considering removing topped-out measures until all possible consequences have been explored. Consequently, physicians should be able to earn maximum scores for reporting such measures until their removal.

**Cost Reporting**
The Society suggests CMS weight the Cost component of the final MIPS score at 10 percent for payment year 2020. As physician practices and health systems develop processes surrounding MIPS it is not advantageous to delay the incorporation of Cost measures as a part of the final MIPS score. This is particularly true if CMS incorporates a significant jump from 0 percent to 30 percent in 2021. However, if CMS chooses to keep the Cost component at 0 percent for 2020 the Society suggests CMS incorporate a phase-in process similar to the current timeline (e.g., 10 percent in 2021 and 30 percent in 2022). Further, given that CMS has expressed its own “concerns about the level of familiarity and understanding of cost measures among clinicians” (p. 136) it would be beneficial to all MIPS-eligible physicians to have, at a minimum, a phase-in of the Cost component. The Society recommends a weight of 10 percent for the Cost component for payment year 2020, or similar phase-in of Cost weighting in subsequent years. We recommend that CMS continue to seek feedback and experience regarding improvement methodologies at least through the MIPS transitional period before adopting an approach which, once put into motion, may be difficult to change.

**Improvement Scoring for Quality and Cost**
The Society recommends that CMS devise a method to reward physicians who already have achieved improvements in quality for performance period 2020. Although CMS is not considering scoring improvement metrics until 2021, rewarding positive outcomes and behaviors prior to 2021 could serve as an added incentive for physicians and encourage broader positive participation in MIPS and movement towards more value-based payments. Further, the Society does not believe that the one year of data on the MIPS program is sufficient to begin measuring improvement, as required by the statute.
Improvement Activities
The Society suggests CMS maintain the limit of only one practice within a tax identification number (TIN) that is required to be recognized as a patient-centered medical home (PCMH). As more physicians and practices become familiar with how the QPP will operate with regards to improvement activities and medical homes then CMS could consider raising the threshold. However, raising the threshold in the second year could disadvantage some providers practicing in a PCMH designated clinics, who are developing their QPP practices.

Advancing Care Information
The Society appreciates CMS’s efforts to reward physicians who report their data to public health registries. When correctly implemented, registry reporting can be an effective means of improving a myriad of public health goals. The Society is concerned that providers in certain states may be at a disadvantage for a bonus simply because their state does not have an active registry or patients wish to have their information withheld from the registry. For example, Wisconsin’s current Birth Defects Registry is an opt-in registry meaning parents have to consent to the information being collected. The Society is working to change the structure of the registry so that it becomes an opt-out registry. The Society encourages CMS to take situations such as this into account when scoring physicians.

Complex Patient Bonus
The Society commends CMS’s willingness to recognize that complex patients present unique challenges and require a significant amount of care and coordination among a team of providers. Complex patients often have higher costs and may need extensive treatment. The Society agrees that a complex patient bonus could help ensure that the physicians are not penalized by Medicare if they treat large numbers of high-risk and/or disadvantaged patients.

A potential component of the complex patient bonus are dual-eligible patients (those eligible for both Medicare and Medicaid). Dual-eligibles are a difficult and costly group to treat. CMS makes clear its consideration of dual-eligibles in developing its Hierarchical Conditions Category (HCC) risk score, but proposes using dual-eligibles only in an alternative scoring methodology. The Society appreciates CMS’s efforts to derive a complex patient score based on actual diagnoses rather than patient eligibility status, and we agree with this approach. However, statistical and historical experience demonstrate that dual-eligibles have some of the highest costs coupled with more complex conditions. Further, as evidenced by Table 35, practices with the higher proposed HCC scores also have a higher concentration of dual-eligible patients. Therefore, were CMS to consider using dual-eligibles as part of a complex patient bonus it would make sense to combine both patient diagnoses and dual eligible status into a composite score, rather than completely substituting dual-eligibles as a proxy for complex patients. The Society suggests that if dual-eligible patients were to be incorporated into a complex patient bonus that they be incorporated alongside the proposed diagnosis-based HCC scoring methodology, but not as a wholesale substitution.

Small Practice Bonus
The Society strongly supports the small practice bonus and agrees that this bonus should be available to group practices, virtual groups, and APM entities that consist of 15 or fewer clinicians as defined under Section 101(c)(2)(B)(iii)(VI) of the Medicare Access and CHIP Reauthorization Act of 2015. Small practices are at a unique disadvantage when it comes to implementing many provisions of the QPP. Small practices in rural areas are at an even greater disadvantage as they are often the only providers for certain communities, and have limited time and resources to develop the capacity necessary to implement QPP. Bearing this in mind it would help to level the playing field for rural practices to extend the small practice bonus to rural providers. Given the significant confusion around the definition of small practices, the Society believes that CMS should continue to make the small practice eligibility determination using claims data. While an attestation option may be easier for physicians, we are concerned that physicians may incorrectly attest that they are a small practice and find out later that they received a penalty based on an incorrect assumption that their practice was small.
Performance Threshold
CMS should keep the performance threshold at 3 points for calendar year 2018. Providers and administrators at all levels are having difficulty incorporating all of the proposed QPP regulations and parameters into their data and payment processes. Raising the threshold to more than five times its current level could place an undue burden on providers at this point in the transition. Maintaining the current threshold would reward providers who are implementing QPP measures into their practices while encouraging those who are reluctant to do so as well.

APM Scoring
To help give providers more flexibility under QPP, CMS should consider extending the All-Payer Combination Option to virtual groups that qualify as an APM. This option would give virtual groups more flexibility in determining how they wish to report under the QPP, and also could incentivize the creation of more virtual groups. Further, the Medicare Threshold Score for individual physicians eligible under an APM should be calculated for the higher of either the APM group score or the individual score. In defaulting to the higher of the two scores CMS would reward the individual physician for providing high quality care, while also getting credit for participating in an APM. Such a change could incentivize an increase in the creation of and participation in APMs.

Virtual Groups
CMS should consider adding the virtual group option in year 2 of the QPP. The virtual group could be comprised of solo practitioners and/or groups with 10 or fewer eligible clinicians. To help accomplish this goal the virtual groups would need to exceed the low-volume threshold at the group level. The virtual groups could include physicians who themselves do not meet the definition of a MIPS-eligible physician. Further, the shift to an APM for a virtual group should be made at the discretion of the virtual group. CMS should not preemptively determine which scoring methodology should be applied towards a virtual group as this would limit flexibility and choice under the QPP. The Society supports the creation of virtual groups and encourages CMS to explore methods to further incentivize their uptake.

Low-Volume Threshold
The Society appreciates the concern CMS has for alleviating burdens on physicians. Raising the low-volume threshold from $30,000 in Part B charges or 100 Part B beneficiaries, to $90,000 or 200 beneficiaries will effectively lower the number of physicians required to participate in MIPS to around 36 percent of all physicians (Table 85). And while this change could benefit small practices, we are concerned that raising the low-volume threshold may have unintended consequences.

First, by raising the low-volume threshold CMS is shrinking the pool of those competing for bonus payments and putting some physicians at a disadvantage. The smaller pool will mean increased competition for bonus payments, particularly in the later years of the program, and physicians who would have seen higher bonus payments may either not receive the bonuses, or suffer a reimbursement. CMS should evaluate ways to mitigate this issue and instead hold harmless those physicians who would have qualified for bonus payments under the old threshold.

Second, the proposed threshold shrinks the pool of MIPS-eligible physicians to just over a third of all physicians, but does not incentivize non-MIPS-eligible physicians to incorporate any quality measures. This potentially could create a two-tiered system of care for Medicare beneficiaries. To address this potential Medicare “tiering,” the Society suggests that CMS could potentially create a MIPS program for smaller practices with reduced reporting requirements. Even limiting the abbreviated MIPS-like program to physicians in the $30,000 to $90,000 range would be sufficient to encourage and incentivize a transition toward quality and value improvements.
The Society also urges CMS to let physicians opt-in to the QPP in future years if they do not exceed either of the low-volume thresholds as currently proposed. Giving physicians the choice to opt in speaks to the flexibility that CMS wishes to extend to physicians. The Society also thinks that offering the option to opt in based on the number of Part B items and services (should CMS consider creating such a threshold), would give physicians the flexibility necessary to successfully implement the QPP. The Society does caution that the threshold for Part B items and services should not be set at a level discouraging participation in the QPP. Rather the Society encourages efforts that reward and incentivize improvements in quality and value. While this provision may add complexity to the eligibility requirements of the QPP the Society contends that this would add greater flexibility to the QPP for those physicians who wish to opt in.

The Society thanks CMS for the opportunity to comment on the revisions to the Quality Payment Program. We are committed to encouraging and promoting quality and value for both physicians and their patients, and wish to be a partner in making the QPP work for both. We hope you take our recommendations under consideration and please feel free to contact us with questions or for additional information.

Sincerely,

Robert Foulks, CPA, CAE
Interim Chief Operating Officer