Illinois State Medical Society

ISMS submitted the following comments to the Centers for Medicare and Medicaid Services requesting modifications to the proposed rules implementing provisions of the Medicare Access and CHIP Reauthorization Act (MACRA). CMS released the Final Rule on October 14, 2016, which included several modifications that are consistent with ISMS comments. For more info, refer to the sections annotated in ***green*** *below.*

June 27, 2016

VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5517-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: **Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models [CMS-5517-P]**

On behalf of the physician members of the Illinois State Medical Society (ISMS), I write with regard to CMS' proposed rule implementing the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) provisions of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). We recognize that in proposing the Quality Payment Program framework CMS has attempted to implement MACRA in a way that promotes quality patient care, reduces administrative burdens for physicians, and provides flexibility for physicians regardless of specialty, practice size, or mode of practice. We appreciate your efforts in this regard and thank you for the opportunity to provide comments to help CMS improve the provisions in the final rule.

Performance Period - SUCCESS
In order to accommodate data collection and processing and to provide feedback to physicians prior to payment adjustments, CMS proposes to establish a calendar year performance period, beginning January 1 two years prior to the year in which the payment adjustment is applied. In order to accommodate the 2019 adjustment start date mandated by MACRA, CMS proposes January 1, 2017 as the first MIPS and APM performance year.

We are extremely concerned that a January 1, 2017 start date does not allow sufficient time for practices to prepare to meet the new requirements under the Quality Payment Program, for either MIPS or the advanced APMs. CMS does not anticipate releasing the final program rules until late summer or early fall, which means that practices would be left with only a few months to

understand and implement the changes in their work flows and technology that would allow them to successfully report under MIPS or identify potential opportunities for Advanced APM participation.

We understand that CMS is required by law to adjust Medicare Part B payments based on MIPS or award bonuses for APM participation beginning in 2019, but believe that the Agency has the authority to establish a performance period that realistically reflects the time needed for physicians to successfully transition to the new system. Specifically, we encourage you to delay the January 1 2017 start date, and to consider implementing a shortened performance period for all participants in the first year.

SUCCESS – The Final Rule makes clear that 2017 is a "transition year" for practices. The performance period has been shortened to a minimum of 90 days, and CMS gives practices three options to avoid negative payment adjustments in 2019. Specifically, practices can choose a "test" option, where they report on only a single measure or activity. There is also a partial reporting option where practices will be eligible for positive payment adjustments if they report data on more than one measure for a minimum performance period of 90 days. Both of these options allow practices to become familiar with the rules of the program before jumping in, and will indemnify them against payment penalties. Practices that are ready and able to participate fully in MIPS will be eligible for larger positive payment adjustments. Importantly, practices that choose to report nothing (not even a single measure under the "test" option) will receive the maximum 4% payment penalty in 2019.

Further Simplify and Streamline Performance Reporting Requirements and Scoring Methodologies – SUCCESS

CMS has indicated that one of the advantages of MIPS is that it streamlines the existing "patchwork" of quality and performance programs into the single MIPS program. Yet it is clear from the proposed rule that additional work needs to be done to implement MIPS in a way that truly integrates the program components and further reduces the administrative burdens and complexities of the program.

While elements of the existing Physician Quality Reporting System, the Value Based Modifier Program and the Meaningful Use programs have been simplified and additional flexibility has been integrated into the proposed rule, we are very concerned the cumulative effect of four (with the addition of the Clinical Practice Improvement Activities category) sets of largely separate measures, scoring methodologies, and reporting requirements as proposed could result in more administrative work for practices, not less. It is also important to keep in mind that while there is flexibility built into the Clinical Practice Improvement Activities category, the effort associated with identifying and engaging in appropriate activities is an additional responsibility that practices will have to fulfill, which may be particularly challenging as physicians adapt to this new type of reporting.

We encourage CMS to consider additional ways to reduce the MIPS reporting burden for all practices. Further reducing required measures or activities in each MIPS category, lowering

measure thresholds, establishing consistent definitions (such as for "small practices") across categories, and providing more opportunities for "partial credit" could help facilitate the overall goals of MIPS by ensuring that physicians have more time to focus on delivering quality care to their patients. We also strongly encourage CMS to ensure that the reporting requirements for MIPS are aligned with each of the American Board of Medical Specialties Member Board's requirements for Maintenance of Certification, particularly activities required to fulfill Part IV: Improvement in Medical Practice.

On a related matter, CMS proposes a 30 day review period before MIPS data is publicly reported on Physician Compare. While this is consistent with existing regulations regarding data reported on Physician Compare, we believe that 30 days is insufficient given the expanded nature of the data being reported through MIPS, particularly as physicians adjust to the new system. We strongly urge CMS to adopt a 90 day review period for reporting MIPS data to Physician Compare, which will provide sufficient time for physicians to thoroughly review and understand the information that is presented, and to identify and work with CMS to correct any discrepancies.

SUCCESS – The Final Rule made several changes to simplify and streamline the reporting requirements. Specifically:

- MIPS scoring for 2017 will be based on only 3 performance categories: Quality, Clinical Practice Improvement Activities, and Advancing Care Information. The Resource Use category has been assigned a weight of 0% for 2017.
- The data completeness threshold for all forms of data submission has been reduced from a proposed 90% of patients to 50% of patients.
- The number of Clinical Practice Improvement Activities that most practices need to attest to in order to receive full credit in the category has been reduced.
- The number of required measures in the Advancing Care Information category has been reduced from 11 to 5.

The Final Rule did not change the review period for public reporting on Physician Compare; the review period remains 30 days.

Accommodations for Small and Rural Practices – SUCCESS

ISMS appreciates CMS' efforts in the proposed rule to provide increased flexibility for solo practitioners and small and rural practices. However, we believe there are additional steps that can be taken to ensure that these types of practices are not disadvantaged under the new payment system.

In particular, reporting burdens disproportionately affect small practices, and the financial and time investment associated with meeting program requirements can create a significant barrier for to successful participation. At a minimum, we encourage you to expand the low-volume thresholds,

both the patient count and dollar values, in order to exempt more physicians who serve a relatively small number of Medicare patients. We also urge you to consider providing explicit exemptions, lower reporting thresholds, and modified reporting periods in all MIPS categories for physicians in small or rural practices. Such accommodations could also be incorporated into the APM requirements to further reduce barriers to APM participation for these types of practices.

In addition, to minimize the financial burdens on small practices, we urge CMS to ensure that there are free or low cost reporting options within each MIPS category. CMS should consider additional proposals for measures and activities that do not require expensive technology or interfaces to implement. Advancing Care Information and Clinical Practice Improvement Activities are two categories in particular in which the existing requirements have the potential to create financial barriers for smaller practices or practices with more limited resources.

We are also strongly encourage CMS to accelerate its timeline for developing guidance on the option of allowing solo and small practices to use "virtual groups" to report under the MIPS program. We believe this option, if designed appropriately, could help distribute administrative burdens and reporting risk among a broader base of physicians, helping to increase chances of success for small practices.

SUCCESS – In addition to the other changes highlighted above that will ease administrative burdens for practices, the final rule included a significant modification to its original proposal regarding the "low volume threshold that would exempt smaller practices from participating in MIPS. Specifically, CMS raised the low volume threshold from $10,000 in Part B revenue AND fewer than 100 Part B patients to $30,000 in Part B revenue OR fewer than 100 Part B patients.

Alternative Payment Models – PROGRESS

CMS has been clear in its intention of encouraging the vast majority of physicians who are paid by the Medicare program to participate in an APM. The incentive and bonus plans articulated in MACRA, as well as the divergent payment updates slated to begin in 2026, appear to offer significant inducements to encourage physicians to pursue APM involvement.

We are extremely discouraged to see that the proposed rule establishes such a high bar for an entity to qualify as an Advanced APM, even to the point of excluding participants in some existing Innovation Center programs. Practices that have made the investment and effort to participate in the Medicare Shared Savings Program ACOs and other initiatives are subject to a very high cliff in terms of the requirements they must meet to be exempt from MIPS and be classified as qualified APM participants. Furthermore, practices that may have been interested in pursuing APM participation because of the new incentives and resources provided for in the MACRA legislation are certain to find themselves discouraged by the complex and excessive risk requirements outlined in the proposed rule, as well as the limited participation choices that will be available if CMS adheres to the proposed 2017 performance period.

ISMS shares the concerns of other stakeholders who have commented that without a smooth "on ramp" for APM participation, practices are likely to continue to pursue traditional fee-for-service

care delivery and engage exclusively with the MIPS payment track. While MIPS will be an appropriate pathway for many practices, CMS should ensure that it provides sufficient opportunities for physicians and practices that are interested in and motivated to explore alternative delivery models. To that end, the final rule should establish timelines and criteria that will allow for existing APMs to be modified and new APMs to be created so that there are appropriate and financially viable options for a wider range of physicians.

PROGRESS – The Final Rule acknowledges that more needs to be done to encourage and facilitate physician participating in APMs. The Final Rule announces that CMS is exploring the development of a voluntary option that would allow ACOs that are currently participating in Track 1 of the Shared Savings Program or newly formed ACOs to participate in a new ACO model that would incorporate more limited downside risk than current Track 2 or 3 ACOs, but would still allow them to qualify for Advanced APM status.

Physician Education and Feedback – PROGRESS

Finally, we strongly encourage you to prioritize physician education during the MACRA implementation process. Physicians need accurate, timely, and actionable feedback to help them achieve the goals of MACRA, and will need help understanding the new program rules. While we appreciate CMS' efforts to implement the legislation in a flexible manner, individual physicians will need significant help understanding their choices and where they fall in terms of thresholds, measure requirements, benchmarks, etc. We understand that CMS intends to develop and make available simple decision support tools that will help physicians understand where they fit in the Quality Payment Program and what they need to do to maximize their chances for success. We believe these types of personalized resources will be critical to the success of the program, and urge CMS to develop and disseminate them as soon as possible.

The Practice Transformation Networks and other technical assistance opportunities will be very valuable for physician practices, especially to the extent that they provide individualized support to individual physicians as they navigate the MIPS and APM options. Especially during the early phases of implementation, it is critical that CMS ensure that these types of "high touch" resources are available to practices.

PROGRESS – The Final Rule articulates several instances where CMS will take responsibility for determining and notifying physicians of conditions that might affect participation status in MIPS or an Advanced APM. Specifically, CMS will calculate and notify physicians of their eligibility for low-volume threshold exemptions, non-patient-facing physician reporting status, qualified participant status for physicians participating in Advanced APMs, and the list of models that qualify as Advanced APMs.

CMS has also created a comprehensive web site https://qpp.cms.gov/ where clinicians can learn more about MIPS and APMs (collectively called the Quality Payment Program), explore quality measures and clinical practice improvement activities, and investigate practice options.

We thank CMS for its careful consideration of physician and stakeholder input in developing the proposed rule, and for its efforts to seek feedback to help improve the provisions in the final rule. We very much appreciate the opportunity to comment on the proposal. ISMS looks forward to the release of the final rule and to working with our member physicians to help educate them about Medicare's new Quality Payment Program.

Sincerely,

William A. McDade, M.D., Ph.D.
Chair, Board of Trustees

cc: Thomas M. Anderson, M.D.
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