December 19, 2016

Andrew M. Slavitt
Acting Administrator, Centers for Medicare & Medicaid Services Department of Health and
Human Services
Attention: CMS-5517-FC
Submitted electronically via http://www.regulations.gov

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

Dear Acting Administrator Slavitt:

The Alliance of Specialty Medicine (the "Alliance") represents more than 100,000 specialty
physicians from 13 specialty and subspecialty societies. The Alliance is deeply committed to
improving access to specialty medical care through the advancement of sound health policy.
For this reason, we are pleased to provide input that will continue to inform your
implementation of the Merit-based Incentive Payment System (MIPS) and Alternative Payment
Models (APMs) under the Quality Payment Program (QPP) established as part of the Medicare
Access and CHIP Reauthorization Act of 2015 (MACRA).

General Sentiments on the Medicare Quality Payment Program

We greatly appreciate the considerable modifications CMS incorporated into its finalized
policies under the QPP, particularly with regard to the "Pick Your Pace" reporting strategy and
reweighting of the MIPS performance categories in the first performance year. Nevertheless,
we continue to believe specialty physicians will struggle with the reporting and performance
requirements, primarily under the MIPS, and that patient health and outcomes will not
significantly improve commensurate with the time and effort providers expend to engage in the
QPP.

We are also concerned that CMS continues to treat the MIPS program as four separate
programs with different requirements and complex scoring mechanisms. CMS must work to
streamline the MIPS, integrating the performance categories into a more cohesive program,
and simplify the scoring, so it is well understood by participants.

"Pick Your Pace"

We agree with CMS that "the iterative learning and development period will last longer than the first year," and that 2018 must also be transitional in nature. Not only will providers need additional time to learn, but CMS will need time to further develop its policies and address a multitude of deficiencies. For these reasons, we urge CMS to continue its "Pick Your Pace" reporting strategy, allowing physicians to select a participation option that meets their level of readiness. We further encourage CMS to minimize the impact of penalties on providers by maintaining a low performance threshold, and keeping the additional performance threshold at a reasonable level so that exceptional performers can access "bonus" funding.

Focused Education and Technical Assistance for Specialty Providers

We appreciate that CMS has worked diligently to provide a significant volume of education and tools for providers on the QPP. A number of recommendations that we made have been implemented, including multiple webinars, easy-to-read fact sheets, and "train-the-trainer" sessions for specialty society staff.

The launch of the QPP web portal includes some easy-to-understand information for providers. Unfortunately, the vast majority of that information has been primary care focused. Specialty physicians face unique challenges in the QPP program, and they have questions that are not easily discernable through the QPP portal or even a thorough review of the final rule. Alliance specialty society staff have submitted questions about their members' specialized issues through to the QPP helpdesk, which are being punted to other helpdesks or CMS program staff and remain unresolved even after 3-4 weeks. Without answers to these important questions, it is difficult to advise specialty practices on how to engage in the program, meet reporting requirements, or how they may be scored.

We urge CMS to expand the volume of educational resources and tools dedicated to specialty physicians. Similarly, we urge CMS to adequately staff its QPP helpdesk so that it can respond in a timely matter to queries on specialty matters.

In addition, specialty practices will need in-house technical assistance as the QPP is implemented. As requested in prior comments, we urge CMS to establish boots-on-the-ground expertise through its Quality Improvement Organizations (QIOs) so they may be able to provide practice-level technical assistance to specialty practices.

Risk-Adjustment

The Alliance remains concerned about the lack of appropriate risk-adjustment in current cost and quality metrics. As noted in this final rule with comment period, the Secretary is required to take into account the relevant studies conducted and recommendations made in reports under section 2(d) of the Improving Medicare Post-Acute Transformation (IMPACT) Act of 2014. We understand that the Office of the Assistant Secretary for Planning and Evaluation (ASPE) has been conducting studies on the issue of risk adjustment for sociodemographic factors on quality measures and cost, as well as other strategies for including social determinants of

health status evaluation in CMS programs, including the Quality Payment Program, and that CMS will incorporate findings as feasible and appropriate through future rulemaking.

This activity cannot be over emphasized; without appropriate risk adjustment, clinicians' ability and willingness to care for the most vulnerable beneficiaries will quickly diminish as the resources they need to care for this population will deteriorate under the current scoring methodology. We urge CMS to work diligently over the next several months to develop a robust and transparent risk-adjustment strategy for the cost and quality performance category.

MIPS Program Details

Virtual Groups

We were disappointed that CMS did not make any proposals for Virtual Groups, given that the concept was an important provision of MACRA for specialty physicians. We urge CMS to issue proposals for Virtual Groups as quickly as possible, defining a group identifier for virtual groups, establishing the reporting requirements for virtual groups, identifying the submission mechanisms available for virtual group participation, and establishing methodologies for how virtual group performance will be assessed and scored. CMS must avoid placing arbitrary limits on a virtual group's minimum or maximum size, geographic proximity, or specialty of virtual groups.

CMS should also establish a web-based platform that assists providers that wish to form or join a Virtual Group. This "Physician Connect" web-site could be linked to Physician Compare so that potential participants could review publicly reported data about those they might form or join a Virtual Group with.

Group Reporting

The Alliance appreciates the flexibility of individual or group level reporting options, but remains concerned about the requirements for group reporting and the confusion that has unfolded, as a result. Several Alliance specialties are particularly confused about group reporting when it comes to the Advancing Care Information (ACI) performance category. Under the predecessor program, group reporting was not an option. We urge CMS to provide additional educational tools and materials to assist with group reporting for this and the remaining categories, preferably with a focus on specialty medicine.

Low-Volume Threshold

We appreciate that CMS modified its low-volume threshold by decoupling the payment threshold from patient count; however, CMS did not go far enough when it increased the payment threshold to $30,000. We believe the low-volume threshold continues to inappropriately retain physicians in the MIPS program that treat relatively few beneficiaries simply because they engage in resource intensive specialties. We urge CMS to increase the low-volume payment threshold to at least $75,000.

In addition, we urge CMS to make the NPI level look-up feature available on the QPP portal as quickly as possible so that individuals and groups can plan for how they will participate in MIPS, if at all, in CY 2017.

Quality Performance Category

Measures Groups

CMS finalized "Specialty Measure Sets" in lieu of "Measures Groups" to meet quality reporting requirements under the quality performance category, leaving no *meaningful* measures for certain specialties and subspecialties and greatly diminishing the value of the measures that it retained as stand-alone measures or as part of new specialty measure sets. The Alliance maintains that this policy runs counter to CMS' stated goals for overall quality improvement and specific condition and/or episode-based performance and measurement. We urge CMS to reinstate Measures Groups as a data submission method.

High Priority Measures

CMS finalized measures of appropriate use as high priority. We urge CMS to ensure that measures of appropriate use are not just limited to overuse. Underuse continues to be an issue, particularly in certain clinical conditions and patient populations.

System Measures

Alliance specialties, especially those that are hospital-based, are interested in the option of having their quality performance score tied to that of their affiliate hospital or health system. CMS recognizes that this may promote more harmonized quality improvement efforts between hospital-based clinicians and hospitals and promote care coordination across the care continuum. To accomplish this, appropriate attribution policies for facility-based measures will need to be established. CMS should consider opening a dialogue with stakeholders through a pre-rulemaking Request for Comment (RFC) process this spring so that it could obtain important feedback and proposals could be made for CY 2018.

Cross-Cutting Measures

We appreciate that CMS did not finalize a cross-cutting measure in this transition year, and oppose the inclusion of a cross-cutting measure requirement in future years of the MIPS program. We urge CMS to continue to focus its emphasis on high-priority measures over cross-cutting measures.

Topped Out Measures

We appreciate that CMS agreed that it should not automatically remove measures that are topped out without considering other factors, such as whether or not removing the measure could lead to a worsening performance gap. We urge CMS to develop a transparent methodology for assessing the continued relevance of individual quality measures that incorporates feedback from the medical community and measure stewards. Quality measures undergo regular maintenance by their owners with input from physicians who use the measures to ensure they reflect the most recent clinical practices and guidelines. This regular

maintenance should not be overlooked by CMS, and therefore measures should not be removed without a request they be withdrawn by the measure owner or going through a transparent process allowing for comments from stakeholders.

Cost Performance Category

The Alliance sincerely appreciates that CMS reduced the weight to 0 percent for this performance category in the first performance year. Nonetheless, CMS finalized that the weight will increase to 30 percent by the third performance year; that it will continue to rely on cost and resource use measures from the Value-based Payment Modifier (VM) program; and, that it will employ new episode-based measures, several of which are new and untested, in future MIPS performance years. We further note that CMS has yet to incorporate proposals for the required patient relationship categories and codes into the cost performance category, which will have a significant impact on specialty physicians.

In addition, CMS' feedback via Quality and Resource Use Reports (QRURs) remains largely incomprehensible to the vast majority of specialty physicians. The information provide does not give a clear picture of how they have a direct impact on a patients total cost of care or how they might improve how they personally deliver and coordinate care in a way that could reduce resource use. They remain confused about the attribution methodologies which make them accountable for clinical conditions and spending that are outside of their expertise and control. It is even more confusing given CMS' attribution methodologies are not consistent across programs.

We oppose CMS' finalized policies for the cost performance category. If CMS is unable to further modify the weighting for this category, it must use its discretion to revise the metrics used to score performance. We provided extensive comment on our specific concerns with the cost performance category to the proposed rule, which we urge CMS to review and reconsider as it revises its policies for the 2018 performance year.

Improvement Activity Performance Category

Improvement Activity Inventory

We urge CMS to reconsider a number of activities previously recommended by the Alliance for inclusion in the improvement activity inventory that are appropriate and meaningful for specialty physicians. These include:

- Attendance and participation in ACGME-accredited events, such as the specialty and subspecialty society conferences and events, including those that are web-based, that exceed certification requirements
- Attendance and participation in other CME and non-CME events that exceed certification requirements
- Fellowship training or other advanced clinical training completed during a performance year
- Participation in morbidity & mortality (M&M) conferences

- Taking Emergency Department (ED) Call
- Voluntary practice accreditation, such as accreditation achieved by the National Committee on Quality Assurance (NCQA), Accreditation Association for Ambulatory Health Care (AAAHC), The Joint Commission (TJC), or other recognized accreditation organizations
- Demonstration of incorporation of evidence-based practices and appropriate use in clinician practices, using evidence-based clinical guidelines, appropriate use criteria, Choosing Wisely recommendations, etc.
- Engagement in state and local health improvement activities, such as participation in a regional health information exchange or health information organization
- Engagement in private quality improvement initiatives, such as those sponsored by health plans, health insurers, and health systems
- Participation in other federally sponsored quality reporting and improvement programs not already affiliated or considered under the MIPS program

In addition, we still seek clarity on language used to describe specific improvement activities as outlined in our prior comments. It is important for specialists to understand whether certain types of improvement activities are covered under existing activities where CMS lists examples, but the examples do not appear to be an exhaustive list.

Request for Comments on activities that will advance the usage of Health IT
We appreciate that CMS seeks to encourage innovation in health IT to support improvement activities, and that it might award improvement activity credit to providers when they use emerging functionalities in their CEHRT. We believe that clinical data registries could also serve as a "test-bed" to support emerging improvement activities. We urge CMS to award improvement activity credit to providers when they use emerging functionalities in clinical data registries to improve patient care.

Advancing Care Information (ACI) Performance Category
The ACI performance category retains the "all-or-nothing" approach of the former Meaningful Use program, holding physicians accountable for measures that may not reflect how technology can best meet their practice needs or patient population. CMS must retool the ACI performance category in a way that is meaningful for specialty physicians, providing a robust "menu" of ACI measures that specialty physicians can choose from to meet the requirements. In the interim, CMS must delay its requirement that providers adopt 2015 Edition CEHRT and begin reporting the ACI Objectives and Measures (formerly Stage 3) beginning January 1, 2018. CMS should allow providers to continue using 2014 Edition CEHRT and reporting the 2017 ACI Transition Objectives and Measures (formerly Modified Stage 2) in CY 2018, and possibly CY 2019.

In addition, the ACI category does not encourage interoperability across disparate health IT systems, including clinical data registries and medical devices. EHR vendors will not address these issues through modifications to their products if there are no meaningful use requirements on providers that necessitate such functionality. In fact, some EHR vendors are holding patient data "hostage" in their systems – preventing providers from accessing that data

for use in other clinically relevant applications. These inappropriate and harmful "data blocking" tactics must be prevented once and for all through regulatory action.

Finally, we remain concerned about the Security Risk Analysis (SRA) requirement. We continue to request that CMS collaborate with its federal agency partners to develop enhanced guidance for specialty practices on conducting security risk assessments; provide data on common security risk failures in specialty practices; and, provide enhanced technical assistance and support on health IT security. These efforts would go a long way in helping many specialists meet the SRA requirement and avoid a "0" score for the entire performance category, which would significantly impact their final score.

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We appreciate the opportunity to provide comments on the aforementioned issues of importance to the Alliance. Should you have any questions, please contact us at info@specialtydocs.org.

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Sincerely,

American Association of Neurological Surgeons
American Academy of Facial Plastic and Reconstructive Surgery
American College of Mohs Surgery
American Gastroenterological Association
American Society of Cataract and Refractive Surgery
American Society for Dermatologic Surgery Association
American Society of Plastic Surgeons
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
North American Spine Society
Society for Cardiovascular Angiography and Interventions

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