February 9, 2016

Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Dear Acting Administrator Slavitt,

The undersigned organizations are writing to express our pressing concern that physicians and group practices will be incorrectly penalized under the PQRS Program as a result of the Centers for Medicare & Medicaid Services' (CMS') inadequate feedback and informal review request processes, and to make recommendations to improve these processes moving forward. As PQRS has ballooned in complexity and transitioned from an incentive program to penalty-based system, the need for actionable feedback and an accessible informal review process has never been more critical. Unfortunately, the 2016 PQRS feedback and informal review processes were plagued with needless obstacles that prevented physicians and group practices from understanding their performance, which in turn prevented them from contesting potentially unwarranted penalties. Without complete and actionable data as well as a streamlined process for correcting data inaccuracies and unwarranted penalties, physicians and group practices may not only be subjected to unfair Medicare reductions in the immediate payment year, but also in future years as they are unable to correct unidentified reporting issues.

In addition to causing undue financial stress, the problematic feedback and informal review processes impede physician practices' ability to accurately reflect on their reporting performance and make improvements moving forward. Therefore, rather than driving quality improvement, the agency is merely adding red tape to an already administratively onerous program.

Additionally, now is not the time to hang up the hat and abandon these processes. Although the separate PQRS program will expire at the end of 2018, physicians face up to 6% Medicare payment penalties in 2017 and 2018 as a result of their PQRS reporting results. The need for relevant and comprehensive performance information will only increase as Medicare transitions to the Merit-Based Incentive Payment System (MIPS), as this program is expressly intended to accelerate the transition from volume- to value-based reimbursement. Without transparency and relevant data, physicians and group practices are left to navigate these increasingly complex programs in the dark, hindering their ability to harness feedback to reduce resource use and ultimately improve patient outcomes.

To improve the PQRS feedback and informal review processes moving forward and for the reasons outlined in detail below, we strongly recommend the following changes:

1. Clearly articulate the cause for a penalty assessment in the PQRS Feedback Report;
2. Promptly communicate and remedy errors in the PQRS Feedback Reports;

3. Hold harmless groups and physicians whose data was unsuccessfully transmitted by third-party vendors;
4. Expand QualityNet Help Desk training and access to feedback information; and
5. Fix flaws in the informal review process.

Incomplete and inconsistent feedback

The most frustrating issue uncovered during the 2016 feedback and informal review processes was a complete lack of transparency regarding the reason that CMS assessed a penalty or determined an eligible professional (EP) or group practice was ineligible for an incentive. Although the lynchpin of successful PQRS participation was achieving a reporting rate of 50% or greater for the required number of measures, CMS failed to include any reporting rate information in the 2014 PQRS Feedback Reports. Rather, CMS included only the measure performance rate, which looks not at the frequency with which measures were reported, but at the number of reported encounters that met the desired process of care or outcome, and is completely distinct from PQRS evaluation. As a result, physicians and group practices wasted scarce resources attempting to decipher their PQRS performance based exclusively on performance rate information, only to eventually arrive at the conclusion that this information was inapplicable.

Recommendations: First and foremost, the PQRS Feedback Report should specify why a physician or group practice is subject to a penalty. To achieve this transparency, the report should include the reporting rate, including the measure-specific numerator and denominator data points, for each reported measure. Additionally, although CMS should correct all errors prior to releasing the feedback reports, we understand that the agency may only be made aware of minor inaccuracies after the reports have been released. When inaccuracies are identified, CMS should promptly notify the impacted practice regarding the errors and how they were corrected to ensure that the practice has the most up-to-date feedback for use in an informal review request and in their practice improvement efforts. If the errors are widespread, CMS should also notify all stakeholders through an announcement using each of its outreach channels, including the MLN Connects Provider eNews and direct correspondence with national medical societies. The announcement should not only specify which errors were identified and corrected, but how group practices can access their revised feedback. Importantly, CMS should also extend the informal review deadline to give practices sufficient time to process the revised information and to make an informed decision about whether they should request an informal review.

When applicable, the PQRS Feedback Reports should articulate in an easy-to-understand manner the results of the Measure Applicability Validation (MAV) calculation. Currently, CMS conducts the MAV calculation behind closed doors, and physician practices can neither verify the accuracy of the outcome, nor challenge its results in an informal review. This lack of transparency generates distrust in the program and reasonably raises suspicion regarding the agency's adherence to its own policies.

CMS should bear in mind that the purpose of these feedback reports is to allow practices to understand their past performance and to identify potential areas for improvement. The agency should design these reports accordingly with specific, actionable information. At a minimum, this includes reporting rate data and an explanation of cause for a penalty, as this basic information is necessary for practices to file an informal review contesting an unfair penalty.

Lack of Recourse for Vendor Transmission Issues

Many physicians and group practices are reporting that they are receiving 2016 penalties due to vendor transmission issues. For whatever reason transmission of data from some EHRs and registries inadvertently did not occur or failed, in several cases multiple times, even after what were believed to be corrective actions taken. In instances where practices were able to identify the penalty was a result of a vendor error and filed an informal review, CMS denied the request. The idea that practices can face a penalty for an error that is out of the practice's hands is completely unfair and further questions the integrity of the PQRS program.

Recommendations: As CMS considers improvements to the programs and process, there must be a process for reviewing and deeming physicians and practices successful PQRS and Value-Based Modifier participants–whether requested by the EHR developer, the registry, or the practice—when transmission from a vendor or registry fails to be successfully sent to or accepted by CMS. This process should explicitly consider and credit evidence provided by the practice, vendor, or registry that a submission was attempted or intended, such as the applicable QRDA file. Practices should not be unfairly penalized due to inactions or errors of external parties, including vendors and CMS itself. CMS also must provide the right to file an informal review request for reasons beyond their control at any point through the payment year and proactively reimburse the practice for all improper penalties.

Inadequate assistance from QualityNet Help Desk

During the informal review process, CMS instructed concerned practices to contact the QualityNet Help Desk to acquire relevant information regarding their 2014 PQRS performance, such as the reporting rate. While we acknowledge the QualityNet Help Desk's responsiveness, the information provided was often inconsistent with the information included in the PQRS Feedback Reports. Moreover, the QualityNet Help Desk often informed practices that they were unable to provide comprehensive information, as they had only limited access to PQRS data.

We believe that this issue is best illustrated through an example in which the QualityNet Help Desk provided a practice requesting more information, including their reporting rates, with an excel spreadsheet consisting of only eight total measures covering only five EPs, despite the practice having 11 EPs. Although it may be logical to assume that three of the EPs included in the report generated by the QualityNet Help Desk belong to one of the three EPs who received a penalty letter, this was not the case. Rather, the spreadsheet included information about two of the three EPs who received a penalty notification letter, as well as three other EPs in the practice who did not receive any penalty notification letter. When this practice explained the many deficiencies with this spreadsheet to the QualityNet Help Desk and asked for further information, the Quality Net Help Desk responded: "Unfortunately at this time, the only information I have available was provided to you in the report that you received. The support tiers that analyze each informal review request have access to more data which will allow them to review all of the measures that were reported by the provider..."

Recommendations: As CMS grows more reliant on the QualityNet Help Desk to disseminate key information and guidance, the agency must ensure that help desk staff are appropriately trained and equipped to provide high-quality support. Specifically, CMS should provide the QualityNet Help Desk with access to all data that will be used during the informal review, rather than limit this

information to inaccessible "tiers" within the agency governance. There is no apparent reason for limiting the contractor's access to critical information. In fact, it seems counter to the agency's own instruction that physicians access this exact information through the QualityNet Help Desk.

Additionally, if the agency releases multiple feedback reports, CMS must ensure that information is consistent across all feedback reports. Many practices have reported that the information included within the individual eligible professional (EP) feedback report was inconsistent and often conflicting with the information provided within the group practice report. We appreciate CMS providing individual and group practice reports, but the information must be consistent. The fact that practices must use several channels to access basic PQRS feedback is already a deterrent to engaging in the feedback process. When CMS compounds this issue by releasing reports that tell different stories, practices must expend already limited staff time and resources to reconcile this information. Unfortunately, this was all too often the case during the 2016 feedback period.

Faulty Informal Review process

After navigating inconclusive and perplexing feedback reports, physicians and group practices then found that the process for filing an informal review request was equally, if not more, frustrating. Because the deadline was approximately three and a half months earlier than in past years, practices had an unreasonably short turn-around window after receiving a notification letter in the mail (if at all), during which time they were expected to consult their own records, solicit necessary information from the QualityNet Help Desk, and request an informal review – all within a matter of weeks.

As mentioned above, the informal review request deadline was previously February 28 of the relevant payment year, which both lined up with the Meaningful Use reconsideration deadline, and more importantly, provided practices with advance notice of any payment adjustments to their claims. In contrast, even with over a month's extension until December 16, the most recent 2014 informal review request deadline left practices without any recourse to contest inaccurate adjustments they may notice on their 2016 payments, as the deadline has already passed. This is particularly concerning, as many practices reported receiving penalty letters that seemed almost intentionally inconspicuous, closely resembling "junk mail," and could have easily been discarded by a front desk staff, while many others reported not receiving a letter at all. We understand CMS' reasoning that an earlier deadline allows the agency to correct errors before payments are processed, and therefore reduces administrative complication. We iterate that practices too have a vested interest in resolving discrepancies before their claims are affected, and thus if given the opportunity and adequate notice, would be inherently incentivized to resolve discrepancies by an earlier date. However, this should not mean that those who notice inaccurate penalties on their Medicare payments in the first few weeks of the payment year should have absolutely no opportunity for recourse, particularly when they are not at fault.

The most recent feedback reports were especially wrought with incorrectly-levied penalties based on vendor mistakes or calculation errors on CMS' end. In many cases, the same physicians that were assessed penalties were actually eligible for an incentive payment. The notion that practices can face a 2-6% penalty to their Medicare payments for an entire year due to a mistake or negligence that is completely out of their control is unfair.

Further, the informal review request form itself fell short. It lacked a basic attachment option for physicians and group practices to upload supporting documentation often essential to properly illustrate their unique situation. Practices also reported receiving an instant, "automatic" rejection after selecting a plausible, but apparently incontestable reason from the form's self-provided drop-down list. At best, this exemplifies an administrative shortcut in an attempt to lessen the agency's workload in reviewing appeals; at worse, it is deceptive. In either case, it undermines the purpose of the review. Practices that conduct all of the leg work to submit a review request, at the very least, deserve to have their request viewed by CMS personnel, and if not ruled in their favor, a clear, and complete explanation of why it was not approved. CMS consistently reiterates that the intent of this program is to drive quality improvements, yet the absence of transparency behind the decision-making process, combined with CMS' removed approach to conducting these informal reviews, suggests the agency is merely "checking the box," rather than truly seeking to educate practices and ultimately improve the quality of care in this country.

Finally, the review determination notices were both confusing and inconsistent, with practices receiving multiple communications containing different language, formatting, and inconsistent information relating to when the payment adjustments would be administered. Aside from an assigned informal review identification number, the communications often lacked any identifying information about the physician in question, adding yet another layer of complication for practices who submit requests for multiple physicians, which is very common. Moreover, once a decision is reached, it is considered final, with absolutely no opportunity for dispute or further appeal. The notion that CMS reaches these decisions with such ambiguous criteria and then is subject to absolutely no oversight raises alarm. Other decisions by the agency, including revocation of Medicare enrollment and billing privileges, have a secondary appeal process. PQRS informal review requests should be no different.

Recommendations: CMS should provide practices with two separate deadlines for informal review requests: an initial deadline whereby practices can submit the request in time to have the error corrected before it affects payments, as well as the February 28 final deadline, which would both provide practices with an incentive to resolve a majority of payment issues in advance of processing affected claims, while still allowing practices adequate time to correct any inaccurate penalties noticed in the first few payment periods of a new calendar year. Further, practices should not be unfairly penalized due to inactions or errors of external parties, including vendors and CMS itself, and should reserve the right to file an informal review request for reasons beyond their control at any point throughout the payment year and be retroactively reimbursed for all improper penalties.

CMS should amend the informal review forms to include fields that allow practices to provide unique situational details, as well as upload supporting documentation. No review determinations should be rejected "automatically." Rather, CMS should consider all review requests on a case-by-case basis, taking into account the unique circumstances of each request.

Finally, the agency should make the informal review request decisions in a much more transparent manner. For example, if the review decision is unfavorable, practices should receive a clear and complete explanation of why their request was not approved, so that corrections can be made to correct the problem and penalties can be avoided in the future. Moreover, CMS should establish a secondary review process for practices to appeal an inadequate informal review decision.

We appreciate the agency's attention to these concerns and strongly urge CMS to adopt these recommendations to improve the feedback and informal review processes moving forward. We welcome the opportunity to discuss these ideas with your staff in more depth. If you have any questions, please feel free to contact Anders Gilberg, Senior Vice President, Government Affairs at the Medical Group Management Association at agilberg@mgma.org or 202-293-3450 and Margaret Garikes, Vice President of Federal Affairs at the American Medical Association at margaret.garikes@ama-assn.org or 202-789-7409.

Sincerely,

American Medical Association
Medical Group Management Association
Advocacy Council of the American College of Allergy, Asthma and Immunology
AMDA – The Society for Post-Acute and Long-Term Care Medicine
American Academy of Allergy, Asthma & Immunology
American Academy of Dermatology
American Academy of Family Physicians
American Academy of Home Care Medicine
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Orthopaedic Surgeons
American Academy of Physical Medicine and Rehabilitation
American Association of Medical Colleges
American Association of Neurological Surgeons
American College of Cardiology
American College of Emergency Physicians
American College of Gastroenterology
American College of Mohs Surgery
American College of Osteopathic Family Physicians
American College of Physicians
American College of Radiology
American College of Rheumatology
American College of Surgeons
American Gastroenterological Association
American Osteopathic Association
American Psychiatric Association
American Society for Gastrointestinal Endoscopy
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Clinical Oncology
American Society of Nuclear Cardiology
American Society of Plastic Surgeons
American Society of Radiation Oncology
American Urogynecologic Society
American Urological Association
College of American Pathologists
Congress of Neurological Surgeons

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Infectious Diseases Society of America
North American Spine Society
Society for Cardiovascular Angiography and Interventions
Society for Gynecologic Oncology
Society for Vascular Surgery
Society of Hospital Medicine
Society of Interventional Radiology
The Society of Thoracic Surgeons