Congress of the United States
Washington, DC 20515

October 6, 2016

The Hon. Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

The Hon. Shaun Donovan
Director
Office of Management and Budget
725 17th Street, NW
Washington, DC 20503

Dear Acting Administrator Slavitt and Director Donovan:

On April 27th, CMS released a proposed rule to implement the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. By repealing the Sustainable Growth Rate Formula, MACRA has the potential to transform the healthcare landscape and the delivery of care. However, if CMS implements the rule in a manner which is inconsistent with Congressional intent, MACRA has the potential to overcomplicate an already burdensome and complex quality reporting system and take more time away from patient care.[1]

According to a *Health Affairs* study published in March of 2016, physician practices in four common specialties spend, on average, 785 hours per physician and more than $15.4 billion each year on quality measure reporting programs. Furthermore, the majority of time spent on quality reporting consists of "entering information into the medical record only for the purpose of reporting quality measures from external entities," and nearly three-quarters of practices stated their group was being evaluated on quality measures that were not clinically relevant. Congress recognized that these programs may actually detract from quality care by driving providers' time away from patients, and, as a result, replaced them with what is supposed to be a streamlined quality program, known as the Merit-based Incentive Payment System (MIPS).

Under MACRA, providers will use either MIPS or an advanced alternative payment model (APM). In an impact analysis within its proposed MACRA implementation rule, CMS projects that as few as 6% of physicians may participate in qualified APMs. While we believe there are ways to expand the APM option to more physicians, it is clear that the vast majority of physicians will be reporting under MIPS in 2017. Given the immediate focus on MIPS, we are particularly concerned about the complexity of MIPS, the timing of the performance period, and the significant impact of the MIPS program on small and rural practices, among other issues.

We urge you to carefully address a number of multi-layered, high-level concerns that will likely require multi-faceted solutions. Thus, we encourage the agency to take note of the technical issues being presented in the comment letters of the various providers, specialty physicians and medical industry stakeholders.

MACRA brings significant changes to physician workflows, yet most physicians remain entirely

[1] According to a survey released in July of 2016 by Deloitte, 74% of physicians already find quality reporting to be burdensome.

PRINTED ON RECYCLED PAPER

unaware of MACRA or its implications. Deloitte recently surveyed 600 primary care and specialty physicians regarding MACRA. Of those surveyed, 50% of physicians reported that they have never heard of MACRA, and an additional 32% said that they have heard of it but are unfamiliar with its requirements. Thus, 82% of physicians are unaware of how their reimbursement will be impacted by this new law. Following publication of the final rule and ahead of the start date, the agency must devote significant resources to educate practices about MACRA.

MIPS is Too Complex

As proposed, even the smallest physician group practices (10 or fewer eligible professionals) would need to expend finite resources on measuring and monitoring their performance on at least 22 measures, including a minimum of eight measures in the quality category, at least two measures in resource use, at least 11 measures in ACI, and at least one measure in the clinical practice improvement activity (CPIA) category.[2] In order to be successful, MIPS must engage clinicians with a reporting system that is not overly burdensome, a scoring system that is simple and transparent, attainable thresholds, and a short enough quality/payment feedback loop to allow physicians to learn and make necessary changes to avoid further penalty.

More detailed feedback reports are needed to assist physicians in understanding their performance rating, including the specific cause for a penalty assessment, the reporting rate for each measure, the calculation methodology and any errors in received data. A transparent process with detailed reports will aid providers to more quickly rectify inaccuracies in their data, and enhance their ability to submit timely appeals before payment reductions are applied and performance ratings are made public. In the past, eligible professionals were left to decipher this rationale on their own, taking valuable time and resources away from patient care.

Within the same vein, an appeals process that is transparent and not administratively burdensome should be readily available to physicians throughout MIPS. An appeals process should have a reasonable time frame for providers to participate, especially given that MIPS will be new to all providers. An appeals process should also promptly address provider concerns with explicit timetables for review.

Start and Length of Performance Reporting Are Unrealistic

The proposed rule requires MIPS performance measurement to start on January 1, 2017, with the first MIPS payment adjustments being made in January 2019. Physicians and the organizations that represent them have expressed the widely-shared view that the timeline is unrealistic, prompting a recent announcement that CMS intends to give physicians considerable flexibility on when and how they meet MIPS participation requirements in 2017. We share the timeline concerns expressed by our physician colleagues and are encouraged that CMS appears to be taking a step in the right direction. We await further details to determine the extent to which this proposal and other provisions in the final rule alleviate potential problems raised by a 2017 start date. Specifically, we want to be sure that physicians have time to prepare with sufficient notice of program requirements in the final rule and a final list of qualified Advanced APMs.

We also ask CMS to adopt a 90-day reporting period, rather than the year-long period called for in the proposed rule, for the Advancing Care Information (ACI) category of MIPS to enable more small practices to succeed. Especially in the initial years of MIPS, a shorter reporting period is necessary

[2] Larger practices would have two additional CPIA measures and one additional quality measure.

for all providers, but particularly smaller practices who have fewer resources to keep up with the changing regulatory environment. A shorter reporting period would ensure that more providers are able to successfully make the transition to MIPS, upgrade their EHR technology and meet the new Stage 3 measures by 2018.[3]

The Impact of the MIPS Program on Small and Rural Practices will Continue to Drive Consolidation

According to the aforementioned Deloitte study, 58% of physicians say MIPS would encourage them to be part of a larger organization to reduce individual increased financial risk and have access to supporting resources and capabilities. In fact, 80% of surveyed physicians believe MACRA will drive consolidation.

To help reduce administrative burden for small practices and allow for flexibility in quality reporting, CMS should lower its patient minimum reporting thresholds. CMS proposed that providers using a registry must report quality measures on 90% of their patients from all payers, and 80% of Medicare patients for those reporting by claims. This is a significant jump from what is currently 50% of Medicare patients. Such a high minimum threshold would be impossible for many physicians, particularly those in small practices, to meet. We recommend that CMS maintain the minimum threshold at a maximum of 50% of Medicare patients.

Additionally, the MACRA statute included the concept of virtual groups to help assist small practices; however, CMS proposes not to implement virtual groups until the 2018 performance period. The newly-announced participation flexibility policy in 2017 may make this delay more acceptable. However, we strongly urge CMS to act swiftly on forming these groups as soon as possible to ensure that this option is communicated to physicians early enough to provide them with sufficient time to organize and participate. Without this assistance, we believe small practices face even greater challenges when attempting to adapt to the MIPS program structure.

CMS should also broaden its MIPS exclusion for providers who treat a low volume of Medicare patients. To help mitigate adverse effects on small practices, CMS has proposed a low-volume threshold that would exempt physicians from MIPS if their practice has less than $10,000 in Medicare allowed charges *and* fewer than 100 unique Medicare patients per year. The proposed threshold, however, would help very few physicians and other clinicians. An AMA analysis of the 2014 "Medicare Provider Utilization and Payment Data: Physician and Other Supplier" file found that just 10% of physicians and 16% of all MIPS eligible clinicians would be exempt under the $10,000/100 beneficiary proposal, and that these clinicians account for less than one percent of total Medicare allowed charges for Physician Fee Schedule services. As one example, by increasing the threshold to $30,000 in Medicare allowed charges *or* fewer than 100 unique Medicare patients seen by the physician, CMS would provide a better safety net for small providers. This would exclude less than 30% of physicians while still subjecting more than 93% of allowed spending to MIPS. We recommend that the low-volume threshold be raised significantly in the final rule.

Resource Measures May Not Provide Accurate and Relevant Assessment of Physician Performance

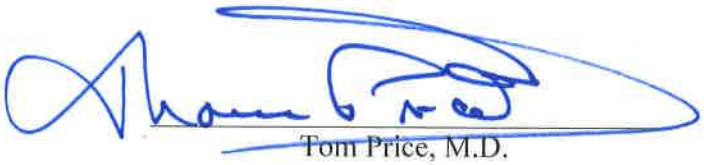
---

[3] CMS must minimize any unfair negative impact to small practices. In Table 64 of the proposed rule, CMS estimates that a disproportionate number of solo practitioners and small practices would fail the Merit-Based Incentive Program and would experience financial penalties as a result. CMS should modify its proposals to ensure an equal opportunity for all providers to succeed in the program.

Resource use measures that CMS has used in the value-based modifier were originally developed for use in hospitals and are neither accurate nor relevant for many physicians. Recognizing this, Congress made clear that this category under MIPS should be limited to 10% *or* less of the total MIPS score in the first year and 15% *or less* in 2020. MACRA also called for the development of new episode measures and physician-patient relationship codes that are intended to improve the reliability and relevance of scores in this category. Final versions of the physician-patient relationship codes are not due to take effect until 2018 and many of the episode measures that CMS has developed to date have not been adequately reviewed by physicians or tested for use in physician offices. We believe that CMS should make the resource use category optional for at least one year while the measures and related methodologies are refined.

We strongly urge CMS to make necessary changes in the final rule so that physicians may be provided with the tools necessary to succeed under this new payment regime. We look forward to continuing to work with CMS to ensure effective implementation of this rule.

Sincerely,



Tom Price, M.D.
Member of Congress

David P. Roe, M.D.
Member of Congress

John Fleming, M.D.
Member of Congress

Andy Harris, M.D.
Member of Congress

Brad Wenstrup, D.P.M.
Member of Congress

Renee Ellmers, R.N.
Member of Congress

Diane Black, R.N.
Member of Congress

Larry Bucshon, M.D.
Member of Congress

Dan Benishek, M.D.
Member of Congress

Paul A. Gosar, D.D.S.
Member of Congress

Earl L. "Buddy" Carter
Member of Congress

Ralph Abraham, M.D.
Member of Congress

Brian Babin, D.D.S.
Member of Congress

Joe Heck, D.O.
Member of Congress

Charles W. Boustany Jr., M.D.
Member of Congress

Tim Murphy, PhD
Member of Congress

Scott DesJarlais, M.D.
Member of Congress

Mike Simpson, D.M.D.
Member of Congress