Mr. Andrew Slavitt June 27, 2016
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
200 Independence Avenue, Southwest
Room 445-G
Washington, DC 20201

RE: CMS-5517-P

Dear Acting Administrator Slavitt:

Our coalition includes the following members: the American Academy of Pain Medicine, the American Academy of Physical Medicine and Rehabilitation, the American Society of Anesthesiologists, the American Society of Interventional Pain Physicians, the American Society of Regional Anesthesia and Pain Medicine, the North American Neuromodulation Society, and the Spine Intervention Society. Our members' practices are typically limited to the treatment of patients with chronic, intractable pain. Our patients are generally referred from primary care physicians, surgeons, neurologists, oncologists or other specialties after not achieving significant improvement in quality of life with the use of other forms of treatment such as oral medications, surgery, physical therapy, chiropractic care, other non-pharmacologic, or intervention services. While our members also prescribe oral medications, our members' practices are focused on treating chronic, intractable pain using minimally invasive techniques such as nerve blocks, joint/spine injections, implanting pumps that release drugs into the central nervous system, and implanting neurostimulators that reduce pain through electrical pulses to the nervous system, among others.

We welcome the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule entitled "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." This proposed rule implements provisions in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

Our recommendations center on the following provisions outlined in the proposed rule:

1. **Advanced APMs**: CMS's proposed approach for incentivizing participation in Advanced APMs strongly disadvantages certain specialties and subspecialties such as ours. Until CMS develops criteria that enable our members to participate in Advanced APMs, the agency should minimize our reporting burden and risk from participating in MIPS.
    - **Comprehensive Care for Joint Replacement Model:** We encourage CMS to make the CJR – as it applies strictly to hip and knee replacements – an Advanced APM, which will allow more of our members to participate in these payment models.

2. **MIPS Low-Volume Threshold and Participation by Solo Practitioners and Small Group Practices:** We support the establishment of a low-volume threshold but oppose the CMS's proposed threshold criteria. We urge the agency to adopt a low-volume threshold based on

clinical practice size such that small group practices with less than 10 clinicians and solo practitioners would be ineligible for MIPS.

3. **MIPS "Non-Patient Facing" Clinicians and Group Designation:** Coding criteria for designating "non-patient facing" MIPS clinicians and groups should designate most anesthesiologists as "non-patient facing" as CMS projects in the proposed rule.

4. **MIPS "Non-Patient Facing" Threshold**: We oppose the proposed threshold of 25 encounters for identifying "non-patient facing" groups and clinicians. Instead, we recommend applying a criterion of 50 patient encounters to individual members of a group practice. If a majority of individual members in the group practice meet the individual "non-patient facing threshold," then the entire group would be considered "non-patient facing" for purposes of MIPS. Additionally, we propose that individual practitioners and small group practices submitting at least one "patient facing" code can elect to participate in MIPS as "patient facing" or "non-patient facing."

5. **MIPS Quality Performance Measurement**: We appreciate CMS's proposed flexibility in reporting quality measures, but believe the reporting and financial burden particularly on solo practitioners and small group practices is too high. We urge the agency to reduce the reporting burden so that individual and small group practices can participate meaningfully in MIPS.
    - **"Non-Patient Facing" Reporting Requirements**: We appreciate the increased flexibility in proposed reporting requirements for "non-patient facing" clinicians but believe CMS should reduce the reporting burden particularly for individual practitioners and small group practices.
    - **Specialty-Specific and Subspecialty-Specific Measure Sets**: We appreciate and strongly support CMS's proposal to allow for the development and reporting on specialty-specific and subspecialty-specific measure sets.
    - **"Call for Quality Measures" Process**: We strongly urge CMS to establish an interim process whereby the agency could adopt subspecialty-specific measure sets on an accelerated, short-term basis until such measures go through the formal "Call for Quality Measures" process. We strongly support adoption of evidence-based measures in the "Call for Quality Measures" process.
    - **Global and Population-Based Measures:** We strongly oppose measurement of our members on global and population-based metrics. Our members do not provide primary care services and simply have no control over the global quality of care provided to patients.
    - **Data Submission Completeness Criteria**: We strongly oppose the proposed criteria, as they will be too burdensome to meet particularly for solo practitioners and small group practices.
    - **Quality Performance Benchmarks**: We strenuously oppose CMS's proposal to include all MIPS eligible clinicians and groups and APM Entities in the same benchmark for purposes of quality performance measurement. We strongly urge CMS to develop separate benchmarks that evaluate MIPS eligible clinicians and groups against their peers and do not include APM Entity performance.

- **Quality Measure Bonus Points**: We are concerned that the proposed bonus structure is unfairly biased against specialists and subspecialists who do not provide the more primary care-type services that are measured to receive bonus points. We urge CMS to develop bonus-point eligible measures that would be appropriate for specialists and subspecialists like our members.

6. **MIPS Resource Use Measurement**: We strongly oppose measuring resource use for specialists and subspecialists like our members who simply have little to no control over resource use in delivering patient care. Until CMS develops meaningful resource use metrics for our specialty and subspecialties, specialists and subspecialists should be exempt from MIPS resource use measurement.
    - **"Non-Patient Facing" Clinician Measurement**: We strongly oppose measuring resource use for non-patient facing clinicians. Until CMS develops meaningful resource use measures for non-patient facing clinicians and groups, non-patient facing clinicians should be exempt from MIPS resource use measurement.
    - **Specialty Mix Adjustment**: We urge CMS to apply the specialty mix adjustment to all resource measures, consistent with the current Value-Based Payment Modifier program.

7. **Facility-Based MIPS Eligible Clinicians and Groups**: We support and appreciate CMS's proposal to allow facility-based MIPS eligible clinicians and groups to use their facility's quality and resource use performance rates as proxy for their performance and suggest appropriate criteria and conditions that CMS should consider at it develops this policy.

8. **MIPS Advancing Care Information (ACI) Measurement**: We strongly oppose the ACI proposals, as they do not achieve meaningful health information technology (HIT) interoperability.

9. **MIPS Clinical Practice Improvement Activities (CPIA) Measurement**: We are very concerned that this new reporting requirement does not measure meaningful CPIAs for specialties and subspecialties such as ours and places substantial new financial and administrative burden on clinicians, particularly solo practitioners and small group practices. To minimize the burden, we urge CMS to adopt participation in Continuing Medical Education (CME) and attestation of compliance with a professional, governmental, or other professionally accepted organization's clinical practice guidelines as CPIAs.

10. **MIPS Composite Performance Score (CPS) Reweighting:** Rather than increasing the weight of the quality score for clinicians who cannot report ACI, instead the ACI component should be calculated with the same weight but using the quality performance score.

11. **Appendix: Proposed New CPIAs**

    - Attestation to Compliance with "CDC Guideline for Prescribing Opioids for Chronic Pain"
    - Attestation to Participation in Continuing Medical Education (CME)

- Attestation to Compliance with Professional, Governmental, or Other Professionally Accepted Organizations' Clinical Practice Guidelines

We look forward to working with CMS to implement provisions in this proposed rule that advance the quality of patient care provided and improve health outcomes, recognizing the particular challenges facing pain physicians.

1. Advanced APMs

Recommendation: Unless and until CMS adjusts its criteria for Advanced APMs and develops additional demonstrations such that subspecialties like ours have a meaningful way to participate, CMS should identify subspecialties that are unable to participate in Advanced APMs and establish ways to minimize our reporting burden and our risk of receiving a penalty under MIPS.

We are very concerned that CMS' proposals regarding advanced APMs, and its long-term approach to incentivize participation in APMs, greatly disadvantages certain specialties and subspecialties, such as ours. The MACRA statute defines an "eligible APM entity" as an entity that participates in an APM that (1) requires participants to use certified EHR technology, (2) provides for payment based on quality measures that are comparable to MIPS, and (3) bears financial risk for monetary losses under the APM that are in excess of a nominal amount, or is a medical home expanded under Center for Medicare and Medicaid Innovation (CMMI). In interpreting this third prong, CMS proposes an incredibly narrow set of criteria. The result is a list of only 5 APMs,[1] which are primarily focused on primary care or limited to nephrology or oncology. Moreover, eligible clinicians will not be considered qualifying APM professionals (QPs), and thus not eligible for the bonus, unless the APM meets certain Medicare Part B payment amount or patient count thresholds.

The stark reality for many of our members is that they have virtually no chance of participating in these Advanced APMs. As noted above, the APMs selected as Advanced APMs are either primary care-focused or are limited to nephrology or oncology. The particular models identified by CMS as Advanced APMs do not typically include patients treated by our subspecialties. Additionally, we are primarily solo and small practice practitioners. Thus, we are not part of large hospital systems or physician networks that would include our members in their Accountable Care Organization (ACO). Moreover, these demonstrations and models are voluntary and are thus not evenly distributed across the country. There are many locations, such as rural areas, where there are no Advanced APMs available to join. Even if an APM entity were available in a particular location, our members are completely dependent on the primary participants agreeing to not only have us affiliate with the entity, but include us on their participant list, even though we are usually not a member of the underlying hospital system or physician network and not a core part of these models' focus. Furthermore, because our practices are focused on patients who have failed oral opioid therapy, we are seen as "cost centers" by APMs because we use more advanced techniques to treat pain instead of prescribing generic analgesics. Unfortunately, not only do APMs have a financial incentive to not include our members as participants but the quality

[1] Medicare Shared Savings Program (Tracks 2 and 3 only); Next Generation ACO Model; Comprehensive ESRD Care; Comprehensive Primary Care Plus, and Oncology Care Model (two-sided risk track only).

measures listed in the proposed rule do not include any measure that references referral of chronic intractable pain patients for interventional treatments.

The inevitable result is that our members will be forced to participate in MIPS, facing a heavy reporting burden and increasing individualized risk over time, with virtually no possibility of moving to an Advanced APM, which provides for better reimbursement rates beginning in 2026 and less individualized downside risk.

In developing its proposals to incentivize Advanced APMs, CMS needs to recognize the burden placed on certain subspecialties and many of their members, such as ours, that may not and will not have the flexibility to participate in many current APMs, let alone Advanced APMs. Such subspecialties should not be unfairly penalized because their practices do not lend themselves to the existing models. Unless and until CMS adjusts its criteria for Advanced APMs and develops additional demonstrations such that subspecialties like ours have a meaningful way to participate, CMS should identify subspecialties that are unable to participate in Advanced APMs and establish ways to minimize our reporting burden and our risk of receiving a penalty under MIPS.

Comprehensive Care for Joint Replacement

Recommendation: **We encourage CMS to make the current CJR model – as it applies strictly to hip and knee replacements – and Advanced APM.**

Some of our members participate in the Comprehensive Care for Joint Replacement (CJR) model, which requires mandatory participation by the roughly 800 hospitals in the 67 geographic areas where the model is being tested. The model aims to support better and more efficient care for beneficiaries undergoing the most common inpatient surgeries for Medicare beneficiaries: hip and knee replacements (also called lower extremity joint replacements or LEJR). This model tests bundled payment and quality measurement for an episode of care associated with hip and knee replacements to encourage hospitals, physicians, and post-acute care providers to work together to improve the quality and coordination of care from the initial hospitalization through recovery.

As with other models deemed to be Advanced APMs, participants in the CJR model are measured on quality and bear two-sided financial risk. Because both Medicare Part A and Part B spending associated with these episodes are evaluated in this model, participating hospitals are incentivized to improve the quality and efficiency of service provided by clinicians throughout the episode of care. In fact, under the model, participant hospitals may enter into arrangements to share payments received from Medicare as a result of reduced episode spending as well as financial accountability for increased episode spending with collaborating providers and suppliers. In the Preamble, CMS notes that the CJR model does not meet the proposed advanced APM criteria and seeks comments on how it might change the design of the CJR through future rulemaking to make it an Advanced APM and how to include eligible clinicians in CJR for purposes of the QP determination.[2]

We believe that the existing CJR model structure meets the statutory requirements of an Advanced APM, including "bear[ing] financial risk for monetary losses under the APM that are in excess of a

[2] 81 Fed. Reg. 28311.

nominal amount."[3] Further, because participation in the CJR model is mandatory, unlike any other APM, we do not believe that it is necessary for participant hospitals (i.e. the APM entity) to provide a Participation List or Affiliated Practitioners list in order to identify eligible clinicians as potential QPs or partial QPs as CMS proposes for other types of APMs. Instead, any eligible clinician who bills for services related to at least one episode of care should be attributed to the CJR model for purposes of determining whether they meet the threshold to be a QP or Partial QP. Contrary to CMS's assertion, we believe that clinicians providing services critical to the success of the CJR are tied to beneficiary attribution, quality measurement, or cost measurement under the APM consistent with CMS's proposed definition of a participant used for QP determination[4] Specifically, the participating hospital is responsible for both the quality and cost of care provided to an attributed beneficiary by all eligible clinicians during an episode of care. For these reasons, we encourage CMS to make the current CJR model – as it applies strictly to hip and knee replacements – and Advanced APM.

2. MIPS Low-Volume Threshold and Participation by Solo Practitioners and Small Group Practices

Recommendation: Our coalition supports CMS's proposal to establish a low-volume threshold below which a clinician would be ineligible to participate in MIPS. We strongly urge CMS to establish a low-volume threshold that is based on practice size – rather than allowed charges and number of patients seen – so that solo practices and those with less than 10 clinicians are ineligible for the MIPS altogether.

Our coalition supports CMS' proposal to establish a low-volume threshold below which a clinician would be ineligible to participate in MIPS. Success in MIPS will depend upon a clinician's ability to invest in electronic health record technology, as well as hire practice clinical and administrative staff to determine the appropriate reporting mechanism and report the required data for the quality, advancing care information, and clinical practice improvement activity performance categories. **The financial and reporting burden from MIPS participation will be insurmountable for solo and small group practices.**

CMS proposes that individuals or groups with less than $10,000 in allowable charges and fewer than 100 Medicare patients would meet the low-volume threshold. We do not support the proposed definition for the low-volume threshold.

[3] Social Security Act § 1833(z), as added by section 101(e)(2) of MACRA.

[4] 81 Fed. Reg. 28319. ("We propose to define participant for the purposes of participation in an APM as an entity participating in an APM under an agreement with CMS or statute or regulation that may either include eligible clinicians or be an eligible clinician and that is directly tied to beneficiary attribution, quality measurement or cost measurement under the APM."). See also 81 Fed. Reg. 28236. ("Some APMs may involve certain types of MIPS eligible clinicians that are affiliated with an APM Entity but not included in the APM Entity group because they are not participants of the APM Entity. We propose that even if the APM meets the criteria to be a MIPS APM, MIPS eligible clinicians who are not included in the list of participants would not be considered part of the APM Entity group for purposes of the APM scoring standard. For instance, MIPS eligible clinicians in the Comprehensive Care for Joint Replacement Model might be involved directly tied to beneficiary attribution, quality measurement, or care improvement activities under the APM.") in the APM through a business arrangement with the APM Entity (the inpatient hospital) but are not directly tied to beneficiary attribution, quality measurement, or care improvement activities under the APM.")

CMS' impact analysis (Table 64) shows that 102,788 eligible clinicians are in solo practices, and that the average Medicare Physician Fee Schedule allowed charges are $12.458 billion, which translates into $121,201 per physician. A similar calculation for groups of 2 to 9 eligible clinicians amounts to $151,154 per physician. The Medicare allowed charges per eligible clinician are much smaller for large group practices - $86,960 for groups of 25 to 99, and $61,006 for groups of 100 or more.

A low-volume threshold that is based on both the practice's Medicare allowed charges and the number of beneficiaries seen will exempt clinicians who see few Medicare beneficiaries, such as pediatricians. However, it does not correct the more pressing concern of the high burden of reporting that will fall on small practices. Solo practitioners and small groups have higher Medicare allowed charges per clinician than large groups, so setting a threshold based on a low level of Medicare allowed charges will be more likely to exempt clinicians in large practices than in small ones.

Table 64 also shows that CMS predicts 87 percent of MIPS-eligible clinicians in solo practices will receive a negative payment adjustment, but only 18.3 percent of MIPS-eligible clinicians in groups of 100 or more will receive a negative payment adjustment. This analysis shows that the playing field is far from level for MIPS-eligible clinicians who are solo practitioners or who have small practices. If there was a level playing field, then both large groups and small groups would be equally likely to receive a negative payment adjustment. CMS' proposal makes a solo practitioner 475 percent more likely to receive a negative payment adjustment than a clinician in a group of 100 or more MIPS-eligible clinicians.

CMS should instead choose a low-volume threshold that is based on the practice size. A group of 100 clinicians can see at least 100 times as many patients as a solo practitioner, and at least 10 times as many as a group of 10 clinicians. CMS's proposal to exempt groups of less than 10 MIPS eligible clinicians from the all-cause hospital readmissions measure is not sufficient to ensure a level playing field. CMS should set a low-volume threshold that makes solo practices and those with less than 10 clinicians ineligible for the MIPS altogether.

3. MIPS "Non-Patient Facing" Designation

Recommendation: Coding criteria for designating "non-patient facing" MIPS clinicians and groups should designate most anesthesiologists as "non-patient facing." Our coalition additionally urges CMS to consider different terminology from "non-patient facing," as we believe the language diminishes the very important role we have in providing high-quality patient care.

CMS introduces the term "non-patient facing" to apply to MIPS eligible clinicians "who typically furnish services that do not involve face-to-face interaction with a patient." CMS indicates in the rule that this typically includes anesthesiologists, pathologists, and radiologists and states that approximately 25 percent of MIPS eligible clinicians will be "non-patient facing." Because certain proposed MIPS measures and activities may not apply, CMS proposed special accommodations for measure reporting and scoring for non-patient facing MIPS eligible clinicians. We applaud CMS's recognition that implementation of MIPS will not succeed with a "one size fits all" approach.

The coding criteria for determination of non-patient facing status should be carefully examined to ensure that its application designates most anesthesiologists as "non-patient facing" MIPS clinicians, as CMS projects in the proposed rule. We raise this issue because even though the list of patient-facing services is not currently available, we assume it will be substantially similar to the list of patient facing

services under the PQRS list of patient facing services. We are concerned because using the PQRS patient-facing code list, it appears likely that many physician anesthesiologists would be categorized as "patient facing." For example, although anesthesia services (CPT® codes 00100 – 01999) are "non-patient facing" under PQRS, physician anesthesiologists also typically perform other services that are included among "patient-facing" services under PQRS. Typical "patient facing" services performed by physician anesthesiologists include insertion of invasive hemodynamic monitoring lines and post-operative pain procedures. These services are provided, when indicated, by physician anesthesiologists during a surgical procedure separate and apart from the anesthesia care they provide related to the surgical procedure.

It is clearly not CMS's intent to consider most anesthesiologists as "patient facing" for purposes of MIPS. Indeed, in the proposed rule, the agency states that it expects that most pathologists, radiologists and anesthesiologists would be considered "non-patient facing" for purposes of MIPS. Hence, we strongly urge CMS to confirm that most anesthesiologists will be considered "non-patient facing" for purposes of MIPS.

Additionally, our coalition requests that CMS consider different terminology for the MIPS eligible clinicians that would be included in the proposed "non-patient facing" category. We believe this term is an inaccurate representation of the role that physician anesthesiologists play and diminishes the important direct clinical care that physician anesthesiologists provide as well as the leadership role they play as a member of a surgical team. We are very concerned that this term will be confusing to patients if it is used in public spaces, such as the Physician Compare website.

4. MIPS "Non-Patient Facing" Threshold

Recommendation: We oppose the proposed threshold of 25 encounters for identifying "non-patient facing" groups and clinicians. As an alternative, we recommend applying a criterion of 50 patient encounters to individual members of a group practice. If a majority of individual members in the group practice meet the individual "non-patient facing threshold," then the entire group would be considered "non-patient facing" for purposes of MIPS. Additionally, we propose that individual practitioners and small group practices submitting at least one "patient facing" code can elect to participate in MIPS as "patient facing" or "non-patient facing."

Statute does not define the term "non-patient-facing MIPS eligible clinician." In the proposed rule, CMS defines this term as an individual or group that bills 25 or fewer patient-facing encounters during a performance period (one calendar year). A threshold of 25 patient encounters is much different at the individual or small group levels from that of a large group—*e.g.,* a single or small number of National Provider Identifiers (NPIs) versus hundreds of NPIs in large groups. Our coalition does not understand the rationale for using the same threshold for large groups and individual MIPS eligible clinicians and believes that the threshold of 25 encounters is too low.

We propose an alternative methodology to more accurately identify non-patient-facing practice groups, regardless of group size. Rather than applying the same criterion to individuals and groups, ASA recommends a two-step process to identify "non-patient facing" groups. First, CMS should apply a criterion of 50 patient encounters to individual members of a group practice. As a second step, if a majority (51 percent or more) of the individual members of the group practice meet the individual "non-patient facing" threshold of 50 or fewer patient-facing encounters, then the entire group would be considered "non-patient facing."

Separately, we propose that all solo practitioners and small group practices submitting at least one "patient facing" code may elect to participate in MIPS as "patient facing" or "non-patient facing" clinicians. Statute directs the Secretary to make special considerations for clinicians in small group practices (less than 15 clinicians) and solo practitioners, as well as "non-patient facing" clinicians. We urge that the Secretary appropriately recognize these special statutory considerations as they pertain to anesthesiology and allow for these individual practitioners and small groups to make a choice as to "patient-facing" or "non-patient facing" status. This is particularly important as we transition to an entirely new payment system that will result in reporting and administrative challenges for providers.

5. MIPS Quality Performance Measurement

Recommendation: **While we appreciate CMS's proposal for additional flexibility in reporting of quality measures, we are very concerned that the quality reporting requirements are too burdensome and costly particularly for solo practitioners and small group practices.**

CMS proposes to reduce the number of quality measures that patient-facing clinicians must report from the current nine in the Physician Quality Reporting System (PQRS) to six and proposes to allow clinicians to choose the most clinically meaningful measures to report on from the MIPS quality measures list**.**

We appreciate CMS's proposed increased flexibility to report on a reduced number of measures and choose amongst measures that are most clinically meaningful to our practices. However, the proposed reporting requirements for quality performance measurement particularly for solo practitioners and small group practices are simply too high and burdensome.

Non-Patient Facing Clinician and Group Reporting Requirements

Recommendation: Our coalition supports the stated intention of CMS to make accommodations for physician anesthesiologists with respect to certain MIPS quality reporting measurements.

In particular, lifting the requirement to report cross-cutting quality measures is a welcome improvement. Given the nature of anesthesia practice, such accommodations are warranted and appropriate. While we appreciate this flexibility, we still have concern that the overall proposed reporting requirements are burdensome particularly for solo practitioners and small group practices.

Specialty-Specific and Subspecialty-Specific Measure Sets

Recommendation: **We strongly support and appreciate CMS's proposed reporting flexibility to permit MIPS eligible clinicians and groups the choice of reporting from the MIPS list of quality measures or a specialty-specific or subspecialty-specific measure set.**

CMS solicits comment on whether it should allow reporting of specialty-specific measure sets to meet the submission criteria for the category quality performance. We strongly support allowing MIPS eligible clinicians and groups the choice of reporting from the MIPS list of quality measures or a specialty-specific or subspecialty-specific measure set. CMS's proposed flexibility will enable specialists and subspecialists the ability to report on the most clinically meaningful measures for the services they provide. Reporting on evidence-based, clinically meaningful measures will improve quality of care and

patient outcomes. We look forward to working with CMS to develop evidence-based measure sets for our specialties and subspecialties.

<u>Recommendation</u>: We strongly support CMS's proposal to allow for the development of subspecialty-specific measure sets for subspecialties that currently do not have subspecialty-specific measure sets. We request that subspecialists have the option of reporting on a subset of the measures – rather than all measures – in the subspecialty-specific set, consistent with the flexibility proposed in other areas of the MIPS quality reporting requirements. Furthermore, we strenuously urge CMS to establish an <u>interim process to allow accelerated adoption of evidence-based subspecialty measures</u> until subspecialty measures are able to go through the more formal "Call for Quality Measures" process.

CMS solicits comment on whether it is appropriate to allow reporting of a measure set at the subspecialty level to meet the submission criteria for the quality performance category, since reporting at the subspecialty level would require reporting on fewer measures. **We strongly support the development of subspecialty-specific measure sets for subspecialties that currently do not have subspecialty-specific measure sets.** Evidence-based subspecialty-specific measure sets will drive improvement in quality of care by measuring subspecialties in clinically meaningful ways. Additionally, we recommend two policies that will advance measurement of subspecialties, particularly in the near future as CMS implements MIPS.

- **<u>Flexibility to report a subset of subspecialty measures</u>: For subspecialty measure sets that have less than six measures, we recommend that MIPS eligible clinicians and groups electing to report on such measure sets maintain the option of selecting to report on 2 to 3 measures, but not all, of the measures within the set to meet the quality performance category criteria.** Nothing would preclude subspecialists from reporting on all measures within their subspecialty measure set. However, similar to the flexibility offered to non-specialist MIPS eligible clinicians and groups, MIPS eligible clinicians and groups reporting on subspecialty-specific measure sets should maintain some choice over the measures on which they report. Allowing subspecialists some choice on the measures they report will encourage them to report on new, more clinically meaningful measures, rather than on the less clinically meaningful list of MIPS quality measures. Moreover, it reduce reporting burdens on solo practitioners and small group practices.

- **<u>Interim subspecialty-specific measure set process</u>: For subspecialties that do not have existing subspecialty-specific measure sets, we strongly urge CMS to establish an interim, abbreviated process for developing subspecialty-specific measure sets until CMS formally adopts subspecialty-specific quality measures through the proposed "Call for Quality Measures" process.** The clear intent of MACRA is to meaningfully measure clinicians on the specific services they provide to improve patient quality of care. Many subspecialties, including ours, simply have not had time since the enactment of MACRA to develop subspecialty-specific measure sets. Establishing an interim process that will allow CMS to meaningfully measure our members will help to advance the quality of patient care provided within our subspecialties – a mutually important goal shared by CMS and our members.

  Under the interim process, during 2017, we would present CMS with subspecialty-specific high quality, evidence-based measures on which Medicare could evaluate the quality of care we provide beginning January 1, 2018. These measures would derive from high-quality evidence

and clinical best practices. CMS would permit evaluation of our quality performance on such measures on an interim basis until the formal adoption of a subspecialty-specific measure set using the "Call for Quality Measures" process.

We request this interim process because we would like Medicare to measure the quality of care we provide based on the actual services we provide. While we agree with the general parameters of the "Call for Quality Measures" process, the timeframe for CMS to actually measure us on measures adopted through that process is quite long. In the mutual interest of meaningful clinical measurement to drive improvements in quality of care, we respectfully ask that CMS consider this interim process until the "Call for Quality Measures" process formally adopts measures for our specialty and subspecialties.

"Call for Quality Measures" Process

Recommendation: We support adoption of evidence-based measures the "Call for Quality Measures" process. We further urge CMS to establish an interim process for adoption of subspecialty quality measure sets until quality measures can go through the "Call for Quality Measures" process so that CMS quickly may be able to assess our members on clinically meaningful measures.

CMS proposes an annual "Call for Quality Measures" process for MIPS quality measures. We support use of rigorous, evidence-based measures to evaluate MIPS eligible clinicians and groups on quality performance as proposed in the "Call for Quality Measures" process. We look forward to working with CMS to develop high quality, evidence-based quality measures for our specialties and subspecialties that will improve health outcomes for patients.

As discussed above, given the proposed timeframe for formally adopting quality measures in the "Call for Quality Measures" process, we strongly urge and request that CMS develop a process for interim adoption of subspecialty quality measure sets. This process would not displace the "Call for Quality Measures" process. Rather, it would serve as a means for CMS to assess subspecialists on high-quality, evidence-based, clinically meaningful measures for their practices on an interim basis until the agency can adopt formal subspecialty measure sets through the formal "Call for Quality Measures" process. As soon as CMS approves subspecialty measure sets through the "Call for Quality Measures" process, the interim process could cease as it would no longer be necessary. We simply want to be measured as quickly as possible on quality measures that are most clinically meaningful to our practices, and an interim quality measurement process could help us advance this very important policy goal.

Global and Population-Based Quality Measures

Recommendation: **We strongly oppose use of global and population-based measures in assessing the quality performance of our members. Because our members are not primary care providers, our members retain little to no control over the global quality of care given to patients.**

CMS proposes to use the acute and chronic composite measures of the Agency for Healthcare Quality and Research (AHRQ) Prevention Quality Indicators (PQIs) that meet a minimum sample size as measures of global and population-based quality. We strongly oppose use of global and population-based measures in assessing the quality performance of our members. Because our members are not primary care providers, our members retain little to no control over the global quality of care given to

patients. Members of our coalition are typically specialists in non-primary care fields, such as interventional pain management, anesthesiology, neurosurgery, neurology, and physical medicine and rehabilitation. We focus on a critical element of patient care - pain management - but are unlikely to be coordinating a patient's overall care. However, under the proposed use of the Value-Based Payment Modifier's (VM) attribution methodology (with slight modification), a patient inappropriately could be attributed to one of our members even though we do not provide primary care services for that patient.

For example, many chronic pain specialists may choose to follow the evidence-based Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids and Chronic Pain to treat chronic pain.[5] The Guideline recommends that chronic pain specialists assess such patients "every 3 months or more frequently" on the potential harms or benefits of continued opioid therapy. Consequently, due to the high frequency of CDC guideline opioid-related visits that clinicians typically code as an Evaluation & Management visit, the VM methodology inappropriately could attribute a chronic pain patient to the chronic pain specialist rather than to that patient's primary care doctor. The treatment of chronic pain through use of opioids is an entirely different type of care than the typical care given by a primary care clinician.

Data Submission Completeness Criteria

Recommendation: **We urge CMS to adopt lower criteria thresholds than those proposed for the data submission completeness criteria for MIPS quality measures. These criteria are simply too high and burdensome, particularly for solo practitioners and small group practices.**

CMS solicits comment on completeness criteria for data submitted on MIPS quality measures. CMS proposes: (1) MIPS eligible clinicians and groups submitting data using QCDRs, qualified registries, or via EHR must report on at least of 90 percent of Medicare and non-Medicare patients; and (2) individual MIPS eligible clinicians would report on at least 80 percent of Medicare Part B patients. We urge CMS to adopt lower criteria thresholds than those proposed for the data submission completeness criteria for MIPS quality measures. These criteria are simply too high and burdensome particularly for solo practitioners and small group practices.

We appreciate that CMS wants to collect as much data as possible to assess quality performance. However, the proposed thresholds are too high for the first year of the program, particularly when the current data submission completeness criteria for the PQRS is 50 percent of Medicare Part B claims. As an alternative, we suggest use of the current PQRS data submission completion criteria of 50 percent of Medicare Part B claims for the first year of MIPS. Moreover, for the initial years of MIPS, we request that CMS not require reporting on a full year of data as clinicians and health information technology systems transition this very new and expansive process. In order for CMS to gain a more complete quality data set, we further suggest that CMS potentially phase-in higher thresholds for data submission completeness criteria over time.

We strongly urge recognition by CMS of the challenges and administrative burdens facing solo practitioners and small group practices for reporting MIPS data generally and request that the agency allow flexibility in reporting all MIPS data through a variety of mechanisms. We strongly support

[5] See Recommendation 7 in the "CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016": http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

claims-based reporting, particularly for these clinicians and small groups because it is less burdensome and does not require additional administrative costs to track or enter data. For example, we specifically recommend that CMS facilitate claims-based reporting for the Opioid Therapy Follow-Up Evaluation (81 Fed. Reg. 28438), Documentation of Signed Opioid Treatment Agreement (81 Fed. Reg. 28439, and Evaluation or Interview for Risk of Opioid Misuse (81 Fed. Reg. 28348). CMS proposes these measures for registry reporting but allowing them to be claims-based would lessen reporting burden particularly for solo practitioners and small group practices.

MIPS Quality Performance Benchmarks

Recommendation: **We strongly oppose CMS's proposal to include in a single benchmark all quality performance data from MIPS eligible clinicians and groups, as well as APM Entities. We strongly urge instead that CMS should develop separate quality performance benchmarks where CMS will compare MIPS eligible clinicians and groups to their peers and never to APM entities.**

CMS proposes to require all MIPS eligible clinicians, regardless of whether they report as an individual or group, regardless of specialty, submit data using the same submission mechanism (e.g., QCDR) be included in the same benchmark. The agency proposes to weight the performance rate of each MIPS eligible clinician and group submitting data on the quality measures by the number of beneficiaries used to calculate the performance rate. CMS proposes to include APM Entity submissions in the benchmark but would not score APM Entities on the methodology.

We oppose CMS's proposal to have a single benchmark for each quality measure include data from all MIPS eligible clinicians, including individual clinicians, those clinicians reporting as a group, and APM Entity submissions, regardless of specialty. In general, CMS should evaluate the performance of MIPS eligible clinicians and groups relative to their peers. Different groups have different levels of resources and capabilities afforded to them that will make achieving high performance on MIPS quality measures more or less challenging. For example, individual practitioners and small group practices simply often do not have the resources to pay for highly interoperable health information technology (HIT) in the same manner as do large group practices or entities that seek to participate as APMs. As such, we strongly urge CMS not to adopt the proposal to require quality benchmarks to include data from all MIPS eligible clinicians and APM entities. Such a single benchmark unfairly and inappropriately would not measure a MIPS eligible clinician or group against comparable peers.

Moreover, CMS appears to have intended its proposal to employ the VM's patient-weighting methodology for the MIPS quality benchmarks as a means to address concerns over inappropriate performance comparisons amongst solo practitioners, small and large groups, and APM entities. Indeed, the proposed methodology does ensure that a group's performance is weighted appropriately relative to solo practitioners. However, the current VM program essentially accounts for the fact that solo practitioners and small groups have significant difficulty achieving the same performance rates as large group practices: the VM holds harmless solo practitioners and small group practices from negative payment adjustments (-2.0 percent in 2017, the first year the VM applies to these practitioners) so long as they meet the PQRS reporting requirements. In contrast to solo practitioners and small groups, CMS mandates negative payment adjustments for large groups (-0.4 percent in 2017) under the VM program and does not hold harmless these providers

Essentially, through the VM program, CMS recognizes that solo practitioners and small groups cannot achieve the same performance rates as large groups and accounts for that recognition by not inappropriately penalizing these providers through negative payment adjustments. In the same manner, CMS should recognize that solo practitioners and small groups cannot achieve similar performance levels to large groups – much the less APM Entities – in MIPS quality performance and should not inappropriately penalize them by negatively adjusting their payments (via low scores on the quality component of MIPS).

Consequently, CMS should compare MIPS eligible clinicians to their peers for purposes of quality performance measurement benchmarks. As such, CMS should construct multiple benchmarks to assess MIPS eligible clinicians and groups on quality performance. The benchmarks would appropriately evaluate MIPS eligible clinicians, groups, and specialists against their peers and would aggregate performance data as follows:

- All MIPS participants compared to all MIPS participants
- Solo practitioners compared to other solo practitioners
- Specialist solo practitioners compared to other same specialist solo practitioners
- Small groups compared to other small groups
- Small group specialists compared to other small group same specialists
- Large groups compared to other large groups
- Large group specialists compared to other large group same specialists

In no instance would the performance rates of MIPS eligible clinicians and groups be compared to performance rates of APM Entities. APM Entities simply are entirely different types of medical providers than solo practitioners, small group, and large group practices and, thus, it would be entirely inappropriate to include them in MIPS quality benchmarks. Consistent with CMS's proposal, the benchmarks would be patient-weighted.

Similar to the proposal for Advanced APMs in which CMS intends to use the greater of an APM Entity's payment amount or patient count thresholds for purposes of maximizing Advanced APM participation, CMS would select the benchmark on which the MIPS eligible clinician or group performs best as the basis for assigning a performance score on a given quality measure. This will better ensure that the measure most captures the actual quality of care provided by the MIPS eligible clinician or group. This overall policy will better inform CMS on how clinicians and groups are performing on quality metrics relative to their peers and will provide useful disaggregated data that can inform future policymaking.

High Priority Quality Measures

<u>Recommendation</u>: We urge CMS to develop high priority measures eligible for quality performance bonus points that assess in a clinically meaningful way the specialized care our members provide.

CMS proposes to award bonus points to a MIPS eligible clinician or group's quality performance score for reporting "high priority" measures. We appreciate that CMS would like to advance high quality care through awarding bonus points to a MIPS eligible clinician or group's quality performance score. **However, we are concerned that our members will not have the same level of opportunity as primary care clinicians and groups to report on many of these "high priority" measures because these measures – at least in some instances – do not assess in a clinically meaningful way the quality of the**

specialized care we provide to patients with intractable chronic pain. This is particularly the case for our members who are non-patient facing clinicians. As such, the general bonus structure for quality measures seems unfairly biased toward primary care MIPS eligible clinicians and groups and away from other providers and specialists, particularly those who are non-patient facing. Therefore, we urge CMS to consider and develop additional "high priority" measures for specialists and non-patient facing MIPS eligible clinicians and groups.

6. MIPS Resource Use Performance Measurement

Recommendation: **CMS should exempt specialties unlikely to provide comprehensive and primary care to patients, including interventional pain management and anesthesiology, from having patients attributed to them under this measure.**

For the MIPS Resource Use Category, CMS proposes to use the total per capita cost measure and the Medicare spending per beneficiary (MSPB) measure currently used in the Value-based Modifier (VM), with technical modifications to the MSPB measure. CMS also proposes to use an unspecified number of 34 proposed Clinical Condition and Treatment Episode-based Measures. As proposed, the score for the resource category will equally weight all of the measures attributed to a MIPS eligible clinician or group. CMS does not propose a minimum number of measures needed to receive a score under the resource use category, which means that the resource use score could be based on a single measure.

We are concerned that the proposed measures are not applicable to many specialists, particularly those specialists that typically practice in the outpatient setting and who do not treat the high cost conditions or provide the high cost services that are the focus of the episode-based measures. It is likely that many clinicians will be evaluated on at most one measure of resource use but it is unclear that any single measure presents a complete and accurate picture of a clinician's impact on spending or service utilization. A clinician's performance on a single resource use measure could have an unjustified effect on their overall performance score, as the weight assigned to the resource use category increases in future years. We recommend that CMS further analyze the number and type of physicians who are expected to have data for each measure and those who will have multiple measures on which to be evaluated, as well as the impact that resource use measure(s) will have on overall composite performance scores.

We are also concerned that it is impossible for clinicians to identify which beneficiaries CMS will attribute to them and hold them responsible for costs under the Total Cost Per Capita measure. CMS proposes that for the total cost per capita measure, patients would be assigned to an individual or group based on a two-step attribution methodology that looks at primary care services received by the patient. Primary care services are defined as certain evaluation and management services and a beneficiary is eligible for attribution only if the beneficiary receives ate least one primary care service. CMS looks first for primary care services provided by a primary care physician (PCP), defined as family practice, internal medicine, geriatric medicine, or general practice, and attributes the beneficiary to the PCP that accounts for a larger share of allowed charges for primary care services than any other PCP. If the beneficiary did not receive any primary care services from a PCP, then the beneficiary would be attributed to the non-PCP clinician responsible for the largest share of total allowed charges for primary care services than any other clinician.

Members of our coalition are typically specialists in non-primary care fields, such as interventional pain management, anesthesiology, neurosurgery, neurology, physical medicine and rehabilitation. We focus on a critical element of patient care - pain management - but are unlikely to be coordinating a patient's overall care. However, under the proposed methodology it is possible that a beneficiary could be attributed to a specialist for purposes of resource use measurement, even if the actual care provided by that specialist is narrowly focused. Specialists may be inappropriately held accountable for services beyond the scope of their practice and would have no way of knowing that a beneficiary has been attributed to them until after their ability to impact the quantity and quality of care provided has passed. Therefore we recommend that CMS exempt specialties unlikely to provide comprehensive care to patients, including interventional pain management and anesthesiology, from having patients attributed to them under this measure.

"Non-Patient Facing" Resource Use Measurement

<u>Recommendation</u>: We strongly oppose measuring "non-patient facing" clinicians and groups on MIPS resource use until CMS develops measures that appropriately assess the resources used by these specialized clinicians and groups.

CMS proposes no alternative resource use measures for "non-patient facing" clinicians and groups. It acknowledges in the proposed rule that many "non-patient facing" clinicians and groups may not be attributed patients for purposes of resource use measurement as a result. CMS indicates it intends to work with "non-patient facing" groups and specialty societies to develop alternative resource use measures for "non-patient facing" clinicians and groups in the future.

Because "non-patient facing" clinicians – including many of our members – are not primary care providers, they retain little to no control over the global cost of care given to patients. Members of our coalition are typically specialists in non-primary care fields, such as interventional pain management, anesthesiology, neurosurgery, neurology, and physical medicine and rehabilitation. We focus on a critical element of patient care - pain management - but are unlikely to be coordinating a patient's overall care. However, under the proposed attribution methodology, a patient inappropriately could be attributed to one of our members for resource use measurement even though we do not provide primary care services for that patient.

Hence, our coalition strenuously opposes CMS measuring "non-patient facing" clinicians and groups on resource use until appropriate measures are developed that evaluate the resources such clinicians and groups contribute to overall patient care. We look forward to working with CMS to develop resource use measures that appropriately evaluate and measure "non-patient facing" clinicians and groups, including some of our members, provide.

Specialty Mix Adjustment

<u>Recommendation</u>: We urge CMS to continue to adjust all resource use measures for differences in specialty mix.

When CMS finalized use of specialty mix adjustment to the cost measures under the VM, it stated: "We believe that the credibility of the quality-tiering approach depends on accurate comparisons among physicians to determine those physicians that are members of high- and low-cost groups. We proposed this method to adjust our benchmarking approach for all cost measures to create more comparable peer

groups through developing a benchmark for each group based on the specialty composition of the group."[6] The coalition believes that CMS was correct in its assessment of the need for comparable peer groups and that specialty mix adjustment continues to be a critical element in evaluating resource use. We urge CMS to include such adjustment in all resource use measures, including the Medicare Spending Per Beneficiary (MSBP) measure which CMS proposes not to specialty adjust.

7. Facility-Based MIPS Eligible Clinicians and Groups Reporting

Recommendation: **We appreciate and support the agency's proposal to allow facility-based MIPS eligible clinicians and groups to elect to use their institution's quality and resource performance rates as a proxy for the MIPS quality and resource use scores**.

CMS states it is considering an option for facility-based MIPS eligible clinicians to elect use of their institution's quality and resource use performance rates as a proxy for the MIPS eligible clinician's quality and resource use scores, but not for Year One of MIPS. We appreciate and support the agency's proposal to allow facility-based MIPS eligible clinicians and groups to elect to use their institution's quality and resource performance rates as a proxy for the MIPS quality and resource use scores. This proposal offers facility-based MIPS eligible clinicians more flexibility in MIPS reporting and could be particularly beneficial to solo and small group practices that will experience substantially increased administrative and reporting burdens with MIPS implementation.

The agency solicits comment on four policy issues with respect to its proposal to allow facility-based MIPS eligible clinicians to elect use of their institution's performance rates as a proxy for the MIPS eligible clinician's quality and resource scores, as discussed below.

1. **Appropriate and representative conditions for use of a facility's quality and resource use performance rates:** Multiple conditions could be appropriate for a facility-based MIPS eligible clinician to use the facility's quality and resource use performance rates as a proxy for the clinician's performance. CMS could consider adopting one or more of the following options:

    - The facility-based MIPS eligible clinician or group is an employee of the facility.
    - The facility-based MIPS eligible clinician or group is not an employee of the facility, but has a contract with the facility to perform medical services exclusively at the facility.
    - The facility-based MIPS eligible clinician or group is not an employee of the facility, but has a contract with the facility to perform services at the facility.
    - The facility-based MIPS eligible clinician or group is not an employee of the facility, but has privileges to perform services at the facility.
    - The MIPS eligible clinician or group is an owner, co-owner, and/or investor of the facility and performs medical services in the facility.

2. **Criteria appropriate for attributing a facility's performance to a MIPS eligible clinician for purposes of quality and resource use performance categories:** Multiple criteria could be appropriate for determining when to attribute a facility's quality and resource use performance

[6] 78 Fed. Reg. 74784

score to a facility-based MIPS eligible clinician. CMS could include one or more of the following options:

- Option 1: The facility-based MIPS eligible clinician performed a plurality of his or her services at the facility in the performance period. This method for attribution generally aligns with the Value-Based Payment Modifier two-step attribution methodology for purposes of MIPS quality and resource use measurement proposed in other parts of the MACRA rule, which attributes a given patient to a clinician if the clinician has performed a plurality of the primary care services for a patient in the performance year.

- Option 2: The facility-based MIPS eligible clinician or group has a payment amount threshold or patient count threshold at the facility that meets the payment amount threshold or patient count threshold finalized for purposes of eligibility to participate in an Advanced APM.

  Following CMS's proposed approach for determination of participation in Advanced APMs via either the payment amount or patient count methods, for both options CMS would calculate threshold scores. CMS then would select the greater of the two threshold scores achieved so that the MIPS eligible clinician or group would have a better chance of being able to use the facility's performance scores as proxy MIPS scores. Like the CMS proposal for Advanced APMs, this policy would maximize the number of facility-based MIPS eligible clinicians that could have the option of using their facility's quality and resource use scores as proxy for their MIPS performance scores in those categories.

3. **Specific measures and settings appropriate for use of a facility's quality and resource use data:** As required by MACRA and proposed in other parts of this rule, CMS should propose specific measures and settings for patient facing and non-patient facing clinicians and groups.

   Patient-facing clinicians: Such clinicians could use quality and resource use measures for patient conditions and episode groups (currently under development) for which CMS has assigned them a clearly defined and clinically meaningful relationship under the patient relationship assignment methodology (currently under development). Each evidence-based quality measure would be counter-balanced with an appropriate resource use measure. Measures potentially could focus on patient safety, high quality care delivery, patient-centered care, communication, care coordination, and cost efficiency.

   To the extent that there are not a sufficient number of clinically meaningful measures for which the MIPS eligible clinician or group has a clearly defined and meaningful patient relationship, the clinician or group may select a limited number of measures from the MIPS quality measures list. To prevent gaming, CMS could limit the number of measures a facility-based MIPS eligible clinician or group could use from the more general MIPS quality measures list. Appropriate settings for such a policy potentially could include inpatient hospitals, outpatient hospitals, ambulatory surgical centers and post-acute care facilities.

Non-patient facing clinicians: In general, the same general requirements as specified for patient-facing clinicians and groups would apply to non-patient facing clinicians and groups. CMS would make a general exception – per statute that allows the Secretary to provide for special considerations for non-patient facing clinicians – that it would not assess non-patient facing MIPS eligible clinicians and groups on global and population-based resource use and quality measures, as these clinicians have little to no control over the global quality and cost of care provided.

4. **Automatic attribution or choice of use of an institution's quality and resource use data:** MIPS eligible clinicians and groups should be able to elect to use an institution's quality and resource data as a proxy for their quality and resource performance. Similar to the choice that CMS affords MIPS eligible clinicians in other parts of this proposed rule – for example in offering the choice of reporting as an individual or a group or reporting on a broad selection of quality measures or a set of specialty-specific measures – we strongly urge CMS to allow facility-based MIPS eligible clinicians the choice of whether or not to allow use of their institution's quality and resource data as a proxy for their MIPS performance. Given the significant impact MIPS places on clinician reimbursement, clinicians should maintain the choice of how best to report their performance on MIPS quality and resource measures. Additionally, a facility registration process as proposed by CMS for facility-based MIPS clinicians who elect to use their institution's quality and resource data could be an appropriate method to facilitate this policy.

8. MIPS Advancing Care Information (ACI) Performance Measurement

Recommendation: We strongly oppose the ACI proposals included in the rule, consistent with comments made by the American Medical Association.

We strongly support and agree with comments provided by the American Medical Association in a June 3, 2016 letter to the National Coordinator for Health Information Technology Dr. Karen DeSalvo and CMS Acting Administrator Andrew Slavitt strenuously objecting to the ACI proposals in the proposed rule because they do not advance interoperability of health information technology.

9. MIPS Clinical Practice Improvement Activities (CPIA) Measurement

Recommendation: We have serious concerns that this new reporting requirement is administratively and financially burdensome – particularly for solo practitioners and small group practices – and does not measure clinical improvement activities that are clinically meaningful to specialists and subspecialists including our members. To minimize the burden, we urge CMS to adopt three proposed CPIAs more relevant to pain specialists that CMS should weight as "high."

The CPIA category is intended to emphasize activities that are associated with improved health outcomes and is not based on an existing Medicare incentive program. Our coalition appreciates CMS's proposal to include more than 90 activities in the CPIA Inventory, and CMS's proposed flexibility with regard to reporting CPIA activities, particularly in the first year of the program. However, we have concern that this new reporting requirement is overly burdensome for providers – particularly for solo practitioners and small group practices – and does not measure meaningfully the clinical practice improvement activities we provide.

To minimize burden, we suggest CMS adopt three CPIAs that would better measure the clinical practice improvement activities that we provide as specialists: (1) participation in Continuing Medical Education, (2) attestation of compliance with a professional, governmental, or other professionally accepted organization's clinical practice guidelines, and (3) attestation of compliance with the CDC Guideline for Prescribing Opioids for Chronic Pain. We have appended formal requests for adoption of these CPIAs at the end of our comment letter.

10. MIPS Composite Performance Score Reweighting

Recommendation: **We oppose reweighting the MIPS Composite Performance Score (CPS) disproportionately to quality for clinicians and groups without an ACI score because this methodology unfairly disadvantages them in the overall calculation of MIPS performance. We propose an alternative that aligns with CMS's proposal to disproportionately reweight performance categories without scores toward quality, while also eliminating the unfair bias against MIPS eligible clinicians and groups not reporting ACI.**

In the proposed rule, CMS recognizes that some MIPS eligible clinicians and groups – particularly specialists – will not have performance scores in each of the MIPS Composite Performance Score categories, most likely in the Resource Use and/or Advancing Care Information categories. Indeed, many of the members of our coalition will not have an ACI score and most likely not a Resource Use score.

For MIPS eligible clinicians and groups that do not have Resource Use and/or ACI scores, CMS proposes to reweight the CPS in one of two ways. First, for clinicians with at least three quality measures, CMS would reassign the weights of the unscored categories disproportionately to the quality category. Second, for clinicians and groups with less than three quality measures, CMS would proportionately reassign the weights of the unscored categories to CPS categories with scores.

An analysis conducted by McDermott + Consulting demonstrates that CMS's proposal to disproportionately reweight performance scores to the quality category for those clinicians and groups reporting at least three quality measures would unfairly disadvantage such clinicians and groups not reporting ACI in the calculation of the CPS.[7] The disadvantage occurs because most MIPS eligible clinicians and groups who have an ACI score will achieve a minimum ACI performance of 50 percent. This results from CMS's proposed ACI scoring methodology, which awards a minimum "Base Score" of 50 points (out of 100 points total) essentially for having the basic components of certified HIT. CMS awards a separate ACI "Performance Score" of 80 points. In contrast, CMS's proposed scoring methodology for the quality performance category includes no minimum or "base" score and at least some MIPS clinicians and groups will score less than 50 percent on quality – including some who also do not have an ACI score.

This mismatch in minimum (ACI) versus no minimum (quality) performance scores produces a scenario in which reweighting the calculation of the CPS disproportionately toward quality for clinicians and groups not reporting ACI unfairly disadvantages them in the overall MIPS performance score. They simply do not maintain the advantage of having a minimum 50 percent performance score on ACI that

[7] McDermott+ Consulting, "Merit Based Incentive Payment System (MIPS): Reweighting when ACI and Resource Use Scores Not Reportable", June 2016.

others reporting ACI do have. Rather, they must receive at least a minimum 50 percent quality score to not be "penalized" in the CPS for not reporting ACI under CMS's proposed reweighting methodology. This in effect holds those MIPS eligible clinicians and groups not reporting ACI to a higher quality standard than those who report ACI.

To eliminate this unfair bias against clinicians and groups not reporting ACI, we urge CMS to maintain the ACI portion of the CPS for additional quality weight and award a 50 percent minimum score – or "floor" – for purposes of calculating the overall MIPS Composite Performance Score. CMS then would replace the "Performance" portion of the ACI score with quality performance scores. This modification would maintain the intent of CMS's proposal to disproportionately reweight performance categories that do not have scores to quality when calculating the CPS, but would not unfairly disadvantage MIPS clinicians and groups not reporting ACI. To ensure that the revised scoring methodology does not incentivize clinicians and groups to not report ACI, CMS could scale the quality score replacing the ACI "Performance" score on a scale of 0 – 80, consistent with the ACI "Performance" score.

Conclusion

Our coalition appreciates the opportunity to comment on CMS's proposed rule to implement provisions of MACRA. We look forward to working with the agency to address the concerns raised by our members so that we can achieve the mutual goal of advancing high quality of care and improving patient outcomes.

Sincerely,

The American Academy of Pain Medicine
The American Academy of Physical Medicine and Rehabilitation
The American Society of Anesthesiologists
The American Society of Interventional Pain Physicians,
The American Society of Regional Anesthesia and Pain Medicine
The North American Neuromodulation Society
The Spine Intervention Society

Proposed Clinical Practice Improvement Activity

CPIA Subcategory	Activity	Weight
Population Management, Patient Safety, Beneficiary Engagement	Attestation to Compliance with "CDC Guideline for Prescribing Opioids for Chronic Pain"	High

Proposed CPIA: Clinicians treating chronic pain patients with opioids attest to following the "CDC Guideline for Prescribing Opioids for Chronic Pain."

Background: Chronic pain represents a substantial health burden on the U.S. population. Analysis of data from the 2012 National Health Interview Study demonstrated that 11.2 percent of adults reported having daily pain.[8] However, it is difficult to estimate the number of persons who could benefit from long-term opioid pain medication. On the basis of data available from health systems, researchers estimate that 9.6 – 11.5 million adults, or approximately, 3 percent to 4 percent of the U.S. population received a prescription for long-term opioid therapy in 2005.[9]

Opioid dependence is a major public health issue that is currently the subject of proposed legislation. In 2013, on the basis of DSM-IV diagnosis criteria, an estimated 1.9 million persons abused or were dependent on prescription opioid pain medication.[10] Having a history of a prescription for an opioid pain medication increases the risk for overdose and opioid disorder.[11]

Rationale: Opioids can be effective in controlling chronic pain. Prolonged opioid use can result in addiction, which produces adverse health outcomes including death. Use of the "CDC Guideline for Prescribing Opioids for Chronic Pain" can improve clinical knowledge, change prescribing practices and benefit patient health. Among other recommendations, the "CDC Guideline for Prescribing Opioids for Chronic Pain" provides recommendations for: (1) when to initiate or continue opioids for chronic pain; (2) opioid selection, dosage, duration, follow-up, and discontinuation; and (3) assessing risk and addressing harms of opioid use.

CPIA Subcategory: The proposed CPIA falls under the following subcategories: (1) "Population Management" by monitoring health conditions of individuals to provide timely health care interventions; (2) "Patient Safety" by encouraging more appropriate prescribing of opioids for chronic pain; and (3) "Beneficiary Engagement" by frequently communicating with patients with complex care needs about treatment.

CPIA Criteria: The proposed CPIA meets the following criteria: (1) relevance to an existing CPIA subcategory (or a proposed new subcategory); (2) importance of an activity toward achieving improved

[8] "CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016": https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

[9] Ibid.

[10] Ibid.

[11] Ibid.

beneficiary health outcomes; (3) CMS is able to validate the activity; and (4) evidence that supports an activity that has a high probability of contributing to improved beneficiary outcomes.

Weight: High. Reducing the incidence of opioid dependence is a public health priority and therefore meets the proposed criteria for "high" weight.

Validation: Clinicians who treat Medicare beneficiaries prescribe opioids. Hence, CMS will be able track patients and opioid prescribing patterns through assessing Medicare ICD claims data to determine if the patient was prescribed opioids or had a substance abuse disorder.

Burden: The reporting burden for providers is relatively minimal because it requires clinicians to simply attest to following the CDC Guideline for Prescribing Opioids for Chronic Pain and maintain such records for validation and audit purposes.

The undersigned reviewed the proposed CPIA and believe a new CPIA should be created for attesting to following the "CDC Guideline for Prescribing Opioids for Chronic Pain" and that it should receive a "high weight."

Proposed Clinical Practice Improvement Activity

CPIA Subcategory	Activity	Weight
Patient Safety and Practice Assessment, Population Management, Care Coordination, Beneficiary Engagement	Attestation to Participation in Continuing Medical Education (CME)	High

Proposed CPIA: Clinicians attest to participating in Continuing Medical Education.

Background: CME helps clinicians maintain and gain new knowledge on clinical practices in their medical fields. Experts in the field impart information and data through CME activities that encompass, but are not limited to, live events, online publications, written publications, audio, video, or internet-based interactions.

Rationale: The Agency for Healthcare Research and Quality (AHRQ) noted in a 2007 report that CME is effective for acquisition and retention of knowledge, attitudes, skills, behaviors, and enhanced clinical outcomes for patients.[12] In fact, some CME programs assist clinicians with improving their practice. For example, the American Society of Regional Anesthesia and Pain Medicine (ASRA) Self-Assessment Module - Pain Medicine (SAM-PM) is a self-study CME program that covers established knowledge in the subspecialty field of pain medicine, and enables clinicians to assess areas of strength and weakness in pain medicine knowledge and target ongoing education in these areas.

CPIA Subcategory: The proposed CPIA falls under the following subcategories: (1) "Patient Safety" by educating clinicians on evidence-based medicine and best clinical practices: (2) "Population Management" by teaching clinicians how to better monitor health conditions to provide timely health care interventions; and (3) "Care Coordination" by educating clinicians about care coordination activities such as effective use of HIT and telehealth; and (4) "Beneficiary Engagement" by teaching clinicians how to develop care assessment plans and engage in patient shared decision-making.

CPIA Criteria: The proposed CPIA meets the following criteria: (1) relevance to an existing CPIA subcategory (or proposed new subcategory); (2) importance of an activity toward achieving improved beneficiary health outcome; (3) representative of activities that multiple MIPS eligible clinicians or groups could perform; (4) feasible to implement, recognizing importance in minimizing burden especially for small (15 or fewer clinicians) practices, practices in rural areas, or in areas designated as geographic Health Professional Shortage Areas (HPSAs) by Health Resources and Services Administration (HRSA); and (5) evidence supports that an activity has a high probability of contributing to improved beneficiary health outcomes.

Weight: High. CME aligns with a CMS national priority to learn methods to improve clinical practice and incorporate evidence-based practices into patient care.

[12] Effectiveness of Continuing Medical Education, Agency for Healthcare Research and Quality, U.S. Dep't of Health and Human Services, AHRQ Publication No. 07-E006 (Jan. 2007), *available at* http://archive.ahrq.gov/downloads/pub/evidence/pdf/cme/cme.pdf.

Validation: CMS can work with CME accrediting organizations to validate that clinicians participated in CME.

Burden: The reporting burden for providers is relatively minimal because it requires clinicians to simply attest to participating in CME and maintain such records for audit and validation purposes.

The undersigned reviewed the proposed CPIA and believe a new CPIA should be created for attesting to participation in Continuing Medical Education and that it should receive a "high weight."

Proposed Clinical Practice Improvement Activity

CPIA Subcategory	Activity	Weight
Population Management, Patient Safety, Beneficiary Engagement	Attestation to Compliance with Professional, Governmental, or Other Professionally Accepted Organizations' Clinical Practice Guidelines	High

Proposed CPIA: Clinicians attest to compliance with professional, governmental, or other professionally accepted organization's clinical practice guidelines.

Background: The Institute of Medicine defined "clinical practice guidelines" as "statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and assessment of the benefits and harms of alternative care options."[13] The National Heart, Lung, and Blood Institute within the National Institutes of Health further clarifies that "trustworthy guidelines should be based on systematic evidence review, developed by a panel of multidisciplinary experts, provide a clear explanation of the logical relationships between alternative care options and health outcomes, and provide ratings of both the quality of evidence and the strength of the recommendations."[14] Clinicians use evidence-based clinical practice guidelines when treating patients to improve quality of care, improve patient outcomes, increase access to care and improve efficiency in care.

Rationale: Use of evidence-based clinical practice guidelines in clinical decision-making can improve quality of care and increase efficiency in care delivery.

CPIA Subcategory: The proposed CPIA falls under the following subcategories: (1) relevance to an existing CPIA subcategory (or proposed new subcategory); (2) importance of an activity toward achieving improved beneficiary health outcome; (3) representative of activities that multiple MIPS eligible clinicians or groups could perform; (4) feasible to implement, recognizing importance in minimizing burden especially for small (15 or fewer clinicians) practices, practices in rural areas, or in areas designated as geographic HPSAs by HRSA; and (5) evidence supports that an activity has a high probability of contributing to improved beneficiary health outcomes.

Weight: High. Clinical practice guidelines address the public health priority of patients receiving high quality and cost efficient care.

Validation: CMS can track Medicare ICD claims to determine whether clinicians are following clinical practice guidelines for specific patient conditions.

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[13] See IOM Standards for Developing Trustworthy Clinical Practice Guidelines: http://www.nationalacademies.org/hmd/Reports/2011/Clinical-Practice-Guidelines-We-Can-Trust/Standards.aspx

[14] See NIH National Heart, Lung, and Blood Institute "About Systemic Evidence Reviews and Clinical Practice Guidelines": http://www.nhlbi.nih.gov/health-pro/guidelines/about

Burden: The reporting burden for providers is relatively minimal because it requires clinicians to simply attest to complying with professional, governmental, or other professionally accepted organizations' clinical practice guidelines and maintain such records for audit and validation purposes.

The undersigned reviewed the proposed CPIA and believe a new CPIA should be created for attesting to compliance with professional, governmental, or other professionally accepted organizations' clinical practice guidelines and that it should receive a "high weight."