



## Sound Policy. Quality Care.

November 17, 2015

Andrew M. Slavitt  
Acting Administrator, Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-3321-NC  
Submitted electronically via <http://www.regulations.gov>

**RE: Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models**

Dear Acting Administrator Slavitt:

As the Alliance of Specialty Medicine (Alliance), our mission is to advocate for sound federal health policy that fosters patient access to the highest quality specialty care. We are writing today to provide input that will inform your implementation of the newly established Medicare physician payment models described in the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.

**Merit-Based Incentive Payment System (MIPS)**

The Alliance urges CMS to make significant improvements to its existing quality improvement initiatives as they are consolidated into the new MIPS program.

We make the following recommendations for the **quality** component:

- At a minimum, maintain the currently available reporting mechanisms to ensure all eligible professionals can report quality data.
- Adopt policies that promote investment in Qualified Clinical Data Registries (QCDR), interoperability between QCDRs and electronic health records (EHR), and permit eligible professionals to meet the quality component of MIPS by participating in a QCDR
  - Use of a QCDR should also count toward any meaningful use requirements related to quality reporting
- Support the development high-quality and relevant measures for specialists and expand the availability of specialty-focused quality measures to ensure all specialty and subspecialties have a fair opportunity to demonstrate quality improvement for the conditions and populations they treat
- Use the National Quality Strategy (NQS) domains only as a guide, rather than a reporting requirement. If this is not immediately possible, CMS should at least permit the assignment of individual measures to multiple domains.
- Adopt outcomes measures as they become available, but maintain balance in performance weighting so that eligible professionals without appropriate outcomes measures are not unduly penalized

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American Urological Association • Coalition of State Rheumatology Organizations • Congress of Neurological Surgeons  
National Association of Spine Specialists • Society for Cardiovascular Angiography and Interventions • Society for Excellence in Evicare

- CMS should recognize patient satisfaction surveys under the Clinical Practice Improvement Activities category of MIPS, rather than under the Quality component, and should recognize a broad range of patient experience surveys beyond the CAHPS for PQRS.
- Should CMS maintain the Measures Applicability Validation (MAV), we urge the agency to ensure that its application does not put eligible professionals in a position where they are penalized for failing to report measures that are not relevant to their practice or patient population. The MAV clinical clusters also must be developed under a more transparent process that relies on the input of relevant clinical stakeholders.

We make the following recommendations for the **resource use** component:

- The current set of cost measures used under the Value Modifier Program are too broad in focus and rely on questionable attribution and risk adjustments methodologies. We strongly urge CMS to invest in the development of more specific and meaningful resource use measures by working with specialty societies and their clinical experts.
- Incorporate socio-economic status (SES) and other demographic factors that have a clear relationship to quality of care and patient outcomes into resource use (and quality) measurement.
- Permit specialties to determine whether there are alternative sources from which to derive appropriate resource-use measures.
- Account for all pharmaceutical costs (ie, Part D and Part B) in resource use calculations

We make the following recommendations for the **meaningful use** component:

- Continue to accept feedback and make significant revisions to the Stage 3 requirements, given the majority of physicians are unable to meet current Stage 2 requirements and the finalized Stage 3 criteria will be impossible for most physicians to meet if not revised.
- Delay Stage 3 requirements until at least 50% of eligible professionals participating in the MIPS are able to successfully meet Stage 2 criteria.
- Allow partial credit that recognizes partial achievement of meaningful use objectives, rather than the current pass-fail, all-or-nothing approach that fails to recognize incremental effort and insufficiently accounts for all exempt circumstances.
- Continue to allow hardship exemptions where appropriate, and ensure that those with an approved hardship exemption are not penalized in regards to their total MIPS score.
- Because interoperability continues to be a pain point for eligible professionals, we urge CMS to work closely with its federal agency counterparts on solutions that will help ensure seamless, bidirectional information exchange (across all health information technology systems and clinical data registries) without additional cost to those eligible professionals and practices that make an investment in certified electronic health record technology (CEHRT).

We make the following recommendations for the **clinical practice improvement activities** component:

- Adopt the proposed additional subcategories as outlined in the RFI.
- Adopt additional subcategories that give credit for enhanced professional education and training, professional and practice accreditation activities, and other clinical practice improvement activities, and include at least the following as clinical practice improvement activities:
  - Attendance and participation in ACGME-accredited events, such as the specialty and

- subspecialty society conferences
- Attendance and participation in other CME and non-CME events
- Fellowship training or other advanced clinical training completed during a performance year
- Voluntary practice accreditation, such as accreditation achieved by the National Committee on Quality Assurance (NQCA), Accreditation Association for Ambulatory Health Care (AAAHC), The Joint Commission (TJC), or other recognized accreditation organizations
- Engagement in state and local health improvement activities, such as participation in a regional health information exchange or health information organization
- Engagement in private quality improvement initiatives, such as those sponsored by health plans, health insurers, and health systems
- Participation in other federally sponsored quality reporting and improvement programs not already affiliated or considered under the MIPS program
- Allow eligible professionals to attest through a simple web-based system on a yearly basis. Due to the nature of some CPIAs (e.g., certification), there may be instances when an EP should only have to attest to certain activities each year without having to demonstrate anything additional (e.g., until certification expires).
- EPs should have the flexibility to choose activities that are most relevant to their practice and should not be required to satisfy any specific subcategory.

In regards to public reporting and feedback:

- The Alliance urges CMS to maintain its current minimum requirements to determine whether measure data are suitable for public reporting (i.e., only measures which prove to be valid, reliable, and accurate upon analysis; are deemed statistically comparable; meet a minimum sample size of patients; are not first-year measures; and have proven, through concept testing, to be of value to consumers). CMS should conduct this process transparently and in consultations with all relevant clinical stakeholders.
- Performance feedback should be provided in real-time, where possible, but at least monthly to ensure providers have adequate time to clinical workflows and processes if there are areas where the EP may need to change direction to ensure success for the year.

### **Alternative Payment Models**

Flexibility is essential for specialty and subspecialty organizations to develop alternative payment models (APMs) for their patient population and practice types. Rather than being overly prescriptive, CMS should identify key elements that must be inherent to any APM, while leaving it open to APM developers to determine how each of the key elements should be met by eligible professionals under the model. The Alliance has previously urge CMS to adopt the following elements as key to any APM: quality measurement; continuous data collection; shared decision making; care coordination and patient reported outcomes.

Finally, we urge CMS to be cautious in its definition of more-than-nominal financial risk. Financial risk for eligible professionals comes in many forms, to include making adjustments in human capital (clinical and administrative), physical and technology infrastructure, and clinical workflows and patient capacity.

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Thank you for considering our comments, and we look forward to working with you as you continue to implement the MACRA and associated policies in years to come. Should you have any questions, please contact Rachel Groman, MPH, at [rgroman@hhs.com](mailto:rgroman@hhs.com).

Sincerely,

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