North Carolina Medical Society
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Leadership in Medicine

November 17, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3321-NC
P.O. Box 8016
Baltimore, MD 21244-8013

RE: CMS-3321-NC; Comments in response to Request for Information regarding implementation of Section 101 of the Medicare Access and CHIP Reauthorization Act of 2015

Dear Administrator Slavitt:

On behalf of the North Carolina Medical Society (NCMS) and our over 12,000 physician and physician assistant members, we are pleased to provide our feedback in response to the Request for Information regarding implementation of the Medicare Access and CHIP Reauthorization Act of 2015. Section 101 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) sunsets payment adjustments as they exist currently under the Physician Quality Reporting System (PQRS), Value-Based Payment Modifier (VBPM) and EHR Incentive programs and replaces them with a Merit-Based Incentive Payment System (MIPS) under the Medicare Physician Fee Schedule. It also creates an incentive structure to encourage physician participation in Alternative Payment Models (APMs). The NCMS supports the move to value-based health care and appreciates the opportunity to provide comments on the implementation of these provisions of MACRA. It is critical that CMS approaches implementation of MACRA carefully and methodically to continue to support the innovations currently underway by many physicians in North Carolina and across the country. If done hastily, the resulting requirements could undermine the success and progress made by these programs.

As CMS considers the larger construct, as well as the technical details regarding MIPS implementation and APM development, we encourage the agency to remember the intent of Congress in passing MACRA; to empower physicians to move away from the current, fragmented fee-for-service payment model and work toward care delivery and payment reforms that allow for coordination and innovative ways of caring for patients while also protecting scarce health care resources. Congress' clear intent was to harmonize and streamline the currently fragmented quality and performance improvement activities that exist in both Medicare and the private payer environment alike. To that end, the NCMS asks CMS to consider the following principles during the early development and strategic planning phase of this massive implementation effort:

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1. CMS should look at the MIPS program as a fresh start, rather than relying on the flawed components of the current, separate programs (PQRS, VBPM, EHR Incentive Program) as a foundation for the new MIPS program. The implementation of MIPS should serve as an opportunity to hit the reset button rather than tweaking and building on flawed aspects of the existing programs. Moreover, CMS must take this opportunity to reevaluate the relevance of performance measurement as it exists in the programs today and alter these programs so they have real-world, practical relevance in physician performance improvement activities currently underway. This must include robust feedback from medical and specialty societies with physicians' input to assist CMS in determining the most relevant measures and appropriate methodologies to drive true performance improvement activities that are meaningful. CMS should encourage physicians' input to promote acceptance of the programs and the measures used.
2. The passage of MACRA should serve as a major opportunity for CMS to truly innovate by removing the current limitations of our antiquated payment system. To move beyond a fee-for-service payment model, CMS must allow for current regulatory barriers to be modified to encourage true innovations in APMs.
3. Timelines for implementation must be reasonable and realistic. To implement these new programs, CMS will need sufficient time to collect meaningful feedback from stakeholders to ensure the problems that have been identified over the last several years can be addressed fully, and appropriately resolved. Thirty days to comment on more than 100 detailed questions is not sufficient, and demonstrates the tight and possibly unreasonable deadlines CMS faces under the current structure.
4. Administrative burdens must be reduced in the implementation of these new programs. We urge CMS to hold multiple and ongoing, cross-departmental internal meetings to be sure there is an understanding of the totality of administrative requirements being placed on physicians and practices in implementing the MIPS program as well as any APM activities. An overly burdensome and overly complex process or set of processes will undoubtedly undermine success and must be avoided at all costs.
5. CMS must ensure a fully transparent process going forward in developing and implementing APMs and the MIPS program. This includes transparent sharing of data and information use to support proposed policy changes.
6. Implementation of MIPS and APMs must be gradual. Physicians have been faced with multiple, competing priorities over the last five years, all of which aim to transform the way they practice medicine. This transition must be made at a pace that does not adversely impact the quality of care. Implementation must be done with careful consideration in each phase of the process. This will allow for reasonable adjustments to be made where necessary, and ensures a successful implementation while encouraging participation in improvement activities and APM participation.
7. Existing practice transformation efforts must be leveraged to encourage continued participation and engagement from the physician community. Many physicians and practices have engaged in tireless work over the past several years to respond to the rapidly changing health care environment. CMS should build on the efforts that have been made and are working well. For example, there are 18 approved Medicare Shared Savings Program ACOs in the state of North Carolina, all of which have devoted significant time, resources and energy in transforming their practices. We must build on and reward this good work by allowing these investments to continue to pay-off by

incorporating models and activities that currently are working into the MIPS program and APMs.

In addition to these principles, we have provided input on more technical questions contained in the RFI below. However, we caution CMS to avoid making decisions on technical details until a majority of the larger, overarching questions about program implementation have been answered. We urge CMS to continue to collect ongoing feedback from stakeholders throughout the implementation process.

Merit-Based Incentive Payment System (MIPS)

1. MIPS identifiers- The NCMS supports both NPI-level and TIN-level identifiers at a minimum. CMS must support both individual-level and practice-level performance evaluation and payment. Additionally, CMS must provide multiple ways for large, multi-specialty practices to report and be evaluated to ensure ample opportunities to report in the way that makes the most sense for the practice.
2. Virtual groups- The NCMS supports permitting the formation of virtual groups for MIPS analysis. This will allow for more broad participation by smaller and rural practices as well as subspecialties, also creating more meaningful measurement and more statistically valid sample sizes to rely on for measurement in the MIPS program. We urge CMS not to make regional barriers to this option and to allow for the broadest participation possible.
3. Quality and resource use performance- We encourage CMS to work with medical and specialty societies to identify problems with quality performance measurement in the existing programs and identify a priority list of issues to be resolved fully prior to the next phase of rulemaking for implementation of MIPS. Measures must focus on real outcomes, and gradually move away from process-oriented measures which make up the majority of measures currently. CMS must find a way to allow for rapid changes to quality measures to be consistent with changes in measurement and best practices.
4. Clinical practice improvement performance- The NCMS believes it was Congress' intent to include the "clinical practice improvement activities" component of the MIPS program to provide credit to physicians currently engaged in clinical practice improvement efforts. For this reason, CMS should allow physicians and/or practices to attest to being involved in such activities to earn credit in this MIPS category. It would then be incumbent on the physician and practice to document their involvement in such activities. CMS must ensure the spirit of the law is apparent in the implementation criteria that result from the addition of this component to the MIPS program.
5. CEHRT use- CMS must first fix the flawed Meaningful Use criteria before mandating participation as part of a total, overall MIPS scoring methodology. Going forward, CMS' should focus on using HIT to improve patient care rather than fulfilling administrative requirements of an incentive program.
6. Inclusion of additional measures- CMS should look to the specialty societies to define measures that are meaningful to physicians and rely on those measures for the MIPS program. Physicians and representative specialties and subspecialties can best identify actual gaps in care and areas for improvement which will result in meaningful changes in the way care is delivered. Additionally CMS should consult all stakeholders in the

measure selection process, including private payers, to co-develop programs to address gaps in care in a particular region.

7. Development of performance standards- When calculating performance standards, CMS must use the most recent data practicable, rely on a fully transparent process for determining benchmarks and other performance standards and allow for robust physician input on the best way to calculate such standards. This should be an ongoing, scientific process with full testing of policies before changes are implemented.
8. Flexibility in weighting performance categories- The NCMS supports allowing a flexible approach to weighting of performance categories in the MIPS program if such changes support the more fair overall analysis of performance.
9. MIPS composite performance score and performance threshold- CMS should adopt policies that support improvement as well as achievement of a performance threshold and find ways to reward all physicians who are able to meet such thresholds.
10. Public reporting- CMS must ensure a fair and transparent process for publishing physician performance data to the general public. More care and consideration should be given to publishing only data that is helpful and useful to consumers and clearly identifies gaps in information or areas that are not fit for comparison. Physicians must have ample time to review data before it is published.
11. Feedback reports- CMS must provide ongoing, real-time feedback on performance and should consult stakeholder groups continuously to determine the best presentation and format for sharing performance feedback information with physicians and practices.

Alternative Payment Models (APMs)

1. Payment incentive for APM participation- CMS must be generous in its application of the APM incentive payments to encourage physicians to take the risks and investments of time, money and effort required to participate in an APM. The NCMS urges CMS to make a broad interpretation of the eligibility requirements to allow as many physicians and practices that have participated in existing models as possible to benefit from these incentives. CMS should also ensure a simple process for making these determinations. The administrative burdens associated with qualifying as an eligible APM must not serve as a disincentive to participate/qualify. This also applies in defining the "nominal financial risk" threshold included in MACRA. In addition to a simple process for qualification, when defining "nominal financial risk" requirements CMS must not forget to take into account the contributions and investments made by physicians and practices that may not be as clearly apparent such as: investments in IT infrastructure necessary for information sharing and analytics key to improvement activities; paying for additional staff to address increased administrative activities that often come with participation in a new care model; hiring additional care coordinators; paying staff for additional coverage hours to avoid unnecessary hospital utilization by its patient population; decreased productivity and disruptions that come from the cultural changes needed to change care processes and work flows; and legal fees for organizing an entity capable of implementing an APM.
2. Medical homes- CMS should recognize all medical home models that meet the criteria included in the law, including state Medicaid medical home models, in its application of the comparability test included in MACRA. The comparability test should be simple and

easy to implement, and those entities replicating the concepts included in Medical Homes as outlined in Section 1115A(c) of the Social Security Act should qualify as a Medical Home for the purposes of MACRA.

3. Eligible Alternative Payment Model Entity requirements- In determining who is an EAPM entity, CMS should look to the individual's direct involvement in the APM model. Any individual who is directly involved in an APM should be provided the full benefits of an EAPM entity. This should be a straightforward and simple determination to reduce administrative burdens and to encourage participation in APMs by physicians.
4. Use of comparable quality measures and CEHRT- CMS should apply a similar standard for APMs and MIPS participants, while allowing for flexibility where an APM may necessitate alternate accommodations (either in quality measures or EHR selection).
5. Physician-focused payment models- The NCMS urges CMS to incorporate physicians in all APM model creation, evaluation and participation. The NCMS supports the focus on, and increased inclusion of specialty-specific care models that include a focus on shared accountability with an ultimate goal of providing integrated and coordinated care for patients. We urge CMS to seek ongoing feedback from the national medical specialty societies and their physicians on how to evaluate and support creating such models.
6. Technical assistance to small practices and practices in Health Professional Shortage Areas (HPSAs)- The NCMS urges CMS to make technical assistance accessible, actionable and hands-on. Small and rural practices need hands-on advice and one-on-one support as well as funding and resources to prepare for value-based systems and to understand how to participate in performance measurement and improvement activities. Additionally, these small and rural practices will need assistance in understanding and evaluating potential APMs for their participation. CMS should work with community representatives such as state medical and specialty societies and regional Quality Improvement Organizations to best determine those in most need of these additional supports.

We look forward to continuing to provide CMS with ongoing and detailed feedback throughout the MACRA implementation process. Should you have any questions, please contact Jennifer Gasperini at jgasperini@ncmedsoc.org.

Sincerely,

Robert W. Seligson
Executive Vice President, CEO