December 19, 2016

Andrew M. Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5517-P, PO Box 8016
Baltimore, MD 21244-8016

VIA ELECTRONIC FILING

Re: [CMS–5517–FC]
Final Rule with Comment Period: 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

Dear Mr. Slavitt:

The Spine Intervention Society (SIS), a multi-specialty association of over 2,600 physicians dedicated to the development and promotion of the highest standards for the practice of interventional procedures in the diagnosis and treatment of spine pain, would like to take this opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) Final Rule on the Medicare Program's Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule and Criteria for Physician-Focused Payment Models [CMS-5517-FC] published in the Federal Register on November 4, 2016.

Overall, SIS is pleased with the changes made between the proposed rule and the final rule and see these as positive steps. However, we believe the final rule remains overly complex, particularly for small or solo physician practices with limited resources to invest in the infrastructure necessary to track and report the measures under the Quality Payment Program (QPP).

Merit-based Incentive Payment System (MIPS)

Time Frame

SIS appreciates the new and more flexible 'pick your pace' MIPS reporting requirements wherein physicians can choose to participate at various levels depending on their own readiness. We are satisfied that, under the final rule, CY 2017 will be treated as a "transition year," with a gradual buildup starting 2018. We also appreciate the refinement of the weight assigned to different performance categories in MIPS and that the resource use/cost category will not count toward the 2017 MIPS score.

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While these are steps in the right direction, we continue to believe that the two-year lag between the performance and payment years is problematic for physicians in terms of tracking their performance and managing that performance at required levels with delayed feedback. The intent of the MACRA statute is to create a change toward value in healthcare delivery and payment. With that time gap, there is no mechanism for timely meaningful feedback: payment changes are either a nice "bonus" related to unclear processes or a "punishment" with little clarity as to how the practice could improve. To address this and the need for the agency to have some lag between the end of a reporting period and the reconciliation year, we suggest CMS require reporting for the first nine months of each year, allowing the last three months for reconciliation of the data such that the performance and payment feedback are available by January of the following year. CMS can use a full year of administrative claims data for the non-reporting measures for a better sample size. This would meet the goals of Medicare by allowing rapid response to physicians at the same time removing the two-year lag between performance and payment.

Size and Characteristics of Physician Practice

SIS appreciates the financial investments in education and technical assistance for small and solo practices, as well as the embedded flexibilities in the proposed rule for such practices. We believe the changes made in the final rule from the proposed rule are positive steps in the right direction. However, even with the adjustment to a threshold of 100 Medicare patients or less than $30,000 in total Medicare charges, we believe CMS could further improve the exemption standards. Specifically, we recommend that CMS increase the threshold number of Medicare patients to 150 Medicare patients as 100 Medicare patients is not a significant exemption threshold.

In addition, even with these improvements the proposed new scoring design will still disproportionately disadvantage solo and smaller practices and we believe further adjustments are warranted.

Non-Patient-Face-to-Face Clinician Exemptions

SIS appreciates that CMS was willing to consider changes to their definition of non-patient-face-to-face clinicians, which was set at 25 Medicare patient encounters or fewer. However, we believe that the adjustments made by CMS to a defined threshold of 100 patient face-to-face encounters or fewer is still too low. We recommend that CMS use number of Medicare patients rather than patient encounters as 100 Medicare patient encounters represents a very small number of encounters. Using 100 Medicare patients as a threshold would also align this definition with the low volume exemption described above.

Provision of Data to Clinicians

SIS remains consistent in our concern that the framework detailed in the rule do not provide enough sufficient information in an actionable timeframe for most physician practices. The program should strive for real-time provision of clinician/practice data instead of the lagged feedback system across all the elements of this new proposed program. Access to timely data that reflect the performance scoring of clinicians is

essential for the success of the QPP. While historical data could be provided as a guide to clinicians, provision of real time data on a quarterly basis could better inform clinicians. SIS believes that small and even medium-sized physician practices will not be able to participate effectively without detailed quarterly feedback on their performance.

SIS also believes the appeals process outlined in the final rule, while improving on the process in the proposed rule, remains not sufficiently transparent or timely and will not provide actionable feedback to providers involved in appeal. We recommend that CMS develop a fully transparent appeals process that can be completed and decided within a short time in order to allow physicians to adjust for future years.

Alternative Payment Models (APMs)

SIS has consistently requested reductions in the unnecessary and burdensome requirements to qualify as part of a new or "Advanced" Alternative Payment Model; these requirements cause resources to be spent on administrative costs rather than patient care. We also recommend the creation of a clearly defined pathway for rapid approval and implementation of physician-focused APMs. We do not believe the changes made in the final rule sufficiently open up the Advanced-APM pathway to small or solo practices or physicians in smaller specialties. While we support the slight reduction in percentage of repayment to Medicare under risk models from 4% to 3% to quality as an Advanced-APM, we believe CMS should further reduce this definition to 2% or less.

We also believe the final rule's standards for consideration as a meaningful participant in an advanced APM are too great for most physicians in the United States to qualify under this pathway, even with the adjustments made in the final rule. We continue to believe the actual impact on the Medicare program will be the opposite of that intended by MACRA, with reduced incentives for physicians to participate and initiate new and innovative models for payment and delivery. We encourage CMS to revise and expand opportunities for physicians to qualify as advanced APMs in future rulemaking. Absent this, small or solo practices are less likely to develop and test new payment models because they are not sufficiently incentivized by the delivery and reimbursement system. This was expressly not the intent of the legislation, and CMS should view the Advanced APM mechanism as an opportunity to encourage small practices to experiment with their reimbursement models and revise the final rule accordingly.

We also urge CMS to consider a new definition of Medical Home Models. Under both the proposed and final rule definition, the focus is on primary care and accountability of empaneled patients across the care continuum. We urge CMS to consider an alternative definition of Medical Home Models such that specialty physicians and clinicians are correctly attributed to their patients, especially when they play the role of the primary physician consultant, and accordingly, receive the incentives due them.

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In conclusion, SIS appreciates the stated goal of moving to value-based payments in Medicare and commends CMS on the tremendous progress made from the proposed rule

to the final rule. We recommend that CMS continues to engage closely with physician stakeholders to adjust and adapt the QPP quickly and decisively to keep the payment system on target toward providing and incentivizing the highest quality care to our patients. We are thankful for the opportunity to comment on some of the proposals, and look forward to continually engaging with CMS in the refinement of this important piece of regulation.

If we may answer any questions or provide any assistance, please feel free to contact Belinda Duszynski, Senior Director of Policy and Practice at bduszynski@spinalinjection.org.

Sincerely,

John MacVicar, MB ChB
President
Spine Intervention Society