August 21, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5522-P
P.O. Box 8016
Baltimore, MD 21244-8013

Re: Medicare Program; CY 2018 Updates to the Quality Payment Program (CMS-5517-P)

Dear Ms. Verma:

On behalf of the Society of General Internal Medicine (SGIM), representing over 3,500 general internists across the country who are deeply involved in providing primary medical care to Medicare beneficiaries, as well as in training the primary care providers of the future and engaging in health services research, we appreciate the opportunity to provide comments on the proposed rule outlining the requirements for Year 2 of the Quality Payment Program (QPP). Many of the SGIM's members care for Medicare patients, and are eager to understand the requirements they will have to meet to succeed in either the Merit-Based Incentive Payment System (MIPS) or as clinicians in advanced Alternative Payment Models (APMs). SGIM recognizes the need to transform the health care delivery to both improve healthcare outcomes and quality of care while controlling costs.

Continued implementation of the QPP represents a major step in this transformation to improve care delivery and SGIM looks forward to working closely with CMS as it moves forward. We offer the following comments related to this proposed rule, which focus on the following areas of particular importance to our members:

1. General Comments on MACRA Implementation
2. Low Volume Threshold
3. Virtual Group Option
4. Cost Performance Category
5. Complex Patient Bonus

General Comments on MACRA Implementation

SGIM supports the steps taken by the agency in this proposed rule to further simplify the requirements of the QPP and reduce the administrative burden on physicians. However, we remain concerned that the existing evaluation and management (E/M) codes that do not accurately define discrete levels of cognitive service and do not capture the broad range of cognitive services are being used as the foundation upon which the QPP is being built. We believe the deficiencies of these service codes will undermine our members' ability to succeed in the program, particularly in advanced APMs.

The primary care workforce shortage is the direct result of this misvaluation, which remains a national crisis despite steps taken by CMS to create new service codes to reimburse physicians for the time and work done coordinating patient care. The value proposition of MACRA will remain unattainable if the foundational deficiencies of the Resource-Based Relative Value Scale (RBRVS) are not addressed in a systematic and sustainable fashion.

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For the QPP to work as intended, shifting physicians into advanced APMs, there must be a balanced workforce, one that not only provides necessary interventions and procedures, but also has a sufficient number of physicians to decide if and when interventions are appropriate, and to provide preventive care that can help reduce the need for expensive procedures and hospitalizations. Cognitive physicians serve as health care advocates for their patients. Primary care physicians manage and coordinate the complex care of patients who have multiple chronic conditions, multiple medications, multiple providers, and multiple diagnostic tests ordered. Cognitive specialists must have an enormous depth of knowledge in order to judiciously apply interventions that range from procedures to high risk and high cost biologic and pharmacologic therapies. There is a "complexity density" within the work of cognates that is not properly identified or valued in the existing fee schedule.

As CMS shifts Medicare to reimbursing physicians for the value of care provided, not the volume, the RBRVS will still be used to assign value to the individual services being delivered. Our members who are currently practicing in advanced APMs are still evaluated and reimbursed based on the RVUs of the services they provide to patients. Furthermore, these E/M service codes fail to provide the granularity needed to represent the work done in these advanced APMs.

SGIM believes it is critically important that new models of care delivery be built from trustworthy building blocks. The agency must prioritize the reworking of E/M service codes using a strong evidence base. With a well-constructed and valid representative knowledge-base, new service codes can be defined and provided with appropriate relative valuations that recognize the complexities and demands of current medical practice; these new codes can then be incorporated in advanced APMs to accurately reflect the care delivered to patients.

Low Volume Threshold

SGIM supports the increase of the low-volume threshold to exclude individual eligible clinicians or groups that have Medicare Part B allowed charges less than or equal to $90,000 or that provide care for 200 or fewer Part B-enrolled Medicare beneficiaries as this will decrease the percent of the MIPS eligible clinicians that come from small and rural practices. We had previously expressed concern about the ability of small private practices, including those in rural areas to be able to succeed in the QPP, and this increase of the low-volume threshold will exempt a greater percentage of small practices.

Virtual Group Option

During the rulemaking cycle for the first year of the QPP, CMS declared its intention to create a virtual group option to give solo practitioners and small practices the option to participate in a large group if they choose to do so. SGIM was disappointed that the agency could not implement this proposal for the first year of the program, but is pleased it's included in this proposed rule and support the proposal.

Cost Performance Category

CMS is proposing to maintain the weight of the cost performance category at zero percent for the 2020 MIPS payment year while continuing to educate providers on cost measures and develop more episode-based measures. We urge CMS to finalize this proposal and appreciate CMS' recognition of the importance of ensuring clinicians have appropriate episode-based measures available. SGIM believes that CMS should continue to delay the implementation of the cost performance category until the attribution methodology is developed, validated, and reviewed publicly.

SGIM has significant concerns about the patient attribution methodology used for this category. As it is currently constructed, the attribution methodology used by the agency will put enormous pressure on individual physicians, particularly hospitalists, who will be held accountable for the performance of all others who also treat the patient. The attribution methodology must be carefully designed so that a link is established between patient and provider. Requiring annual patient attestation could accomplish this. If attribution is based solely on the assignment of costs and usage patterns, the potential for inappropriate linkages of patients to providers increases. Inappropriate attribution could be potentially devastating to individual providers and small groups. We urge CMS to carefully consider this issue as it formulates the required regulations to give all providers the greatest chance to succeed.

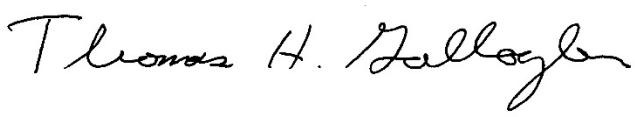
Complex Patient Bonus

CMS has proposed the creation of a complex patient bonus of no more than three points to add to the final MIPS score for the 2020 MIPS payment year for clinicians that submit data for at least one performance category. The bonus would be calculated by finding an average HCC risk score for each MIPS eligible clinician or group. SGIM is pleased to see CMS taking the initiative to factor in the care of complex patients provided by providers and groups and offering to recognize that care when totaling MIPS scores.

Despite this, our support for the concept behind this bonus, SGIM has significant reservations about using HCC risk scores to determine the bonus. HCC risk scoring is a concept that originates from the Medicare Advantage program. While the concept works well under that specific program, it has never been applied specifically to measure and calculate the risk of individuals in a different program, like MIPS. Before establishing this bonus to reward clinicians for the care they deliver to highly complex patients, it is important that we are sure the bonus will work as intended. Factors outside of the clinician's control, like compliance and socioeconomic status, have an enormous impact on quality outcomes. Any failure to adequately account for these factors could potentially lead to unequal and inadequate care. Unfortunately, we do not believe there are already developed risk models that accurately account for the complex patients treated by our members. We urge CMS refine its thinking on how to reward clinicians for caring for complex patients rather than use an imperfect tool.

SGIM appreciates the opportunity to provide comments to CMS on this proposed rule. Please do not hesitate to contact Erika Miller at emiller@dc-crd.com or (202) 484-1100, if we may provide any additional information or assistance as CMS moves forward in this process.

Sincerely,



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