December 19, 2016

Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Program: Merit-based Incentive Payment System(MIPS) and Alternative Payment Model(APM) under the Physician Fee Schedule, and Criteria for Physician-focused Payment Methods (CMS-5517-F)

Dear Acting Administrator Slavitt:

The Advocacy Council of the American College of Allergy, Asthma and Immunology (the AC) and its sponsoring organization, the American College of Allergy, Asthma and Immunology (ACAAI), appreciate this opportunity to comment on provisions in the final MACRA rule. Our organizations are national specialty organizations that represent over 3500 physicians board-certified or board-eligible in allergy and immunology and over two thousand allied health professionals. Our physician members provide care to the millions of individuals with allergic diseases and conditions, including the over 3 million Medicare beneficiaries with asthma.

Overview

We commend CMS for the many changes it has made to the final MACRA rule that provide for increased flexibility and more time for physicians to transition to MIPS. We share CMS' goals of increasing the quality of health care we provide to our patients and, at the same time, controlling costs. However, we are concerned that the ever-increasing documentation and reporting requirements are creating a climate of physician burn-out. We hear constantly from our members that they are overwhelmed by the competing reporting and other regulatory requirements imposed by Medicare, Medicaid, and commercial payers. The majority of allergists (approximately 60%) are in solo practice or small groups and do not have the resources or economies of scale available to larger practices. Many of the reporting and electronic health records requirements are overly complex, take time away from patient care, and often contribute little in the way of improved quality.

Our comments and recommendations for improvement on specific aspects of the MIPS and APM rules are set forth below.

Low-Volume Exception

While we greatly appreciate the changes made between the proposed and final rule to increase the availability of the low-volume exception, we believe that more is needed.
First, we believe that, for small groups, there should be a low volume exception that would be applied at the group level. Specifically, we ask CMS to consider an exception for small group practices if either 1) the average Medicare Part B allowed charges for all clinicians in the group is below the low-volume dollar or patient threshold; or 2) if at least 75 percent of the group's clinicians are below the threshold. There is certainly precedent for the second alternative in CMS' policy of excluding from MIPS groups in which at least 75 percent are non-patient facing clinicians.

We are also very concerned that the low-volume exception is not available to those clinicians who would otherwise qualify, but are in groups that choose to report to MIPS as a group. CMS has stated that in these circumstances not only would the clinicians eligible for the low-volume exception be required to report to MIPS, but they would be disqualified from receiving any MIPS bonus attributable to their performance. This goes counter to the goal of the Quality Payment Program to reward physicians for participating in quality improvement activities. It could also inadvertently discriminate against physicians that work less than full-time and could disproportionately impact women, older physicians that are moving toward retirement, and physicians with disabilities who work a reduced schedule. These individuals would be more likely to qualify for the low-volume exception but if their group wants the benefits of group reporting, these individuals would still have to report to MIPS without receiving any of the potential benefits of reporting.

We believe physicians that qualify for the low-volume exception and who are in groups that want to report as a group should have the option of not reporting to MIPS. Conversely, those that meet the low-volume exception but would like to report should be eligible to participate in MIPS.

MIPS Transition

We appreciate that CMS has provided physicians with more time to transition to MIPS and that they can avoid a penalty in 2017 by reporting one quality measure. However, we are very concerned that many physicians, especially those in small practices, will not be ready for full participation by 2018. We urge CMS to consider further extending the timeline through at least 2018.

MIPS Cost Category

We commend CMS for its decision to delay implementation of the MIPS cost category for at least one year. We do not believe cost should be counted in the MIPS scoring until all of the building blocks (e.g. patient relationship categories, patient condition codes, and care episodes) are in place and there is appropriate risk adjustment.

We have seen many instances in which patients have been inappropriately attributed to allergists, under the current value modifier, even though allergists provided only specialized care and had no control over the patient's other costs. We believe it is critical that MIPS not repeat these mistakes and that costs be accurately attributed. In addition, given the complexity of this aspect of MIPS, we also believe it must be properly tested before it is implemented.

MIPS Quality Measures

We continue to be concerned about the lack of meaningful measures for our specialty, in particular the absence of appropriate outcomes measures. Most of the process measures available for reporting by the allergy/immunology specialty do not contribute meaningfully to the quality of patient care and the burdens of reporting are substantial. Our specialty is working on measure development but most of the measures approved by CMS for the allergy and immunology measures group were not developed by the specialty and many are focused on primary care management and not the type of care provided by specialists. While we appreciate that CMS has reduced the number of reportable quality measures from nine to six, we believe that even six measures is too many, at least until meaningful specialty appropriate measures have been established.

Advanced Alternative Payment Model (AAPM) Approval Process

We are concerned that the process for obtaining recognition of an alternative payment model (APM) as an AAPM is far from clear. We believe the process for obtaining approval by the Physician –focused Payment Model Technical Advisory Committee (PTAC) and CMS needs to be more transparent. Our specialty is investing considerable resources in the development of alternative payment models but without any assurance that if the models meets the appropriate criteria that they will be approved. It is essential, if specialties are to be encouraged to develop new APMs, that the process be as transparent and as streamlined as possible.

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We appreciate your consideration of our views on these important issues. If we can be of further assistance, please do not hesitate to contact Susan Grupe at suegrupe@acaai.org or 847-427-1200.

Sincerely,

Stephen A. Tilles, MD
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