December 28, 2017

Seema Verma, MPH, 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: Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year; 42 CFR Part 414 [CMS-5522-FC and IFC]

Dear Administrator Verma:

The Spine Intervention Society (SIS), a multi-specialty association of over 2,700 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 Quality Payment Program Calendar Year 2018 Update [CMS-5522-P].

SIS is pleased that CMS has used the Quality Payment Program (QPP) calendar year update for 2018 to offer significant regulatory relief from current regulations for the QPP. We appreciate this collaborative approach outlined in the Final rule and look forward to working closely with the agency to make the QPP successful for interventional spine care physicians.

In particular, SIS supports the additional exemptions and opportunities for providers in solo and small practices who are the most likely to face limitations in how completely and how quickly they have access to, and can adopt and implement, the infrastructure necessary to positively participate in the QPP.

In order to continue this positive momentum toward greater collaboration with physicians we urge the agency to continue to work with stakeholders to identify and work directly with the providers, administrators, directors, and other staff who are operationally responsible for the implementation and management of data collection, reporting, and incentivizing quality care. It is likely that within health systems and stakeholder groups there are a small handful of highly knowledgeable and committed leaders who would serve as essential resources for CMS as the agency continues to lead the evolution of our health care system into a more patient-focused, value-based system for all stakeholders

We believe the Calendar Year final rule largely continues the positive momentum from the

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proposed rule. However, the QPP continues to present substantial challenges to physicians and SIS continues to have substantial concerns about the impact on physicians and physician practices as a result of the implementation of the QPP. Our largest concern with changes from the proposed rule to the final rule involves the final rule's reversion to including the cost category under MIPS for a physician's total score. We believe this will result in inaccurate results for performance year 2018 and will cause frustration and alienation for physicians. We recommend that CMS reconsider this policy and seek to retroactively implement the proposed policy to set the weight for the MIPS cost category to 0% before payment year 2020.

Merit-based Incentive Payment System (MIPS)

Low-volume threshold

The SIS appreciates the agency's expansion of the low volume threshold exemptions from current regulations and the agency's finalization of the changes outlined in the proposed rule.

Under 2017 regulations, the low volume threshold applies to providers with less than $30,000 in Medicare Part B allowed charges annually or fewer than 100 Part B beneficiaries annually, and in the 2018 proposed and final rules, CMS outlines a significantly higher threshold – less than $90,000 in Part B allowed charges annually or less than 200 Part B beneficiary visits annually.

While this change represents a significant improvement, going forward SIS continues to recommend using a percentage of Medicare to total revenues and percentage of Medicare patients to total patients as opposed to the use of claims and patients. This would more accurately account for providers with a true low volume of Medicare patients and encounters, and would represent a fairer standard for an exemption.

Lag between performance year and payment year

SIS continues to believe that the two-year lag between the performance and payment years is problematic for physicians in terms of tracking and managing performance at required levels when they receive delayed feedback. The intent of the MACRA statute, and the QPP program, is to create a change toward value in healthcare delivery and payment. With the two-year time gap, there is no 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. One way to achieve more closely aligned performance and payment timeframes is to require reporting under MIPS (especially for the active reporting requirement measures) for the first nine months of each performance year, designating the last three months for reconciliation of the data such that 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 and, at the same time, removing the two-year lag between performance

and payment. We recommend that for future year's rulemaking, the agency consider removing the two-year lag.

Virtual groups

SIS appreciates the new regulations that create an option for solo and small practices to form virtual groups enabling their participation in the MIPS program. While supportive of the concept, however, we believe it is crucial for CMS should provide extensive and individualized support and learning opportunities for clinicians and their practice management staff on how to create virtual groups or implement changes in these groups. Absent significantly more explicit and targeted guidance, it will be unlikely that virtual groups will be a viable alternative path towards increased participation in MIPS.

In addition, SIS believes the virtual group regulations, while promising, are both complex and vague. CMS should also provide tools for solo and small practices to determine if forming virtual groups will be beneficial for their patients and their practices. A significant investment of resources will be needed just to set up the virtual groups, including, but not limited to, finding potential group members, drawing up legal contracts, expensive third-party reporting, as well as identifying health information technology vendors and administrative staff to support the virtual group functioning. We appreciate CMS' development and publication of a toolkit. However, it is essential that CMS develop additional toolkits and materials that provide adequate information and simple and actionable guidelines to clinicians to make necessary decisions about forming virtual groups. Without more robust guidance for the creation and maintenance of virtual groups, important finite physician and practice resources potentially may redirected from the care provided to Medicare beneficiaries.

Unfortunately, CMS missed a critical opportunity to better address these issues, which were raised in feedback during the proposed rule comment period. We recommend CMS refine and improve the virtual group pathway in MIPS in future rulemaking.

Additional Flexibilities

SIS appreciates and supports the additional flexibilities and opt in or out options added in the final rule for physicians employed in Ambulatory Surgical Center (ASC) and Hospital employed physicians as well. We believe these additional exemptions are appropriate as employed physicians have less control over many of the measures included in MIPS.

MIPS Performance Measurement Categories

MIPS Performance Categories: Quality

While there are many positive aspects to the changes from 2017 Calendar Year to 2018 Calendar Year within the Quality MIPS category, SIS is disappointing CMS did adopt the revisions suggested by SIS and other stakeholders to the Quality performance category. Specifically, we recommend that CMS consider in future year rulemaking revising the policy

around phasing out so called "topped out" measures after three years and instead allow four full years of data. This will enable physicians in less common specialties such as spine care to continue to have a sufficient volume of quality measures for reporting and scoring.

MIPS Performance Categories: Cost

SIS is disappointed with the agency's move away from the proposal to set the cost category at 0 for the 2018 performance year and revert to a 10% weighting for total MIPS scoring. SIS believes this to be an error in principle, but also believes the agency compounded the impact of the flawed policy by proposing the 0% weighting and then reversing this in the final rule. If the agency is going to revise the policy, as we believe should occur, it now will have to be done retroactively which is much more cumbersome and difficult. This difficulty, however, should not preclude CMS from acknowledging the reasoning that led to the proposal to rest the weight to 0% was sound and worth doing retroactively. With the two year lag between performance year and payment year, CMS would be able to adjust the payment setting for payment year 2020 far enough in advance to avoid erroneously adding to the difficulty of meeting MIPS standards. Resource use and attribution are complex issues and it may take several performance years for the cost category to evolve and mature into valuable and reliable measurements of resource use and hence, CMS needs to explore all regulatory avenues to make the cost category an effective component of the overall MIPS program going forward. We recommend resetting the cost category to 0% of total MIPS scoring for performance year 2018, even if it needs to be retroactively.

MIPS Performance Categories: Improvement Activities

SIS appreciates and supports the expansion of available clinical performance improvement activities in the final rule. The final rule increased the total number of available activities to 112. While we believe more work needs to be done to expand the range of clinically relevant activities available to non-primary-care providers, SIS is pleased with CMS' actions to increase the aggregate number of activities.

Alternative Payment Models (APMs)

SIS strongly supports the efforts by CMS to make the QPP's Alternative Payment Model (APM) avenue more accessible. However, SIS is disappointed that the final rule did not address stakeholder input to accelerate the approval and integration of available Advanced APMS. As noted in past comments, APMs relevant to many specialty physicians and, as such, the Advanced APM pathway is not relevant for most physicians, including most spine care physicians. We continue to urge CMS to work closely with stakeholders to more quickly approve and implement a broad and robust set of Advanced APMs.
We also urge CMS to adopt a lower threshold for financial risk than the finalized 8%. We would recommend a general threshold of less than 5% nominal risk as well as allowing for qualification as an Advanced APM even in situations where the financial risk is lower but the other components (use of CEHRT, payment innovation, etc.) are actively advancing better

patient care with fewer resources. We believe a focus on financial risk is too narrow and does not match the goals of QPP to improve quality of patient care as well as the more efficient use of resources.

All-payer Combination APMs

While the new regulations provide new avenues for participation in Advanced APMs, this option is limited to CMS programs such as Medicaid and Medicare Advantage. Consolidation with private payer APMs will truly hasten the movement to value-based payment and will increase the breadth of patients who are provided high-quality care. In fact, the Health Care Payment Learning & Action Network (LAN) was established as a collaborative network of public and private stakeholders, including health plans, providers, patients, employers, etc. and the recommendations of their technical expert panels and working groups should be taken into consideration to accelerate specialty-focused APMs. We are supportive of the all-payer combination APM pathway, but we believe CMS can more robustly develop this pathway and make it more viable, particularly for specialty physicians in future rulemaking. In addition, similar to the Advanced APM comments above, SIS believes the all-payer combination APM should have lower and more flexible financial risk settings.

Physician-Focused Payment Models (PFPMs)

SIS strongly believes physician leadership and physician-led APMs are critical to the development of effective and sustainable APMs. If the primary goal of these innovative demonstrations is to manage resources while improving the quality of care, physicians should be incentivized to lead the episodes to improve efficiency and effectiveness. Moreover, physician leadership becomes imperative as the QPP is implemented and attribution algorithms become significant for accurate reimbursement.

The SIS strongly supports the final rule's broadened definition of Physician-Focused Payment Models (PFPM) to include payment arrangements that involve Medicaid or the Children's Health Insurance Program (CHIP) as a payer, even if Medicare is not included as a payer.

While SIS is encouraged with the expansion of PFPM, however we were disappointed with the maintaining of the nominal risk at 8% requirement for approval as a PFPM. SIS believes a PFPM could be approved even if it does not feature or focus on nominal risk. Many potential APMs could be approved if the agency and the Physician-Focused Payment Model Technical Assessment Committee (PTAC) are willing to accept and approve as APMs a variety of new delivery models. We believe a focus on results and outcomes, as opposed to the methods and means, is consistent with the goals of the program and should be the priority for the PTAC in evaluating proposals for PFPM.

In conclusion, SIS appreciates the stated goal of moving to value-based payments in Medicare and commends CMS on the Final rule, which is mostly in line with the complicated tasks of the MACRA statute. We are thankful for the opportunity to comment on some of the proposals, as

above, and look forward to engaging with CMS in this transformation of our healthcare delivery system.

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@SpineIntervention.org.

Sincerely,

Timothy P. Maus, MD
President
Spine Intervention Society