



June 27, 2016

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5517-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: CMS-5517-P, 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; Proposed Rule

Dear Acting Administrator Slavitt:

The American Chiropractic Association (ACA) is the largest professional association in the United States representing over 130,000 doctors of chiropractic (DCs), chiropractic assistants (CAs) and chiropractic students. ACA promotes the highest standards of ethics and patient care, contributing to the health and well-being of over an estimated 27 million individuals across the United States. ACA appreciates the opportunity to provide comments on the Notice of Proposed Rulemaking (NPRM) regarding the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, published in the Federal Register on May 9, 2016.

ACA would like to begin by commending Congressional efforts to repeal the fatally flawed Sustainable Growth Rate (SGR) formula. We also applaud the Centers for Medicare and Medicaid Services (CMS) for the extensive work that has been done to transform the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) legislation into rules and regulations that would implement the Merit-Based Incentive Payment System (MIPS) and the Alternative Payment Model (APM) program. We strongly support changes to the Medicare physician payment system that recognizes providers for value and quality of the care they provide versus the volume of patients seen. ACA was an advocate for repeal of the SGR and streamlining the requirements for reporting of performance metrics in what have been separate programs. We believe that the provisions presented in this proposed rule are the first step toward incorporating these vital elements; however, there is still concern by eligible clinicians, including doctors of chiropractic, regarding the number and complexity of the proposed rule provisions. We offer the following comments and recommendations and encourage CMS to continue dialogue with stakeholders to ensure the transition to the Quality Payment Program is effective and in the best interest of clinicians and the patients they serve.

ACA supports CMS' decision to maintain and streamline existing quality reporting programs (i.e. the Physician Quality Reporting System (PQRS) and Medicare Electronic Health Record (EHR) Incentive Program), while the programs transition to MIPS. Providing consistency with established programs will allow clinicians to transition more smoothly to MIPS, while simultaneously giving providers the opportunity to familiarize themselves with the new participation and reporting requirements.

E. MIPS Program Details

II.E.2.a. Definition of a MIPS Eligible Clinician

In the “Request for Information Regarding Implementation of the Merit-Based Incentive Payment System,” non-MD/DO providers, including doctors of chiropractic, were denied participation in two performance categories due to the proposed use of a limiting definition of physician found at subsection 1861(r)(1) of the Social Security Act (SSA). ACA commends CMS for their decision to expand the scope of their definition in this proposed rule and include all provider types defined at Section 1861(r) of the SSA in their definition of MIPS Eligible Clinicians in year 1 and 2. Doctors of chiropractic are primary spine care physicians, and provide key services for a range of conditions that impact America’s seniors. We are encouraged by CMS recognition of the critical role that non-MD/DO providers play in the care of Medicare patients.

II.E.2 MIPS Eligible Clinician Identifier

ACA supports CMS’ proposed use of the existing National Provider Identifier/Taxpayer Identification Number (NPI/TIN) as the identifier to assess performance of an individual MIPS eligible clinician. The use of existing identifiers to identify MIPS eligible clinicians will allow for an easy transition and avoid the increased administrative burden and potential confusion associated with creating a new MIPS identifier. However, ACA also recommends that CMS consider allowing for greater flexibility in the reporting requirements and allow providers to participate either individually or as a group for each of the four (4) performance categories. Depending on the eligible clinician’s practice, there are circumstances where it may be reasonable to report individually for some categories and as a group for other categories. For example, eligible clinicians may opt to report individually for the Quality Performance category, but then report as part of a group for the Clinical Practice Improvement Activity (CPIA) and Advancing Care Information categories because those activities are performed and monitored at the group level in their practice. Thus, we believe that the MIPS program would benefit from greater flexibility in allowing a combination of individual and group reporting for the different categories, while using a single NPI/TIN identifier for assessing performance and applying the payment adjustment.

II.E.3.c. – Low-Volume Threshold

CMS proposes that in the first two years of the program, MIPS eligible clinicians with the low-volume threshold will be exempt from participation in the MIPS program. Low-volume threshold clinicians are defined as those who have Medicare billing charges less than or equal to \$10,000 and who provide care for 100 or fewer Medicare Part B beneficiaries.

ACA appreciates CMS’ acknowledgement of the population of clinicians who may be disproportionately burdened if expected to meet the program requirements and have, therefore, proposed the exclusionary criteria for low-volume threshold clinicians. However, we strongly urge CMS to modify the exclusionary definition so that clinicians with Medicare charges less than or equal to \$10,000, ~~and~~ **OR** those who provide care for 100 or fewer Medicare Part B beneficiaries would be exempt from participation. While we agree that individually, these criteria are value-oriented, it is our opinion that basing the exclusion on two thresholds simultaneously would be antithetical to measurements of quality based on outcomes.

Patient care can be very expensive and, as currently proposed, some eligible clinicians could be denied the low-volume threshold after seeing only a few very complex patients over the course of the performance period. However, the \$10,000 figure may also prove excessive for certain types of eligible clinicians. The only Medicare covered service provided by doctors of chiropractic is spinal chiropractic manipulative treatment (CMT) and the average participating provider reimbursement amount for CMT (CPT® codes 98940, 98941 and 98942) is only \$35.00. Further, although clinically and legally required (e.g., by licensure statutes and Medicare) to take a history, perform an examination, and establish diagnoses and treatment plans, doctors of chiropractic are the only physician level providers who are not covered for reimbursement under Medicare for Evaluation

and Management (E/M) CPT® codes. Therefore, while a doctor of chiropractic could see 100 or more Medicare beneficiaries during a performance period, their Medicare charges may not meet the \$10,000 threshold.

Additionally, there are concerns that the proposed exclusionary criteria may lead to eligible clinicians in solo or small practices withdrawing as Medicare providers, or limiting the number of Medicare patients they treat over the course of a performance period, to avoid the administrative burden, complexity of reporting, and additional expenses that would be incurred with the adoption/implementation of certified electronic health record technology and/or engaging a third-party data submission vendor. This could have some unintended consequences on Medicare beneficiaries who may experience decreased access to care, especially in medically underserved and rural settings. Given the burgeoning demand for primary care providers, and the access issues Medicare beneficiaries already encounter, this modified low-volume threshold definition more appropriately accounts for clinicians who should be granted an exemption from the MIPS program requirements and takes into consideration the impact of MIPS on solo and small practices.

II.E.3.e. – Virtual Groups

Within MACRA there is a provision which would allow voluntary virtual groups to be established for the purpose of certain MIPS assessment. ACA respects CMS' decision to not hurry the development and implementation of the technological infrastructure that will be required to successfully operationalize virtual groups as a beneficial option for MIPS eligible clinicians or groups. We do encourage CMS to publish its proposal, outlining the criteria and requirements regarding the execution of virtual groups, as soon as possible. Forming virtual groups could result in a larger number of cases for performance measurement and could encourage movement towards more organized systems. However, we are concerned with CMS' proposal to limit virtual group size to not more than 10 eligible clinicians for a performance period of a year. Given other language in the proposed rule that encourages virtual groups, like ACO-affiliated physicians, to participate in MIPS as a group, it seems odd to limit the size of a voluntary virtual group to just 10 clinicians. We encourage CMS to reconsider this size limitation to ensure clinicians that elect to move toward more organized systems are not discouraged.

II.E.4. – MIPS Performance Period

As previously stated, ACA supports CMS' decision to maintain and streamline existing quality reporting programs while transitioning to MIPS; however, ACA is greatly concerned with how rapidly CMS has proposed to implement the new Quality Payment Program. While CMS seeks to increase clinician flexibility and reduce reporting burdens, the newly developed programs are very complex for many clinicians, especially those that are solo practitioners or in and small practices, as are the majority of doctors of chiropractic. Additionally, there are several critical areas within the proposed rule that will remain unknown until publication of the final rule in November 2016. Following publication, specialty societies and other stakeholders will need time to digest the final provisions, and develop and execute an extensive outreach and education effort to ensure that all clinician types are fully prepared not only to participate, but successfully achieve the goals and principles of the underlying MACRA bipartisan legislation. If properly implemented, the new MIPS and APM framework will promote improvements in the delivery of care for Medicare patients; therefore, it is our recommendation that that CMS consider extending implementation to, at minimum, 6 months (June 2017) to allow sufficient time for providers to learn how to implement the new reporting requirements, as well as train their staff on the new requirements.

II.E.5.b. – Quality Performance Category

ACA agrees that CMS' proposal for the Quality Performance Category could provide eligible clinicians with greater flexibility, a more simplified reporting process, and more meaningful measurement of quality. We appreciate CMS' proposal to maintain the claims-based reporting option. Several clinician types, including doctors of chiropractic, are currently in the process of implementing registry and/or QCDR reporting options for the profession. Additionally, there are numerous limitations for the majority of the chiropractic profession to report using EHR data submission vendor products.

That said, ACA continues to have great concerns for the chiropractic profession regarding submission criteria. CMS proposes reporting at least six (6) measures including one cross-cutting measure and at least one outcome measure. ACA, through our Committee on Quality Assurance and Accountability, has been very proactive in developing clinically useful performance measures and in educating chiropractic physicians in the appropriate use of reportable measures. We continue to actively collaborate with various organizations that are responsible for developing and evaluating performance measures, including: AQA Alliance, National Quality Forum (NQF), National Committee on Quality Assurance (NCQA), Physician Quality Measurement Management Team (PQMM), and the AMA's Physician Consortium on Performance Improvement (PCPI). Despite this effort, year after year doctors of chiropractic have only been eligible to report on the following two (2) quality measures under the Physician Quality Reporting System (PQRS):

- Measure #131: Pain Assessment and Follow Up; and
- Measure #182: Functional Outcome Assessment.

Under Medicare, covered chiropractic services are limited to spinal chiropractic manipulative treatment (CMT) codes (CPT® codes 98940, 98941 and 98942). Although clinically and legally required (e.g., by licensure statutes and Medicare) to take a history, perform an examination, and establish diagnoses and treatment plans, DCs are not covered for reimbursement under Medicare for Evaluation and Management (E/M) CPT® codes. DCs are the only physician level providers who are not reimbursed for such services by Medicare. Therefore, the profession has been precluded from a number of reportable measures due to their limited coverage under Medicare. As quality or value-based care dictates, the majority of measures (i.e. outcome, appropriate use, patient safety, efficiency care coordination, and patient experience) are both work and diagnosis specific and therefore coverage of E/M codes is mandatory to report these measures.

Further, CMS has also proposed to increase the thresholds for reporting on quality measures from 50 percent of Medicare Part B beneficiaries to 90 percent of all patients if through a registry/QCQR and electronic health record (EHR), or 80 percent of Medicare Part B beneficiaries if reporting via claims. This is a considerable increase in reporting thresholds and it is our recommendation that CMS maintain the 50 percent denominator data submission threshold for all reporting options to allow eligible clinicians sufficient time to adopt the changes to this performance category, as well as any modifications made to individual measure specifications.

Finally, due to the limited nature and number of quality measure available to doctors of chiropractic and many other specialties under previous quality reporting programs, ACA strongly supports CMS' continued application of a process similar to the Measure-Applicability Validation (MAV). A checks and balances process is critical to those eligible clinicians that do not have enough measures to meet the defined criteria to ensure that they do not face enormous barriers to successfully meeting the requirements of the MIPS quality performance category.

II.E.5.c.(9) – Cross-Cutting Measures for 2017 and Beyond

CMS has proposed to eliminate 13 cross-cutting measures that were available under PQRS for 2016 reporting but are not being proposed as cross-cutting measures for 2017 reporting. CMS states: *“Under MIPS, we are proposing fewer cross-cutting measures than those available under PQRS for 2016 reporting; however, we believe the list contains measures for which all patient-facing MIPS eligible clinicians should be able to report, as the measures proposed include commonplace health improvement activities such as checking blood pressure and medication management.”*

ACA disagrees with CMS' statement above, as well as CMS' proposal to eliminate PQRS measure #131 – Pain Assessment and Follow Up, and measure #182 – Functional Outcome Assessment from the list of cross-cutting measures for 2017 reporting. As stated in the previous section, due to their limited coverage under Medicare, the chiropractic profession has been precluded from all but two reportable measures under PQRS since the program's inception; therefore, the list of cross-cutting measures does not contain measures for which all patient-facing MIPS eligible clinicians can report. Additionally, the elimination of Measure #131 and #182 from

the list of cross-cutting measures for 2017 reporting establishes yet another barrier for doctors of chiropractic to successfully participate in the MIPS quality performance category by proposing to eliminate the only two measures on which doctors of chiropractic are currently eligible to report. Therefore, ACA urges CMS to include one, if not both, of the above stated measures in the list of cross-cutting measures for 2017 reporting.

II.E.5.e. – Resource Use Performance Category

ACA has identified several areas of concern with CMS' proposal for the resource use category. While we agree that the premise for the category is positive, we believe that there are serious flaws with the existing Physician Value-based Payment Modifier (VM) program, including a flaw mentioned in this proposed rule that was raised by many stakeholders – many of the measures were created for hospitals, not individual clinician providers, and are therefore inappropriate.

The current methodologies for measuring spending during episodes of care, for attributing spending to physicians, and for risk adjusting spending measures have many serious weaknesses that have the potential to harm providers, particularly solo practitioners and small practices.

Additionally, the future of the resource use category attribution logic remains unclear. This issue is specifically critical to doctors of chiropractic due to the limited coverage of services allowed and reimbursed under the Medicare payment system. Without the ability to bill for evaluation and management (E/M) services, doctors of chiropractic will be unable to have patients attributed to them. However, Medicare's rapid movement towards data-driven, value-based care provides a unique opportunity to evaluate the care provided by doctors of chiropractic within a broader health care delivery context.

According to the United States Bone and Joint Initiative, musculoskeletal diseases affect nearly three out of four people age 65 and over.¹ Treatment options that are effective, conservative, and inexpensive should be encouraged for Medicare beneficiaries. CMT services, including associated but separately defined E/M services are among such treatment options for the following reasons.

- CMT has been extensively studied: A recent systematic review revealed that spinal manipulative therapy more effectively treated chronic low back pain (cLBP) than sham or an ineffective control intervention and had a similar treatment effect when compared to analgesics, exercise, or medical care.²
- Practice guidelines recommend CMT:
 - The American Pain Society/American College of Physicians Clinical Practice guidelines found good evidence that spinal manipulative treatment is effective for chronic LBP.³
 - In January 2015 the Joint Commission revised its pain management standard to include chiropractic therapy.⁴
 - The American Geriatric Society has found chiropractic care to be an appropriate method for managing chronic back pain.⁵
- The risk profile of CMT is extremely low: Calculated at between 5-10 serious complications per 10 million manipulations.⁶

¹ <http://www.boneandjointburden.org/>

² Rubinstein SM, Terwee CB, Assendelft WJ, de Boer MR, van Tulder MW. Spinal manipulative therapy for acute low back pain: an update of the cochrane review. *Spine (Phila Pa 1976)*. 2013;38(3):E158-77. Epub 2012/11/22. PMID: 23169072.

³ Chou R, Qaseem A, Snow V, Casey D, Cross JT, Jr., Shekelle P, et al. Diagnosis and treatment of low back pain: a joint clinical practice guideline from the American College of Physicians and the American Pain Society. *Ann Intern Med*. 2007;147(7):478-91.

⁴ <http://bit.ly/1qEuR0e>

⁵ American Geriatrics Society. The management of chronic pain in older persons: AGS Panel on Chronic Pain in Older Persons. *J Am Geriatr Soc*. 1998;46:635-51.

- Chiropractic care is effective: Beneficiaries are protected from declines in functioning as measured by Activities of Daily Living, instrumental Activities of Daily Living and self-rated health.⁷
- High levels of Patient Satisfaction: Chiropractic patients report very high levels of satisfaction with the chiropractic care they receive. The Brandeis Report to Congress on the Demonstration of Expanded Coverage of Chiropractic Services under Medicare noted that 60% of chiropractic patients reported “complete” or “a lot” of relief from symptoms and 87% reported high satisfaction with care (8 or higher on a 10-point scale), with 56% indicating a perfect 10. Similarly high proportions reported that DCs listened carefully to, and spent sufficient time with, these Medicare beneficiaries.⁸
- Chiropractic care provides an alternative to more invasive treatments that are increasingly used and may have severe drawbacks:
 - Medicare spending on various invasive treatments for back pain increased substantially over the decade. According to an article published in 2009, a review of the literature found that over approximately a decade, epidural steroid injections increased by 629% and spinal fusions, by 220%; however, these increases were not accompanied by improvements in patient outcomes or reductions in disability rates.⁹ Indeed, several recent articles have documented the potential negative impacts of spinal fusion.^{10, 11, 12}
 - During that same period, opiate use increased by 429% and recent studies have documented high utilization rates of opiate use among younger, disabled Medicare beneficiaries. Opiates are expensive, addictive, and present health risks that may result in downstream treatment costs.¹³

Clearly, chiropractic care is consistent with the emphasis on treatments that are considered patient centered, high value, and cost efficient. And while we are happy that doctors of chiropractic are included in the definition of MIPS Eligible Clinician at the onset of the Quality Payment Program, it is the opinion of ACA that doctors of chiropractic are at an enormous disadvantage for participation in the program due to the limited coverage under the Medicare program. Current policy dictates that DCs are *expected to perform E/M services that are not currently reimbursed by Medicare, as a condition of payment for another service that is reimbursed by Medicare.* Because E/M services must be delivered as a prerequisite of the spinal manipulation itself, they clearly fall within the statute’s description of “chiropractic services.” As such, E/M services should be covered as required in statute. ACA encourages CMS to expand the billing codes for doctors of chiropractic to cover the full scope of licensure, which not only allows for equal opportunities for chiropractic in the Quality Payment Program, but to allows greater patient access and expansion of spine care that achieves improved care, positive health outcomes, and reduced costs.

⁶ Hurwitz EL, Aker PD, Adams AH, Meeker WC, Shekelle PG. Manipulation and mobilization of the cervical spine. A systematic review of the literature. *Spine*. 1996;21(15):1746-59. <http://www.ncbi.nlm.nih.gov/pubmed/8855459>

⁷ Weigel, Paula, et al., “The Comparative Effect of Episodes of Chiropractic and Medical Treatment on the Health of Older Adults,” *Journal of Manipulative and Physiological Therapeutics*, March/April 2014, page 143.

⁸ Brandeis University, Report to Congress on the Evaluation of the Demonstration of Coverage of Chiropractic Services Under Medicare, June 16, 2009, page 7.

⁹ Deyo, Richard, “Overtreating Chronic Back Pain: Time to Back Off?,” *Journal of the American Board of Family Medicine*, 2009; 22(1): 62-68

¹⁰ Marquez-Lara A, Nandyala SV, Fineberg SJ, Singh K. “Cerebral Vascular Accidents Following Lumbar Spine Fusion.” *Spine (Phila Pa 1976)*. 2013 Dec 30. [Epub ahead of print]

¹¹ Fineberg SJ, Nandyala SV, Kurd MF, Marquez-Lara A, Noureldin M, Sankaranarayanan S, Patel AA, Oglesby M, Singh K. “Incidence and risk factors for postoperative ileus following anterior, posterior, and circumferential lumbar fusion.” *Spine J*. 2013 Oct 31. pii: S1529-9430(13)01610-0. doi: 10.1016/j.spinee.2013.10.015. [Epub ahead of print]

¹² Martin BI, Mirza SK, Franklin GM, Lurie JD, MacKenzie TA, Deyo RA. “Hospital and surgeon variation in complications and repeat surgery following incident lumbar fusion for common degenerative diagnoses.” *Health Serv Res*. 2013 Feb;48(1):1-25. doi: 10.1111/j.1475-6773.2012.01434.x. Epub 2012 Jun 20.

¹³ Wolters Kluwer Health: Lippincott Williams and Wilkins, High Prevalence of opioid use by social security disability recipients, *Science Daily*, August 14, 2014.

ACA also seeks clarification on the attribution methodology, which will likely become further complicated with the addition of patient relationship categories and codes. ACA recommends that the weight of this category be decreased to five percent, and the remaining five percent should be shifted to the Clinical Practice Improvement Activities (CPIA) category in the first two years of the program. Alternatively, if doctors of chiropractic or other provider types do not meet the attribution threshold, we recommend that the entire ten percent be reallocated to the CPIA category. The weight of the category can increase after the first two years, when there is a better understanding of the attribution and impact of measures.

II.E.5.f. – Clinical Practice Improvement Activity (CPIA) Performance Category

ACA supports the addition of Clinical Practice Improvement Activities (CPIA) as a new performance category to meet the goals of using a patient-centered approach to program development that leads to better, smarter, and healthier care. We also welcome the implementation of CPIAs to drive movement toward delivery system reform principles and Alternative Payment Models (APMs). We believe CMS has accurately developed the list of CPIAs that are relevant to all types of eligible clinicians and will result in improved patient outcomes.

As previously mentioned, the chiropractic profession is currently in the process of implementing a new registry and a Qualified Clinical Data Registry (QCDR). We are thrilled that the doctors of chiropractic will finally have these reporting options; however, time is needed for the profession to sign up, be educated, and begin proper reporting. Therefore, ACA strongly urges CMS to make it technically feasible to utilize administrative claims data to supplement CPIA data submission for 2017.

With regard to submission criteria, ACA applauds CMS for their proposal to offer full and partial credit based on weighting of the CPIAs selected for this performance category. Abandoning the all-or-nothing reporting requirements and scoring for this and the other MIPS categories is an immense improvement to the quality reporting process, especially with the addition of a completely new performance category that providers will need to learn and implement. We also commend CMS for providing flexibilities to eligible clinicians in solo or small group practices to allow for greater success in meeting the performance requirements for this category. However, we believe that additional clarification is needed regarding the 2017 performance period for this category. The proposed rule states that CPIAs must be performed for 90-days. We respectfully request that CMS clarify in the final rule whether the intent is to have eligible clinicians report CPIAs for 90 consecutive days, any 90 days within the performance period, or another 90-day reporting timeframe.

While we remain somewhat concerned about a doctor of chiropractic's inability to furnish and bill for Evaluation and Management (E/M) services that are directly tied to the subcategories of clinical practice improvement activities (i.e. care coordination, population management), ACA's optimism has greatly increased with the changes that CMS has proposed to incorporate into this performance category when compared to the MIPS RFI proposal. ACA encourages CMS to continue to work with specific provider groups and their associated specialty society to ensure *appropriate and relevant* Clinical Practice Improvement Activities are sanctioned as requirements for this performance category become more stringent in future years. Active dialogue with specialty societies will allow CMS to determine measures or other demonstration of activities that are applicable to the clinical practice of their physician members, have improved clinical practice and/or care delivery, and resulted in improved outcomes.

II.E.5.g. – Advancing Care Information Performance Category

ACA is pleased with CMS' recognition of the flaws and impediments that clinicians experienced with the Meaningful Use program. We are encouraged to see that CMS is proposing to offer greater flexibility and time for providers to update their software, train staff, and change practice workflows to accommodate new technology. However, we do have concerns about the proposed multi-leveled scoring for this performance category. The proposed approach to scoring is very complex and much more confusing than the methodology used for Meaningful Use. We are concerned about the difficulties that specialty societies and providers will

experience in their effort to translate and fully grasp the requirements for performance and reporting. In an effort to simplify this information for eligible clinicians and specialty society staff, we request that CMS provide further clarification in the final rule as well as issue additional resources (i.e. fact sheets, FAQs) to describe the proposed scoring methodology for the objectives and measures for Patient Electronic Health Access, Coordination of Care through Patient Engagement, and Health Information Exchange.

We encourage CMS to continue down the path of providing greater flexibility to eligible clinicians in how they meet the requirements for the Advancing Care Information performance category. However, we do recommend that CMS change its proposed policy in the Notice of Proposed Rulemaking and allow eligible clinicians to earn a performance score and bonus score even if they fail the base score. It is also our opinion that a full year reporting period for the Advancing Care Information performance category poses a significant burden on eligible clinicians. This category contains a high degree of complexity and eligible clinicians will not have sufficient time to review the rule and begin a full year of reporting by the proposed implementation date. Therefore, the ACA recommends that CMS establish a 90-day reporting period for 2017 to ensure eligible clinicians are given sufficient time to learn and successfully execute the new reporting requirements.

We also have some concerns regarding the complexity of how Certified Electronic Health Record Technology (CEHRT) will interact with other products and registries and what capabilities should be certified. We ask that CMS work with the Office of the National Coordinator (ONC) on how QCDRs, Qualified Registries, and health IT vendors are working with CEHRT in practice today, and adjust and clarify their intentions for these third-party data submission methods.

While we understand the need for consistency as eligible clinicians transition to MIPS, ACA strongly encourages CMS to explore and offer alternatives for this performance category, such as testing of alternative participation models for demonstrating meaningful use. It is critical to have a program that is truly meaningful and applicable to all provider types, and does not cause serious financial and administrative burdens. The chiropractic profession has experienced a slower adoption rate for Electronic Health Records (EHR), which could be attributed to several factors. First is the fact that Regional Extensions Centers, while well intentioned to serve as a support and resource center to assist providers in EHR implementation and Health IT needs, did not consider chiropractic physicians as a "priority provider" for EHR adoption. Secondly, a very high percentage of doctors of chiropractic are solo practitioners that employ little or no staff in their practice, and face significant burdens to adopt and maintain this type of technology. Third, these burdens are exacerbated by the low reimbursement amounts for a very limited number of covered services that doctors of chiropractic provide to Medicare beneficiaries, as well as non-coverage for services that they do provide and are included in their full scope licensure.

The cost of participating in MIPS is prohibitive to doctors of chiropractic. They can either assume the huge financial burden of purchasing and adopting CEHRT technology, or they face receiving a score of zero for the Advancing Care Information category which accounts for 25 percent of the MIPS score. With doctors of chiropractic and other eligible clinician types in mind we commend CMS for proposing to continue offering hardship exemptions to providers that meet the specific criteria defined in the Stage 2 Final Rule (i.e. insufficient internet connectivity, extreme and uncontrollable circumstances, lack of control over the availability of certified EHR technology, and lack of face-to-face interaction). However, ACA recommends that CMS consider expanding the criteria for 2017 and 2018 to include specific provider types that can prove that they would incur major administrative and financial burdens by adopting EHR technology for the first and second performance period. In doing so, those eligible clinicians could be granted a one year pass to find a product that would work best for their practice type, purchase and receive the necessary vendor training on how to use the new technology, and learn how to successfully report under the Advancing Care Information performance category. Additionally, if the eligible clinician is granted the hardship exemption, we recommend that the entire 25 percent be reallocated and equally redistributed to the other performance categories.

II.E.6. – MIPS Composite Performance Score Methodology

ACA appreciates the simplicity of the overall MIPS scoring methodology proposed by CMS for most of the performance categories. As previously stated, the overall shift from the all-or-nothing reporting requirements and scoring for the MIPS categories is a significant improvement to the quality reporting process.

However, after reviewing the proposed rule, there are many technicalities and levels of complexity within the program requirements in each of the categories. ACA is greatly concerned about the data presented in Table 63, titled “MIPS Proposed Rule Estimated Impact on Total Allowed Charges by Specialty: Mid-Point Estimate.” CMS estimates that only 1.5 percent of doctors of chiropractic will receive a positive MIPS payment adjustment, while the remaining 98.4 percent are likely to receive a negative adjustment. Furthermore, the smaller the practice size, the greater the burden of participation and increased likelihood of a negative adjustment. Although CMS issued a fact sheet that the table was based on 2014 data that is not representative of reporting by smaller practices, the 2014 data is the most recent data available to the public, and is also the only data available to providers as part of their feedback reports. The fact that the 2014 data cannot be used to forecast participation and used for analysis erodes our confidence in the applicability, appropriateness, and use of the data. Further, CMS’ decision to distance itself from the information published in its proposed rule undermines our confidence that, given the complexities and nuances of the rules that are being proposed, the agency will be able to accurately calculate clinician payment adjustments. Given these computing and data challenges, we are concerned about CMS and the future effectiveness of the MIPS program to improve patient care and outcomes.

It is also unclear what benchmarks will be used for the performance and payment thresholds. With the current program structure, it seems that the higher the performance threshold, the greater the likelihood that poor performers will get the lowest adjustment. In this case, the low-scoring performers will continue to be low-scoring performers, and they will find it increasingly difficult to achieve a higher score each year. This has unintended consequences, such as putting many solo clinicians, such as doctors of chiropractic, and those providers in rural and medically underserved areas out of practice due to the range of the negative payment adjustment. Additionally, it is unclear how the benchmark payment is set each year. We ask that CMS provide clarification as to whether the MIPS adjustment is included in or excluded from the base rate for services each year. Additionally, is it similar to APMs where it resets each year?

II.E.8.a. – Feedback and Information To Improve Performance

We strongly encourage CMS to develop timely, actionable, and detailed feedback reports for MIPS eligible clinicians to improve performance. In the past, CMS has not adequately provided information that providers needed to make necessary changes during a reporting period that would allow them to meet satisfactory reporting requirements for specific measures. As a result, providers have incurred negative payment adjustments, without explanation or full understanding of how to change their reporting practices to successfully meet requirements and avoid future reductions to their Medicare reimbursement. Under the MIPS quality performance category, eligible clinicians may score poorly if they: 1) reported on less than 90 percent of his or her MIPS eligible patients; 2) did not report on a cross-cutting measure if he or she is a patient-facing clinician; 3) had a zero performance rate on a measure or a 100 percent performance rate for an inverse measure; or 4) did not pass the validation process. The quality performance category is critical to all eligible clinicians, but especially for doctors of chiropractic. Therefore, it is imperative that eligible clinicians are adequately notified, in a timely manner, about specific elements that are leading to satisfactory or unsatisfactory reporting within this category.

CMS must take every possible step to close the time gap between performance and payment. While ACA appreciates the technical problems that lead to the proposed two-year gap between the performance period (2017) and application of the related payment adjustment (2019), eligible clinicians need and should be afforded the opportunity to receive feedback in a timely manner so that, if necessary, the provider can make modifications in order to meet the criteria for each performance category. Ideally, six months should be the

target, to allow for unavoidable claim run-out and adjudication processes. Payment adjustments for 2021, for example, would ideally be based on a performance period running from July 1, 2019 to June 30, 2020.

Due to the complexity of the new Quality Payment Program, the extent of outreach and education that will be required to prepare eligible clinicians and the significant time investment required for clinicians to make changes in their practices workflows to accommodate the new reporting systems – all while continuing to treat their patients and run their practices – ACA strongly urges CMS to consider the first two years of the program as a trial period for providers to learn and properly implement the program. We believe it would be more beneficial and valuable to build the data and grow the program, allowing providers to adapt to the program requirements, similar to the opportunity being provided to non-eligible MIPS clinicians. Additionally, it will allow CMS time to develop and implement a mechanism to provide actionable, timely, detailed feedback reports to MIPS eligible clinicians as well as close the time gap between performance and payment.

F. Overview of Incentives for Participation in Advanced Alternative Payment Models

ACA appreciates the extensive efforts by CMS to develop and propose multiple Alternative Payment Models (APM) pathways in an effort to recognize different approaches to value based payment. We strongly support the transition to APMs and the core policy principles derived from both the MACRA law and the Department of Health and Human Services' broad vision for better care, smarter spending, and healthier people. The ACA looks forward to working with CMS and the Physician-focused Payment Technical Advisory Committee (PTAC) to develop, review and assess additional Physician-Focused Payment Models.

We encourage CMS to allow stakeholders, such as ACA and The Spine Institute for Quality™ (Spine IQ™), the opportunity to develop and test models that are simple to implement and flexible enough to allow clinicians to provide patient centered care that yields improved patient outcomes. Spine IQ is a not-for-profit organization with the mission to increase the patient-centered value of spine care by leveraging multi-disciplinary models, measures, education, and research. This is critical given the overwhelming public health significance of musculoskeletal or spine-related disorders and increasing concern that currently widely used interventions may be ineffective and/or carry unacceptable levels of risk.

In collaboration with CMS, the PTAC, and Spine IQ, ACA is standing at the ready to establish an Advanced APM that will lower costs, improve quality, and provide efficient, highly satisfying care to patients.

Again, ACA applauds CMS for the extensive work in developing the Quality Payment Program and we sincerely appreciate the opportunity to provide comments on the proposed rule. We will be happy to work with CMS going forward to ensure successful implementation of MACRA and the associated payment and quality reporting programs. If you should have any questions, please feel free to contact Meghann Dugan-Haas, Senior Director of Federal and Regulatory Affairs, at (703) 812-0242. Thank you.

Respectfully,



David A. Herd, DC
President