



November 17, 2015

Andrew M. Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-3321-NC
P.O. Box 8016
Baltimore, MD 21244-8016

Re: *CMS-3321-NC: Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models*

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 33 million individuals across the United States. The ACA appreciates the opportunity to provide input on the development and implementation of the Merit-Based Incentive Payment System (MIPS) and the Alternative Payment Models (APMs). The ACA commends the Centers for Medicare and Medicaid Services (CMS) for providing stakeholders the opportunity to provide input and feedback on these critical issues. To this end, the ACA strongly supports the agency's efforts to: establish a new methodology that ties annual Physician Fee Schedule (PFS) payment adjustments to value-driven, quality care; create of an incentive program to encourage participation in APMs; and provide technical assistance to small practices and practices in health professional shortage areas. We offer the following comments and recommendations.

THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

The ACA fully supports the provision in MACRA that requires the creation of the Merit-Based Incentive Payment System (MIPS) and combine current quality incentive programs into one comprehensive program. We appreciate the creation of a more streamlined approach which will alleviate much of the administrative burdens physicians currently have with maintaining participation in three separate programs. We believe this will result in a physician's ability to focus more on providing quality patient care.

1. MIPS EP Identifier and Exclusions

The use of existing identifiers to identify MIPS EPs would allow for an easy transition; however, the use

of the Tax Identification Numbers (TIN), National Provider Identifier (NPI), or combination of the two has proven to cause confusion and problems in existing quality driven programs. The assignment of a separate/individual MIPS identifier will allow CMS to circumvent many of the problems as well as create safeguards to ensure that MIPS EPs do not switch identifiers if they are considered 'poor-performing' and prevent other unintended consequences. Additionally, we believe it would be optimal for providers to be required to update their identifier(s) within the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) on an annual basis. This will also drive providers to ensure that their enrollment information in their PECOS record is maintained and accurate.

2. Quality Performance Category

a. Reporting mechanisms available for Quality Performance Category

As stated in the RFI, "there are collectively 7 available mechanisms to report data to CMS as an individual EP and as a group practice participating in the PQRS GPRO...: Claims-based reporting; qualified registry reporting; QCDR reporting; direct EHR products; EHR data submission vendor products; Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS; and the GPRO Web Interface." The ACA strongly urges CMS to maintain all Physician Quality Reporting System (PQRS) reporting mechanisms under MIPS, and especially supports the preservation of the claims-based reporting option. Several specialties, including chiropractic, are in the process of, but have not yet implemented registry reporting for the profession. Additionally, there are numerous limitations for the majority of the profession to report using EHR data submission vendor products. Without the claims-based reporting option, the chiropractic profession faces the prospect of being unable to participate in the quality performance category. This coupled with the profession's major limitations later discussed regarding resource use and clinical practice improvement activities performance categories, the chiropractic profession could essentially be eliminated from participation in the Merit-Based Incentive Payment System.

We do believe it would be beneficial for CMS to require that reporting mechanisms include the ability to stratify data by demographic information such as race, ethnicity, gender and socioeconomic status. This data could be used to further identify those characteristics that affect the health of specific patient populations, allowing for greater use and implementation of evidence based care to address individual patient's needs.

The ACA urges CMS to maintain the same or very similar PQRS reporting criteria under MIPS. PQRS is an established and well understood program that healthcare professionals have learned and successfully implemented in their practices. Using the experience under the PQRS to shape the processes and policies under the quality performance category will increase success for CMS as well as the provider community.

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, currently doctors of chiropractic may report on only two (2) PQRS measures:

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

Although clinically and legally required (e.g., licensure, Medicare) to take a clinical history, perform an appropriate examination, identify functional deficits and establish diagnoses and treatment plans, as expected by all other physician-level providers, doctors of chiropractic are not covered for reimbursement under Medicare for Evaluation and Management (E/M) CPT® codes. Therefore, the profession has been precluded from a number of reportable measures, under the PQRS due to their limited coverage under Medicare. As quality or value-based care dictates, the majority of process and outcomes measures (e.g., safety, cost-effectiveness, positive outcomes) are both work and diagnosis specific and therefore coverage of E/M codes is mandatory to report these measures.

Due to the limited nature and number of current PQRS measure available to doctors of chiropractic, and many other specialties, the ACA strongly supports CMS' continued application of the Measure-Applicability Validation (MAV) process, but with modifications to make it less confusing to the general provider in the field. Those professions that do not have enough measures to meet the defined criteria for reporting could face enormous barriers to successfully meeting the MIPS quality performance category without the implementation of a process similar to the MAV; however, the current process of analyzing claims data to "validate, using the clinical relation/domain test and the minimum threshold test, to confirm that more measures and/or NQS domains were not applicable to the eligible professional's practice" is not easily understood. Additionally, while CMS has attempted to develop resources to explain clusters of measures or why certain measures pass or fail the clinical relation test, the process continues to be an analytically complex and widely misunderstood by health care providers.

The ACA urges CMS to maintain the Measure #131: *Pain Assessment and Follow Up* and Measure #182: *Functional Outcome Assessment* as they establish the list of quality measures MIPS EPs may choose for purposes of assessment during a performance period in the MIPS quality performance category. The ACA also proposes that CMS implement a mechanism to allow specialties, especially those who currently have fewer existing measures, to develop new, and/or improve upon already utilized quality measures that are meaningful to patients AND clinically useful to individual providers. Each specialty should have the ability to identify and utilize those measures that are relevant to their practice, demonstrate improved clinical outcomes, and link quality care to payment under the Medicare. We encourage the inclusion of medical specialty societies, as well as various consensus-based organizations, including but not limited to AQA Alliance, NQF, NCQA, PCPI, Physician Quality Measure Management (PQMM), and URAC (formerly known as the Utilization Review Accreditation Commission), in the development of meaningful quality measures and clinical improvement activities using a standard process.

b. Data Accuracy

As previously stated, currently the chiropractic profession does not have the ability to report to a registry and the majority of the profession is unable to report using EHR data submission vendor products. However, we do agree that registries and qualified clinical data registries should be required to submit data to CMS using certain standards, such as the Quality Reporting Document Architecture (QRDA) standard, which certified EHRs are required to support. This will aid in consistency and reduce duplication of both services and data collection for quality measurement and reporting purposes.

Qualified registries, QCDRs, and health IT systems should undergo review and qualification by CMS for this reason.

2. Resource Use Performance Category

The ACA is very concerned that the MACRA provision related to improving resource use measurement by developing episodes of care and patient condition and classification codes, as well as chronic care management provisions, denies non-MD/DO providers, including doctors of chiropractic, from participating due to the use of a limiting definition of physician found at subsection 1861(r)(1) of the Social Security Act. Doctors of chiropractic are primary spine care physicians, and provide key services for a range of conditions that impact America's seniors. As the agency continues their efforts to refine the MACRA provisions, the ACA strongly urges consideration of the importance of non-MD/DO providers in the management and coordination of Medicare patients' health care needs. Including non-MD/DOs, and other conservative care providers, such as doctors of chiropractic, in the process of identifying specific care episodes and the resources associated will provide greater awareness and more accurate data collection on how these services prove to yield high quality, cost effective and efficient care – all of which are components that lead to improved resource use within the system. CMS would be remiss to ignore the critical role of non-MD/DO providers by not expanding the scope of these provisions.

3. Clinical Practice Improvement Activities Performance Category

The ACA supports the use of clinical practice improvement activities as one of the performance categories used in determining the composite performance score under MIPS. This will also allow for providers to prepare for the transition to Alternative Payment Models. However, the provision includes items such as "population management," "care coordination, such as timely communication of clinical information," and "establishment of care plans." All of these clinical activities require a physician's ability to furnish and bill for Evaluation and Management (E/M) services to properly evaluate and manage a patient's condition(s), order necessary testing, develop an appropriate treatment plan, and counsel the patient on risk avoidance and health promotion activities. It is critical to note, while well intentioned overall, the subcategories specified by the Secretary for a performance period created an initiative that would be essentially closed to doctors of chiropractic.

CMS should allow for the broadest definition of Clinical Practice Improvement Activities possible and ensure that all provider types can fully participate in this performance category. It is important to consider the language in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) in which Congress made it clear that Clinical Practice Improvement Activities should be considered as actions that providers are already performing/providing. By allowing for a broad definition, based on established specialty specific actions, providers will not be required to incorporate burdensome administrative, irrelevant activities, but will be afforded the opportunity to participate in each of these critical performance subcategories in a way that is relevant to their practice and to the care provided to their patients.

In addition to allowing for a broad definition of what constitutes as Clinical Practice Improvement Activities, ACA urges CMS and HHS work directly with specialty societies to determine measures or other demonstration of activities that are applicable to the clinical practice of their physician members and have improved clinical practice and/or care delivery and resulted in improved outcomes. Affording specialty societies this opportunity will allow for a comprehensive evaluation of established programs

and criteria as well as incorporation of effective, relevant and patient-centered, and profession-specific principles and practices.

4. *Meaningful Use of Certified EHR Technology Performance Category*

The ACA believes that the performance score for this category should be based on the percentage of achievement of meaningful use. If a provider should meet or exceed all of the thresholds of all meaningful use objectives and measures, they should receive full credit under the performance category; however, if the provider only meets or exceeds some of the objectives and measures, their score should be based on the percentage that they were able to successfully achieve. We have heard from our member doctors, as well as from other professions, that they are discouraged that the meaningful use program is an all-or-nothing system, and even in some cases, providers have chosen to not participate at all or even drop out of the reporting program and become subject to the payment adjustment. Additionally, the chiropractic profession has experienced a slower adoption rate for Electronic Health Records (EHR), which could be attributed to the fact that Regional Extensions Centers, while well intentioned to serve as a support and resource center to assist providers in EHR implementation and HealthIT needs, did not consider chiropractic physicians as a “priority provider” for EHR adoption. Allowing for partial credit under this performance category may encourage more providers to adopt and begin meaningful use reporting, as well as discourage providers from dropping out of the program.

We agree that CMS should use a tiered methodology for determining levels of achievement in this performance category that would allow EPs to receive a higher or lower score based on their performance relative to the thresholds established in the Medicare EHR Incentive program’s meaningful use objectives and measures. We also agree that the scoring should be based on an EP’s performance relative to the performance of his or her peers, and not to relative to the required thresholds of the objectives and measures. And finally, we do agree that there should be “hardship exemptions” granted, only under specific circumstances and only if CMS determines that providers have demonstrated that those circumstances pose a significant barrier to their achieving meaningful use.

The ACA believes and has stated on many occasions that many of the current measures and objectives under Meaningful Use were designed specifically for primary care physicians and are not easily attainable by non-MD/DO and specialty providers. For example, measures such as computerized provider order entry for laboratory or radiology reports and medication reconciliation and are not relevant to chiropractic practice or the services they provide to patients. Requiring providers to attest to, or prove exclusion for Meaningful Use measures that are not relevant to their practice is inefficient. Eligible Professionals should only be required to report Meaningful Use measures that are relevant to the specialty and will actually improve the quality of care they provide to patients.

5. *Other Measures*

It is vital for CMS to align, standardize, and harmonize quality measures that are used for payment under the Physician Fee Schedule with those being used in other payment systems (existing Medicare programs, Medicaid, commercial models, etc.). Doing so will greatly ease the administrative burden that providers currently have in meeting numerous reporting requirements and metrics.

6. Flexibility in Weighting Performance Categories

In our comments above, we have proven that there are situations in which Eligible Professionals cannot be assessed for a particular performance category. As previously stated, currently non-MD/DO providers, including doctors of chiropractic, are precluded from participating in the Resource Use Performance Category due to the use of a limiting definition of physician found at subsection 1861(r)(1) of the Social Security Act. Therefore, in these cases, provider groups should be exempt. In order to account for the applicable weight for the category in which a provider cannot be assessed, CMS could equally distribute the weight among the other applicable performance categories.

7. Feedback Reports

The ACA strongly urges CMS to begin providing real-time, detailed, user-friendly feedback to providers on their performance as frequently as possible. The current two-year lookback approach has caused much confusion and discouragement among providers. Additionally, data contained in the reports downloaded via the web-based portal should be consistent with the reports requested when contacting the QualityNet Help Desk. It will also be important that providers are able to obtain information on their participation for each of the performance categories and not only quality and resource use performance categories. Full transparency in a timely and frequent fashion will allow providers to make necessary adjustments to ensure that they are meeting the requirements, and are subsequently not surprised if they do not receive full credit for each performance category.

ALTERNATIVE PAYMENT MODELS

The ACA strongly supports the idea of providing technical assistance to small practices, especially solo-practitioners, to educate and ease the transition to Alternative Payment Models. Assistance could come in a combination of ways, such as national provider calls, recorded videos/webinars, MLN Articles, and webpages with helpful information and resources. The technical assistance could be provided directly by CMS, or through something similar to the Regional Extension Centers that were established to assist providers with the adoption of Electronic Health Records; however, our earlier comments regarding how Regional Extension Centers failed to consider doctors of chiropractic as “priority providers” in the past would need to be rectified. Provider groups and individual physicians are going to require a great amount of time and education to implement this important aspect of payment reform.

OTHER COMMENTS

Encouraging Care Management for Individuals with Chronic Care Needs

While this Request for Information specifically addresses provisions in Section 101 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the ACA also feels it is necessary to address provisions within Section 103, *Encouraging care management for individuals with chronic care needs*. As with the legislative language pertaining to the Resource Use Performance Category, while well intentioned overall, we are concerned that that the definition used for physician providers (Section 1861(r)(1) of the Social Security Act) creates, without foundation or precedent, a provider classification that precludes non-MD/DO providers from participating in chronic care management.

Additionally, while prevention and wellness has been a cornerstone of chiropractic education and practice since the profession’s inception more than one hundred years ago, current legislative

language (Section 1861(hhh)) precludes doctors of chiropractic from performing annual wellness visits for Medicare patients. Long before these subjects received serious attention in the healthcare community, chiropractic colleges and universities required courses in nutrition, exercise, and evidence based wellness strategies for the restoration and maintenance of good health. Doctors of chiropractic should be added to the list of qualified health care professionals to perform wellness services in a manner that meets the standard of care and promotes best practices.

The burden of chronic illnesses now accounts for almost 93 percent of Medicare spending.¹ Moreover, stress and chronic pain account for more healthcare spending dollars than heart disease, diabetes, and cancer combined. Musculoskeletal pain and disease weigh heavily on our health care system, society and industry. According to a report from the Institute of Medicine (IOM) in 2011, an estimated 100 million Americans are affected by chronic pain, with an estimated annual cost to American society of at least \$560-\$635 billion.² This figure represents the monetary impact of providing healthcare to patients experiencing pain and the cost of this health issue in lost productivity; however it does not account for the toll in human suffering underlying these figures.³ Low back pain (LBP), in particular, is the single leading cause of disability worldwide⁴ and a recent systematic review showed that LBP rates sixth in terms of overall disease burden.⁵ Further, according to the United States Bone and Joint Initiative, musculoskeletal diseases affect nearly three out of four people age 65 and over.⁶

The majority of patients in pain, including those with chronic symptoms, will seek treatment from primary care providers (PCPs) to get relief.⁷ Low-back pain in particular is the most common neuromusculoskeletal symptom presenting to primary care providers and the fifth most common cause for all physician visits.⁸ But current systems of care do not adequately train or support internists, family physicians and pediatricians, and other healthcare providers who provide primary care, in meeting the challenge of treating pain as a chronic illness. Primary care providers often receive little training in the assessment and treatment of complex chronic pain condition.⁹ In one interview study, primary care providers perceived back pain as a low clinical priority and uninteresting in comparison to the major chronic illnesses such as heart disease, or diabetes that they must manage for their patients.¹⁰ In the same study, shifting this population of patients to a non-physician provider was perceived by PCPs as a positive step towards alleviating their burden of work.

¹ CMS Press Release. Medicare Dashboard Advances ACA Goals For Chronic Conditions. March 28, 2013. www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2013-Press-releases-items/2013-03-28.html. Accessed 6/8/15.

² Institute of Medicine Report from the Committee on Advancing Pain Research, Care, and Education: *Relieving Pain in America, A Blueprint for Transforming Prevention, Care, Education and Research*. The National Academies Press, 2011. http://books.nap.edu/openbook.php?record_id=13172&page=1

³ Buckenmaier, C. & Schoomaker, E. (2014). Patients' use of active self-care complementary and integrative medicine in their management of chronic pain symptoms. *Pain Medicine*, 15(S1), S7-S8.

⁴ Global Burden of Disease Study 2010. <http://www.thelancet.com/global-burden-of-disease>. Accessed June 15, 2015.

⁵ Hoy D, March L, Brooks P, et al. "The global burden of low back pain: estimates from the Global Burden of Disease 2010 study" *Annals of the Rheumatic Disease* (2014);73:968-74.

⁶ <http://www.boneandjointburden.org/>

⁷ Breuer B, Cruciani R, Portenoy RK. Pain management by primary care physicians, pain physicians, chiropractors, and acupuncturists: a national survey. *South Med J*. 2010 Aug; 103(8):738-47.

⁸ Deyo RA, Weinstein JN: Low back pain. *N Engl J Med* 344:363, 2001.

⁹ The Mayday Fund. A Call To Revolutionize Chronic Pain Care in America: An Opportunity for Health Care Reform

¹⁰ Sanders et al. "Perceptions of general practitioners towards the use of a new system for treating back pain: a qualitative interview study" *BMC Medicine* (2011); 9:49.

To date, deficiencies in the training of primary care providers in pain management as well as the failure to adequately educate consumers about the benefits of conservative health care options has resulted in unnecessary suffering, exacerbation of other medical conditions, enormous loss of human potential, and massive financial and personal costs. However, we are now faced with the opportunity for reform to promote the integration of healthcare professionals, including doctors of chiropractic, into care coordination teams to offer holistic, evidence-based and patient-centered services to those Medicare beneficiaries that choose to receive it. By doing so, it would meet the goal of maximizing health care outcomes for Medicare patients living with chronic conditions.

Medicare patients should be empowered to play a greater role in managing their health and meaningfully engaging with their health care providers. The ACA believes that one way this can be accomplished is by educating all health consumers about early intervention from conservative health care providers, like doctors of chiropractic. Chest pain does not always indicate the need for a cardiologist and an MRI or surgery should be the exception rather than the rule for an episode of back pain. Management options that are patient centered, cost-effective, and conservative, should be encouraged for all health consumers, including Medicare beneficiaries. Doctors of chiropractic (DCs) are trained in conservative treatment methods for neuromusculoskeletal conditions and our health care systems should provide incentives for patients and other health care providers to exhaust these options before resorting to riskier and more invasive treatments such as surgical and opioid interventions. When other medical conditions exist, chiropractic care may complement or support medical treatment by relieving the musculoskeletal aspects associated with the condition. Utilizing 1861(r) as the definition of physician under the chronic care management section, as opposed to 1861(r)(1), would allow beneficiaries, when appropriate, the ability to seek conservative care interventions for chronic conditions. CMS would be remiss to ignore the critical role of non-MD/DO providers by not expanding the scope of these provisions.

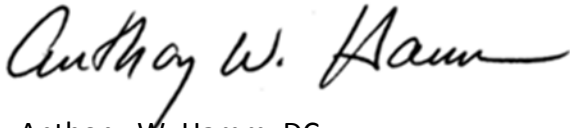
The ACA also feels it is critical that we express again that there are multiple issues within this request for information that will restrict the chiropractic profession's ability to participate appropriately and with any level of basic parity due to a doctor of chiropractic's inability to report Evaluation and Management (E/M) services. In the Calendar Year 2014 Medicare Physician Fee Schedule proposed rule, CMS sought comments to determine whether to expand Medicare coverage to include E/M services provided by doctors of chiropractic. Subsequently, in the CY 2014 final rule, CMS stated "Any possible changes to our current policy on allowing chiropractors to bill E/M services will be addressed in future notice and comment rulemaking." However, since that time, this issue has not been addressed in any proposed or final rule.

The issues we have provided comment on are extremely time sensitive and must be rectified prior to the implementation of the provisions in Section 101 and 103 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Without changing the limiting definition pertaining to the Resource Use Performance Category and Chronic Care Management, entire provider groups will be eliminated from participation and could face the prospect of inequitable payment updates. Further, given the prevalence of acute and chronic musculoskeletal conditions in today's society, and the growing research support for conservative chiropractic care, it is axiomatic that chiropractic care be a covered and integrated condition-based service, rather than a limited intervention (i.e., "manual manipulation of the spine to correct a subluxation") in a modern, value-based health care system. All

other physician-level providers and professions have coverage provisions for E/M reimbursement under the Medicare Payment system. Chiropractic should no longer be the exception.

Once again, the ACA appreciates the opportunity to provide comments on the request for information regarding implementation of the MIPS and APMs. If you should have any questions, please feel free to contact Meghann Dugan-Haas, Director of Federal and Regulatory Affairs, at (703) 812-0242. Thank you.

Respectfully,

A handwritten signature in black ink that reads "Anthony W. Hamm". The signature is written in a cursive style with a long, sweeping tail on the letter "m".

Anthony W. Hamm, DC
President

Cc: Ms. Molly MacHarris
Ms. Alison Falb