June 27, 2016

Andrew M. Slavitt
Acting Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5517-P

Submitted electronically via http://www.regulations.gov

RE: Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models

Dear Acting Administrator Slavitt:

The American Association of Clinical Urologists (AACU) is a specialty medical organization representing over 4600 urologists nationwide, approximately 46% of all urologists, with membership comprised of independent, employed, and academic physicians. The AACU is dedicated to advocating for the socioeconomic issues affecting urologists, their patients, and their practices. The AACU appreciates the opportunity to provide comment on the proposed implementation of MIPS and APMs under the Medicare Access and CHIP Reimbursement Act.

While the AACU appreciates the intentions behind this attempt at a return to patient centered care, we are concerned with a number of overly burdensome and draconian requirements included in the proposed rule. It is our belief that these requirements will, in short order, increase the cost of care while decreasing its value.

We oppose the aggressive commencement of implementation of a regulation of this complexity. The proposed performance period for the APM and MIPS 2019 adjustment begins January 1, 2017. This proposal does not allow ample time for physicians and other stakeholders to adequately prepare for the changes brought on by these new policies. While the flexibility of choice between
alternative payment participation provided for under the proposal is a move in a positive direction, this is a choice fraught with complexity. The administrative burden associated with the new requirements is prohibitive on many levels, including financial and human resource costs as among the most obvious and detrimental. The punitive negative adjustment in reimbursement that will occur due to mistakes or misunderstanding leading to lack of compliance is onerous and unjust, especially given the unnecessary speed with which this is being implemented. CMS must reconsider the start date, preferable moving it back by one full year so that physicians and their staff may adequately prepare.

To add further burden to MACRA implementation, both the APM and MIPS programs require the use of Electronic Health Record Technology by all providers beginning in 2018. While the intent of this requirement may be to facilitate expanded healthcare delivery, the actual effect will be just the opposite. Under current, less stringent requirements, many providers and hospitals are struggling immensely with EHR adoption, and many have elected to forego their use completely, despite penalties to reimbursement. Many physicians view EHR as nothing more than a barrier to treating patients, not to mention the prohibitive cost structure associated with EHR. In addition to upfront costs and ongoing fees associated with EHR, revenue loss from paper to EHR transition and the additional cost of hiring staff with the expertise to manage EHR system is simply too great for many practices to assume.

Liability is another significant consideration in the EHR debate, and as of yet, has not been addressed by CMS. Who is responsible for compliance issues arising out of EHR system malfunctions – the vendor, or the physician? Who is responsible for data breeches – the vendor, or the physician? When this question was raised to Acting Administrator Slavitt at the June meeting of the American Medical Association House of Delegates Meeting, he did not have an answer. The fact that this issue has clearly not been considered is of great concern to us.

The administrative compliance burden created by the proposal is of serious concern to the AACU, especially with regard to small and rural practices. Though the proposal attempts to mitigate the negative effect on this subset by including an exemption for those who meet the low volume threshold, this threshold is insufficient and many practices or groups will be forced out of business. In addition, the low volume threshold is based on the level of Medicare billings from providers, not the actual size of the practice.

The MACRA proposal has also removed the ability to opt out of MIPS reporting by simply paying a penalty, so anyone accepting Medicare must report compliance. This creates a disincentive for providers to accept Medicare patients, with commercially insured and cash patients becoming a much more attractive patient class.

Acting Administrator Slavitt has stated that the goal for CMS in implementing MACRA is to “simplify wherever, whenever.” The AACU struggles to understand how a 962 page policy could be viewed as simple. To add perspective, the original Title 18 amendment to the Social Security Act establishing Medicare was 18 pages; the MACRA proposed rule is 962. As we have stated, the complexity of this proposal is overly burdensome and will have a
negative effect on access to and delivery of medical care. Additionally, included in Title 18 was a promise not to interfere in the practice of medicine:

"Nothing in this title shall be construed to authorize any federal officer or employee to exercise any supervision or control over the practice of medicine, or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer, or employee, or any institution, agency or person providing health care services...."

The “practice guidelines” and arbitrary “value standards” being imposed on medical providers stands in direct contradiction to this promise. Both the MIPS and APM payment models strongly influence via bureaucratic means the care that providers give to their patients.

The AACU offers the following suggestions for CMS’ consideration in determining the final rule:

1. Postpone the performance period for at least one year, enabling physicians and their staff to gain an understanding of the many complexities involved in this new system.

2. Provide incentives to encourage transition to EHR technology, as opposed to penalties for those who are unwilling or unable to make the transition. In addition, strengthen protections for physicians with regard to liability issues that will arise from EHR use.

3. Raise the low volume threshold for Medicare billing, or associate the threshold with actual practice size so that exemptions are appropriately applied and small/rural offices and hospitals are not burdened to the point of closure over this new policy. Additionally, reinstate the opt-out option for providers who would rather pay a penalty than assume the financial and human resource burden associated with the volume of reporting requirements.

We were glad to hear Acting Administrator Slavitt’s comments to the American Medical Association House of Delegates on June 13, where he expressed his intent to work with physicians and allow for open dialogue in crafting CMS policies. The AACU hopes that the CMS leadership will truly consider the comments and suggestions that have been submitted by stakeholders, including the AACU.

Should you have any questions, please direct them to Julia Norwich at julia@wjweiser.com.

Sincerely,

Martin K. Dineen, MD
President
American Association of Clinical Urologists