SVS Goes to Bat for Surgeons for MACRA Changes

Read the SVS letter to CMS

SVS has sent a letter to the Centers for Medicare & Medicaid Services urging changes in the way the CMS proposes to pay physicians and specialists. The Society is among many physician organizations and stakeholders urging the federal government to delay a proposed rule that will affect Medicare reimbursements.

The current proposed rule impacts small practices negatively, is too complex and lacks opportunity for specialists to participate in Alternative Payment Models, said the organizations, responding to a Centers for Medicare & Medicaid Services request for comments.

The nearly 1,000-page rule replaces the former Sustainable Growth Rate formula, which Congress eliminated in 2015, and is part of the Medicare Access and CHIP Reauthorization Act of 2015 which changes physician payments.

SVS’ Washington office has been active in trying to shape the new rules, including meeting with lawmakers, analyzing the effects of various components and urging that physicians be allowed to help structure the details of reimbursement rates

In summary, our letter stresses the following:

- SVS government specialists and staff believe that the CMS needs to create an identification option for specialists so that they can be scored based on the care they provide. The SVS believes this is a fundamental and very important element of the quality payment program under MACRA.
- SVS also urges the CMS to slow down the implementation and treat the first year as transitional since it requires fundamental changes. During that time, we are asking for the first six months to be a time when physicians submit the measures they are going to report on in 2017 and get concurrence from CMS that those measures are acceptable. In addition we are asking that some of the $15 million set aside for quality measurement be permitted to be used to add data fields and upgrades for society registries.
- We are very concerned about the financial and time commitment burden of data collection on
physicians and that physicians will be deterred from participating. Also, SVS is concerned with what CMS is planning to do with the all-payer data and what obligation SVS members have with their private insurance contracts to safeguard this data that would now be in CMS’ hands. SVS believes that Medicare should only collect and make payment decisions on Medicare data. A 50 percent threshold is simply a more realistic reporting level that acknowledges potential problems, such as a vendor not updating measure specifications at the start of the reporting period, a practice switching EHR vendors, power outages, inaccurate coding or natural disaster. Therefore, SVS urges CMS to reduce the quality reporting threshold back to 50 percent.

- The SVS believes the proposed resources use category of MIPS carries over many of the problematic areas of the Value-based Modifier, including using measures that use hospital costs that physicians have no control over and have no say in how they are set by the hospital. In light of these shortcomings, the SVS urges CMS to use the discretion in the MACRA law to reduce the percentage on the resource category in year one, 2017 performance for 2019 payment to five percent, with the remaining five percent being re-attributed to CPIA.

- SVS urges CMS to hold town hall meetings this summer where it showcases several scenarios and receives feedback from the medical society community. While only a small section in the MACRA law, the concept of risk adjustment was a major tenet of this new program and so far it has received very little attention from CMS.

- We strongly urge CMS to use this opportunity to work with medical specialties to identify and refine those episodes that seem most promising and then pilot-test them with groups or individual physicians. Again, this would be another opportunity for face-to-face meetings this summer between CMS staff and medical society leadership.

- SVS believes that physicians should be compared to their peers both on quality and on resource use. And, we believe that a peer should be defined as any physician that is performing the same types of procedures with a similar patient/case-mix in the same region of the country.

- SVS urges CMS to reduce the number of activities required for reporting in year one of the CPIA program. The cost to a practice of increasing or adding six new activities, including possibly participation in a QCDR is very expensive and time consuming for a practice. A maximum of three CPIA activities should be the bar set by CMS in year one. Also, participating in the quality improvement activities of a QCDR should be seen as adequate to achieve the entire year one reporting score.

- The SVS believes that the Advancing Care Information (ACI) performance category should be a simple program where a physician attests to three to four main elements – like protocols in place to protect patient PHI and ability to share data with the hospital and other providers. CMS should take immediate action to reduce the overall complexity of the ACI category.

- The SVS opposes the all-or-nothing scoring system used to compute a base score as a MIPS-eligible clinician. At least for the 2017 reporting and 2019 payment year, CMS should finalize the base score performance, with the suggested changes by the SVS, as the entire ACI program. At a minimum, we request that CMS outline a process for simplifying the ACI program for 2017 reporting and a process for considering new ACI measures.
Regarding MIPS composite performance scoring, we believe that CMS must provide clarification in order for physicians to understand the numerous point systems and how CMS came to their final score under the proposed methodology. SVS urges CMS to provide all the information to physicians on all elements of the scoring system prior to the start of the 2017 reporting period. The SVS urges CMS to consider the implications of the score attribution model to the validity of the MIPS program and work with specialty societies to make it more meaningful in future years.

SVS is concerned about the timeliness of feedback reports to physicians and benchmarking. At the very least, CMS must produce quarterly reports on a physician’s resource use/cost information compared to other MIPS EC’s since the information is based on claims’ submission. CMS needs to devote the necessary resources, including dedicated CMS staff, to help physicians and administrators interpret the feedback reports. CMS needs to make it clear on Physician Compare if the information being reported on a physician is based on group reported data or individual physician reported data.

Regarding APMs, with the complexity of the MACRA Proposed Rule, a “look back” period of two years beginning January 1, 2017 for incentive payments in 2019 is unrealistic. There is no justification for requiring that eligible APMs be implemented and physicians be participating in them on January 1, 2017. We strongly urge CMS to delay APMs for one year, so the look-back period would begin on January 1, 2018 and the incentive payments would begin on January 1, 2020.

RE physician-focused payment models (PFPMs) - CMS must establish an easy pathway for PFPMs to be proposed to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and adopted by the agency as Advanced APMs that focus on specialty physicians; this is not in the Proposed Rule. The Final Rule needs to provide more opportunities for specialists who are not primary care physicians to participate in MIPS APMs and Advanced APMs. Without significant changes to the APM policies in the Final Rule, it will be difficult for many proposed APMs to be implemented and for Medicare beneficiaries to benefit from these care improvements.

We urge numerous modifications and explanations for the phrase “more than nominal financial risk.” Furthermore, vascular surgeons treat older, sicker patients and manage both episodic and procedural care, along with chronic care for a range of conditions.