October 2, 2017

The Honorable Orrin G. Hatch
Chairman
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden:

The undersigned state and national specialty medical organizations share a common interest in ensuring successful implementation of the Medicare Access and CHIP Reauthorization Act (MACRA). Since the enactment of MACRA, we have worked closely with policymakers and the Centers for Medicare & Medicaid Services (CMS) to ensure that implementation of the law reflects the intent of Congress to focus payment on improving quality and value and that physician practices are able to successfully participate.

Thanks to statutory provisions designed to provide necessary flexibility during implementation, CMS has been able to ensure that practices can participate from the outset and increase their engagement over time as physicians and other clinicians become more accustomed to the new reporting requirements and CMS finalizes cost measures, improves data feedback, and provides tools to improve performance and help providers succeed. In order to continue the progress made to date, we believe that there are several specific adjustments that will require statutory changes or clarification before CMS is required to publish proposed rules for the program's third year of operation.

Several provisions of MACRA have been particularly helpful in ensuring successful implementation thus far. The first, at 1848(q)(5)(E) has allowed CMS to proceed with implementation despite the fact that resource use (cost) measures necessary under the Merit-based Incentive Payment System (MIPS) are still under development. This provision allows the Secretary, for the first two years of the MIPS program, to weight the resource use component at not more than ten percent for the first year and not more than 15 percent for the second year. Given the state of readiness of resource use measures, CMS used this flexibility in the final rule for 2017 and weighted this component at zero percent. For 2018, CMS has again proposed to weight this component at zero percent. This action in no way is meant to diminish the commitment of CMS or the physician community to incorporating resource use as an integral component of performance measurement. It is instead an acknowledgement that work remains to be done to ensure that these new measures are developed and integrated in a way that accurately reflects the complexities of cost measurement and does not inadvertently discourage clinicians from caring for high-risk and medically complex patients, as was the case under the value-based modifier.

A second provision critical to the successful implementation of MACRA is the flexibility provided at 1848(q)(6)(D) that allows the Secretary to select a performance threshold during the first two years other than the "mean or median" standard. Gradually increasing the performance threshold gives physicians the opportunity to implement necessary practice changes as they gain experience. It also ensures that the performance threshold is not set too high, which could discourage participation or negatively impact practices with fewer resources.

Unfortunately, both of these provisions expire after the second year of the MIPS program, and CMS will be required by statute to implement a "mean or median" performance threshold and count resource use measures for a full 30 percent of the performance score, regardless of the readiness of those measures or their applicability to a particular practice. CMS will be required to propose these changes in the next proposed rule, which is due in the spring of next year.

We believe that CMS will be more successful in achieving Congress's intent to focus payment systems on improving quality and value if some elements of the current flexibility provided for in statute are extended for an additional three years. To be clear, we are not proposing to prevent CMS from implementing resource use measurement or a higher performance threshold if they believe that moving forward with these elements is appropriate. Rather, **we are proposing to continue the existing flexibility in the MACRA statute that CMS is currently using for an additional three years so that the agency may move forward as the necessary program elements are put in place.**

Additionally, we would call to your attention a number of other provisions of MACRA which we believe should be tweaked to improve the overall program implementation without altering Congressional intent. Modifications are needed to: clarify that Medicare Part B drugs and other items and services outside the physician fee schedule are not included in the application of MIPS payment adjustments and determination of MIPS eligibility; rationalize what is considered a "small practice; and explicitly authorize the Physician-focused Payment Model Technical Advisory Committee (PTAC) to provide technical assistance to developers of Advanced Payment Models. We do not believe that these elements are being implemented in a manner consistent with Congressional intent and some technical changes in the legislative language are likely required.

We appreciate your attention to these issues and look forward to working with you and your colleagues to ensure the implementation of MACRA continues to be successful.

Sincerely,

American Medical Association
Academy of Physicians in Clinical Research
Advocacy Council of the American College of Allergy, Asthma and Immunology
AMDA – The Society for Post-Acute and Long-Term Care Medicine
American Academy of Allergy, Asthma and Immunology
American Academy of Dermatology Association
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Family Physicians
American Academy of Home Care Medicine
American Academy of Hospice and Palliative Medicine
American Academy of Ophthalmology
American Academy of Otolaryngology—Head and Neck Surgery
American Academy of Pain Medicine
American Academy of Physical Medicine and Rehabilitation
American Academy of Sleep Medicine
American Association of Child & Adolescent Psychiatry

American Association of Clinical Endocrinologists
American Association of Neurological Surgeons
American Association of Neuromuscular & Electrodiagnostic Medicine
American Association of Orthopaedic Surgeons
American College of Cardiology
American College of Emergency Physicians
American College of Gastroenterology
American College of Osteopathic Surgeons
American College of Phlebology
American College of Physicians
American College of Radiology
American College of Rheumatology
American College of Surgeons
American Congress of Obstetricians and Gynecologists
American Gastroenterological Association
American Geriatrics Society
American Orthopaedic Foot & Ankle Society
American Osteopathic Association
American Psychiatric Association
American Society for Clinical Pathology
American Society for Gastrointestinal Endoscopy
American Society for Radiation Oncology
American Society for Surgery of the Hand
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Clinical Oncology
American Society of Dermatopathology
American Society of Echocardiography
American Society of Hematology
American Society of Nuclear Cardiology
American Society of Plastic Surgeons
American Society of Retina Specialists
American Urogynecologic Society
American Urological Association
Association of American Medical Colleges
College of American Pathologists
Congress of Neurological Surgeons
Heart Rhythm Society
Infectious Diseases Society of America
International Society for the Advancement of Spine Surgery
Medical Group Management Association
National Association of Medical Examiners
National Association of Spine Specialists
Renal Physicians Association
Society for Vascular Surgery
Society of Cardiovascular Computed Tomography
Society of Critical Care Medicine
Society of Gynecologic Oncology
Society of Nuclear Medicine and Molecular Imaging

Society of Thoracic Surgeons
Spine Intervention Society
The Endocrine Society

Medical Association of the State of Alabama
Alaska State Medical Association
Arizona Medical Association
Arkansas Medical Society
California Medical Association
Colorado Medical Society
Connecticut State Medical Society
Medical Society of Delaware
Medical Society of the District of Columbia
Florida Medical Association Inc.
Medical Association of Georgia
Hawaii Medical Association
Idaho Medical Association
Illinois State Medical Society
Indiana State Medical Association
Iowa Medical Society
Kansas Medical Society
Kentucky Medical Association
Louisiana State Medical Society
Maine Medical Association
MedChi, The Maryland State Medical Society
Massachusetts Medical Society
Michigan State Medical Society
Minnesota Medical Association
Mississippi State Medical Association
Missouri State Medical Association
Montana Medical Association
Nebraska Medical Association
Nevada State Medical Association
New Hampshire Medical Society
Medical Society of New Jersey
New Mexico Medical Society
Medical Society of the State of New York
North Carolina Medical Society
North Dakota Medical Association
Ohio State Medical Association
Oklahoma State Medical Association
Oregon Medical Association
Pennsylvania Medical Society
Rhode Island Medical Society
South Carolina Medical Association
South Dakota State Medical Association
Tennessee Medical Association
Texas Medical Association
Utah Medical Association

Vermont Medical Society
Medical Society of Virginia
Washington State Medical Association
West Virginia State Medical Association
Wisconsin Medical Society
Wyoming Medical Society