Association of American Physicians and Surgeons
FLORIDA STATE CHAPTER

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(Via online Rules Comment)

June 24, 2016

**Comments by Florida Chapter, Association of American Physicians and Surgeons and David McKalip, M.D., June 24, 2017 on MIPS Rules pursuant to MACRA**

On behalf of the Florida Chapter of the Association of American Physicians and Surgeons (AAPS-FL) and myself as a private physician subject to the implementation of HR2 (MACRA), I write to offer comments on proposed rules (Medicare Program: Merit-Based Incentive Payment System and Alternative Payment Model Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models).

We and I reserve our rights to further complain about these rules under the Constitution of the United States and object to any rule, law or procedure that would impede those rights as unlawful and unconstitutional. Any specific complaint made now should not be taken as an indication of lack of any other right to act against these rules based on their implementation (and the difficulty in discerning the complex nature of these proposed rules and applicable laws). Our reserved right to future actions to complain about these rules, their implementation and impact includes our right to appeal to have them recognized as and declared as invalid (including those rights protected under the Constitution of the United States of America).

We (AAPS-FL and David McKalip, M.D.) write to point out that the proposed rules are an invalid exercise of delegated parliamentary authority. They are written in an arbitrary and capricious fashion and violate applicable administrative and other law. They are over-broad and will cause harm to physicians and their patients. These rules would cause patients harm by 1) causing physicians to alter practice patterns to satisfy the rules to achieve a bonus, avoid a penalty or avoid other harm to their practices and 2) interfering with the ability to practice medicine independently and in the best interest of their patients. The rules will cause substantial and unacceptable unfunded expenses and burdens on physician practices and deprive physicians of their time with patients since they must instead be coerced to spend time on onerous compliance activities.

(1) Mandatory Participation is unlawful.

There is a glaring and obvious violation of the law. The rule states that all MIPS eligible clinicians "MUST" (emphasis added) submit data and more.

> "§ 414.1325 Data submission requirements. (a) Data submission performance categories. MIPS eligible clinicians and groups must submit measures, objectives, and activities for the quality, CPIA, and advancing care information performance categories."

The law authorizing these rules (HR2, 114th Congress, "MACRA") specifically denies the ability of any agency of the government to require submission of any data under MIPS. Title I, Section 101 indicates that participation in the MIPS program is completely voluntary. Page 41 of HR2 (as published by the GPO) indicates that Title I, Section 101, (c)(1)) amends Section 1848 of the Social 7 Security Act (42 U.S.C. 1395w–4) and adds the following language:

> " ((q)(5)(B) INCENTIVE TO REPORT; ENCOURAGING USE OF CERTIFIED EHR TECHNOLOGY FOR REPORTING QUALITY MEASURES.—
>
> ''(i) INCENTIVE TO REPORT.—Under the methodology established under subparagraph (A), the Secretary shall provide that in the case of a MIPS eligible professional who fails to report on an applicable measure or activity that is required to be reported by the professional, the professional shall be treated as achieving the lowest potential score applicable to such measure or activity.
>
> '(ii) ENCOURAGING USE OF CERTIFIED EHR TECHNOLOGY AND QUALIFIED CLINICAL DATA REGISTRIES FOR REPORTING QUALITY MEASURES.—Under the methodology established under subparagraph (A), the Secretary shall— ''(I) encourage MIPS eligible professionals to report on applicable measures with respect to the performance category described in paragraph (2)(A)(i) through the use of certified EHR technology and qualified clinical data registries; and ''(II) with respect to a performance period, with respect to a year, for which a MIPS eligible professional reports such measures through the use of such EHR technology, treat such professional as satisfying the clinical quality measures reporting requirement described in subsection (o)(2)(A)(iii) for such year."

It is thus clear that Congress specifically intended and legislated that participation be completely voluntary. The cited language refers to "incentives" to report and of "encouraging use" of certain technology. Congress then described the penalties that would apply to physicians that chose not to participate in the MIPS by stating they Secretary was authorized to assign them the lowest possible participation score for MIPS. Financial penalties for such scores are defined elsewhere. There was no language requiring or mandating participation as envisioned by these rules as indicated above.

Thus, these rules should be modified here and elsewhere to implement HR2 solely within the specific limits proscribed by law on this and all other issues.

(2) Name change.

The term "MIPS Eligible Clinicians" was created in the rules but does not appear in the law, potentially subjecting all of the rules to becoming invalid everywhere where this language is used.

(3) Reweighting.

The rule envisions reweighting the scoring system to decrease the percentage that is attributed to quality as follows:

> "**§ 414.1330 Quality performance category.**
> (b) Subject to CMS's authority to reweight performance category weights under section 1848(q)(5)(F) of the Act, performance in the quality performance category will comprise:
> (1) 50 percent of a MIPS eligible clinician's composite performance score for 2019.
> (2) 45 percent of a MIPS eligible clinician's composite performance score for 2020.
> (3) 30 percent of a MIPS eligible clinician's composite performance score for each year thereafter.

However, the enabling legislation states as follows.

> ''(F) CERTAIN FLEXIBILITY FOR WEIGHTING PERFORMANCE CATEGORIES, MEASURES, AND ACTIVITIES.—Under the methodology under subparagraph (A), if there are not sufficient measures and activities (described in paragraph (2)(B)) applicable and available to each type of eligible professional involved, the Secretary shall assign different scoring weights (including a weight of 0)—''(i) which may vary from the scoring weights specified in subparagraph (E), for each performance category based on the extent to which the category is applicable to the type of eligible professional involved; and ''(ii) for each measure and activity specified under paragraph (2)(B) with respect to each such category based on the extent to which the measure or activity is applicable and available to the type of eligible professional involved.

Of note, the legislation envisions the percentage of the scoring system should be adjusted only "if there are not sufficient measures and activities (described in paragraph (2)(B)) applicable and available to each type of eligible professional involved". Thus Congress is envisioning a downward adjustment of weighting for quality when fewer quality measures are available. However the rules envision dropping the percentage of the composite score attributed to quality over time, even though more time would be available for the development of a greater number of quality measures among various eligible professionals. The rules thus are invalid as they extend beyond the law. Further, they deemphasize the purported mission to improve quality and instead create a much stronger weight toward cost control and control of physician practice of medicine through other compliance activities.

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(4) Access to care by Medicare Patients and improved physician payments.

HR2 was created and passed to improve physician payments and to strengthen access to care by Medical patients. The legislation is introduced as follows:

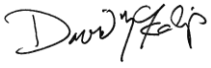
> "To amend title XVIII of the Social Security Act to repeal the Medicare sustainable growth rate and strengthen Medicare access by improving physician payments and making other improvements, to reauthorize the Children's Health Insurance Program, and for other purposes."

The rules do not Improve physician payments and make payment to physicians harder to obtain for their services to patients. The rules impair the ability of physicians not only of maintaining a cost-effective practice, but of practicing medicine at all in the manner in which they see fit, especially in a private or small practice. This violates Section 1801 of the Health Insurance for the Aged Act that says "Nothing in this [subchapter] 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...." (Title 42, Section 1395, USC).

In addition, the rule harms access to care by Medicare patients by creating compliance protocols that are primarily based on cost of care and administrative factors. These rules specifically refer to a budget neutrality goal. The rule refers to withholding "incentives" from doctors who do not obtain arbitrarily defined budget and spending goals that can only amount to a rationing of medical care. Furthermore, physicians are coerced to comply with so called "quality measures" and are penalized for not obtaining arbitrary compliance thresholds set by the government and these rules. Such compliance fails to recognize the unique needs of individual patients, including those covered by Medicare. This amounts to a "one-size-fits-all (or most)" program that denies the specific medical care required by individual patients at different times in their lives based on the training, experience and judgment of the patient's physicians. In addition, compliance with such measures has been specifically shown, in valid scientific studies, to directly injure or cause death to some patients and interfere in access to care for higher risk and other patients. Such programs do not increase access to Medicare, but decrease it, and these rules thus fail to comply with the law as proscribed by Congress.

We suggest modifying these rules substantially to address these and many other concerns. The MIPS program should not be implemented by the administration as currently envisioned by the proposed rules.

David McKalip, M.D.



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