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Society of Interventional Radiology
The vision to heal

June 27, 2016

Centers for Medicare & Medicaid Services,
Department of Health and Human Services
Attention: CMS-5517-P
P.O. Box 8013
Baltimore, MD 21244-8013.

RE: Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models: CMS-5517-P

Dear Acting Administrator Slavitt:

The Society of Interventional Radiology (SIR) appreciates the opportunity to submit comments to the Centers for Medicare and Medicaid Services (CMS) regarding the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Proposed Rules. The SIR thanks CMS for the effort to propose rules for implementing the Medicare Access and CHIP Reauthorization Act (MACRA).

The Society of Interventional Radiology (SIR) is a professional medical association that represents approximately 6,500 members, including most US physicians who are practicing in the specialty of vascular and interventional radiology. In preparing these comments, we have consulted also with the American College of Radiology (ACR) on key parts of the CMS proposed rule.

In 2012, the American Board of Medical Specialties approved a new primary certificate, the "Dual Certificate in Interventional Radiology and Diagnostic Radiology." A primary certificate is different from a subspecialty certificate as it designates a unique and distinct area of medicine. A new interventional radiology residency training program launched in 2016, and by 2023, the first new residents will be certified in the Dual Certificate. Interventional radiology is a clinical specialty in which the physician has direct interaction with patients, performing image-guided interventions and providing clinical care prior to and following procedures. It is important to note that all interventional radiologists receive training in interpretation of imaging studies and are certified to interpret diagnostic imaging studies. Interventional radiology trainees undergo additional rigorous training in minimally invasive surgical techniques and associated patient management, including the provision of longitudinal patient care. We urge CMS to fully appreciate that there is an important clinical distinction between the specialties of Interventional Radiology and Diagnostic Radiology, with imaging being central to both domains.

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From the first transluminal angioplasty procedure performed in 1964, interventional radiologists have been at the forefront of developing new and minimally invasive procedures to treat an array of clinical diseases and conditions obviating the need for open surgery. Interventional radiology (IR) treatments have become first-line care for patients with a wide variety of conditions, including peripheral arterial disease, deep vein thrombosis, symptomatic uterine fibroids, cancer, and stroke. IRs are also at the forefront of essential core hospital care functions - ranging from acute services including embolization of a bleeding artery in an exsanguinating auto accident victim, intracranial interventions for stroke, post-surgical care, to essential everyday services such as central venous access placement. Current techniques also allow interventional radiologists to offer minimally invasive treatments for pain management, including diagnostic and therapeutic spinal procedures, major nerve blocks to ease cancer-related pain, and painful and ulcerating wounds with a substantially decreased reliance on oral opioid analgesics.

General comments:

We appreciate CMS' focus on incentivizing quality and value over volume. One of the stated goals is to minimize the burden on clinicians. While the proposed rule does decrease some burden by introducing some new efficiencies, significant reporting burdens remain. For interventional radiologists, there will be a significant increase in the administrative burden of having to better understand resource use and the potential complexities of patient relationship coding as applicable to IRs. In addition the infrastructure to streamline reporting on clinical practice improvement activities needs to be developed and we need to ensure that our members are apprised of advancing care information reporting requirements.

SIR also applauds the use of the RFI process to consult stakeholders regarding the content of specialty-specific measures and activities in the four MIPS performance categories.

We appreciate CMS's proposed flexibility regarding "outcome" vs "high-priority measures" with an exemption clause for eligible clinicians who do not have an adequate number of available measures to report on. Most of our comments below will focus on MIPS, due to the challenges for specialty physicians to initiate APMs in the current environment.

As a general comment, we ask that CMS score all bonuses and penalties under MIPS based on actual Part B physician payments. Medicare payments to physicians who practice in non-facility sites of service include the total costs(e.g., supplies, clinical labor) of providing the service, which is markedly different than Part B payment when the procedure is performed in a hospital.

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Patient-Facing Threshold (pp. 49-55)

Concern:

MACRA requires CMS, in specifying measures and activities for a performance category, to give consideration to the circumstances of MIPS eligible clinicians who typically furnish services that do not involve face-to-face interaction with a patient. The proposed rules (pp 48-58) define a "non-patient facing MIPS eligible clinician" as a MIPS eligible clinician or group that bills 25 or fewer patient facing encounters during a performance period. While we await the list of "patient-facing-encounter" codes, we consider the practice of interventional radiology a patient-facing vocation and anticipate that most interventional radiologists will be considered patient facing clinicians. With respect to this concept, SIR raises two concerns with this section of the proposed rule:

1. Patient encounters can sometimes be reported by several surgical procedure codes under PFS. Since CMS proposes to define a MIPS eligible clinician by encounters which themselves can be defined by a surgical CPT code, SIR requests clarification: Is a MIPS eligible clinician fundamentally defined by a series of encounters or by a series of CPT codes?

2. SIR believes potential unintended consequences may result from this section of the proposed rule. Specifically, there is a possibility that patient access to low-complexity but critical IR services in some localities will be limited, particularly in smaller hospitals and rural communities. Our concern derives from the proposed differential treatment of patient-facing and non-patient-facing reporting requirements (fewer required MIPS measures/categories for non-patient-facing eligible clinicians). A number of interventional radiologists participate in small group practices, often within small and rural hospital settings. These group practices have historically used the group practice reporting option (GPRO) to simplify the administrative burden of measure reporting under the PQRS and VBM. Since the GPRO under MIPS requires that all eligible clinicians be of the same patient-facing status, we are concerned that there could be an impetus for groups with mixed patient-facing (interventional radiology) and non patient-facing (diagnostic radiology) physicians to discourage the interventional radiologist(s) members of the group from performing services that elevate the status of the entire group to patient-facing necessitating greater reporting requirements, which for some members of the group will be impossible.

Proposed Solution:

SIR proposes that the threshold defining a MIPS eligible patient-facing clinician be specified as 100 Evaluation and Management (E&M) codes reported to Medicare within the performance year. We believe the majority of interventional radiologists would far exceed the 100 E&M threshold and would be appropriately categorized as patient-facing. However, by raising the

threshold and by defining it by E&M codes rather than surgical codes, we believe this would afford the opportunity to support patient access to key services in most localities.

We also propose, along with the ACR that, if CMS continues with the 25 services definition as proposed, **CMS allow scaling of the patient encounter codes when defining whether a group practice is eligible for the MACRA mandated special considerations for non-patient-facing clinicians.**

We further request that a mixed patient-facing/non-patient-facing group be allowed to report under GPRO the non-patient facing eligible clinician measures/categories. Because of the diverse and varied procedures performed by IR and the aggressive implementation timeline proposed, we would additionally request that these groups be allowed to report the patient-facing eligible clinician measures under the same TIN to minimize business disruption. As we read the proposed rule, this seems permissible since the individual clinician's NPI can be linked to their patient-facing services.

MIPS Exclusion for New Medicare Clinicians (pp 65-66)

The proposed rule allows for exclusion of new Medicare enrolled clinicians (as determined by unique new PECOS registration) for the 1st year of practice. CMS indicated that these clinicians will not be subject to the MIPS adjustment in the first year, presumably the performance year. However, CMS does not indicate how these individuals will be considered for the 2nd year of practice. **We ask CMS to forego the MIPS adjustment for the second year as well, as under the rule, the performance year always predates the adjustment year by two years.**

Low Volume Threshold (p. 67)

Eligibility to be categorized as a MIPS eligible clinician is subject to low-volume thresholds set by the HHS Secretary on an annual basis. **SIR recommends that these thresholds be set with a two-year notice of change to allow clinicians the opportunity to adjust practice and reporting given that there is a two-year lag between performance and adjustment years.** Further, due to presumed disproportionate effect of these rules on small and rural practices (see regulatory analysis comment below), **we encourage a rather "high" low-volume threshold to exempt solo physicians and small group practices which would serve to maintain patient access.**

Virtual Groups (pp. 71-74)

We are concerned that reporting for MIPS is likely to be more difficult for smaller practices. We also understand that the Proposed Rule is not intended to disadvantage smaller practices, and that CMS has requested suggestions for how Virtual Groups might be used to support small practices to be successful under MACRA payment requirements.

We believe that the use of virtual groups would be helpful to allow solo practitioners or small IR groups, particularly those who work within larger diagnostic radiology groups, to work together to report MIPS measures by efficiently using administrative resources required to report those measures. Given the diversity of many diagnostic radiology practices, many radiology groups far exceed the size limit (≤ 10 members) applicable to virtual groups. In effect these measures would be reported as a virtual Group Practice Reporting Option (vGPRO). For instance, individual interventional radiologists who practice within larger diagnostic radiology groups may want to form a Virtual Group with other similarly situated interventional radiologists, reporting as a separate vGPRO rather than reporting as part of the diagnostic radiology group.

SIR recommends that CMS eliminate entirely the size limit (currently proposed to be ≤10 members) applicable to virtual groups or increase the limit to ≤40 members. We also believe that for virtual groups to function well, election to participate in virtual group reporting necessitates election prior to the start of the performance year. **CMS should articulate a deadline for election and registration in a future rule**. **Further, we encourage CMS to consider virtual groups around disease states**. For example, in July of 2015, several professional associations partnered together to give testimony to the MEDCAC on peripheral arterial disease and appropriate clinical care. It could be that broad consensus on specific conditions could be used as an organizing concept to create a type of virtual group.

MIPS Performance Period (pp. 75-79)

The proposed rule indicates a January 1, 2017 start date for the first full-year reporting period for MIPS and APM performance periods. SIR believes this target start date is impractical because there will only be two months between finalization of the MACRA rule and initiation of the reporting period. Two months is insufficient time for MIPS eligible clinicians to adapt to the requirements. **SIR asks CMS to delay the start date for the first performance year to at least July 1, 2017 employing a 6 month performance period, as permitted in statute.** CMS has made use of shorter performance periods for the past several years and even proposes partial year measurements in the proposed rule for MIPS ECs who have <12 months data reported.

Qualified Clinical Data Registries (pp 86-87)

Concern:

We support the Agency's use of Qualified Clinical Data Registries to measure quality. However, currently, practitioners are limited to reporting through a single QCDR. In addition, each QCDR is capped to enable reporting for only 30 quality measures. Given the breadth and variety of practice within interventional radiology, interventional radiologists provide a wide variety of different therapies in different areas of the body for many diseases (and the mix of those services varies widely from practice to practice), our members need a sufficiently wide variety of

measures from which to choose in order to meaningfully and accurately report on their performance.

Proposed Solutions:

We strongly urge CMS to increase the cap of 30 measures within any given QCDR. Increasing the cap will allow multi-specialty groups comprised of diagnostic radiologists and interventional radiologists to report via the same QCDR. This is very important as several of the imaging dose related measures within the American College of Radiology's National Radiology Data Registry (ACR NRDR) are appropriate for interventional radiologists to report and would allow the group to share resources and measures.

We strongly urge CMS to consider allowing clinicians to report across multiple QCDRs. Allowing clinicians to report through multiple QCDRs would permit the specificity of reporting required for diverse specialties, but without increasing the information technology integration burden on practices who might already be reporting through these registries. For instance, many interventional radiologists have robust practices treating peripheral arterial disease could opt to use the Vascular Quality Initiative registry for reporting that portion of their practice, whereas the IR Quality Registry housed within the ACR NRDR QCDR may be better suited for reporting on care provided to oncology patients. The flexibility of defining measures in a QCDR is complementary to the annual call for MIPS measures process and would increase the likelihood that interventional radiologists would be able to report on quality measures meaningful to the Medicare patient population they treat.

Concern:

The rule encourages eligible clinicians to report on applicable measures under the quality performance category through the use of CEHRT and QCDRs. The rule proposes that only MIPS eligible clinicians using CEHRT to report measures to QCDRs are eligible for a bonus point for adhering for "end-to-end electronic reporting." We believe this is too restrictive, as a variety of non-CERHT software platforms (such as TRIAD, Hi-IQ®, PowerScribe® or M*Modal®) are commonly used in IR nationally and are critical for automated data collection and transmission to the IR QCDR. The inability to use a wider range of software platforms for reporting will likely create an unnecessary burden for MIPS eligible clinicians, including IRs, and as such may delay QCDR adoption.

Proposed Solution:

We are concerned that limiting data sources to CEHRT alone would unduly burden many interventional radiologists because some data sources for interventional radiology QCDRs may not be CEHRT standards. We suggest that "in conformance to the standards relevant for the

measure and submission pathway" simply means in the manner that the registry requires the data submission. The data are derived from an electronic source. **We ask that CMS consider any measures coming from an electronic source to an electronic source, following the registry standard, as eligible for the electronic reporting bonus points consideration for quality measures.**

Quality Performance Category Measures (pp. 90-130)

Concern:

After reviewing the proposed Quality Performance measures, we are concerned that there are not enough quality measures that pertain directly to IR practices to allow IRs to fulfill the MIPS scoring and reporting requirements.

Many interventional radiologists practice in both facility and outpatient settings, including office settings and ambulatory surgery centers, and can see their patients in all these sites of service. As such it is possible that reporting data can be collected by multiple mechanisms (registries, QCDR). We understand that CMS will be flexible by scoring all measures by mechanism. However SIR believes this may disadvantage IRs who have low volume practices at multiple locations. SIR desires direction on how and when to incorporate measures in these varied settings and looks forward to CMS' clarification of the scoring process.

Further, on page 107 of the proposed rule, CMS indicates that groups reporting by a QCDR mechanism must report 90% of all patient data pertinent to the measure. Similarly, individual MIPS eligible ECs must report 80% of all Medicare patient data pertinent to the measure. Given that IRs practice in multiple sites with multiple IT vendors providing support for EHRs, SIR believes these reporting thresholds at the outset of the MIPS program are onerous.

Finally, page 118 of the proposed rule indicates that newly accepted measures will be established by final rule no later than November 1st in the year proceeding the performance year to which the measure can first be used.

Proposed Solutions:

SIR would like CMS to make public the scoring methodology that will be used for each category to allow ECs the opportunity to calculate a more timely assessment of reported data than CMS has planned. In the proposed rule assessments will be reported by six months following the conclusion of the performance year, which does not enable adequate time for eligible clinicians to adjust their practices to improve the delivery of quality care during the performance year.

SIR recommends decreasing the reporting thresholds to 50% for performance year 1 with a ramp up period of 3 years to achieve the 90%/80% goal.

SIR urges CMS to consider an earlier rule date each year (at least 3 to 6months lead time) so practices and ECs can incorporate the new measures into their reporting mechanisms.

Specialty-Specific Measure Sets (pp 887-890)

Concern:

On pages 887-890 of the rule, measure sets specific to each specialty are shown. Table 20B-Interventional Radiology- lists four measures stewarded by other societies. The SIR estimates that the majority of interventional radiologists would only be able to report on one of the four proposed measures as part of the specialty measure set. Although the scope of procedures covered by the proposed measure set does fall within the purview of interventional radiology, based on differences in training and practice settings we believe that three of the four specialty measures shown on the table are not commonly performed by the majority of interventional radiologists.

Proposed Solution:

SIR desires to work with CMS to enhance/define IR specialty-specific measure set(s). The practice of interventional radiology is widely varied. To that end, we offer an initial alternative measure(s) set for interventional radiology that is pertinent to the practice of interventional radiology. Although we believe that the CMS proposed measure PQRS 265: Biopsy Follow-up falls within the purview of the majority of IR practices, the measure design as proposed by the Society of Dermatology is outdated given the availability of electronic notifications and tracking embedded within EHRs. As a result we did not include this measure in our proposed measure set.

Proposed Table 20B Interventional Radiology Specialty-specific Measure Set:

- PQRS 16-421: Appropriate Assessment of Retrievable Inferior Vena Cava Filters for Removal
- PQRS 16-437: Rate of Surgical Conversion from Lower Extremity Endovascular Revascularization Procedure
- PQRS 145: Exposure time reported for procedures using fluoroscopy
- PQRS 076 / NQF 2726: Prevention of Central Venous Catheter-related blood stream infections

- PQRS 374: Closing the referral loop: Receipt of a Specialist Report
- PQRS 16-420: Varicose Vein Treatment with Saphenous Ablation: Outcome Survey

The SIR will continue to work with CMS to submit quality measures under the annual submission process to increase the stable of interventional radiology relevant performance measures for MIPS.

Resource Use (p. 131-160)

Concern:

SIR welcomes the inclusion of resource use (i.e. cost) in measuring healthcare performance. Interventional radiologists perform minimally invasive, impactful procedures that have been shown in studies to have significantly lower costs with equal or better outcomes compared to open surgical alternatives (e.g. uterine fibroid embolization vs. hysterectomy for symptomatic fibroids, radiofrequency ablation of liver tumors vs. surgical resection). Most importantly, these cost benefits are realized over episodes of care, with most primary IR procedures occurring in the outpatient setting or resulting in a shorter length of stay compared to their alternatives. In other instances, IR provides essential cost-efficient services (e.g. tissue biopsy, drainage of fluid collections, embolization of bleeding blood vessels) that are critical for inpatient hospitalizations and treating complications of surgical procedures. We have several comments on the proposed rule's approach to Resource Use.

1. Calculation of resource use allowable amounts: The use of Part A, Part B and DME services to calculate resource use for measures such as Medicare Spending Per Beneficiary places IRs at a disadvantage. Frequently the largest proportion of these costs (i.e. angiography room costs, disposable item costs, medical devices) are negotiated and determined by hospitals without input from individual IRs. Tying physician reimbursement to costs over which they have no control will be unfair and disproportionally affect physicians who provide procedural services in hospital settings.

2. Attribution of beneficiaries to IR: Attribution of beneficiaries is a significant problem for IR. In instances where IR provides an ancillary service (embolization of diverticular bleeding vessel) during an acute condition based episode, it is possible that the procedural services provided result in attribution of the beneficiary to IR, even if the condition (gastrointestinal hemorrhage) and hospital course were managed by a different specialty. In instances, where IR provides the primary service (e.g., endovascular AAA stent grafting), peri-procedural care provided by other providers may result in complications, which lead to resource use beyond the IRs control (e.g., hospital acquired pneumonia and/or other hospital acquired conditions).

3. Episode grouper methodology (inclusion of IR specific codes): We are concerned that there are a limited number of conditions that are covered under episode groupers, as shown in Tables 4 and 5 of the proposed rule. If episode groupers remain the primary resource for calculating resource use, we urge CMS to carefully evaluate claims data so that the relevant IR codes are captured in the Episode. Examples of proposed episode groupers in which IR provides services that may not yet be included in resource calculation include the following:

• Abdominal or thoracic aortic aneurysm (typical IR services: diagnostic angiography, endograft repair) • Acute DVT (typical IR services: thrombolysis, mechanical thrombectomy, IVC filter placement) • Acute PE (typical IR services: mechanical thrombectomy or thrombolysis, IVC filter placement) • Atrial fibrillation (typical IR services: systemic thromboembolization complication treatment; e.g. vascular embolization) • Cholecystectomy/Cholecystitis (typical IR services: cholecystostomy tube placement as alternative therapy; percutaneous biliary drainage for bile leak) • C. Difficile Colitis (typical IR services: central venous access) • Dialysis access (typical IR services: AV fistula creation/revision) • Diverticulitis (typical IR services: abscess drainage, central venous access) • GI hemorrhage (typical IR services: diagnostic angiography, embolization)	• Ischemic Stroke (typical IR services: mechanical thrombectomy or thrombolysis) • Kidney UTI (typical IR services: percutaneous drainage of an obstructed urinary tract, central venous access placement) • Mastectomy (typical IR services: biopsy for staging, treatment of metastatic disease, central venous access) • Osteoporosis (typical IR services: vertebral augmentation) • Pacemaker (typical IR services: diagnosis or therapy for venous occlusion inhibiting placement of Pacemaker) • Peripheral venous disease (typical IR services: vein ablation, vein angioplasty/stenting) • Peripheral arterial disease (typical IR services: diagnostic angiography, revascularization) • Pneumonia (typical IR services: central venous access) • Spinal stenosis (typical IR services: lumbar facet joint injections)

4. Attribution of each beneficiary to a single provider/specialty: This approach risks compartmentalizing care and creating unintended incentives for physicians to direct care in a manner that results in attribution of sicker patients to other providers. E.g. a patient with a diverticular bleed with numerous co-morbidities could be referred for angiography rather than colonoscopy if a gastroenterologist assumes care or vice versa.

Proposed Solution:

- **Invite specialty societies to participate in creation, evaluation and revision of episode groupers.**

- **Limit resource use allowable amounts to physician professional reimbursements rather than include DME and disposable items or medical devices i.e. items with variable costs that are determined by hospitals.**

- **Consider a prospective assignment of each beneficiary in an episode grouper based on trigger codes or other methodologies to a physician so that the physician whose performance is measured on resource use during that episode is also the physician who can assume a lead role in care delivery.**

- **Consider attributing beneficiaries to more than one physician based on specialty (e.g. IR, gastroenterology, intensivist for the condition GI hemorrhage) to foster a collaborative approach and shared responsibility to patient care.**

Clinical Practice Improvement Activities (CPIA) (p. 161)

Concern:

We appreciate CMS providing a range of activities under six categories to provide an assortment of activities to choose from. Under the proposed rule, physicians could be required to report on as many as six medium-weight activities in order to receive the full CPIA score. While the activities vary in required time and resources, collecting data on six different projects in a reporting year is overly burdensome.

While SIR understands that attestation is allowed, the audit requirements and details for each CPIA proposed are not clear. Further, no target improvement for quality improvement nor guidelines are provided on baseline performance in the CPIA. We are concerned that these elements are unclear and request clarification.

Proposed Solution:

The SIR recommends that a lower number be used to fulfill the CPIA category in the final rule and that CMS provide more high-value activities for MIPS eligible clinicians to use. For physicians who are unable to report certain MIPS categories, the rule primarily increases the impact of the quality score. Instead of this approach, physicians should be able to choose to increase the weight of the CPIA category since most will be able to find relevant CPIA measures for their practice.

The SIR encourages CMS to consider that **QI projects performed through QCDRs should each be credited as a separate clinical performance improvement activity**.

We appreciate that multiple CPIAs would recognize participation in a QCDR. Because QCDR participation is so comprehensive and entails multiple activities that contribute to quality improvement, **we request that CMS consider giving clinicians participating in a QCDR**

automatic credit for the CPIA category rather than having to attest to each individual CPIA. We ask that CMS consider using the term "clinical registries" rather than QCDRs throughout the CPIA since many MIPS eligible clinicians currently participate in clinical registries outside of MIPS participation.

Along with the ACR, the SIR requests that CMS to consider Maintenance of Certification (MOC) Part IV participation as a CPIA in all CPIA sub-categories, not just the Patient Safety/Practice Assessment sub-category. There very well may be MOC activities that are relevant in each of the six CPIA sub-categories. CMS should not limit the types of Part IV activities that are considered a CPIA. **SIR recommends that CMS should defer to the specialty boards on what is an acceptable activity under Part IV.**

Advancing Care Information (ACI) Performance Category (pp. 187-247)

It is unclear to SIR how many of its members have been participating in Meaningful Use. Many of our members use EHR as part of their clinic records and as part of their hospital records. However, many of those EHR systems are controlled by the hospital or entity other than the practitioner and the practitioner often has no influence on compliance of the EHR. Clinicians should be held accountable ONLY if they are procurers/maintainers of the EHR.

CMS asks for comments on two possible ACI performance base score proposals. **SIR favors the yes/no reporting proposal announced as the "primary proposal"**.

CMS proposes to rebase the ACI category ***AFTER*** analysis of the percentage of users during the performance year. Doing so does not give participating ECs the ability to plan for and implement appropriate strategy to maximize his/her composite MIPS score. Rebasing unfairly disadvantages those who have made effort to meaningfully use EHR during the performance year. **SIR suggests rebasing only applies to future performance years, not completed performance years.**

MIPS Composite Score Methodology and Payment Adjustments (pp. 289-373)

CMS seeks feedback on how to assess improvement where MIPS eligible clinicians do not have the required case minimum for measures to be scored or where methods of reporting vary from year to year. **SIR favors option #1 as the least subjective method for assessing improvement.**

SIR applauds the proposal that payment adjustments follow the TIN/NPI combination rather than the TIN alone.

It appears that CMS will aggregate performance category scoring into a composite MIPS score that will be compared to an undefined threshold. How will this threshold be determined? **SIR**

requests that CMS clarify in the Final rule how the performance thresholds will be set each year.

MIPS Performance Feedback and Correction of MIPS Score (pp. 374-388)

CMS intends to provide feedback on quality measure and resource use performance once per year (July 1) in the year following the performance period (X). This late reporting makes the EC unable to adjust performance to effect payment adjustment for X+2 years, effectively making performance measurement a two year long process.

In order to assist clinicians in achieving success, the **SIR requests CMS consider providing more timely, accurate and actionable feedback.** Physicians should not go into a reporting period without knowing how they performed in the immediately prior performance period or the performance benchmarks on which they will be measured.

Alternative Payment Models (pp. 440-602)

The SIR supports the work of the newly formed Physician-Focused Payment Model Technical Advisory Committee, or PTAC.

We encourage the PTAC process to have additional transparency so that all specialties may understand the requirements of the application and vetting process. We also believe that it is vital to this process that the review of Physician Focused APM be performed in consultation with individuals with expertise in the discipline(s) of medicine being reviewed. **The SIR encourages PTAC to incorporate a procedural rule that requires PTAC, when evaluating a physician-focused payment model application made by a specialty, to seek an advisory opinion of at least one specialist in that specialty**. The SIR also encourages CMS and/or PTAC to spell out a very clear path from PTAC approval of a PFPM proposal to CMS execution, perhaps through the CMS Innovation Center. It may be that AAPMs will need detailed input from the community of medicine, and a process similar to the RBRVS Update Committee (RUC) can be established to vet all proposed models and allow specialties to participate in a process.

The SIR understands that the ultimate goal of MACRA is to move clinicians into APMs for value based payment purposes. Unfortunately, the current requirements for creating APMs, particularly specialty-focused APMs, present very high barriers to entry. We understand that CMS has not fully determined processes for specialist clinicians to be involved in APMs more applicable to their practices. **We look forward to hearing further thoughts from CMS that can guide our development of APM proposals.** SIR supports the perspective of the American Medical Association, regarding definition of substantial and nominal risk. We know that interventional radiology will have multiple opportunities for improving the quality, efficiency and cost of healthcare delivery, and are beginning the work of translating those opportunities

into proposals for APMs. We hope that CMS will look favorably on perhaps innovative ideas for APMs that are designed to help achieve the goals of improved efficiency and value for the Medicare program.

Burden estimates in Regulatory Impact Analysis (pp. 654-684)

SIR believes the estimates CMS provides in the regulatory impact analysis are much too low and fail to underscore the breadth and impact this new program would have on practices, particularly smaller practices where patient access is at greater risk. Based on Table 64 we believe most smaller practices will be subject to cuts emphasizing the fact that only large practices are likely to succeed due to the efficiencies of size that can be applied to larger practices.

CMS projects that roughly 60% of MIPS-eligible IR physicians will receive a positive MIPS payment adjustment for 2019 (note: these 2019 payment adjustments are based on performance on MIPS measures in 2017). The remaining 40% of IR physicians would receive a negative payment adjustment. From the data provided, however, the SIR is unable to break down the percentage of IR physicians that would receive the maximum negative adjustment (-4% for 2019).

In closing, our specialty thanks CMS for your consideration of our comments. If we can be of any future assistance, please do not hesitate to contact Susan Sedory Holzer, SIR's Executive Director, at (703) 691-1805, or sholzer@sirweb.org.

Sincerely,

Charles E. Ray Jr., MD, PhD, FSIR
2016-2017 President
Society of Interventional Radiology