



September 8, 2015

Andy Slavitt  
Acting Administrator  
Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
Attn: CMS-1631-P  
Room 445–G, Hubert H. Humphrey Building  
200 Independence Avenue SW  
Washington, DC 20201

**Re: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016; Proposed Rule (CMS-1631-P)**

Dear Acting Administrator Slavitt:

On behalf of the American College of Physicians (ACP), I am writing to share our comments on the proposed rule for the Calendar Year (CY) 2016 Medicare Physician Fee Schedule (PFS). The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 143,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

**I. Summary of ACP Recommendations**

Throughout this letter, ACP provides a number of recommendations to the Centers for Medicare and Medicaid Services (CMS) in order to improve the final CY 2016 Medicare physician fee schedule. Our top priority recommendations are summarized below and discussed in greater detail within this letter.

***Determination of Practice Expense (PE) Relative Value Units (RVUs)***

- **ACP urges CMS to conduct a new Physician Practice Expense Information Survey (PPIS) to validate the practice expense component of the RVUs.**

***Potentially Misvalued Services under the Physician Fee Schedule***

- **Moderate Sedation: ACP recommends that there be a standard Resource-Based Relative Value Scale Update Committee (RUC) survey to determine the work and direct practice expense inputs of moderate sedation.** Codes that contain moderate sedation should have the work value and direct practice expense inputs removed, which would allow the moderate sedation to be separately reported.

- Surgical Global Periods: **ACP recommends that CMS use the additional time from the delay in collecting data on global periods to develop a methodology to fairly re-allocate malpractice RVUs for services converting from a 90- or 10-day to a zero-day global period.**

### ***Refinement Panel***

- ACP has concerns with the elimination of this panel and solely relying on agency staff to determine if the comment is persuasive in modifying a proposed rule. **The College recommends that CMS maintain an objective and transparent formal appeals process that is consistently applied and open to any organizations that would like to comment.**

### ***Improving Payment Accuracy for Primary Care and Care Management Services***

#### Improved Payment for the Professional Work of Care Management Services

- **ACP recommends that CMS investigate the adequacy of payment for physician services that typically take place outside of a face-to-face patient encounter.** The College urges CMS to recognize non-face-to-face services that enable primary care physicians who provide chronic disease management and care coordination to provide valuable and timely care to their patients.

#### Diabetic Care Management

- The College encourages CMS to use payment approaches that are aligned with the goal of moving payments away from volume to value-based care such as by exploring bundling of codes for certain chronic diseases.
- **Therefore, ACP recommends that a code bundle for Diabetic Care Management (DCM) be developed to emphasize better care coordination, communication, and integration of the care team aimed at a better overall outcome cost of care for the Medicare beneficiary.**
- ACP also recommends that Medicare cover evidence-based lifestyle modification programs under the traditional Medicare benefit, such as the Diabetes Prevention Program or the Stanford Chronic Disease Management Program.

#### Collaborative Care Models for Beneficiaries with Common Behavioral Health Conditions

##### Establishing Separate Payment for Collaborative Care

- The College supports CMS' recognition of the need to value the delivery of behavioral health services within the Physician Fee Schedule.
- **The College recommends that the described "collaborative care" model be implemented through a Center for Medicare and Medicaid Innovation (CMMI) demonstration and be rapidly expanded within Medicare through the Secretary's authority based upon the results and learnings of this demonstration.**
- **The College further recommends that CMMI, through a request for proposals (RFP) procedure, encourage the testing of evidence-based models, in addition to the specific "collaborative care model," to address the full gamut of behavioral health issues present within the primary care setting.**

- The College recommends the immediate inclusion of changes within the PFS to recognize the importance of non-face-to-face consultations between primary care physicians and consulting specialists—in this case a behavioral health specialist—by providing coverage of e-consultation codes.
- The College also recommends that CMS create a code and provide reimbursement for e-consultations both between hospitalists and primary care physicians and specialists and primary care physicians.

#### Chronic Care Management Code

- ACP strongly recommends that CMS develop add-on codes for time increments greater than 20 minutes such as 21-40 min; 41-60 min; and greater than 1 hour.
- ACP recommends that the electronic care plan sharing requirement be suspended until such time that EHRs have the ability to support such capabilities.

#### *Target for Relative Value Adjustments for Misvalued Services*

- ACP strongly recommends that CMS review their approach to determine if there are other methods that can be employed to come closer to reaching the target established by the law.
- More specifically, the College strongly recommends that codes with large volume changes, due to a new structure of the codes, be included in the target for reductions.
- Additionally, ACP urges CMS to establish a transparent process in calculating the “target for relative value adjustments for misvalued services.”

#### *Phase-in of Significant RVU Reductions*

- ACP supports CMS’ proposal of a 19 percent reduction as the maximum first year reduction, with any remaining reduction occurring in the second year. However, in line with an open and transparent process, CMS should establish a consistent methodology for codes with phased-in RVU reductions and ensure stakeholders are fully aware of the impact the net target reduction will have on physician payment.

#### *Valuation of Specific Codes*

- ACP applauds CMS for the way the agency has structured code GXXX2 for shared decision-making visits for chest CTs. The College recommends that CMS clarify this code to specify that the structure allows the code to be used as a stand-alone code or with an evaluation and management (E/M) with the modifier 25, with no disease-specific diagnosis, specialty, or frequency edits intended, and it can be billed by multiple different clinicians as the patient considers the issue (e.g., primary care, pulmonologist, and diabetologist or rheumatologist). **Given that this code is for a screening service, ACP recommends that CMS specify that this code will not require a co-payment.**

### Advance Care Planning

- **ACP applauds CMS for its decision to allow Medicare reimbursement for advance care planning services. This is an important step to improve care for Medicare patients with serious illness.**
- ACP recommends that CMS establish a National Coverage Determination (NCD) for Advance Care Planning to provide consistency in coverage of these important services.

### ***Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Services***

- **ACP strongly recommends that CMS roll-out this project with an initial focus on a limited number of clinical conditions and related AUC.**
- **The College further recommends that the roll out begin with health systems and large group practices—along the lines of how the Medicare Value-Based Modifier Program has been rolled out—and, over time, be expanded into the small, independent practice-size setting.**
- **The College also recommends that the qualifying process for AUC developed, modified, or endorsed that are determined to be “non-evidence based” include a requirement for review by the Medicare Evidence Development and Coverage Advisory Committee (MedCAC) --- rather than that the AUC simply “may be reviewed” --- to determine the adequacy of the supporting elements.**

### ***Physician Compare***

- The College supports the overall goals of the Physician Compare Website and supports efforts to improve transparency in the health care system.
- **ACP recommends that CMS hold off on including check marks for the Value-based Payment Modifier (VM) until a more adequate system can be implemented that indicates EPs who received no VM adjustment because they are classified as average.**
- **The College recommends that CMS consider noting on the profile pages of affected physicians that they successfully reported quality data but it could not be analyzed due to circumstances beyond their control.**
- **ACP recommends that CMS be transparent with regard to the methodology used to calculate these scores and ensure that scores are accurately and appropriately risk adjusted.**
- **The College recommends that CMS look at additional cross-cutting measures for future reporting on Physician Compare (i.e., measures pertaining to influenza, pain assessment and treatment, depression screening, etc.).**

### ***Physician Payment, Efficiency, and Quality Improvements – Physician Quality Reporting System (PQRS)***

- The College appreciates that CMS did not make significant changes to PQRS reporting requirements for CY 2016. Given that this is the final reporting period prior to implementation of the Merit-Based Incentive Payment System (MIPS), maintaining stability in requirements is important as practices prepare for selecting which track to

participate in under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

- **ACP strongly recommends that CMS engage in additional outreach to all practices to encourage them to participate in the PQRS program and work to increase PQRS participation rates.**
- **ACP recommends that the Agency maintain the application of the CAHPS requirement for only those groups with 100 or more eligible professionals (EPs) for performance year 2016 as well.**
- **The College recommends that CMS implement the requirement to report data on race, ethnicity, sex, primary language, and disability status through a phased-in approach by starting with a subset of measures so that obstacles can be identified and corrected before the policy is more broadly applied.**
- **ACP strongly recommends that CMS select measures for PQRS that receive a Measure Applications Partnership (MAP) recommendation of “support.” Measures given the “encourage continued development” recommendation should be resubmitted to the MAP once the suggested development occurs.**

#### ***Request for Input on Provisions Included in MACRA***

##### Low-Volume Threshold

- **The College recommends that CMS implement a low-volume threshold in a manner similar to PQRS.** An EP should potentially be eligible if he/she has as few as one Medicare Part B patient for participation in MIPS.
- **ACP recommends that CMS consider determining the statistical reliability of results in a manner similar to its determination of minimum episode count for the Medicare Spending per Beneficiary (MSPB) measure for the cost component of the value-based modifier program.**
- **ACP also recommends that practices and solo EPs with insufficient numbers of claims/patients to yield statistically valid, reliable results when calculating performance on measures should be exempted or held harmless from MIPS performance scoring.**
- **The College further recommends that CMS develop a hardship exceptions process for MIPS through which EPs can apply to CMS on a case-by-case basis with special circumstances that warrant exclusion from MIPS for a performance period.**

##### Clinical Practice Improvement Activities

- **ACP appreciates that Congress recognized the value of the Patient-Centered Medical Home (PCMH) by mandating in MACRA that PCMHs and PCMH specialty practices receive full credit for the clinical practice improvement activities performance category.**
- **Therefore, the College recommends that CMS begin considering and seeking feedback on the specific approaches that the Agency will employ to recognize PCMHs and PCMH specialty practices under both the MIPS and Alternative Payment Model (APM) tracks in the future.**

- In addition to the subcategories and examples specified in MACRA, the College believes that any quality improvement activity that an EP is involved in should count toward the clinical practice improvement activities category.
- The College urges CMS to ensure that administrative burden associated with documentation of the clinical practice improvement activities, as well as the cost of performing the activities and submitting documentation is minimal—and constructed to be extremely flexible in the early years as the Agency and the participating clinicians gain experience with this new reporting category.
- Additionally, any practice participating in clinical practice improvement activities under the Transforming Clinical Practices Initiative (TCPI) automatically get full credit for the clinical practice improvement activities category, and no further reporting by the practice should be necessary.

#### Alternative Payment Models

- The College will await the forthcoming request for information (RFI) on alternative payment models to provide more detailed recommendations; however, in advance of that RFI, ACP recommends that CMS:
  - **Harmonize performance measures between the MIPS and APM tracks to the greatest extent possible.**
  - **Develop a strong educational component for existing and future APMs that includes a platform for EPs to share best practices.**
  - **Provide substantial support for practices implementing APMs.**
  - **Announce the grant awards under the Transforming Clinical Practice Initiative immediately to give awardees time to develop and enhance practice transformation supports in advance of the first MACRA performance period.**
  - **Consider extending the use of exceptions (waivers) to current Medicare fee-for service program requirements (e.g., waiver of the skilled nursing facility 3-day hospital stay rule, post-acute care referral limitations, home health homebound requirement, co-payments, and telehealth requirements) for APMs when relevant.**
  - **Create safe harbor protections related to antitrust laws for all APMs to promote care coordination and efficient resource use.**
  - **Fast-track the development of and testing of additional models through CMMI that are focused on primary care (i.e., PCMH-like models including the Comprehensive Primary Care initiative (CPC)), specialty practice-focused models (i.e., PCMH-medical neighborhood), and models designed for small practices (see also comments on the proposed CPC initiative expansion below).**
  - **Develop stronger contractual agreements with other payers in multi-payer APMs such as the CPC initiative to ensure that all payers participate in the program for the duration (see additional comments on multi-payer participation in our comments on the CPC initiative expansion).**

- Ensure availability in a timely manner of data related to the utilization of clinical services by attributed beneficiaries—including mental health and substance abuse-related services.
- Include organizations that are participating within the Medicare Shared Savings Program (MSSP) one-sided risk option in the Agency’s definition of entities bearing more than nominal financial risk for the purposes of qualifying as an APM under MACRA.
- Release the final rule outlining the MIPS and APM requirements for the initial performance period (CY 2017) no later than mid-year 2016 to ensure sufficient time for EPs to evaluate their options and adjust their practices to the new payment system.

***Electronic Clinical Quality Measures (eCQM) and Certification Criteria and Electronic Health Record (EHR) Incentive Program— Comprehensive Primary Care (CPC) Initiative and Medicare Meaningful Use Aligned Reporting***

- The College supports the change from certifying the capability to calculate and report individual eCQMs to certifying the capability to support the underlying eCQM standards (QRDA I and III as well as CMS specified "form and manner").
- The College supports changing the certification process from one focused on certifying for individual measures to one focused on certifying the ability to produce the measure reporting formats. However, ACP is concerned that EPs reporting MU for the first time who choose to use the CPC group reporting for the CQMs will be penalized in 2017 for not meeting MU requirements in 2016. **While the College understands that the timing of reporting for EPs in this situation makes it difficult for CMS to follow its normal procedure, ACP recommends that CMS refund the 2017 penalty for these EPs at a later date.**

***Potential Expansion of the Comprehensive Primary Care (CPC) Initiative***

- ACP strongly supports the expansion of this initiative both to additional geographic regions, as well as in existing CPC initiative areas. The College also supports continued support and evaluation of the model with the current CPC initiative participants. It is imperative that practices continue to receive support as they further refine their processes to cut costs and improve quality. **The College offers the following additional comments addressing the expansion issues specifically identified within the proposed rule:**
  - **ACP believes that it is not appropriate to require the use of a currently certified EHR system as a condition of participation in any program other than the CMS EHR Incentive Program. The current certification program is designed to meet the needs of the EHR Incentive Program only. It specifies functionality that is not required for the purpose of this CPC initiative, and it fails to address the many functionalities required for the delivery of true comprehensive primary care (such as functions required for care planning and care management).**
  - **Given the large number of patients with behavioral health needs that present themselves within the primary care setting, the College recommends addressing**

**behavioral health issues as an additional milestone.** This milestone could be added as the next phase for current CPC initiative participants.

- **ACP strongly urges consideration of ways to minimize what has been described as the “immense” reporting burden associated with meeting the milestones.**
- **Given the very promising early data recently released regarding the CPC initiative, the College recommends a hybrid approach to expansion—one that allows expansion within existing CPC regions and expansion to new regions where the required payer and clinician interest exists.**
- **The College recommends increased opportunities within the program (and in any expansion) for the sharing of best practices and opportunities to collaborate and network to address barriers encountered by participating practices.**
- **The College recommends that CMS carefully analyze this potential policy issue to determine if CPC initiative participants can be put at a disadvantage compared to their colleagues that are not participating in these models but who can bill for the CCM code.**

### ***Medicare Shared Savings Program***

#### **Proposed New Quality Measure**

- **The College has significant concerns with the proposed measure and recommends that CMS further develop and get endorsement of a measure that more adequately addresses this important issue.**
- **The College suggests that maintaining a measure as or reverting a measure to pay-for-reporting when the measure owner has determined that the measure no longer meets best clinical practices is NOT the most appropriate way to handle such situations and requests that CMS further explore their authority to immediately SUSPEND measures that are determined no longer to be valid. Thus, the College recommends that the measure not be expanded.**
- **ACP recommends that the goal within the MSSP should not be the achievement of higher levels of health information technology (HIT) adoption.**
- **ACP recommends that the measures used should reflect the achievement of specified functionalities determined to be related to the delivery of high value care.**

### ***Value-Based Payment Modifier (VM) and Physician Feedback Program***

- **The College supports transitioning our health care system to a value-based payment approach. Additionally, we appreciate that CMS made only minimal changes to the VM program for performance year 2016 given that this is the final performance period prior to the implementation of MIPS.**
- **The College recommends reducing the maximum payment at risk in the VM to 2.0 percent for group practices with 10 or more EPs.**
- **ACP recommends that CMS continue to hold solo EPs and small group practices (2-9 EPs) harmless from downward payment adjustments for an additional year.**
- **The College supports allowing groups in which at least 50 percent of the EPs meet the criteria to avoid the PQRS payment adjustment as individuals to be classified in category**



1, regardless of whether the group registers for PQRS GPRO. **ACP recommends that CMS make every effort to extend this policy to the 2017 VM as well.**

## II. Detailed ACP Comments on Proposed Rule

### Determination of Practice Expense (PE) Relative Value Units (RVUs)

The Centers for Medicare and Medicaid Services (CMS) are proposing to make modifications to two steps in the Calculating the Direct Cost PE RVUs methodology. For Step 2, calculate the aggregate pool of direct PE costs for the current year. The proposal is to set the aggregate pool of PE costs equal to the product of the ratio of the current aggregate PE RVUs to current aggregate work RVUs and the proposed aggregate work RVUs. This proposed modification would result in greater stability in the relationship among the work and PE RVU components in the aggregate. It is not anticipated to affect the distribution of PE RVUs across specialties. For Step 7 of the PE methodology, CMS proposes to refine this step to use an average of the three most recent years of available Medicare claims data to determine the specialty mix assigned to each code.

#### **ACP Comment:**

Since it has been almost ten years since CMS conducted its last Physician Practice Expense Information Survey (PPIS), much of the data on practice expense is outdated. **Therefore, ACP urges CMS to conduct a new PPIS to validate the practice expense component of the RVUs. As we move into a new era of physician payment models, the College believes that revalidation of the PE RVUs will be beneficial to the overall structure of physician reimbursement.** ACP believes that accurate valuation of Physician Fee Schedule services is essential, as the Medicare Payment Advisory Commission (MedPAC) and other researchers have described the effect of pricing on the availability and utilization of services. ACP applauds CMS' effort to achieve greater stability in the relationship among the work and PE RVU components in the aggregate. The College also agrees with the idea of using an average of three years of the most recent available Medicare claims data. This will decrease the fluctuation from year to year in determining the specialty mix, especially for low-volume and new services.

### Potentially Misvalued Services under the Physician Fee Schedule

#### Valuing Services That Include Moderate Sedation as an Inherent Part of Furnishing Procedures

To establish an approach to valuation for all Appendix G services based on the best data about the provision of moderate sedation, CMS needs to determine the extent of the misvaluation for each code. Therefore, CMS is seeking recommendations from the Resource-Based Relative Value Scale Update Committee (RUC) and other interested stakeholders for appropriate valuation of the work associated with moderate sedation before formally proposing an approach that allows Medicare to adjust payments based on the resource costs associated with the moderate sedation or anesthesia services that are being furnished.

#### **ACP Comment:**

**ACP recommends that there be a standard RUC survey to determine the work and direct practice expense inputs of moderate sedation. Codes that contain moderate sedation**

(appendix G codes) should have the work value and direct practice expense inputs removed, which would allow the moderate sedation to be separately reported.

ACP also recommends explicit recognition that several different code sets would be required:

- **Option 1 - The physician performing the procedure provides moderate sedation. In this situation, provision of moderate sedation could be more intense work than if the same sedation was performed by a different clinician, dedicated solely to the moderate sedation. This possibility highlights the importance of proceeding with the RUC process for evaluating the physician work.**
- **Option 2 – A different clinician performs the moderate sedation. That clinician may or may not be an anesthetist.**
- **Option 3 - An anesthesiologist provides deep sedation (i.e., propofol or other sedatives).**

There must be a distinction between moderate sedation and deeper levels of anesthesia (deep sedation or other forms of monitored anesthesia care). Recognizing that greater than 50 percent of colonoscopies, for example, now involve anesthesia care, the current inappropriate distribution of work RVUs and practice expense needs to be corrected. Such variation in anesthetic care for many endoscopies (respiratory as well as gastrointestinal) and other procedures highlights the need for the three different types of coding outlined above to ensure proper relative valuation and payments for the differing types of services.

#### Improving the Valuation and Coding of the Global Package

Beginning in CY 2019, CMS must use the information collected, as appropriate, along with other available data to improve the accuracy of valuation of surgical services under the PFS. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) authorizes the Secretary, through rulemaking, to delay up to 5 percent of the PFS payment for services for which a physician is required to report information until the required information is reported. CMS is soliciting comments from the public regarding the kinds of auditable, objective data (including the number and type of visits and other services furnished by the clinician reporting the procedure code during the current post-operative periods) needed to increase the accuracy of the values for surgical services. The Agency is also seeking comment on the most efficient means of acquiring these data as accurately and efficiently as possible.

#### ***ACP Comment:***

**ACP recommends that CMS use the additional time from the delay in collecting data on global periods to develop a methodology to fairly re-allocate malpractice RVUs for services converting from a 90- or 10-day to a zero-day global period.**

Data collected from large group practices for CPT code 99024 (Post-operative follow-up visit), which is normally included in the surgical package, could be examined to determine if an evaluation and management (E/M) service(s) was performed during a post-operative period for reasons related to the procedure.

Alternatively, CMS, along with the RUC, could also review the Medicare Part A claims data to determine the length of stay of surgical services performed in the hospital facility setting. Matching the average length of stay with the post-operative visits in the physician time file would provide the opportunity to identify anomalies within the data set that could be further reviewed. The RUC, working along with CMS, could review post-operative visit length of stay data for outliers.

### **Refinement Panel**

Beginning in CY 2016, CMS is proposing to eliminate the refinement panel and instead publish the proposed rates for all interim final codes in the PFS proposed rule for the subsequent year. With this change the proposed codes adopted in the CY 2015 final rule are being valued in the CY 2016 PFS proposed rule. This process will allow for stakeholder comments at the time of proposal of valuation for codes and when the value is set.

#### ***ACP Comment:***

Historically, ACP physician members have served in an advisory capacity to the Multi-Specialty Refinement Panel, providing an independent and unbiased primary care physician voice to the process. ACP has concerns with the elimination of this panel and solely relying on agency staff to determine if the comment is persuasive in modifying a proposed rule. **The College recommends that CMS maintain an objective and transparent formal appeals process that is consistently applied and open to any organizations that would like to comment.**

### **Improving Payment Accuracy for Primary Care and Care Management Services**

#### **Improved Payment for the Professional Work of Care Management Services**

ACP is encouraged that CMS remains committed to supporting primary care and recognizing care management as one of the critical components of primary care that contributes to better health for individuals and reduced expenditure growth. Patient care is evolving and becoming increasingly more complex. Caring for patients with chronic illness requires care outside of the office visit, much of which not captured in statistical data or separately reimbursed under current Medicare guidelines.

The internal medicine/primary care physician, in addition to spending time treating acute illnesses, spends substantial time working toward optimal outcomes for patients with chronic conditions and patients who they treat episodically, which can involve additional work not reflected in the codes that describe E/M services. This additional work is not typical across the wide range of clinicians who report the same codes. It involves medication reconciliation, the assessment and integration of numerous data points, effective coordination of care among multiple other clinicians, collaboration with team members, continuous development and modification of care plans, patient or caregiver education, and communication of test results.

#### ***ACP Comment:***

**As an immediately achievable step towards CMS' goal of managing chronic disease, the College recommends that CMS employ tools that already exist in CPT by establishing Medicare payment for existing CPT codes that describe non-face-to-face evaluation and**

management services. **ACP recommends that CMS investigate the adequacy of payment for physician services that typically take place outside of a face-to-face patient encounter. The College urges CMS to recognize non-face-to-face services that enable primary care physicians who provide chronic disease management and care coordination to provide valuable and timely care to their patients.** The Agency has declined to provide separate Medicare payment for these services—consistently considering them bundled into the payment made for E/M services or as Medicare non-covered services—despite the CPT Editorial Panel and the RUC taking extreme care to establish protections in the code description and the relative value recommendation that would prevent duplicate payment for the same work.

**ACP strongly recommends CMS reimburse the following non-face-to-face services, which have been surveyed and valued by the RUC:**

**Telephone Services (99441 - 99443):** a recent study<sup>1</sup> has shown that a primary care physician receives on average 23.7 telephone calls per day of which more than a third of the phone calls are for a new acute problem. ACP's position has always been to have CMS pay for such services. The majority of these calls (79.7 percent) are handled directly by the primary care physician and should not be overly diluted if they are paid for, regardless of the specialty. In addition, other cognitive internal medicine services are also provided over the phone.

**Prolonged Service without Direct Patient Contact (99358 - 99359):** the purpose of these codes would be primarily to tackle new issues that arose out of review of lab results or other studies that are then subsequently managed over the phone or via email. These codes could also apply to reading and interpreting letters from consultants and incorporating that information into the patient's care plan. Again, these codes are not exclusive to primary care, but the College believes that primary care will benefit the most from these codes, followed by cognitive specialists. For consistency, these codes should be allowed to be billed with smaller parcels of time, even with the same time durations as the phone codes.

Existing non-face-to-face services that ACP feels should be paid by CMS are:

- Anticoagulant Management (99363 and 99364);
- Medical Team Conference (99366 - 99368);
- Care Plan Oversight Hospice/Home Care NH (99374 - 99380);
- Interprofessional Consultation (99446 - 99449);
- Telephone Services (99441 - 99443);
- Prolonged Service without Direct Patient Contact (99358 - 99359);
- On-line Medical Evaluation (99444);
- Education and Training for Patient Self-Management (98960 - 98962); and

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<sup>1</sup> What's Keeping Us So Busy in Primary Care? A Snapshot from One Practice. Richard J. Baron, M.D. N Engl J Med 2010; 362:1632-1636 April 29, 2010 DOI: 10.1056/NEJMon0910793.  
<http://www.nejm.org/doi/full/10.1056/NEJMon0910793>.

- Review of Data/Preparation of Special Reports (99090, 99091).

### Diabetic Care Management

The College encourages CMS to use payment approaches that are aligned with the goal of moving payments away from volume to value-based care such as by exploring bundling of codes for certain chronic diseases.

#### ***ACP Comment:***

**ACP recommends that a code bundle for Diabetic Care Management (DCM) be developed to emphasize better care coordination, communication, and integration of the care team aimed at a better overall outcome and cost of care for the Medicare beneficiary.**

**ACP also recommends that Medicare cover evidence-based lifestyle modification programs under the traditional Medicare benefit, such as the Diabetes Prevention Program<sup>2</sup> or the Stanford Chronic Disease Management Program.<sup>3</sup>**

### Collaborative Care Models for Beneficiaries with Common Behavioral Health Conditions Establishing Separate Payment for Collaborative Care

#### *E-consultation Codes*

The RUC has surveyed and valued codes for Interprofessional Consultation (99446 - 99449) for the use of the consultant.

#### ***ACP Comment:***

**The College recommends that CMS create a code and provide reimbursement for e-consultations both between hospitalists and primary care physicians and specialists and primary care physicians. CMS could use the existing codes and create a modifier or use an existing modifier such as modifier 27 to allow the primary care clinician to bill and be reimbursed for such consultation services or create a separate code for the primary care clinician.**

In the changing environment of patient care, patients are being admitted to hospitals that are likely unaware of the patient's history. Because some hospitals and insurance companies have chosen to exclude the primary care physicians from admitting patients to the hospital, there can be a deficiency in communication between hospitals, hospitalists, and the patient's primary care physician, which may lead to unnecessary or ineffective services (e.g., unnecessary testing, medications prescribed that the patient previously used without success, etc.). This leads to poorer outcomes and unnecessary costs that could be avoided if the primary care physician was consulted.

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<sup>2</sup> [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(09\)61457-4/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)61457-4/fulltext)

<sup>3</sup> <http://patienteducation.stanford.edu/programs/cdsmp.html>

When a hospitalist does ask the patient’s primary care physician to consult on the patient’s care (most often via e-consultation/telephone), the primary care physician’s service must be viewed as medically necessary concurrent care, especially when the hospitalist and primary care physician are of the same specialty. ACP believes that recognizing the value that the patient’s primary care physician brings to the hospital in these situations is critically important. The creation and recognition of an e-consultation code would align with the Agency’s broader payment reform efforts to decrease unnecessary testing, numerous specialty consultations, and prolonged hospitalizations, thus leading to decreased costs of hospitalizations. Further, evidence suggests there are benefits in primary care physicians being involved with patient care in a hospital setting in terms of both improved outcomes and cost savings to the health system. Gorroll and Hunt make the case for this model in the January 22, 2015, issue of the *New England Journal of Medicine*.<sup>4</sup>

Patients with chronic conditions often also require consultations and care from specialty/subspecialty physicians. Recent studies<sup>5</sup> reflect that many of these specialist/subspecialist visits can be avoided and care effectively provided through the use of e-consultations between the primary care and referred to specialty/subspecialty physician. This approach speeds up the delivery of care (long waiting-list time is avoided), allows the patient to obtain needed care without unnecessarily taking off from work or other responsibilities, and is a cost savings to the payer.

### *Behavioral Health Services*

CMS is interested in receiving comments on ways to recognize different resources (particularly in cognitive work) involved in delivering broad-based, ongoing treatment beyond those resources already incorporated in the codes. One potential code specifically described in the rule recognizes the importance of addressing behavioral health issues in the provision of comprehensive primary care --- the provision of behavioral health care within the “Collaborative Care” model.

“Collaborative Care” is an evidence based approach to caring for patients with common behavioral health conditions. Collaborative Care is typically provided by a primary care team, consisting of a primary care physician and a care manager, who works in collaboration with a psychiatric consultant. The psychiatric consultant provides regular consultations to the primary care team to review the clinical status and care of patients and make recommendations. CMS is seeking comment on how this coding under the PFS might facilitate appropriate valuation for services delivered in a “collaborative care” model.

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<sup>4</sup> Allan H. Gorroll, M.D., and Daniel P. Hunt, M.D. “Bridging the Hospitalist–Primary Care Divide through Collaborative Care.” *N Engl J Med* 2015; 372:308-309. <http://www.nejm.org/doi/full/10.1056/NEJMp1411416>

<sup>5</sup> A. Chen and H. Yee. Improving Primary Care–Specialty Care Communication ARCH INTERN MED/VOL 171 (NO. 1), JAN 10, 2011. <http://archinte.jamanetwork.com/article.aspx?articleid=226311&resultClick=3>

**ACP Comment:**

The College supports CMS' recognition of the need to value the delivery of behavioral health services within the Physician Fee Schedule and offers the following recommendations:

- **The College recommends that the described “collaborative care” model be initially implemented by the Center for Medicare and Medicaid Innovation (CMMI) through a demonstration project and be rapidly expanded within Medicare through the Secretary’s authority based upon the results and learnings of this demonstration.** While there is substantial evidence in the literature in support of the general tenets of the model (particularly addressing depression and anxiety), we believe there are a significant number of questions that need to be addressed prior to full implementation throughout the variety of types of practices and geographic areas covered under the Medicare program. These include:
  - What is the set of conditions (and related screenings) that would qualify for this type of “bundled payment?”
  - What are the minimal staff and infrastructural requirements to support this model?
  - What are the specific functionalities required by staff within the case manager and behavioral health consultant roles?
  - Given the lack of availability of adequate qualified behavioral health workforce (psychiatric and other mental health professionals) in many geographic areas, what degree of flexibility will there be regarding the training/licensing of individuals assuming the case manager and consultant roles will support effective care?
  - What are the minimal communication and staff “time spent” requirements to qualify for payment under this code?
  - What performance measure(s) should be required to ensure true integration is taking place and quality services are being provided?
- **The College further recommends that CMMI, through a request for proposals (RFP) procedure, should encourage the testing of evidence-based models, in addition to the specific “collaborative care model,” to address the full gamut of behavioral health issues present within the primary care setting.**
- **Finally, ACP recommends the immediate inclusion of changes within the PFS to recognize the importance of non-face-to-face consultations between primary care physicians and consulting specialists—in this case a behavioral health specialist—by providing coverage of e-consultation codes (as referenced in the College’s comments above).** This would have the effect of immediately supporting the efforts of primary care physicians addressing behavioral health needs ---- particularly for patients who are not progressing or for whom the intensity of the problem is beyond the competencies of the treatment team. This is consistent with our comments above regarding establishing separate payment for collaborative care more generally between primary care and other specialty physicians.

### Chronic Care Management (CCM) Code

In CY 2013, CMS implemented separate payment for transitional care management services, and in CY 2015, implemented separate payment for CCM services. Both have many service elements and billing requirements that the physician or non-physician clinicians must satisfy in order to fully furnish these services and to report these codes. These elements and requirements are relatively extensive and generally exceed those for other E/M and similar services. Since the implementation of these services, it has become apparent that some of the service elements and billing requirements are too burdensome.

The original CCM code that the RUC recommended to CMS was for 1 hour of non-face-to-face services; however, CMS ultimately approved only 20 minutes of services per month in the 2015 physician fee schedule final rule.

#### ***ACP Comment:***

**ACP strongly recommends that CMS develop add-on codes for time increments greater than 20 minutes such as 21-40 min; 41-60 min; and greater than 1 hour.** For patients who are frail with more severe multiple chronic conditions, time spent by clinical staff unquestionably reaches 45 to 60 minutes. In order to meet the needs of physician practices, particularly small practices, and encourage involvement in chronic care management services, a valuation that truly incentivizes clinicians is needed—one that is based on the resources required to perform chronic care management.

When CMS originally proposed coverage of CCM in July 2013 (in the CY 2014 Proposed Rule), the Agency proposed to cover two codes. This original proposal provided a means for compensation if significantly more non-face-to-face time than the specified 20 minutes is needed during the 30-day period. ACP further recommends that the values for the add-on codes describe each additional 20 minutes of service with the same values proposed for code 99490 (i.e., an RVU of 0.61 for each additional 20 minutes of clinical staff time). This would allow for 0.61 work RVUs for the initial 20 minutes of time spent with the patients having multiple chronic conditions and 0.61 additional work RVUs for the physician supervision and oversight of each additional 20 minutes of time for patients that require more time and additional resources.

Additionally, the electronic sharing of the care plan creates administrative burdens for the use of the CCM code. As ACP noted last year in our response to the proposed and final rules and in our recent comments on electronic health record (EHR) certification, care plan data requirements, as laid out by CMS, are not fully supported by any currently existing EHRs and may result in some clinicians having to both enter and maintain duplicative information in multiple systems or split what should be a single clinical data repository into multiple disconnected systems. **ACP recommends that the electronic care plan sharing requirement be suspended until such time that EHRs have the ability to support such capabilities.**

Finally, ACP is concerned about the issue of a patient co-payment for the CCM code, as it is widely recognized as a barrier to code utilization and causes additional burden, and feels



compelled to raise this concern. However, the College understands that CMS believes that the Agency lacks the authority to change this requirement absent a change in statute.

### **Target for Relative Value Adjustments for Misvalued Services**

The Protecting Access to Medicare Act of 2014 (PAMA), enacted on April 1, 2014, established an annual target for reductions in PFS expenditures that should result from adjustments to relative values of misvalued codes. This section of PAMA applied to CYs 2017 through 2020 and set the target at 0.5 percent of the estimated amount of expenditures under the PFS for each of those 4 years. Under PAMA, if the estimated net reduction for a given year is equal to or greater than the target, then the reduced expenditures will be redistributed in a budget-neutral manner within the PFS—with any reductions exceeding this target being treated as a net reduction for the succeeding year. However, if the estimated net reduction in expenditures for a year is less than the target, then fee schedule payments for the year are reduced by the difference between the target and the amount of misvalued services identified in that year. However, the Achieving a Better Life Experience (ABLE) Act, which was enacted in December 2014, doubles the amount of that target, and therefore the amount at risk to be cut to 1 percent cut of all Medicare reimbursements. The ABLE Act also moves up the start date for this target to be met to 2016. Following the 1 percent target for 2016, it sets a 0.5 percent target for 2017 and 2018.

In order to meet the requirements initially established by PAMA and then accelerated by the ABLE Act, CMS is proposing to define the reduction in expenditures as the net result of adjustments to RVUs for misvalued codes to include the estimated pool of all services with revised input values (both increases and decreases in values). The agency notes that this definition would incorporate all reduced expenditures from revaluations for services that are deliberately addressed as potentially misvalued codes, as well as those for services with broad-based adjustments that are redefined through coding changes.

Many codes have also undergone changes in values measured over 3 years rather than 2 years—with the original value in place the first year, the interim value in the second year, and the final value in the third year. CMS outlines a number of potential problems with including these codes in the calculation for the 2016 target and so therefore is proposing to exclude any code value changes for CY 2015 interim values from the calculation of the CY2016 misvalued code target.

Further, CMS is proposing to use the approach of comparing total RVUs (by volume) for the relevant set of codes in the current year to the update year, and then dividing that by the total RVUs (by volume) for the current year. The agency is seeking comment on this approach.

### ***ACP Comment:***

**ACP strongly recommends that CMS review their approach to determine if there are other methods that can be employed to come closer to reaching the target established by the law. The proposed approach results in a net reduction of approximately 0.25 percent of the estimated total amount of expenditures under the fee schedule for CY 2016. Therefore, CMS**

will be 0.75 percent below the target outlined in the ABLE Act, resulting in overall fee schedule payments being reduced by that difference, including reductions to those services that are already universally regarded as being undervalued (e.g., the evaluation and management codes, particularly when they are provided by primary care physicians and many internal medicine subspecialists). These reductions would also impact the newly established transitional care management and chronic care management services, as well as the advance care planning services, if finalized—codes that CMS, ACP, and many others are hoping will increase in use so that their impact on health outcomes and patient experience can be better understood over time. Unfortunately, these laws do not recognize the effort that has been put into the misvalued code project since 2006, which has resulted in a redistribution of more than \$3.5 billion. The requirement in PAMA, subsequently modified by the ABLE Act, for CMS to implement this target almost ten years into the misvalued code project is essentially penalizing physicians for having undergone the difficult work of identifying and re-valuing potentially misvalued codes.

As noted above, CMS proposes to include services rendered that encompass the “revised input values net reduction in expenditures.” ACP does agree with this approach given there has been substantial work on practice expense that has occurred recently, including moderate sedation monitoring time and the film-to-digital migration.

However, ACP does not agree with the approach the Agency has proposed of excluding existing codes with large volume changes. CMS noted that these existing codes would not be included in the target reduction because inputs are not changing. **However, the College strongly recommends that codes with such large volume changes, due to a new structure of the codes, be included in the target for reductions.** These codes should be included because the utilization of these services is changing, with these changes being related to the activity of either the misvalued code project and/or the CPT Editorial Panel. Volume changes could result when large code families of services have changes and codes have been deleted or become obsolete. The RUC identifies these codes within the utilization crosswalk spreadsheet. The addition of the codes to the calculation should move the Agency closer to achieving the required target.

**Finally, ACP urges CMS to establish a transparent process in calculating the “target for relative value adjustments for misvalued services.”** Establishing and publishing an estimated dollar amount as well as the estimated impact on the net target reduction would be an important step in the transparent process. The combined impact and/or the impact of each family of services should be published by CMS. Each year CMS should publish the exact target reduction number and individual service-level impacts; this would ensure that the stakeholder community can fairly and accurately calculate the published reduction.

#### **Phase-in of Significant RVU Reductions**

PAMA specifies that for services that are not new or revised codes, if the total RVUs for a service for a year would otherwise be decreased by an estimated 20 percent or more as compared to the previous year, the adjustments in work, PE, and MP RVUs should be phased in

over a 2-year period. PAMA required that this phase-in process begin in 2017; however, the ABLE Act accelerated the phase-in to begin in CY 2016.

CMS is proposing to apply this phase-in to all services that are described by the same unrevised code in both the current and update year and to exclude codes that describe different services in the current and update year. The agency is also proposing to estimate the total RVUs for a service prior to the budget-neutrality redistributions that will result from implementing phase-in values. Additionally, rather than phasing-in these value changes with an approach of 50 percent the first year and 50 percent the second year (which could result in some value changes near, but just below, the 20 percent threshold experiencing a significantly higher reduction in one year than other codes values that are at or just above the 20 percent threshold), CMS is proposing to consider a 19 percent reduction as the maximum first year reduction, with any remaining reduction occurring in the second year. The agency is seeking comment on this approach.

***ACP Comment:***

**ACP supports CMS' proposal of a 19 percent reduction as the maximum first year reduction, with any remaining reduction occurring in the second year. However, in line with an open and transparent process, CMS should establish a consistent methodology for codes with phased-in RVU reductions and ensure stakeholders are fully aware of the impact the net target reduction will have on physician payment.**

**Valuation of Specific Codes**

In the calendar year 2015 PFS final rule with comment period, CMS finalized a new process for establishing values for new, revised, and potentially misvalued codes. Under the new process, CMS includes proposed values for these services in the proposed rule rather than establishing them as interim final in the final rule with comment period. Calendar year 2016 is the transition year for this new process. For 2016, CMS is proposing new values in the proposed rule for the codes which they received complete RUC recommendations by February 10, 2015. For recommendations regarding any new or revised codes received after the February 10, 2015, deadline, including updated recommendations for codes included in this proposed rule, CMS will establish interim final values in the final rule with comment period, consistent with previous practice. CMS has noted that the Agency will consider all comments received in response to proposed values for codes in this rule, including alternative recommendations to those used in developing the proposed rule. If the RUC or other interested stakeholders submit public comments that include new recommendations for codes for which the agency proposed values as part of this proposed rule, CMS would consider those recommendations in developing final values for the codes in the CY 2016 PFS final rule with comment.

**Lung Cancer Screening Counseling and Shared Decision-Making Visit (GXXX2)**

CMS has proposed to value the lung cancer screening counseling and shared decision-making visit (GXXX2) using a crosswalk from the work value for G0443 (Brief face-to-face counseling for alcohol misuse, 15 minutes), which has a work RVU of 0.45. The Agency added 2 minutes of pre-service time and 1 minute post-service time, which they valued at 0.0224 RVU per minute,

yielding a total of 0.062 additional RVUs, which were then added to 0.45, bringing the total proposed work RVUs for GXXX2 to 0.52. The direct PE input recommendations from the American College of Radiology were refined according to CMS standard refinements and appear in the CY 2016 proposed direct PE input database.

***ACP Comment:***

**ACP applauds CMS for the way the agency has structured code GXXX2 for shared decision-making visits for chest CTs. The College recommends that CMS clarify this code to specify that the structure allows the code to be used as a stand-alone code or with an E/M with the modifier 25, with no disease-specific diagnosis, specialty, or frequency edits intended, and it can be billed by multiple different clinicians as the patient considers the issue (e.g., primary care, pulmonologist, and diabetologist or rheumatologist). The services can be provided in the context of an E/M (however in this context the clinician would forego the opportunity to code them separately). Given that this code is for a screening service, ACP recommends that CMS specify that this code will not require a co-payment.**

Advance Care Planning

For CY 2015, the CPT Editorial Panel created two new codes describing advance care planning (ACP) services: CPT code 99497 (Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional; first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate); and an add-on CPT code 99498 (Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health profession; each additional 30 minutes (List separately in addition to code for primary procedure)).

For CY 2016, CMS is proposing to assign these codes a PFS status indicator “A” which is defines as: “Active code. These codes are separately payable under the PFS. There will be RVUs for codes with this status.” The presence of an A indicator does not mean that Medicare has made a national coverage determination regarding the service. Contractors remain responsible for local coverage decisions in the absence of a national Medicare policy. CMS is proposing to adopt the RUC –recommended values for CPT codes 99497 and 99498 beginning in CY 2016 and will consider all public comments that they receive on this proposal. Advance care planning code(s) should be reported when the described service is reasonable and necessary for the diagnosis or treatment of an injury or illness. However, advance care planning services do not necessarily have to occur on the same day as an E/M service.

***ACP Comment:***

**ACP applauds CMS for its decision to allow Medicare reimbursement for advance care planning services. This is an important step to improve care for Medicare patients with serious illness.** ACP believes that access to these voluntary services under Medicare provides people important and often timely opportunities to think about, establish, and document their goals of care, preferences, and proxy decision-maker in the event that they can no longer speak

for themselves. As CMS notes, “advance care planning is a service that includes early conversations between patients and their practitioners, both before an illness progresses and during the course of treatment, to decide on the type of care that is right for them.”<sup>6</sup> The visit should focus on discussion and counseling and may include a review of forms. More specifically, these discussions include addressing the patient’s current disease state, disease progression, available treatments, cardiopulmonary resuscitation, life sustaining measures, life expectancy considering the patient’s age and co-morbidities, and clinical recommendations of the treating physician, as well as reviews of patient past medical history, medical documentation/reports, and response(s) to previous treatments. While the College fully supports CMS’ decision to reimburse for Advance Care Planning services, we favor a consistent approach to ensure that all Medicare beneficiaries have access to these voluntary services. **Therefore, ACP recommends that CMS establish a National Coverage Determination (NCD) for Advance Care Planning to provide consistency in coverage of these important services.** The College appreciates the fact that CMS is allowing Local Coverage Determinations (LCDs) and encourages the contractors to establish these LCDs for coverage of Advance Care Planning beginning January 1, 2016. However, ACP believes that it will ultimately be more beneficial to have a national coverage policy in the future.

The College also appreciates the way the Agency has structured codes 99497 (Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional; first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate); and an add-on CPT code 99498 (Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional; each additional 30 minutes). The College recommends that CMS clarify this code to specify that the structure allows the code to be used as stand-alone code or with an E/M with the modifier 25, with no disease-specific diagnosis, specialty, or frequency edits intended. The services can be provided in the context of an E/M (however in this context the clinician would forego the opportunity to code them separately).

### **Appropriate Use Criteria for Advanced Diagnostic Imaging Services**

In this section, CMS is proposing definitions of terms necessary to implement the Appropriate Use Criteria (AUC) program, which was mandated under the Protecting Access to Medicare Act (PAMA). The agency is particularly seeking comment on the proposed definition of “provider-led entity;” on the AUC development process; on the concept and definition of priority clinical areas; and on a process by which non-evidence-based AUC will be identified and discussed in the public domain. Additional components of the program will be addressed through future rule-making.

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<sup>6</sup> CMS Fact Sheet: Proposed policy, payment, and quality provisions changes to the Medicare Physician Fee Schedule for Calendar Year 2016. July 8, 2015. Accessed at: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-07-08.html>.

The intent of the AUC program is to reduce the utilization of unnecessary and inappropriate advanced imaging services. Starting in January 1, 2017, physicians ordering advanced diagnostic imaging exams (CT, MRI, nuclear medicine and PET) must consult CMS-approved, evidence-based appropriate-use criteria through a Clinical Decision Support (CDS) system. The physicians furnishing advanced imaging services (not the physician that ordered the service) will only be paid if claims for reimbursement confirm that the appropriate-use criteria was consulted by the ordering physician --- only consultation is required. By 2020, ordering physicians who are identified as outliers based on the approved AUC criteria, will have to follow a prior authorization protocol to order these services.

CMS, in this proposed rule, discusses alternative approaches for how to best roll-out AUC into clinical practices, using the results of the Medicare Imaging Demonstration and other private sector efforts to implement imaging AUC. In addition, CMS clearly defines the legislatively required implementation dates for each of the components of the AUC program --- beginning with establishing defined AUC by November 15, 2015, defining mechanisms for AUC consultation by April 1, 2016, and then requiring AUC consultation by ordering clinicians and reporting on these AUC consultations by January 2017. ACP is concerned that this is an overly rapid implementation schedule for a process that will affect a large number of Medicare-participating clinicians.

***ACP Comment:***

**Therefore, ACP strongly recommends that CMS roll-out this project with an initial focus on a limited number of clinical conditions and related AUC.** The CMS defined process to identify priority clinical areas, as outlined within this proposed rule, appears to be an appropriate approach to identify these initial limited number of conditions. **The College further recommends that the roll out begin with health systems and large group practices—along the lines of how the Medicare Value-Based Modifier Program has been rolled out—and, over time, be expanded into the small, independent practice-size setting.** These large entities have the infrastructure to implement more effectively and efficiently the required consultation and reporting procedures, and more likely have previous experience (particularly the large health systems) in employing AUC approaches. These recommendations will help address potential problems associated with the required rapid implementation of the program.

**The College supports the definitions proposed in this rule as first steps to implement the program. However, ACP has concerns regarding the potential of AUC to be used inappropriately to direct referrals for services to entities that have developed, modified or endorsed specific AUC, and that can financially benefit from the service being defined by that AUC.** Thus, we appreciate CMS limiting AUC development, modification, or endorsement to “provider-led entities,” and the inclusion of strong financial interest transparency requirements as part of the qualifying process to be approved as a “provider-led entity.” **We further recommend that the qualifying process for AUC developed, modified, or endorsed that are determined to be “non-evidence based” include a requirement for review by the Medicare Evidence Development and Coverage Advisory Committee (MedCAC) --- rather than that the AUC simply “may be reviewed” --- to determine the adequacy of the supporting elements.**

The College is also pleased to see that the qualifying process requires the publishing of developed criteria, including its authors and evidentiary basis on the “provider-led entity’s” website. The availability of this information will help referring physicians and other clinicians choose those AUC that are most appropriate for the populations they primarily treat.

ACP looks forward to the opportunity to address the large number of additional aspects of importance to this program as they are released for comment through the rulemaking process.

### **Physician Compare**

This section of the proposed rule continues the phased-in approach to developing the Physician Compare website, which includes information on physicians and other eligible professionals (EPs) enrolled in the Medicare program. CMS proposes to make a broader set of quality measures available for publication on the website.

In 2015, an indicator was included if EPs satisfactorily reported four individual PQRS cardiovascular prevention measures. CMS now proposes to also include an indicator for EPs who satisfactorily report on the new Cardiovascular Prevention measures group under the physician quality reporting system (PQRS) (if the measures group is finalized).

CMS proposes to continue to make available for public reporting on Physician Compare on an annual basis the performance rate for all PQRS group practice reporting option (GPRO) measures (across all reporting mechanisms), all measures reported by Shared Savings Program accountable care organizations (ACOs), and all PQRS measures for individual EPs (across all reporting mechanisms).

CMS also proposes to continue to make available for public reporting individual EP-level qualified clinical data registry (QCDR) PQRS and non-PQRS measure data (that have been collected for at least a full year). The Agency also proposes to make available for public reporting group practice-level QCDR PQRS and non-PQRS measure data that have been collected for at least a full year (this is contingent on CMS finalizing the proposal to allow group practice QCDR reporting for PQRS). Each QCDR would be required to declare during self-nomination if it plans to post data on its own website and allow Physician Compare to link to it or will provide data to CMS for public reporting on Physician Compare.

Additionally, the Agency proposes to expand the section on each individual EP and group practice profile page to include a green check mark to indicate those EPs and groups who received an upward adjustment for the value modifier (VM). The 2018 VM would be based on the 2016 payment year quality reporting data. CMS would include information on physician compare on those EPs and groups who will receive 2018 VM upward adjustments no earlier than late 2017. CMS believes that including the check mark is a positive first step in making important information available to consumers in a way that is most likely to be accurately interpreted and beneficial.

**ACP Comment:**

The College supports the overall goals of the Physician Compare Website and supports efforts to improve transparency in the health care system. Transparent health care information is useful for a wide range of stakeholders, and can help patients and their families make more informed health care choices. The College supports alignment with the PQRS reporting and using nationally recognized performance measures and data collection methodology in the Physician Compare Website. Furthermore, ACP supports increased efforts to determine and employ the most effective means of presenting performance information to patients/consumers and to educate these information users on the meaning of performance differences among clinicians, and on how to use this information effectively in making informed healthcare choices. Therefore, ACP is supportive of the proposal to have all measures be available for download and to only include a select group of measures on the webpage. ACP supports working with consumer groups to identify the meaningful measures for consumers and encourages CMS to ensure that measures on the webpage remain patient centered and reflect potential differences in risk/benefit for specific populations.

However, ACP is concerned that including a check mark only for those EPs who receive an upward adjustment for the VM may be confusing to patients. Beneficiaries may assume that every EP without the check mark received a negative adjustment even though the majority of EPs fall into the average group. **Therefore, ACP recommends that CMS hold off on including check marks for the VM until a more adequate system can be implemented that indicates EPs who received no VM adjustment because they are classified as average.**

Additionally, the College is concerned that CMS' review of the CY 2014 submission data and identified errors or inaccuracies in the QRDA I, QRDA III and QCDR data. These errors included missing or incorrect performance rates, missing or invalid numerator data, missing or invalid denominator data and calculation errors. Due to these findings, CMS is unable to use these data to determine quality performance and/or establish benchmarks for the 2014 reporting year and therefore cannot include it on Physician Compare or analyze it for purposes of the VM. ACP is concerned with how consumers might interpret these missing data when using the Physician Compare website as there might be negative connotations associated with physicians who lack quality data on their profile pages. **The College recommends that CMS consider noting on the profile pages of affected physicians that they successfully reported quality data but it could not be analyzed due to circumstances beyond their control.**

New Benchmarking Methodology

CMS proposes to report publicly on Physician Compare an item or measure-level benchmark derived using the Achievable Benchmark of Care (ABC<sup>TM</sup>) methodology annually based on the PQRS performance rates most recently available (e.g., in 2017 report a benchmark derived from 2016 PQRS performance rates). This would only apply to measures deemed valid and reliable and that are reported by enough EPs or group practices to produce a valid result.



***ACP Comment:***

The College is supportive of CMS calculating composite scores for measures as they often are easier for consumers to understand and give a broader picture of clinical quality. **However, ACP recommends that CMS be transparent with regard to the methodology used to calculate these scores and ensure that scores are accurately and appropriately risk adjusted.** If CMS finalizes the ABC methodology for benchmarking, it is crucial that the methodology be subjected to ongoing research and monitoring to ensure that it supports the patient-physician relationship, contributes positively to adoption of best practices, and does not unintentionally undermine patient care, such as by contributing to disparities by penalizing hospitals or physicians who care for poorer or sicker patients.

Future Rulemaking Considerations

For future rulemaking, CMS is seeking comment on:

- The types of quality measures that will help fill gaps and meet the needs of stakeholders and would benefit future reporting on Physician Compare;
- Adding Medicare Advantage (MA) information to group and individual EP profile pages (specifically which MA plans are accepted with a link to more information on the medicare.gov plan finder site);
- Including additional VM cost and quality data on Physician Compare (i.e., an indicator for downward or neutral VM adjustments and cost composite or other VM cost measure data);
- Including open payments data on individual EP profile pages; and
- Including EP and group practice-level quality measure data stratified by race, gender, and ethnicity if feasible and appropriate.

***ACP Comment:***

**The College recommends that CMS look at additional cross-cutting measures for future reporting on Physician Compare (i.e., measures pertaining to influenza, pain assessment and treatment, depression screening, etc.).** These broader measures have the potential to provide consumers with better information to compare across clinicians than condition-specific measures, which can be problematic, especially in the context of patients with multiple chronic conditions. The College supports adding Medicare Advantage information to the group and individual EP profile pages on Physician Compare as well as including open payments data on individual EP pages. Giving patients/consumers additional information on clinicians is important in allowing them to make informed healthcare choices. ACP does not believe that providing quality measure data stratified by race, gender, and ethnicity is appropriate at this time. The College also recommends that CMS consider utilizing the Physician Compare website to begin educating patients on the upcoming changes to Medicare physician quality, cost, and payment data as the Merit-based Incentive Payment System (MIPS) program is implemented.

**Physician Payment, Efficiency, and Quality Improvements – Physician Quality Reporting System**

CMS proposes to include the following reporting mechanisms for PQRS performance year 2016 consistent with previous policy: claims; qualified registry; EHR (including direct EHR products

and EHR data submission vendor products); the GPRO web interface; certified survey vendors, for CAHPS for PQRs survey measures; and QCDR. The complete requirements for satisfactorily reporting PQRs for each reporting mechanism for performance year 2016 are outlined in the table below.

Beginning in 2016, CMS proposes to allow QCDRs to submit quality measures data for group practices. The Agency also proposes to require group practices with 25 or more EPs that register to participate in the PQRs GPRO and select the web interface as the reporting mechanism to select a CMS-certified vendor to collect Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRs data for 2016, whenever possible. This was previously only required for groups with 100 or more EPs. CMS is excluding group practices that report using the qualified registry, EHR, or QCDR mechanisms from this requirement. Group practices that are required or voluntarily elect to report CAHPS will need to select and pay a CMS-certified vendor to administer the surveys. The administration of the CAHPS for PQRs survey will only contain 6 months of data.

***ACP Comment:***

The College appreciates that CMS did not make significant changes to PQRs reporting requirements for CY 2016. Given that this is the final reporting period prior to implementation of MIPS, maintaining stability in requirements is important as practices prepare for selecting which track to participate in under MACRA. ACP also supports allowing QCDRs to submit quality measures data for group practices.

Additionally, due to continuing low participation rates in PQRs among physicians,<sup>7</sup> **ACP strongly recommends that CMS engage in additional outreach to all practices to encourage them to participate in the PQRs program and work to increase PQRs participation rates.** It is crucial to engage clinicians and practices in quality reporting in 2016 to ease their transition to MIPS in 2017.

ACP supports measuring patient care experiences. However, the College is concerned with expanding the CAHPS requirement to practices with 25 or more EPs that participate using the PQRs GPRO web interface option. Given that CMS requires practices to cover the cost of the administration of the CAHPS survey, this could present a significant financial burden on practices, especially the smaller groups. CMS is requiring the largest group practices (those with 100 or more EPs) to select a certified vendor and take on the financial costs of administering CAHPS for PQRs for the first time in 2015. **Given that we have not yet seen the financial impact or the results of this, ACP recommends that the Agency maintain the application of the CAHPS requirement for only those groups with 100 or more EPs for performance year 2016 as well.**

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<sup>7</sup> Centers for Medicare and Medicaid Services. 2013 Physician Quality Reporting System and eRx Reporting Experience and Trends. Accessed at: [https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2013\\_PQRS\\_eRx\\_Experience\\_Report\\_zip.zip](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2013_PQRS_eRx_Experience_Report_zip.zip)

### Future Rulemaking Considerations

The ACA requires CMS to report data on race, ethnicity, sex, primary language, and disability status. CMS intends to require collection of these data elements within each PQRS reporting mechanism in the future. CMS is seeking comments on the facilitators and obstacles clinicians and vendors may face in collecting and reporting these attributes and on preference for a phased-in approach (i.e., starting with a subset of measures versus requiring across all possible measures and reporting mechanisms).

#### ***ACP Comment:***

**The College recommends that CMS implement this requirement through a phased-in approach by starting with a subset of measures so that obstacles can be identified and corrected before the policy is more broadly applied.** ACP believes that it would be helpful if this information can be pulled out of EHRs. We also note that ethnicity and language preference are data that might not be readily available in many cases.

### Selection of Quality Measures for 2016 and Beyond

In selecting measures, CMS is required to select measures that have been endorsed by a consensus organization that has a contract with CMS, which is currently the National Quality Forum (NQF). However, in the case of a specified area or medical topic determined appropriate by CMS for which a feasible and practical measure has not been endorsed by NQF, the Agency may consider measures that have not been endorsed as long as due consideration has been given to measures that have been endorsed or adopted by a consensus organization. The statute is silent as to how measures that are submitted to the contracted consensus organization (NQF) are developed. The steps for developing measures may be carried out by a variety of different organizations, and CMS does not believe that there need to be specific restrictions on the makeup of organizations doing measures development (i.e., that they are physician-controlled organizations).

Additionally, CMS must establish a pre-rulemaking process under which certain steps occur including convening multi-stakeholder groups to provide input on the selection of measures. This is currently done by NQF through the Measure Applications Partnership (MAP). CMS must make publicly available by December 1 of each year the measures that it is considering for selection, and NQF must provide CMS with the MAP's input by February 1.

Aside from NQF endorsement, CMS requested that stakeholders apply the following considerations when submitting measures for possible inclusion in the PQRS measure set:

- Measures that are not duplicative of another existing or proposed measures
- Measures that are further along in development than a measure concept.
- The Agency is not accepting claims-based-only reporting measures in this process.
- Measures that are outcome-based rather than clinical process measures.
- Measures that address patient safety and adverse events.
- Measures that identify appropriate use of diagnosis and therapeutics.
- Measures that include the NQS domain for care coordination and communication.

- Measures that include the NQS domain for patient experience and patient-reported outcomes.
- Measures that address efficiency, cost and resource use.

***ACP Comment:***

The College is very concerned that a majority of the new measures that CMS proposes to add to PQRS were given a MAP recommendation of “encourage continued development.” This MAP designation is reserved for measures that often lack strong feasibility and/or validity data. Additionally, very few of the measures that have been proposed are NQF-endorsed or have been submitted to NQF. CMS is required to select measures that are NQF-endorsed unless special circumstances dictate that there is a gap in which NQF-endorsed measures do not exist.

**ACP strongly recommends that CMS select measures for PQRS that receive a MAP recommendation of “support.” Measures given the “encourage continued development” recommendation should be resubmitted to the MAP once the suggested development occurs.**

**Request for Input on Provisions Included in MACRA**

The CMS proposed rule for the Medicare Physician Fee Schedule for Calendar Year (CY) 2016 contained a request for comments on several components of MACRA for both the Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) tracks as outlined below. In addition to these provisions, CMS also solicited comments and recommendations on any additional provisions of MACRA that are not specifically listed in the proposed rule.

**Low-Volume Threshold**

Under MACRA, the HHS Secretary is required to set a low-volume threshold for the purpose of excluding certain clinicians from MIPS. The Secretary may use any of the following criteria in setting the low-volume threshold:

- Minimum number of individuals enrolled under Medicare Part B who are treated by the EP for the performance period involved;
- Minimum number of items and services furnished to individuals enrolled under Medicare Part B by such EP for such performance period; and
- Minimum amount of allowed charges billed by such EP under Medicare Part B for such performance period.

CMS is seeking comment as to what would be an appropriate low-volume threshold for purposes of excluding certain EPs from the definition of a MIPS EP. The Agency is also seeking comment as to whether CMS should consider establishing a low-volume threshold using more than one or a combination of factors or, alternatively, whether CMS should focus on establishing a low-volume threshold based on one factor. CMS invites comments on which factors to include, individually or in combination, in determining a low-volume threshold.

CMS currently uses low-volume thresholds in other reporting programs. For example, EPs and acute care hospitals must meet certain Medicaid patient volume thresholds to be eligible for the Medicaid EHR Incentive Program (in general, 30 percent for EPs and 10 percent for acute care hospitals). The Agency would consider proposing similar thresholds, such as to exclude EPs

that do not have at least 10 percent of their patient volume derived from Medicare Part B encounters from participating in the MIPS. CMS seeks comment as to whether this would be an appropriate low-volume threshold for the MIPS. In addition, the Agency invite comments on the applicability of existing low-volume thresholds used in other CMS reporting programs toward MIPS.

***ACP Comment:***

**The College recommends that CMS implement a low-volume threshold in a manner similar to PQRS.** An EP should potentially be eligible if he/she has as few as one Medicare Part B patient for participation in MIPS. CMS should then consider the validity and applicability of measures based upon an EP or group practice's patient population to ensure that there are valid measures that are applicable to the EP or group practice.

**ACP recommends that CMS consider determining the statistical reliability of results in a manner similar to its determination of minimum episode count for the Medicare Spending per Beneficiary (MSPB) measure for the cost component of the value-based modifier program.** Under the refined CMS methodology, the Agency uses a specialty-adjusted measure to determine the reliability of a measure for different group sizes as the case minimum increases. CMS uses this methodology to ensure that EPs have a sufficient number of episodes for a measure to meet a reliability threshold and avoid applying downward payment adjustments to EPs who have an insufficient number of cases for a measure to be statistically reliable. The Agency should consider taking a similar approach in determining whether an EP meets the low-volume threshold under MIPS.

**ACP also recommends that practices and solo EPs with insufficient numbers of claims/patients to yield statistically valid, reliable results when calculating performance on measures should be exempted or held harmless from MIPS performance scoring. The College further recommends that CMS develop a hardship exceptions process for MIPS through which EPs can apply to CMS on a case-by-case basis with special circumstances that warrant exclusion from MIPS for a performance period.** This might include EPs that are significantly impacted by a natural disaster such as a hurricane or earthquake, adoption of new technology that results in inability to report, etc.

Clinical Practice Improvement Activities

Under MIPS, EPs are evaluated in terms of four different performance categories for purposes of determining the composite performance score: quality, resource use, clinical practice improvement activities, and meaningful use of electronic health records. In the law, clinical practice improvement activities are defined as activities that relevant EP organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, are likely to result in improved outcomes. Clinical practice improvement categories, specified by the Secretary, must include at least the following subcategories:

- **Expanded practice access**, such as same day appointments for urgent needs and afterhours access to clinician advice;
- **Population management**, such as monitoring health conditions of individuals to provide timely health care interventions or participation in a qualified clinical data registry;
- **Care coordination**, such as timely communication of test results, timely exchange of clinical information to patients and other providers, and use of remote monitoring or telehealth;
- **Beneficiary engagement**, such as the establishment of care plans for individuals with complex care needs, beneficiary self-management assessment and training, and using shared decision-making mechanisms;
- **Patient safety and practice assessment**, such as through use of clinical or surgical checklists and practice assessments related to maintaining certification; and
- **Participation in an alternative payment model.**

CMS is seeking comments on what activities could be classified as clinical practice improvement activities according to this definition.

***ACP Comment:***

ACP appreciates that Congress recognized the value of the Patient-Centered Medical Home (PCMH) by mandating in MACRA that PCMHs and PCMH specialty practices receive full credit for the clinical practice improvement activities performance category. **The College recommends that CMS begin considering and seeking feedback on the specific approaches that the Agency will employ to recognize PCMHs and PCMH specialty practices under both the MIPS and APM tracks in the future.**

**In addition to the subcategories and examples specified in MACRA (listed above), the College believes that any quality improvement activity that an EP is involved in should count toward the clinical practice improvement activities category.** This includes participation in a local quality improvement initiative such as that offered by a local hospital or health system and quality improvement activities done as a part of a program with private insurers. CMS should also consider including participation in a broader range of quality improvement activities such as participation in hospital, health system, or other health care organization’s quality improvement committee.

**Additionally, ACP recommends that CMS include in its classification of clinical practice improvement activities:**

- Documented preventive screenings and vaccinations;
- Participation in quality improvement programs such as Bridges to Excellence;
- Participation in initiatives such as the Million Hearts Initiative; and
- Participation in quality improvement initiatives that are part of a national organization’s program such as ACP Quality Connect programs for adult immunizations and diabetes.

**Finally, in assessing the performance of EPs on clinical practice improvement activities, the College urges CMS to ensure that administrative burden associated with documentation of the activities, as well as the cost of performing the activities and submitting documentation is minimal—and constructed to be extremely flexible in the early years as the Agency and the participating clinicians gain experience with this new reporting category.** Additionally, any practice participating in practice improvement activities under the Transforming Clinical Practices Initiative (TCPI) should automatically get full credit for the clinical practice improvement activities category, and no further reporting by the practice should be necessary. CMS should link with the Practice Transformation Networks to get information on those practices that are participating in TCPI.

### Alternative Payment Models

MACRA introduces a framework for promoting and developing APMs and providing incentive payments for EPs who participate in APMs, with payment implications for EPs beginning in 2019. CMS is broadly seeking public comment on the topics in this section through this proposed rule. In preparation to implement the changes introduced by the section of MACRA on Promoting Alternative Payment Models, the Agency intends to publish questions for public comment on these amendments through a forthcoming Request for Information (RFI). The Promoting Alternative Payment Models section includes the following provisions:

- Increasing Transparency of Physician-Focused Payment Models and Criteria and Process for Submission and Review of Physician-focused Payment Models;
- Incentive Payments for Participation in Eligible Alternative Payment Models;
- Encouraging Development and Testing of Certain Models;
- A study on Integrating Medicare Alternative Payment Models in the Medicare Advantage payment system; and
- Study and Report on Fraud Related to Alternative Payment Models under the Medicare Program.

CMS intends to publish specific questions in the forthcoming RFI on topics within these provisions, including the following:

- The criteria for assessing physician-focused payment models;
- The criteria and process for the submission of physician-focused payment models eligible APMs, qualifying APM participants;
- The Medicare payment threshold option and the combination all-payer and Medicare payment threshold option for qualifying and partial-qualifying APM participants;
- The time period to use to calculate eligibility for qualifying and partial-qualifying APM participants, eligible APM entities, quality measures and EHR use requirements; and
- The definition of nominal financial risk for eligible APM entities.

In anticipation of the future RFI and subsequent notice and comment rulemaking, CMS welcomes comments on approaches to implementing any of the topics listed in this section, including in provisions not enumerated above, and any other related concerns.

**ACP Comment:**

The College wishes to offer the following recommendations on APMs in advance of the forthcoming RFI. **ACP recommends that CMS:**

- **Harmonize performance measures between the MIPS and APM tracks to the greatest extent possible.** Given the Agency’s goal of tying 30 percent of Medicare fee-for-service payments to quality or value through APMs by 2016 and 50 percent by 2018, it is crucial to have closely aligned performance measures to ease the transition for EPs who want to move from the MIPS to an APM. ACP encourages CMS to consider adopting a core set of measures that are methodologically sound and MAP-endorsed for use in the MIPS and APM programs, perhaps in line with the Brookings Institute recommendation quoted in italics below:

*We recommend reducing the scope of reporting requirements for physicians under MIPS, which are built on existing requirements under PQRS, Meaningful Use, and the Value based Modifier. Instead, physicians in the MIPS program should be required to use patient experience and engagement measures at the individual physician level, as well as a limited number of core measures reflecting the patient conditions they treat. At present, physicians can generally use individual-level Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures; suitable outcome measures are not available for most specialties, but progress is occurring and should be accelerated. The measures should progress over time from appropriateness measures toward use of clinical outcome measures, patient-reported outcomes measures and total patient cost/resource use measures. Individual outcome measures should be used only for certain specialties and procedures/services in which it is feasible and appropriate to attribute the outcomes to a specific physician . . . We recommend that physicians in APMs be expected to measure a similar concise set of meaningful performance measures reflecting these same priorities: clinical outcomes, patient-reported outcomes, patient experience, and appropriateness. These key quality measures should be accompanied by total cost/resource use and efficiency measures. By 2018, such measures should reflect most of the patient care that they provide, as well as for care of their total patient population.<sup>8</sup>*

To that end, the College is currently working with a coalition organized by America’s Health Insurance Plans (AHIP) to identify a smaller core set of quality measures that could be utilized to ease reporting requirements across all payers. ACP encourages CMS to consider utilizing the core set of measures identified through the AHIP coalition pending approval by the organizations involved, which include both physician and consumer organizations and CMS.

- **Develop a strong educational component for existing and future APMs that includes a platform for EPs to share best practices.** The APM structure is foreign to most EPs, and

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<sup>8</sup> <http://www.brookings.edu/~media/research/files/papers/2015/01/012715-medicare-physician-payment-refom-web.pdf>.



a strong education component is crucial to giving practices the tools they need to successfully transition to APMs.

- **Provide substantial support for practices implementing APMs.** It is important that models that CMS tests occur in an environment in which there is substantial multi-payer participation (i.e., substantial payment penetration), a community infrastructure that facilitates necessary data aggregation and exchange, and a strong regional education structure (e.g., collaborative) to support the continued skill building required. Regarding the educational structure, successful implementation of the Transforming Clinical Practice Initiative (TCPI) can potentially fulfill this requirement.
- **Announce the grant awards under the Transforming Clinical Practice Initiative immediately to give awardees time to develop and enhance practice transformation supports in advance of the first MACRA performance period.**
- **Consider extending the use of exceptions (waivers) to current Medicare fee-for service program requirements (e.g., waiver of the skilled nursing facility 3-day hospital stay rule, post-acute care referral limitations, home health homebound requirement, co-payments, and telehealth requirements) for APMs when relevant.** Physicians and practices that are determined to be APM participants should have reduced burdens to allow for greater flexibility in improving care delivery. Burdensome policies including documentation and prior authorization requirements that are applicable to FFS must be eased for APM participants to encourage participation in these types of models of care. Physicians should be able to document what is necessary for appropriate patient care rather than what is required for billing.
- **Create safe harbor protections related to antitrust laws for all APMs to promote care coordination and efficient resource use.**
- **Fast-track the development of and testing of additional models through CMMI that are focused on primary care (i.e., PCMH-like models including the Comprehensive Primary Care initiative (CPC)), specialty practice-focused models (i.e., PCMH-medical neighborhood), and models designed for small practices (see also comments on the proposed CPC initiative expansion below).**
- **Develop stronger contractual agreements with other payers in multi-payer APMs such as the CPC initiative to ensure that all payers participate in the program for the duration (see additional comments on multi-payer participation in our comments on the CPC initiative expansion).**
- **Ensure availability in a timely manner of data related to the utilization of clinical services by attributed beneficiaries—including mental health and substance abuse-related services.** For multi-payer initiatives, CMS must mandate that this data be provided by all payers in a consistent format.
- **Include organizations that are participating within the Medicare Shared Savings Program (MSSP) one-sided risk option in the Agency’s definition of entities bearing more than nominal financial risk for the purposes of qualifying as an APM under MACRA.** The start-up costs alone for an MSSP are estimated to average around \$2 million. ACP believes that this significant cost burden reflects ample financial risk for participating physicians.

- Release the final rule outlining the MIPS and APM requirements for the initial performance period (CY 2017) no later than mid-year 2016 to ensure sufficient time for EPs to evaluate their options and adjust their practices to the new payment system.

**Electronic Clinical Quality Measures (eCQM) and Certification Criteria and Electronic Health Record (EHR) Incentive Program— Comprehensive Primary Care (CPC) Initiative and Medicare Meaningful Use Aligned Reporting**

**Certification Requirements for Reporting Electronic Clinical Quality Measures (eCQMs) in the EHR Incentive Program and PQRS**

Physicians and other EPs participating in PQRS and the EHR Incentive Programs under the 2015 Edition must possess EHRs that have been certified to report eCQMs according to the format that CMS requires for submission. To allow EPs to upgrade to 2015 Edition CEHRT before 2018, CMS proposes to revise the CEHRT definition for 2015 through 2017 to require that EHR technology is certified to report eCQMs, in accordance with the optional certification, in the format that CMS can electronically accept. Rather than requiring certification for each eCQM, this would require technology to be certified to use the HL7 QRDA Category I and III standards and the optional CMS “form and manner.” CMS also proposes to revise the CEHRT definition for 2018 and subsequent years to require that EHR technology is certified to report eCQMs using the same standards. The proposed CEHRT definition for 2015 through 2017 included in the Stage 3 proposed rule allows EPs to use 2014 Edition or 2015 Edition certified EHR technology.

The Agency also proposes to revise the CEHRT definition for 2018 and subsequent years to require that EHR technology is certified to report eCQMs using the same standards. These proposed revisions would apply for EPs, eligible hospitals, and CAHs. CMS is proposing these amendments to ensure that EPs participating in PQRS and the EHR Incentive Programs under the 2015 Edition possess EHRs that have been certified to report eCQMs according to the format that CMS requires for submission.

***ACP Comment:***

The College supports the change from certifying the capability to calculate and report individual eCQMs to certifying the capability to support the underlying eCQM standards (QRDA I and III as well as CMS specified “form and manner”).

**EHR Incentive Program-Comprehensive Primary Care (CPC) Initiative Aligned Reporting**

Under this initiative, CMS pays participating primary care practices a care management fee to support enhanced, coordinated services. Simultaneously, participating commercial, state, and other federal insurance plans are also offering enhanced support to primary care practices that provide high-quality primary care. CPC practice sites are required to report to CMS a subset of the CQMs that were finalized in the EHR Incentive Program Stage 2 final rule for EPs beginning in CY 2014. For 2016, CMS proposes to require CPC practice sites to submit at least 9 CPC CQMs that cover 3 domains (rather than the current requirement of 2 domains). CMS believes that

reporting across 3 domains is reasonable given the increased number of measures in the CPC eCQM set, the sufficient time that CPC practices have had to upgrade their systems, and the fact that this requirements aligns with what is required for the Medicare EHR Incentive Program CQM reporting.

CMS also proposes that for CY 2016, EPs who are part of a CPC practice site and are in their first year of demonstrating MU may use the CPC group reporting option to report their CQMs electronically instead of reporting CQMs by attestation through the EHR Incentive Program's Registration and Attestation System. However, EPs who choose this CPC group reporting option must use a reporting period for CQMs of one full year (not 90 days), and the data must be submitted during the submission period from January 1, 2017 through February 28, 2017. This means that EPs who elect to electronically report through the CPC practice site cannot successfully attest to meaningful use prior to October 1, 2016 (the deadline established for EPs who are first-time meaningful users in CY 2016) and therefore will receive reduced payments under the PFS in CY 2017 for failing to demonstrate meaningful use if they have not applied and been approved for a significant hardship exception under the EHR Incentive Program.

***ACP Comment:***

The College supports changing the certification process from one focused on certifying for individual measures to one focused on certifying the ability to produce the measure reporting formats. However, ACP is concerned that EPs reporting MU for the first time who choose to use the CPC group reporting for the CQMs will be penalized in 2017 for not meeting MU requirements in 2016. **While the College understands that the timing of reporting for EPs in this situation makes it difficult for CMS to follow its normal procedure, ACP recommends that CMS refund the 2017 penalty for these EPs at a later date.**

**Potential Expansion of the Comprehensive Primary Care (CPC) Initiative**

To show CMS's commitment to supporting advanced primary care, the Comprehensive Primary Care (CPC) Initiative was launched by CMMI on October 1, 2012. This four-year multi-payer initiative is a collaboration between public and private health payers to test a payment model consisting of non-visit based, risk-adjusted, per-beneficiary-per-month care management payments and shared savings opportunities. The payment model is designed to support practices in the provision of these five comprehensive primary care functions: 1) Risk-Stratified Care Management; 2) Access and Continuity; 3) Planned Care for Chronic Conditions and Preventive Care; 4) Patient and Caregiver Engagement; and 5) Coordination of Care across the Medical Neighborhood. Participating practices in the seven states or regions must demonstrate progress by meeting nine annual Milestones: 1) budget; 2) care management for high risk patients; 3) access and continuity; 4) patient experience; 5) quality improvement; 6) care coordination across the medical neighborhood; 7) shared decision-making; 8) participate in learning collaborative; and 9) health information technology.

CMS is seeking public comments about issues surrounding a potential expansion of the CPC initiative. The Agency would use additional rulemaking in the future if CMS decides to expand the CPC initiative. Areas that the Agency has identified for potential issues in the expansion are:

- Practice readiness;
- Practice standards and reporting;
- Practice groupings;
- Interaction with state primary care transformation initiatives;
- Learning activities;
- Payer and self-insured employer readiness;
- Medicaid participation;
- Quality reporting;
- Interaction with the CCM fee; and
- Provision of data feedback to practices.

***ACP Comment:***

The College provides the following comments for the requested input pertaining to expansion of the CPC initiative. These comments are reflective of previous comments provided by the College in response to the CMMI Request for Information on Advanced Primary Care Model Concepts.<sup>9</sup> **ACP strongly supports the expansion of this initiative both to additional geographic regions, as well as in existing CPC initiative areas. The College also supports continued support and evaluation of the model with the current CPC initiative participants. It is imperative that practices continue to receive support as they further refine their processes to cut costs and improve quality. The College offers the following additional comments addressing the expansion issues specifically identified within the proposed rule:**

**Practice Readiness:** The College supports baseline requirements for practice participation within any expansion of the CPC initiative provided that those requirements are built upon a demonstrated ability to deliver and perform defined aspects of comprehensive primary care (as reflected by recognition as a PCMH through a national recognition or accreditation program, by a private payer and/or state government program including state Medicaid programs, as well as those developed by national specialty societies, state medical societies, county medical societies, community-based physician groups, or other entities as deemed appropriate), and the ability to monitor and report defined practice level electronic clinical quality measures (eCQMs).

**However, ACP believes it is not appropriate to require the use of a currently certified EHR system as a condition of participation in any program other than the CMS EHR Incentive Program. The current certification program is designed to meet the needs of the EHR Incentive Program only. It specifies functionality that is not required for the purpose of this CPC initiative, and it fails to address the many functionalities required for the delivery of true comprehensive primary care (such as functions required for care planning and care management).**

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[https://www.acponline.org/acp\\_policy/letters/acp\\_comments\\_cms\\_rfi\\_advanced\\_primary\\_care\\_payment\\_2015.pdf](https://www.acponline.org/acp_policy/letters/acp_comments_cms_rfi_advanced_primary_care_payment_2015.pdf).

The College, based on reports from our members, believes that to accomplish the five comprehensive primary care functions required within the CPC initiative, practices will need significant technical and financial support from CMS and other payers. These functions consist of 1) Risk-Stratified Care Management; 2) Access and Continuity; 3) Planned Care for Chronic Conditions and Preventive Care; 4) Patient and Caregiver Engagement; and 5) Coordination of Care across the Medical Neighborhood. The need to provide multi-payer support to practices to make it possible for them to accomplish these comprehensive primary care functions should be available independent of the size or configuration of the primary care practice.

**Practice standards and groupings:** The College, in general, supports the current CPC milestone approach. Current milestones relate to 1) budget; 2) care management for high risk patients; 3) access and continuity; 4) patient experience; 5) quality improvement; 6) care coordination across the medical neighborhood; 7) shared decision-making; 8) participate in learning collaborative; and 9) health information technology. **We recommend the addressing of behavioral health issues as an additional milestone --- given the large number of patients with behavioral health needs that present themselves within the primary care setting. This milestone could be added as the next phase for current CPC initiative participants.**

**ACP strongly urges consideration of ways to minimize what has been described as the “immense” reporting burden associated with meeting the milestones.** One approach to address this problem would be to work toward increased harmonization of the reporting required by CMS and the different payers participating within a CPC initiative geographic region. The College also emphasizes that the meeting of these milestones requires substantial use of financial and human resources on the part of the participating practices --- thus, it is important that the timelines used to gauge progress adequately recognize the required effort.

**Practice Groupings:** **Given the very promising early data recently released regarding the CPC initiative, the College recommends a hybrid approach to expansion—one that allows expansion within existing CPC regions and expansion to new regions where the required payer and physician interest exists.** In considering new regions, the College suggests increased efforts to develop contractual agreements with participating payers that ensures their involvement throughout the full length of the initiative (the College has heard that this has been a problem in some existing regions) and preference given to those regions that have the infrastructure (e.g., a health information exchange, additional (non-CMS) sources of technical support for practice transformation, etc.) to promote comprehensive primary care. As CMS considers expansion of the CPC initiative, consideration should be given to the impact of geography and healthcare delivery patterns. For purposes of calculating shared savings, consideration should be given to grouping practices that have comparable attribution of risk severity. This could encourage practices to continue to provide services to beneficiaries with multiple chronic conditions and high severity of illness.

**Interaction with state primary care transformation initiatives:** The College would support efforts to expand the CPC initiative in regions that are already engaged in a separate primary care transformational effort ---- such an approach has the potential to mutually benefit both

efforts through a sharing of resources and preventing duplication. For example, practices in states that have State Innovation Model grants to integrate behavioral health in primary care would have focused tools and resources already available to supplement what is offered through CPC initiative participation. Nonetheless, we agree that such an expansion may encounter a number of issues with aligning goals and reporting requirements and should be initially approached in a very limited way. Over time, as the CMMI gains experience with this type of situation, fuller expansion in such regions can occur. Obviously, preference should be given to those areas where the requirements and goals of the different programs are maximally aligned and collaboration is occurring.

**Learning Activities:** ACP supports the learning activities that are occurring in the current CPC initiative practices ---- reports from our participating members have been generally quite positive. **The College recommends increased opportunities within the program (and in any expansion) for the sharing of best practices and opportunities to collaborate and network to address barriers encountered by participating practices.**

Besides the learning activities inherent to the CPC initiative, resources scheduled to be provided through the Transforming Clinical Practices Initiative, the continued efforts of quality improvement organizations (QIOs) and HIT Regional Extension Centers in various areas, various related state funded initiatives, and the \$100 million included in MACRA for small practice technical assistance can help complement CPC initiative efforts. The College recommends that CMS give some consideration on how best these additional resources can be used and leveraged.

**Payer (including Medicaid) and self-insured employer readiness:** From the perspective of our members, the crucial issue is the total amount of “penetration” within their patient panels provided by the multi-payers involved in a given region. Regions in which the penetration of participating payers is low would make necessary transformation difficult. As mentioned above, the College further encourages efforts by CMS to develop contractual agreements with participating payers that ensures their involvement throughout the full length of the initiative. Furthermore, the contracts (agreements) with payers should, as much as possible, attempt to align reporting requirements expected from the participating practices, and ensure the delivery of crucial healthcare utilization information to the participating practices from the payers in a usable and timely manner.

**Quality reporting:** A requirement for CPC initiative participation should be a practice's ability to aggregate quality data at the practice level for submission --- this should be a component of the readiness assessment. Quality data aggregation functionality required by this program may not be available in certified EHR systems, as this is not a requirement of the EHR Incentive Program. Therefore, practices will have to acquire this functionality either as an add-on from their vendor or as a service provided by third parties, and both approaches will result in additional costs to the practices that need to be considered. As mentioned above, every effort should be made to harmonize the reporting requirements for all payers.

**Interaction with the CCM payment:** The College supports CMS' efforts to not provide duplicative payments. However, ACP does not agree that the services provided in the CPC initiative are necessarily duplicative of those provided under the CCM code. The workflows that practices currently need to put into place to be successful in the CPC initiative (and other PCMH programs) and to bill the CCM code are not aligned and thus, do not allow the CCM code to be an ideal "on ramp" for practices towards APM participation. Currently, the uptake of the CCM code has been quite limited due to its (overly) strict and burdensome billing requirements. We expect uptake in use of this code to increase over time as CMS refines the code criteria and practices develop effective and efficient ways of meeting the billing criteria. As practices increase the use of the CCM code, at some point it may become a "business decision" regarding whether to participate within the CPC initiative or continue to have the capability to bill for the CCM code. **The College recommends that CMS carefully analyze this potential policy issue to determine if CPC initiative participants can be put at a disadvantage compared to their colleagues that are not participating in these models but who can bill for the CCM code.**

**Provision of data feedback to practices:** The College emphasizes the importance of participating practices receiving timely and actionable data from all payers involved in a geographic region. This includes CMS developing mechanisms to deliver the quarterly feedback reports in a more efficient manner, and increasing efforts to help these practices understand and apply the information included within these reports to deliver more value-oriented comprehensive primary care. In order to inform these suggested improvements, we suggest that CMS make a more intensive effort to elicit feedback from the current CPC initiative practices on the usability of the current reports and on the additional technical support required to turn the data from the reports into action.

### **Medicare Shared Savings Program**

#### **Proposed New Quality Measure**

CMS is seeking comment on the proposed addition of only one new quality measure for the Medicare Shared Savings Program (MSSP) in 2016. The Statin Therapy for the Prevention and Treatment of Cardiovascular Disease measure would be added to the Preventive Health domain. The measure was developed by CMS in collaboration with other federal agencies and the Million Hearts® Initiative and is intended to support the prevention and treatment of cardiovascular disease by measuring the use of statin therapies according to the updated clinical guidelines for patients with high cholesterol.

#### ***ACP Comment:***

The College recognizes and supports the intent of CMS to add this measure that addresses a current important gap in MSSP measures --- addressing the quality of services delivered to patients at high risk of cardiovascular disease due to high cholesterol. Nonetheless, **the College has significant concerns with the proposed measure:**

- The measure has not received the endorsement of the NQF, and review by the NQF Measure Applications Partnership (MAP) encouraged further development --- the College believes that endorsement by a multi-stakeholder group such as the NQF is

important to ensure that a measure is feasible to measure, provides consistent and credible information, and can be used for quality improvement and decision-making.

- The guidelines underlying the proposed measure have been updated and this change is not reflected in the proposed measure.
- The College further believes that there is not enough publicly available information (e.g. report from a field testing) to meaningfully answer the question of whether the measure should be considered a single measure with weighted denominators or three separate measures.

**Thus, ACP recommends that CMS further develop and get endorsement of a measure that more adequately addresses this important issue; recognizing that this would result in a significant delay in the use of this measure within the MSSP program.**

#### Proposed Policy for Measures No Longer Aligning With Clinical Guidelines, High Quality Care or Outdated Measures that May Cause Patient Harm

CMS is proposing to add a new provision to reserve the right to maintain a measure as pay-for-reporting, or revert a pay-for-performance measure to pay-for-reporting, if a measure owner determines the measure no longer meets best clinical practices due to clinical guideline updates or clinical evidence suggests that continued application of the measure may result in harm to patients. This flexibility will enable CMS to respond more quickly to clinical guideline updates that affect measures without waiting, as currently is required, for a future rulemaking cycle to retire a measure or revert to pay for reporting.

#### ***ACP Comment:***

**The College suggests that maintaining a measure as or reverting a measure to pay-for-reporting when the measure owner has determined that the measure no longer meets best clinical practices is NOT the most appropriate way to handle such situations and requests that CMS further explore their authority to immediately SUSPEND measures that are determined no longer to be valid.** It is our understanding that such measure suspensions take place within other CMS quality programs (e.g., inpatient hospital setting). Only if it is clearly determined that CMS must wait to change quality measures through the rulemaking process does the proposed approach seem at all reasonable.

#### Request for Comment Related to Use of Health Information Technology

CMS is not proposing any changes to the current Health Information Technology (IT) measure “Percent of PCPs Who Successfully Meet Meaningful Use Requirements” (ACO-11) at this time. Through this proposed rule, the Agency is seeking comments on how this measure might evolve in the future to ensure that the agency is incentivizing and rewarding EPs for continuing to adopt and use more advanced health IT functionality and broadening the set of EPs across the care continuum that have adopted these tools.

#### ***ACP Comment:***

The College has supported the efforts of CMS and ONC to facilitate the implementation of EHR capability throughout the healthcare system primarily through the Meaningful Use program



and appreciates CMS' and ONC's efforts to address noted problems in that program (e.g., changes in Stage 2 requirements that are pending release). With that said, ACP also believes that the use of health information technology (HIT), in itself, should not be an incentivized goal. Rather, programs such as the MSSP should define specific functionalities that directly improve the value of healthcare delivery, and the participating programs should have the flexibility to innovate and design solutions that fit their individual situations, which may or may not consist of the use of a certified EHR. **Based upon these positions, the College provides the following comments in response to the specific questions posed in the rule:**

1. Although the current measure focuses only on primary care physicians, should this measure be expanded in the future to include all eligible professionals, including specialists?

ACP believes that while the current Meaningful Use criteria (particularly at Stage 1) are generally appropriate for primary care physicians, the general appropriateness of these criteria for most other specialists is less evident. **Thus, the College recommends that the measure not be expanded.**

2. How could the current measure be updated to reward clinicians who have achieved higher levels of health IT adoption?

**ACP, based on the general position outlined above, recommends that the goal within the MSSP should not be the achievement of higher levels of HIT adoption.** The goal, and the measures used to assess the achievement of that goal, should be to incentivize specific functionalities that are related to the delivery of high quality healthcare in an efficient manner.

3. Should CMS substitute or add another measure that would focus specifically on the use of health information technology, rather than meeting overall Meaningful Use requirements, for instance, the transitions of care measure required for the EHR Incentives Program?

**ACP, again based on the position outlined above, recommends that the measures used should reflect the achievement of specified functionalities determined to be related to the delivery of high value care.** So, in the case of a transition of care measure, the goal should be the ability of the program to deliver critical patient information to a transfer setting or to other clinicians involved in patient treatment in a timely manner rather than it necessarily be accomplished through the use of a certified EHR. Specifically related to the transition of care measure, which assesses the exchange of the Summary of Care Document (SoCD), many physicians and other healthcare clinicians have complained that a large number of informational fields included within this template are unnecessary in many situations, thus creating "busy work." There is a call for greater refining and flexibility in the information required.

4. What other measures of IT-enabled processes would be most relevant to participants within ACOs? How could CMS seek to minimize the administrative burden on clinicians in collecting these measures?

As noted above, ACP recommends that CMS create specific defined functionalities that directly improve healthcare delivery while allowing for flexibility to innovate and design individualized solutions that are relevant to each participant within an ACO. CMS can minimize the administrative burden by not tying these defined functionalities exclusively to the achievement of higher levels of HIT adoption or the Meaningful Use program.

#### Minor Technical Changes Regarding PQRS Reporting and Beneficiary Attribution

The proposed rule includes minor technical/methodological changes to further align the MSSP with PQRS reporting and to address attribution issues.

#### ***ACP Comment:***

The College supports the proposed changes to align reporting of EPs within the ACOs in the MSSP to be consistent with the PQRS GPRO. The College also supports the proposal to amend the definition of primary care services at §425.20, for purposes of the Shared Savings Program, to exclude services billed under CPT codes 99304 through 99318 when the claim includes the POS 31 modifier. This change will allow for more appropriate attribution and also remove the inappropriate restriction of ACO participants within that service setting (particularly hospitalists) to only one ACO based on the CMS MSSP exclusivity policy.

#### **Value-Based Payment Modifier and Physician Feedback Program**

Continuing its policy established in the final rule for 2015, CMS proposes to continue to apply the value-based payment modifier (VM) to all physicians based on performance data from payment year 2016. Quality reporting data for performance year 2016 will be used to calculate each EP or group practice's VM for payment adjustment year 2018. In addition to applying the VM in 2018 to all physicians, CMS proposes to expand the group of EPs subject to the VM in 2018 to include physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNSs), and certified registered nurse anesthetists (CRNAs) in addition to all physicians.

CMS proposes to use CY 2016 as the performance period for the CY 2018 VM, consistent with policy in previous years. This would be the final performance period under the current VM and PQRS structures, as the first performance period for both tracks created by MACRA would be CY 2017. CMS proposes to continue to include all PQRS GPRO and PQRS individual reporting mechanisms in the VM for payment adjustment year 2018. All of the quality measures that are available to be reported would be used to calculate a group or solo EP's VM to the extent that data on these measures are submitted. Additionally, CMS proposes to not recalculate the VM upward payment adjustment factor after it is made public unless there was a significant error made in the calculation of the adjustment factor.

**ACP Comment:**

The College supports transitioning our health care system to a value-based payment approach, and ACP looks forward to working with CMS through the Health Care Learning and Payment Action Network to help achieve this goal. The College believes that a new value-based system should facilitate coordinated, comprehensive, longitudinal care provided by physicians working in collaboration with other clinicians. ACP recognizes that CMS is required by law to apply the value modifier to all physicians in 2017. The College appreciates that CMS made only minimal changes to the VM program for performance year 2016 given that this is the final performance period prior to the implementation of MIPS.

Quality Tiering

CMS proposes to continue to use a two category approach for the CY 2018 VM based on participation in PQRS by groups and solo EPs during performance year 2016, as outlined below.

*Category 1:*

- Solo EPs that meet the criteria to avoid the PQRS payment adjustment;
- Groups that meet the criteria to avoid the PQRS payment adjustment as a group practice participating in PQRS GPRO; and
- Groups that have at least 50 percent of the EPs meet the criteria to avoid the PQRS payment adjustment as individuals, regardless of whether the group registers for PQRS GPRO. In previous years, this option was only available to groups that did not register to participate in PQRS GPRO. If technically feasible, CMS proposes to extend this policy to the 2017 VM as well.

*Category 2:* groups and solo EPs that are subject to the 2018 VM and do not fall in category 1 (e.g., those that do not meet the PQRS satisfactory reporting/participation criteria).

Consistent with policy for the previous year, CMS proposes to apply to category 2 EPs (i.e., non-PQRS reporters) an automatic 4.0 percent downward payment adjustment VM to groups of 10 or more EPs and a 2.0 percent downward adjustment VM for solo EPs and groups of 2-9 for payment adjustment year 2018. These VM payment adjustments would be in addition to the 2.0 percent downward payment adjustment for failing to satisfactorily report PQRS data for payment adjustment year 2018 (performance year 2016).

**ACP Comment:**

**The College supports allowing groups in which at least 50 percent of the EPs meet the criteria to avoid the PQRS payment adjustment as individuals to be classified in category 1, regardless of whether the group registers for PQRS GPRO. ACP recommends that CMS make every effort to extend this policy to the 2017 VM as well.**

**The College recommends reducing the maximum payment at risk in the VM to 2.0 percent for group practices with 10 or more EPs.** When combined with the 2.0 percent PQRS penalty, the total amount of combined payment at risk for PQRS and the VM would be 4.0 percent for larger group practices. Because this is the last performance year under the current programs prior to

the implementation of MIPS, we believe it makes sense to make the policy for 2016 consistent with the 4.0 percent maximum downward adjustment in the first year of MIPS (2017).

**Additionally, ACP recommends that CMS continue to hold solo EPs and small group practices (2-9 EPs) harmless from downward payment adjustments for an additional year.** Due to the ongoing low PQRS participation rate for small practices and solo EPs as cited earlier, CMS should focus over the next year on communication with and education of these practices and clinicians to help them learn about the quality reporting system and prepare so that they can ultimately be successful in the transition to MIPS.

#### Policies Related to ACOs, the CPC Initiative, and other Innovation Center Models

Beginning with the CY 2017 payment adjustment period, CMS proposes:

- To apply the VM adjustment percentage for groups and solo EPs that participate in two or more ACOs during the applicable performance period based on the performance of the ACO with the highest quality composite score. This is only applicable to ACOs under the Medicare Shared Savings Program.
- To apply an additional upward payment adjustment of +1.0x to Shared Savings ACO Program participant TINs that are classified as “high quality” under the quality-tiering methodology, if the ACOs in which the TINs participated during the performance period have an attributed patient population that has an average beneficiary risk score that is in the top 25 percent of all beneficiary risk scores nationwide as determined under the VM methodology.
- To waive application of the VM for groups and solo EPs, as identified by TIN, if at least one EP who billed for PFS items and services under the TIN during the applicable performance period for the VM participated in the Pioneer ACO Model, CPC initiative, or other similar Innovation Center models during the performance period (e.g., Next Generation ACOs, Oncology Care Model, Comprehensive ESRD Care Initiative).

For the CY 2018 payment adjustment period, CMS proposes:

- To apply the VM for groups and solo EPs who participate in an ACO under the Shared Savings Program during the applicable performance period, regardless of whether any EPs in the group or the solo EP also participated in an Innovation Center model during the performance period.
- If the ACO does not successfully report quality data as required by the Shared Savings Program, all groups and solo EPs participating in the ACO will fall in Category 2 for the VM and will be subject to a downward payment adjustment.
- To include CAHPS Surveys in the VM for Shared Savings Program ACOs.

#### ***ACP Comment:***

The College appreciates the proposal to waive application of the VM if at least one EP (in a group or solo) billed for PFS items and services and participated in a Pioneer ACO, CPC initiative, or similar Innovation Center model during the performance period. **ACP further encourages CMS to consider extending the waiver of application of the VM to practices if an EP participated in a Medicare Shared Savings Program ACO.**

### Modifications to Evaluation of Quality and Resource Use

CMS plans to disseminate QRURs during the fall of 2015 that contain CY 2014 data to all groups and solo EPs that show all TINs their performance during 2014 on all of the quality and cost measures that will be used to calculate the CY 2016 VM. The informal review submission period will occur during the 60 days following release of the QRURs for the 2016 VM and subsequent years. These QRURs will provide data on a group's or solo EP's performance on PQRS quality measures as well as the three claims-based outcome measures calculated for the FM. The reports will accommodate new PQRS reporting options including QCDRs and CAHPS for PQRS. Cost measures in the 2014 QRUR are payment-standardized and risk-adjusted as well as specialty-adjusted to reflect the mix of physician specialties in a TIN. Beginning in Spring 2016, CMS plans to extend dissemination of the mid-year QRURs to non-physician EPs, solo EPs, and groups composed of non-physician EPs. CMS invites feedback on which aspects of the QRURs have been most useful and how the Agency can improve access and actionability of performance reports.

CMS proposes to modify its benchmarking policy to separately benchmark the PQRS electronic clinical quality measures (eCQMs) beginning with the CY 2018 VM. CMS notes that there are several factors that differentiate eCQMs from other equivalent PQRS measures including the inclusion of all-payer data for eCQMs and the different annual update cycle. This proposed change would be made beginning with the CY 2016 performance period, for which the eCQM benchmarks would be calculated based on CY 2015 performance data.

The Agency proposes to reclassify a TIN as Category 1 when PQRS determines on informal review that at least 50 percent of the TIN's EPs meet the criteria for satisfactory reporting of data on PQRS quality measures as individuals for the relevant CY PQRS payment adjustment, or in lieu of satisfactory reporting, satisfactorily participate in a PQRS QCDR for the relevant CY PQRS payment adjustment. Additionally, if the group was initially classified as Category 2, then CMS will likely not have data for calculating the quality composite, in which case the individual/group would be classified as "average quality." However, if the data is available in a timely manner, then CMS proposes to recalculate the quality composite.

CMS uses a minimum episode count for the Medicare Spending per Beneficiary (MSPB) measure for inclusion in a TIN's cost composite. In previous years, the Agency used a 20 episode case minimum that was non-specialty adjusted. However, based on more recent analysis CMS has found this to have lower reliability when specialty adjusted. Therefore, CMS proposes to increase the minimum to 100 episodes beginning with the CY 2017 payment adjustment period and CY 2015 performance period. The Agency notes that this may create a situation in which a group that would have performed well on this measure will no longer have it included in its cost composite, which could negatively impact their cost composite and ultimately their VM adjustment. CMS also considered a 75 episode minimum rather than 100 and is seeking comments on both alternatives.

***ACP Comment:***

The College supports separately benchmarking eQMs from other equivalent PQRs measures because the factors that differentiate them create a situation where they cannot be accurately compared with each other directly. The College supports CMS' proposal to reclassify a TIN as Category 1 when the Agency determines on informal review that at least 50 percent of the associated EPs meet the criteria for satisfactory reporting. The College supports the CMS proposal to increase the minimum episode count for the MSPB measure to 100 episodes. ACP does not believe that EPs should be arbitrarily given downward payment adjustments based on a measure for which they reported too few episodes to have reliable data to analyze.

**Future Rulemaking Considerations**

CMS also seeks comment on, but makes no proposals regarding, stratifying cost measure benchmarks by beneficiary risk score. The Agency notes that stakeholders have suggested that the CMS hierarchical condition categories (HCC) Risk Adjustment methodology used in the total per capita cost measures for the VM does not accurately capture the additional costs associated with treating the sickest beneficiaries. CMS is considering an option in which cost measure benchmarks would be stratified so that groups and solo EPs are compared to other groups and individuals treating beneficiaries with similar risk profiles. In this way, within a given grouping (e.g., a quartile or decile), there remains an opportunity to gain efficiencies in care and lower costs, while beneficiary severity of illness and practice characteristics may be more fully recognized at a smaller, and likely less heterogeneous, attributed beneficiary level.

***ACP Comment:***

**The College recommends that CMS use a frailty adjuster to better account for beneficiary risk in the sickest patients such as the methodology used in the Program of All-Inclusive Care for the Elderly (PACE). In addition, ACP encourages CMS to explore appropriate ways to adjust quality and cost scores for socioeconomic status and location of care to ensure accurate physician-to-physician comparison groups.**

**Physician Self-Referral Updates**

The rule proposes a number of new exceptions and clarifications to the physician self-referral laws and requests comments from stakeholders on changes that may need to be made to the self-referral laws so that they do not inappropriately restrict the financial relationships necessary to achieve the clinical and financial integration required for successful value-based health care delivery and payment reform.

Due to lack of internal legal and financial expertise, the College will not comment on the specific new exceptions and clarifications to the self-referral regulations included in the proposed rule. ACP does support the Agency's recognition of the need to consider the need for additional modifications, exceptions, and safe harbors to the self-referral, kickback, and gain-sharing regulations to facilitate innovation towards the goal of the delivery of and payment for value-based care in a manner that provides adequate protection to the best interests of beneficiaries.

Thank you for considering ACP's comments. Please contact Shari M. Erickson, MPH, Vice President, Governmental Affairs and Medical Practice, by phone at 202-261-4551 or e-mail at [serickson@acponline.org](mailto:serickson@acponline.org) if you have questions or need additional information.

Sincerely,

A handwritten signature in black ink, appearing to read "Robert McLean MD, FACP, FACR". The signature is written in a cursive style with some capital letters.

Robert McLean, MD, FACP, FACR  
Chair, Medical Practice and Quality Committee