December 19, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS-5517-FC
Room 445–G, Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

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

Dear Acting Administrator Slavitt:

On behalf of the American College of Physicians (ACP), I am pleased to share our comments on the Centers for Medicare and Medicaid Services' (CMS) final rule with comment regarding the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) – Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule and Criteria for Physician-Focused Payment Models. The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 148,000 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. Guiding Principles

The College would like to reiterate the following guiding principles that were included in our comments on the MACRA proposed rule[1] and the Draft CMS Quality Measures Development Plan:[2]

[1] https://www.acponline.org/acp_policy/letters/comment_letter_macra_proposed_rule_2016.pdf

[2] https://www.acponline.org/acp_policy/letters/comments_cms_draft_quality_measures_development_plan_2016.pdf

First, as outlined in our comments on the CMS Quality Measure Development Plan, ACP reiterates its call for CMS to use the opportunity provided through the new MACRA law to build a learning health and healthcare system. It is critically important that the new payment systems that are designed through the implementation of MACRA reflect the lessons from the current and past programs and also effectively allow for ongoing innovation and learning. **Also important is the need to constantly monitor the evolving measurement system to identify and mitigate any potential unintended consequences**, such as increasing clinician burden and burn-out, adversely impacting underserved populations and the clinicians that care for them, and diverting attention disproportionately toward the things being measured to the neglect of other critically important areas that cannot be directly measured (e.g., empathy, humanity).

Second, the College recommends that CMS work to ensure that patients, families, and the relationship of patients and families with their physicians are at the forefront of the Agency's thinking in the development of both the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APM) pathways, including the development and implementation of the performance measures to be used within these programs. It is critically important to recognize that the legislative intent of MACRA is to truly improve care for Medicare beneficiaries and thus, the policy that is developed to guide these new value-based payment programs must be thoughtfully considered in that context.

Third, the College strongly recommends that CMS collaborate with specialty societies, frontline clinicians, patients, and EHR vendors in the development, testing, and implementation of measures with a focus on integrating the measurement of and reporting on performance with quality improvement and care delivery and decreasing clinician burden.

II. Summary of ACP's Top Priority Recommendations

Throughout this letter, the College makes a significant number of specific recommendations to the Agency of ways we believe the final rule can be improved prior to implementation or in future rulemaking. We believe all of these recommendations are important for CMS to consider, but below have summarized a subset of them that reflect our top priority areas (detailed explanations for each recommendation are included in the main text of the letter). This approach is intended to ensure that these key issues for ACP and internal medicine as a whole are not lost within the more detailed and thorough discussions that follow.

Priority Area #1: Simplify the Implementation of the Quality Payment Program (QPP)

- ACP recommends that CMS simplify and clarify performance scoring through future regulation to allow physicians to better assess the scoring and weighting within each category.
    - More specifically, the College strongly recommends that CMS continue modifying the point values within the overall MIPS performance scoring to reflect a more unified approach by making the points available for performance

on each category and measure reflective of the value it has in the overall composite performance score (CPS).

- Additionally, ACP appreciates the Agency's efforts to add some overlap with the performance categories but recommends that CMS continue to consider additional options in rulemaking to promote taking on quality improvement activities that crossover into multiple performance categories to strengthen MIPS and make the program more comprehensive rather than siloed.
- The College also recommends CMS use the time during the 2017 transition year to refine the feedback mechanisms that will be utilized for QPP performance and allow for appropriate user feedback and end-to-end testing.

Priority Area #2: Allow Flexibility in the Performance Period and Reporting Requirements

- The College appreciates that CMS created flexible reporting options to protect eligible clinicians (ECs) from downward payment adjustments in the transition year. This addresses ACP's recommendation that the Agency hold small practices harmless from downward payment adjustments in the initial performance period in absence of a virtual groups option while allowing ECs with varying levels of experience in CMS reporting programs to choose an option that best suits their practice.
- ACP strongly urges CMS to maintain similar flexible reporting options in the second performance period in 2018. It is not reasonable to expect that an EC or group that elected to test participation in MIPS by reporting on one quality measure at some point in the transition year will be ready to move to reporting a full set of quality measures for a full year in year two.

Priority Area #3: Patient-Centered Medical Homes as Advanced Alternative Payment Models (APMs)

- A reasonable reading and interpretation of the statute can lend one to understand what we believe to be the clear congressional intent—that CMS should allow a medical home to qualify as an [advanced] APMs, without bearing more than nominal financial risk; if it is a medical home that meets criteria comparable to medical homes expanded under section 1115A(c).
- ACP recommends that CMS take the following steps to provide multiple pathways for medical homes to be included in the advanced APM pathway, to be implemented in a timely enough basis for eligible medical homes to qualify as Advanced APMs within the first year of program implementation, if feasible, and no later than the second performance period (2018).
    - Immediately initiate plans to undertake an expedited analysis of the results of the Comprehensive Primary Care initiative (CPCi) to determine whether the statutory requirements for expansion by the Secretary are met (i.e., Section 1115A(c), cited above). This analysis should be completed no later than six months from promulgation of the final rule to allow for a determination to

expand CPCi in time for medical home practices to qualify as Advanced APMs no later than the 2018 performance period.
        - In parallel with this analysis, CMS should initiate advanced planning to develop their expansion approach for the CPCi program.
    - Establish a deeming program or process to enable practices enrolled in medical home programs run by states (including state Medicaid programs), other non-Medicare payers, and employers as being deemed to have met criteria "comparable to medical homes expanded under section 1115A(c)."
    - Allow inclusion of medical home programs as Advanced APMs that meet the Medical Home Model Standard for financial risk and nominal amount as outlined in the final rule.
- The College, in recognition of the up-front costs of establishing the infrastructure required to deliver services within this model and the limited ability of most primary care practices to accept even minimal downside risk, reiterates its recommendation that the 2.5 percent risk requirement remain at that level until it is determined that a sufficient number of model participants have demonstrated the ability to succeed under even this minimal downside risk requirement.
- ACP strongly recommends that the Medical Home Model nominal risk standard also be applied to comparable specialty practice models.

Priority Area #4: Advanced APM Options for Internal Medicine Subspecialists and other Medical Specialties

- CMS should provide priority for consideration through the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and for CMMI testing for models involving physician specialty/subspecialty categories for which there are no current recognized APMs and Advanced APM options available. We further recommend that CMS provide a clear pathway for models recommended by PTAC to be implemented as APMs under MACRA.
- ACP recommends that there be a period of stability and predictability for Advanced APMs. The "more than nominal risk" standard of at least 8 percent of APM Entities' Medicare Parts A & B revenues or 3 percent of the expected expenditures should remain in place for no less than a 3-year period. After an initial 3-year period that allows for stability and predictability, an assessment should be completed based on the data to assess whether the financial viability of the APM entities could support a modest incremental increase or not.
- The College urges CMS to make clear in regulation that the nominal amount standard is either 8 percent of Medicare Parts A and B revenues (the "revenue-based standard") or 3 percent of expected expenditures (the "benchmark-based standard"), whichever is more advantageous for the entity.
- CMS must create a platform to accelerate the testing for APM acknowledgment of bundled payment and similar episodes of care payment models.

- The College reaffirms its belief that Track One MSSP ACOs should qualify as meeting the nominal risk requirement for determining an advanced APM.
- The College thanks CMS for taking the recommendation of ACP and others of adding a new track within the MSSP that helps bridge the transition for one-sided to two-sided risk through the new Track 1+ ACO model.

Priority Area #5: Improve the Advancing Care Information (ACI) Performance Category

- We strongly recommend that CMS rethink their position on ACI Performance Scores in future rulemaking.
- ACP strongly recommends that CMS eliminate all thresholds and scores associated with the ACI Performance Category and reward clinicians for participation in the learning healthcare system.
- The College recommends that measures and thresholds for ACI be based upon a scientific review process that involves four domains: purpose and importance to measure, clinical evidence base, measure specifications, and measure implementation and applicability.

III. Summary of ACP Recommendations by Section

ACP wishes to highlight the following key recommendations that have been excerpted from our more detailed comments. The College's complete, detailed comments, including additional recommendations, can be found in the body of the letter.

A. Merit-Based Incentive Payment System (MIPS)

1. MIPS Performance Period

- The College appreciates that CMS created flexible reporting options to protect ECs from downward payment adjustments in the transition year. This addresses ACP's recommendation that the Agency hold small practices harmless from downward payment adjustments in the initial performance period in absence of a virtual groups option while allowing ECs with varying levels of experience in CMS reporting programs to choose an option that best suits their practice.
- ACP strongly urges CMS to maintain similar flexible reporting options in the second performance period in 2018. It is not reasonable to expect that an EC or group that elected to test participation in MIPS by reporting on one quality measure at some point in the transition year will be ready to move to reporting a full set of quality measures for a full year in year two.

2. Complexity in MIPS Performance Scoring

- ACP recommends that CMS simplify and clarify performance scoring through future regulation to allow physicians to better assess the scoring and weighting within each category.
    - More specifically, the College strongly recommends that CMS continue modifying the point values within the overall MIPS performance scoring to reflect a more unified approach by making the points available for performance on each category and measure reflective of the value it has in the overall composite performance score (CPS).
- Additionally, ACP appreciates the Agency's efforts to add some overlap with the performance categories but recommends that CMS continue to consider additional options in rulemaking to promote taking on quality improvement activities that crossover into multiple performance categories to strengthen MIPS and make the program more comprehensive rather than siloed.
- The College also recommends CMS use the time during the 2017 transition year to refine the feedback mechanisms that will be utilized for QPP performance and allow for appropriate user feedback and end-to-end testing.

3. Performance Threshold

- In order to encourage continued participation, ACP strongly recommends that CMS make similar considerations in setting the performance threshold and allowing flexibility in reporting requirements in the second performance period.

4. Group Reporting

- ACP strongly urges CMS to modify this policy to allow group practices additional reporting options when they choose to report at the group-level by allowing TINs to choose to subdivide into smaller groups for the purposes of being assessed for performance in MIPS.

5. Virtual Groups

- ACP strongly urges CMS to establish a pathway where clinicians/practices could attest to working together as a virtual group with all participants submitting an attestation to belong to a unique identified group.
- Collaborative efforts will be required in assisting small practice clinicians in identifying similar compatible practices/groups with which to attest. ACP recommends that CMS consider how those entities that are awarded a portion of the $100 million in funding for direct technical assistance for small and rural practices might play a role in helping

practices determine other compatible practices with which to join together as a virtual group.

- The College supports attestation as an initial method of notifying CMS of the participants in a virtual group as it assists in relieving the administrative burden that is having an increasing impact on physicians.
- The College requests that CMS issue a preliminary virtual groups policy proposal for comment prior to including a policy in the next MACRA proposed rule.

6. Low-Volume Threshold

- ACP thanks CMS for incorporating our recommendation that the Agency raise the threshold to $30,000 in Medicare Part B allowed charges OR require fewer than 100 unique Medicare beneficiaries be seen by the clinician, as this would help provide a better safety net for small practices and certain specialists/subspecialists with a small Medicare patient population.
- The College further recommends that CMS develop a hardship exceptions process for MIPS through which ECs can apply to CMS on a case-by-case basis with special circumstances that warrant exclusion from MIPS for a performance period.

7. Telemedicine in MIPS

- We continue to recommend weighting the telehealth services activity under Expanded Practice Access as "high" to further incentivize the use of clinically relevant and appropriate telehealth services.
- The College also supports the use of administrative claims data, when feasible, for reporting on this specific telehealth activity within the improvement activities performance category (e.g., an EC using the telehealth modifier GT code would receive automatic full credit for this activity without having to report it separately). When this claims-based reporting option is available for ECs, it is a step towards lessening any unnecessary or duplicative reporting burden.

8. Quality Performance Category

a. Measure Requirements

- ACP reiterates our call for CMS to use the opportunity provided through the new MACRA law to actively build a learning health and healthcare system. Overall, quality measurement must move toward becoming more relevant and accurate, and toward effective approaches of measuring patient outcomes.
- The College strongly recommends that CMS collaborate with specialty societies, frontline clinicians, patients, and EHR vendors in the development, testing, and implementation of measures with a focus on integrating the measurement of and

reporting on performance with quality improvement and care delivery and on decreasing clinician burden.

- ACP recommends that any measures CMS proposes to use outside of the core set identified by the Core Quality Measures Collaborative be those recommended by the Measure Application Partnership (MAP).
- ACP also recommends that CMS take concrete actions to provide clear options for those specialties and subspecialties that may be most impacted by too few appropriate measures. These actions, which are detailed in ACP's comments on the MACRA proposed rule,[3] should include:
    - Developing a process to determine in advance of the reporting year which quality measures are likely applicable to each eligible clinician—and only holding them accountable for these relevant measures (i.e., weighting performance on the remaining measures higher, rather than penalizing them with a score of zero on unreported measures).
    - Putting a process in place, for the short term, to address the significant issues of validity and ability to implement associated with using measures that are not MAP-recommended, NQF-endorsed, and/or ACP recommended.[4]
    - Establishing safe harbors for entities that are taking on innovative approaches to quality measurement and improvement as was recommended in a recent article by McGlynn and Kerr. [5]
    - The College also calls on CMS to provide clear protections for individual clinicians who participate in these types of activities—this could be done by having the entities register certain measures as "test measures."
    - Ensuring that the flexibility for QCDRs to develop and maintain measures outside of the CMS selection process is protected.
- The College also reiterates our recommendation, as outlined in our response to the draft MDP—that it will be critically important for CMS over the longer term to continue to improve the measures and reporting systems to be used in MIPS to ensure that they measure the right things, move toward clinical outcomes and patient- and family-centeredness measures, and do not create unintended adverse consequences.
- ACP is disappointed that CMS did not remove the mandate for clinicians to report on at least one outcome measure, even though we recognize there is flexibility in that a "high priority" measure may be used when an outcome measure is not available.
- ACP recommends that CMS remove the All-Cause Hospital Readmissions measure from the quality score for groups that meet the size and case minimum requirements. If CMS wants to continue to use this measure, ACP recommends that it be included in feedback reports as information only and excluded from the calculation of the quality performance score.

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[3] https://www.acponline.org/acp_policy/letters/comment_letter_macra_proposed_rule_2016.pdf
[4] https://www.acponline.org/clinical-information/performance-measures
[5] McGlynn, E.A. and E.A. Kerr. Creating Safe Harbors for Quality Innovation and Improvement. *JAMA.* 2016;315(2):129-130. http://jama.jamanetwork.com/article.aspx?articleid=2481012

- In order to move toward developing measures that are appropriate for individual clinicians, CMS must collaborate with clinicians and specialty societies to ensure that individuals are not held accountable for measures that are designed to assess community-level outcomes.
- ACP recommends that CMS hold off on requiring that a cross-cutting measure be mandatory for the Quality Performance Category for the early years of QPP implementation.
- The College appreciates that CMS has now added the Consumer Assessment of Healthcare Providers & Systems (CAHPS) for MIPS survey as an option in the Improvement Activities Performance Category. In line with the comments on the CMS Quality Measure Development Plan,[6] ACP strongly recommends that reporting CAHPS for MIPS remain voluntary at a minimum in future years—and further recommends that this survey be removed from the quality component.
- The College recommends that CMS consider an approach recently outlined by McGlynn, Schneider, and Kerr,[7] which calls on measure developers to actively consider how to integrate patient preferences and goals into measure design
- The College reiterates its recommendation that CMS use its resources in an active effort to continually improve the risk adjustment methodology employed within MACRA implementation.
- ACP recommends that the Agency actively work to incorporate socioeconomic status (SES) into its risk adjustment methodologies given that there is existing literature on the impact of SES on the rates of hospitalizations, readmissions, and other factors—and the ASPE report, once available, can be additionally informative on this issue.

b. Qualified Clinical Data Registries (QCDRs)

- The College continues to recommend that CMS ensure that the flexibilities that were given to QCDRs in law to develop and maintain measures that are outside of the CMS selection process are protected.
- ACP encourages CMS to remove the arbitrary restriction on the number of non-MIPS measures that a QCDR can utilize. Further, the College recommends that CMS allow QCDRs to utilize measures from other QCDRs (with permission).
- The College recommends that the Agency publish the specific criteria that they plan to use in evaluating QCDR measures moving forward.
- If CMS decides to deny the use of a measure in a QCDR, the College also recommends that the Agency provide the measure developer/steward with specific information on

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6 https://www.acponline.org/acp_policy/letters/comments_cms_draft_quality_measures_development_plan_2016.pdf

7 Elizabeth A. McGlynn, Ph.D., Eric C. Schneider, M.D., and Eve A. Kerr, M.D., M.P.H. "Reimagining Quality Measurement." N Engl J Med 2014; 371:2150-2153. http://www.nejm.org/doi/full/10.1056/NEJMp1407883.

what criteria were not met that led to a measure not being accepted for use and provide a process for immediate reconsideration when the issues have been addressed.

c. Data Completeness

- The College appreciates that CMS accepted our recommendation to maintain the current 50 percent data completeness requirements for quality reporting during the first performance period under MIPS.
- ACP urges CMS to maintain the 50 percent data completeness criteria in future years as ECs are learning how to report under QPP.
- The College further recommends that that higher data completeness requirements are phased in only after review has determined that doing so is both appropriate and feasible and that CMS utilize a slow, incremental phase-in of any new data completeness requirements for quality reporting in MIPS.

d. Topped-out Measures

- ACP appreciates that CMS accepted our recommendation that measures in the first year of being identified as topped out will be treated in the same manner as other measures and maintain the 10-point maximum scoring standard. However, the College remains concerned that CMS is contemplating removing or reducing the maximum number of points for topped out measures in the second year without regard for the value of the quality actions that are being measured.
- ACP reiterates its recommendation that CMS publicly disclose any measures that are topped out prior to a performance period in advance.

e. CEHRT Bonus for Quality Performance Category

- The College applauds CMS for taking our recommendations into consideration and allowing ECs to obtain the CEHRT bonus for reporting to otherwise qualified registries that are not yet capable of supporting the required standards for the submission of *all* data elements.

9. Resource Use Performance Category

- The College applauds CMS for reducing the Cost Performance Category down from 10 percent to zero percent of the overall MIPS composite score in the first performance period.
- Given the remaining concerns with the cost measures, ACP recommends that CMS zero out the cost performance category in the second performance year as well and continue to focus on the development and refinement of the new code sets to ensure than when cost is accounted for in the composite performance score, it is done in a more

appropriate manner that factors in components such as patient condition and the costs associated with clinicians in the role in which they treat each patient.

10. Improvement Activities Performance Category

- The College appreciates that CMS accepted our recommendation and reduced the number of activities that must be reported to earn full credit in the Improvement Activities Performance Category. We further thank the Agency for making accommodations for small, rural, and non-patient facing physicians to be able to meet reduced requirements to earn credit in this category.
- The College reiterates our recommendations for adding certain programs to the improvement activities list, which are outlined in further detail in our comments on the proposed rule:[8]
    - Inclusion of completing ACP Practice Advisor® modules as an Activity in the subcategory of Patient Safety and Practice Assessment.
    - Inclusion of ACP's High Value Care resources,[9] which can be used by clinicians to implement optimal diagnostic and treatment strategies in their practice, including Clinical Guidelines & Recommendations, a Pediatric to Adult Care Transitions Toolkit, the High Value Care Coordination Toolkit, as well as High Value Care Cases.
    - Allowing credit for certain defined CME activities:
        - Accredited CME activities that involve assessment and improvement of patient outcomes or care quality, as demonstrated by clinical data or patient experience of care data.
        - Accredited CME that teaches the principles of quality improvement and the basic tenets of MACRA implementation, including application of the "three aims," the National Quality Strategy, and the CMS Quality Strategy, with these goals being incorporated into practice.
- The College also recommends that CMS establish a clear and transparent process for adding new items to the list of improvement activities that facilitates broad stakeholder input.
- ACP reiterates is recommendation that CMS permit practicing clinicians to submit alternative activities for credit and/or consideration for future credit, as this will help ensure that clinicians are able to identify and undertake quality improvement activities aimed at meeting their own specific goals, even if those activities are not yet included on the improvement activities list.

[8] https://www.acponline.org/acp_policy/letters/comment_letter_macra_proposed_rule_2016.pdf
[9] https://www.acponline.org/clinical-information/high-value-care

a. PCMHs within the Improvement Activities Performance Category

- ACP applauds CMS for incorporating our recommendation that the Agency broaden its definition of patient-centered medical home and comparable specialty practices for the purposes of full improvement activities credit to specifically be inclusive of programs that have a demonstrated track record of support by non-Medicare payers, state Medicaid programs, employers, and/or others in a region or state (but that do not yet meet all of the requirements to be deemed an advanced APM program per the recommendation later in this letter).
- ACP recommends that CMS carefully consider the 500-practice certification requirement that it has placed on those non-national recognition entities (e.g., state or regional, private payers, etc.) to determine the appropriateness of that threshold and allow flexibility as warranted.

11. Advancing Care Information (ACI) Performance Category

- We strongly recommend that CMS rethink their position on ACI Performance Scores in future rulemaking.
- ACP strongly urges CMS to keep the "Pick Your Pace" level of reporting requirements for ACI for a minimum of years two and three of the MIPS program, and perhaps indefinitely.
- ACP strongly recommends that CMS eliminate all thresholds and scores and reward clinicians for participation in the learning healthcare system.
- The College recommends that measures and thresholds for ACI be based upon a scientific review process that involves four domains: purpose and importance to measure, clinical evidence base, measure specifications, and measure implementation and applicability.

12. MIPS APMs

- ACP makes the following recommendations to improve MIPS APMs participation:
    - ACP recommends that the Agency, through its authority under the Innovation Center and through the efforts of the Physician-Focused Payment Model Technical Advisory Committee (PTAC) process, expand MIPS APMs availability.
    - While we appreciate that CMS plans to give MIPS APMs full credit for the Improvement Activities Performance Category in the first year of MIPS, ACP continues to recommend that participants within a MIPS APM receive 100 percent of the potential points under the Improvement Activities Performance Category in subsequent years to recognize and encourage their efforts to provide valued-oriented care.
    - We recommend that CMS add a fourth review date, December 31st, to the process for identifying participants in MIPS APMs to further ensure that those eligible clinicians that qualify for APM Entity group status are included.

B. Alternative Payment Models (APMs)

1. Medical Home Models

- A reasonable reading and interpretation of the statute can lend one to understand what we believe to be the clear congressional intent—that CMS should allow a medical home to qualify as an [advanced] APMs, without bearing more than nominal financial risk; if it is a medical home that meets criteria comparable to medical homes expanded under section 1115A(c).
- ACP recommends that CMS take the following steps to provide multiple pathways for medical homes to be included in the advanced APM pathway, to be implemented in a timely enough basis for eligible medical homes to qualify as Advanced APMs within the first year of program implementation, if feasible, and no later than the second performance period (2018).
    - Immediately initiate plans to undertake an expedited analysis of the results of the Comprehensive Primary Care initiative (CPCi) to determine whether the statutory requirements for expansion by the Secretary are met (i.e., Section 1115A(c), cited above). This analysis should be completed no later than six months from promulgation of the final rule to allow for a determination to expand CPCi in time for medical home practices to qualify as Advanced APMs no later than the 2018 performance period.
        - In parallel with this analysis, CMS should initiate advanced planning to develop their expansion approach for the CPCi program.
    - Establish a deeming program or process to enable practices enrolled in medical home programs run by states (including state Medicaid programs), other non-Medicare payers, and employers as being deemed to have met criteria "comparable to medical homes expanded under section 1115A(c)."
    - Allow inclusion of medical home programs as Advanced APMs that meet the Medical Home Model Standard for financial risk and nominal amount as outlined in the final rule.
- The College, in recognition of the up-front costs of establishing the infrastructure required to deliver services within this model and the limited ability of most primary care practices to accept even minimal downside risk, reiterates its recommendation that the 2.5 percent risk requirement remain at that level until it is determined that a sufficient number of model participants have demonstrated the ability to succeed under even this minimal downside risk requirement.
- ACP strongly recommends that the Medical Home Model nominal risk standard also be applied to comparable specialty practice models.

2. Availability of Alternative Payment Models and Advanced Alternative Payment Models to Non-Primary Care Specialists/Subspecialists

- ACP recommends that CMS:
    - Provide priority for consideration through the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and for CMMI testing for models involving physician specialty/subspecialty categories for which there are no current recognized APMs and Advanced APM options available. We further recommend that CMS provide a clear pathway for models recommended by PTAC to be implemented as APMs under MACRA.
    - Allow for a period of stability and predictability for Advanced APMs. The "more than nominal risk" standard of at least 8 percent of APM Entities' Medicare Parts A & B revenues or 3 percent of the expected expenditures should remain in place for no less than a 3-year period. After an initial 3-year period that allows for stability and predictability, an assessment should be completed based on the data to assess whether the financial viability of the APM entities could support a modest incremental increase or not.
    - Make clear in regulation that the nominal amount standard is either 8 percent of Medicare Parts A and B revenues (the "revenue-based standard") or 3 percent of expected expenditures (the "benchmark-based standard"), whichever is more advantageous for the entity.
    - Create a platform to accelerate the testing for APM acknowledgment of bundled payment and similar episodes of care payment models.

3. Treatment of Non-Fee-For-Service Payments

- ACP recommends that CMS withdraw its proposal to decide on a case-by-case basis whether to exclude many payments made to physicians that are not traditional Medicare Physician Fee Schedule payments from calculations of the five percent lump sum payments to participants in Advanced APMs.

4. Medicare Shared Savings Program (MSSP)

- The College reaffirms its belief that Track One MSSP ACOs should qualify as meeting the nominal risk requirement for determining an advanced APM.
- The College thanks CMS for taking the recommendation of ACP and others of adding a new track within MSSP, ACO Track 1+, that helps bridge the transition for one-sided to two-sided risk. We have a number recommendations to assist CMS as it develops the new ACO Track 1+ including:
    - Availability for participation: We support making Track 1+ a voluntary model that is available to both existing Track 1 ACOs and those new to the program. We further encourage the Agency to available to MSSP Tracks 2 and 3 as well as Next Generation ACOs and Pioneer ACOs. Current ACOs should be able to move into

Track 1+ at the beginning of any performance year rather than waiting until the start of a new agreement period.

- Length of agreement: ACP recommends that CMS utilize a three-year agreement period for Track 1+ ACOs, and we further urge the Agency to allow ACOs to remain in Track 1+ indefinitely and not be limited to a certain number of agreements in Track 1+.
- Beneficiary assignment: The College urges CMS to allow Track 1+ ACOs (as well as those in all other MSSP tracks) the option of choosing prospective or retrospective assignment of beneficiaries. We further encourage CMS to allow for voluntary beneficiary alignment as the Agency finalized for other MSSP ACOs in the 2017 physician fee schedule rule.
- Waiver authority: We encourage CMS to extend to Track 1+ ACOs and all other ACO models waiver authority from legal and regulatory barriers (i.e., home heath homebound requirements, SNF 3-day stay rule, telehealth restrictions, primary care co-payments, etc.).

IV. Merit-Based Incentive Payment System (MIPS)

A. MIPS Performance Period

Background:
CMS modified the performance period proposal to provide clinicians with additional time to prepare their practices. The initial performance period under MIPS, which the Agency is now calling the transition year, will occur during calendar year (CY) 2017 (January 1 – December 31, 2017), with payment adjustments occurring in CY 2019. Rather than the full year performance period that was proposed, clinicians will be able to pick the pace that best suits their practice capabilities for the initial performance period through test participation or more fully reporting for at least 90 days. ECs who do not participate in 2017 and do not meet any exclusion criteria will receive a negative 4 percent payment adjustment in 2019.

Transition year participation options:

- *Test participation:* Clinicians can choose to experiment or test participation in MIPS by reporting one quality measure or one improvement activity or reporting the required measures (base measures) of the advancing care information performance category and avoid a negative MIPS payment adjustment in 2019. Test participation must be based on performance that occurs at any point during calendar year 2017. However, there are not specific requirements as to the amount of data that must be reported or the length of performance.

- *Partial participation:* ECs can choose to more fully report during the transition period by reporting for a minimum of a continuous 90-day period up to a full year during calendar year 2017. By reporting on more than one quality measure or more than one

improvement activity or more than the required base measures in the advancing care information performance category, ECs will be about to avoid a negative payment adjustment in 2019 and potentially earn a small positive adjustment based on their performance.

- *Full participation:* ECs should report for a full 90-day period or, ideally, the full year by reporting on the following criteria:
    - 6 quality measures (including one outcome measure or other high priority measure);
    - 4 medium-weighted or 2 high-weighted improvement activities (or, for small and rural practices, 2 medium-weighted or 1 high-weighted activities); and
    - The 5 base measures in the advancing care information category.

  CMS encourages ECs to report for a full year if possible since this will give the most quality reporting options and a better chance of earning a higher positive adjustment in 2019.

For the transition year, the Agency finalized a minimum of a 90-day continuous performance period, up to and including a full year, for the majority of submission mechanisms as long as the 90 days occurs within calendar year 2017. Data for the cost performance category as well as quality performance reported through the CMS Web Interface, the CAHPS for MIPS survey, and the all-cause hospital readmission measure for practices with 16 or more ECs will be based on a full 12-month period rather than a minimum of 90 days due to the sampling methodologies used with these submission mechanisms.

For the second performance period, occurring in 2018, CMS finalized a 90-day performance period for the improvement activities and advancing care information performance categories. For the cost performance category and all submission mechanisms used for quality reporting, CMS finalized a full year performance period in CY 2018. The Agency also indicated its intention to move the performance period closer to the payment adjustment period in the future.

ACP Comments:
The College appreciates that CMS created flexible reporting options to protect ECs from downward payment adjustments in the transition year. This addresses ACP's recommendation that the Agency hold small practices harmless from downward payment adjustments in the initial performance period in absence of a virtual groups option while allowing ECs with varying levels of experience in CMS reporting programs to choose an option that best suits their practice. We further thank the Agency for addressing the College's concerns with regard to the proposed January 1 start date. Allowing ECs and groups that want to participate more fully the flexibility to report for 90 days up through a full year in 2017 will give clinicians options to begin reporting later in the year as they see fit.

ACP strongly urges CMS to maintain similar flexible reporting options in the second performance period in 2018. It is not reasonable to expect that an EC or group that elected to

test participation in MIPS by reporting on one quality measure at some point in the transition year will be ready to move to reporting a full set of quality measures for a full year in year two. CMS should instead facilitate the idea of a learning health care system and implement incremental increases in the amount of measures and activities that must be reported to avoid a negative payment adjustment over the course of several years. We also encourage implementation of incremental increases in the measures and activities that must be reported under the partial participation option to ensure that practices can smoothly transition into more fully reporting in QPP.

We also thank the Agency for reducing the performance period to 90 days for the advancing care information performance category for the first two years. The College encourages CMS to maintain a 90-day performance period for the ACI and improvement activities in subsequent years as it will be important to add stability to reporting on these performance categories as practices adapt to QPP requirements. This 90-day reporting period for ACI is critical to facilitate learning and improvement on this performance category.

Following a substantial transition period over the course of several years, ACP does ultimately want CMS to move to a performance period that is shorter and closer to the payment adjustment year in the future. However, we have concerns with moving making a determination on the length of the performance period without a review of the data that are available on the impact such a change will have on clinicians' ability to report data that is reliable and valid, especially on small practices and specialists. Therefore, ACP reiterates its recommendation that CMS conduct and release a thorough analysis of performance data including analysis based on practice size and specialty using the quality and resource use data and consider an appropriate length of performance period based on an analysis that indicates that a significant majority of solo physicians and small practices (including specialist/subspecialist practices) would have data sufficient to be reliable and valid under the performance period. It is important that an analysis of this kind be conducted to provide assurances that any decrease in the length of the performance period not have unintended negative consequences for any practice types including small practices and those with specialists/subspecialists.

B. Complexity in MIPS Performance Scoring

Background:
When Congress sunsetted the payment adjustments associated with PQRS, the value-based payment modifier, and the EHR Incentive Program through MACRA, the intent was that these programs would be rolled into one streamlined program – MIPS – that combines the piecemeal approach to assessing clinicians into a single program with a single payment adjustment attached to it. CMS made modifications to the overall scoring methodology in the final rule; however, ACP still has concerns with the finalized scoring structure of MIPS because overall it continues to allow each performance category to operate within its own fragmented silo. Most significantly, there are still different scoring systems across the performance categories, and

while all of this may have been well-intentioned, the inconsistent construction adds significant and unnecessary complexity to the already complicated Quality Payment Program.

In the final rule, CMS modified the performance standards in each of the MIPS performance categories used to evaluate the measures and activities as well as the methodology to create a final MIPS composite performance score (CPS):

- Zeroed out the weight of the Cost Performance Category – which was initially proposed to account for ten percent of the overall CPS.
- Increased the weight of the Quality Performance Category from 50 to 60 percent of the CPS.
- Lowered the overall performance threshold for the CPS to three points in alignment with the "Pick Your Pace" policy change in the 2017 transition year.
- Ensured that MIPS ECs who submit data and meet program requirements under any or all of the three performance categories for which data must be reported (i.e., quality, improvement activities, and advancing care information) will receive a final MIPS CPS at or slightly above the overall performance threshold of **three** and thus a neutral to small positive adjustment – as performance at any level during the transition year receives points towards the overall performance score.
- Ensured that ECs with average to high overall performance will receive a final MIPS CPS above the performance threshold of **three** and thus a higher positive adjustment.
- Converted all measures in the Quality and Cost Performance Categories to a 10-point scoring system providing a framework to universally compare different types of measures across different types of MIPS eligible clinicians.

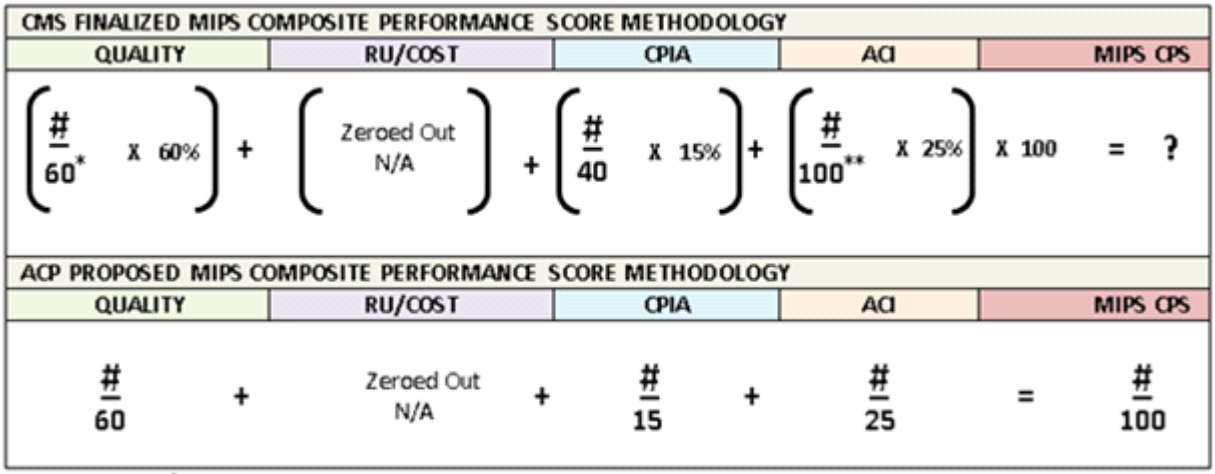
ACP Comments:
While CMS did reduce the reporting requirements in most performance categories, the point values within the performance scoring methodology have not been simplified sufficiently and the points available with each measure are not reflective of the value a measure or activity has in the overall composite performance score in most cases. There is still a different methodology for the weight of points in each performance category that does not fully align with the value of the category in contributing to the overall CPS (where there is a total of 60 or 70 points needed for a full performance score, depending on practice size). With the Cost Performance Category zeroed out for the 2017 transition year, the Quality Performance Category now accounts for 60 percent of a physician's CPS. Advancing Care Information is even more complex, with a base score of 50 points that must be met in order to achieve any credit, an additional 90 points available for performance on other activities, and a total of 15 available bonus points for a total of 155 possible points. However, the maximum points for full credit in the ACI Performance Category is 100 points (even though 155 points are possible), and this only equates to 25 percent of the CPS. In the Improvement Activities category, ECs select two to four activities, depending on the weighting of the activities selected (medium or high), to reach a maximum score of 40 points, which then equates to 15 percent of the CPS.

The variation in point values and weighting within each performance category creates a system that is overly complex and confusing, making it difficult for physicians to determine where to invest their resources to maximize their performance under MIPS. **ACP recommends that CMS simplify and clarify performance scoring through future regulation to allow physicians to better assess the scoring and weighting within each category.** The scoring system should be set up in a simpler format that allows physicians to easily determine the impact that reporting on a measure, objective, or IA could have on their overall CPS (i.e., 100 points).

More specifically, the College strongly recommends that CMS continue modifying the point values within the overall MIPS performance scoring to reflect a more unified approach by making the points available for performance on each category and measure reflective of the value it has in the overall CPS (see Figure 1). This means that the all of the available points within the quality component would add up to a total of 60 points – counting for 60 percent; the points within IA would add up to 15 – counting for 15 percent; the points within ACI would add up to 25 – counting for 25 percent (and not 155, with only 100 of those points actually "counting," as described in this final rule); and when cost is eventually recalculated into the overall CPS, the points would add up to however much it is weighted in the overall score (10 points if 10 percent; 30 points if 30 percent). By simplifying the scoring to allow the maximum points for each measure or activity to directly translate to its contribution to the overall CPS, the scoring will be streamlined to better account for MIPS as one comprehensive program rather than silos for each performance category. This will allow physicians to better focus their efforts on the activities and measures that are most meaningful to their patients and practice. (See Table 1 for our more detailed recommendations for calculating the ACI performance score later in this letter).

Figure 1

Comparison between CMS Finalized and ACP Proposed MIPS Composite Performance Score Methodology



* could be #/70 depending on EC

** 155 possible points

Additionally, ACP appreciates the Agency's efforts to add some overlap with the performance categories but recommends that CMS continue to consider additional options in rulemaking to promote taking on quality improvement activities that crossover into multiple performance categories to strengthen MIPS and make the program more comprehensive rather than siloed. This could be done through the provision of bonus points or other performance incentives for participating in cross-performance category quality improvement initiatives. For example, immunizations are an important public health priority for both patients and physicians, and practices could be rewarded for selecting quality measures and IAs that have an immunization component in addition to performing on the public health registry objective in ACI. **The College also recommends CMS use the time during the 2017 transition year to refine the feedback mechanisms that will be utilized for QPP performance and allow for appropriate user feedback and end-to-end testing.**

C. Performance Threshold

Background:
The performance threshold is the composite performance score amount at which ECs and groups receive a neutral payment adjustment. Those that fall below the performance threshold likely receive a negative payment adjustment; and those above the performance threshold have the potential to earn a positive payment adjustment. The top performers also have the potential to earn an exceptional performance adjustment by reaching the additional performance threshold. Given that CMS decided to make year 1 of MIPS a transition year, the Agency determined that it would be inappropriate to set a performance threshold that would result in downward adjustments to payments for many clinicians who may not have had time to prepare adequately to succeed under MIPS. CMS believes that providing a pathway for many ECs and groups to succeed in year 1 will encourage early participation and enable more robust engagement over time. For the first two performance periods, CMS has additional flexibility under MACRA to establish a performance threshold and additional performance threshold, which the Agency is utilizing to establish transition year policies.

CMS proposed to set the performance threshold in the first year at a level where approximately half of ECs will fall below the threshold and half will be above, which CMS believes is consistent with the requirements of MACRA beginning in year three. However, the Agency did not finalize this proposal and is instead using its flexibility to set a performance threshold that will enable most clinicians to avoid a payment adjustment. For the initial performance period (in 2017), CMS finalized setting the performance threshold at 3 points to encourage participation and allow clinicians to gain experience. By reporting under the test participation option, ECs and groups are assured of earning at least 3 points and therefore avoiding a negative payment adjustment. This can be achieved by reporting on one quality measure, one improvement activity or the ACI base measures at some point in 2017. CMS also finalized decoupling the performance threshold and the additional performance threshold, setting the additional performance threshold at 70 points. ECs and groups that earn at least 70 points toward their

composite performance score will therefore be eligible for the exceptional performance bonus on top of any positive payment adjustment that they qualify to receive. CMS notes that the Agency intends to increase the performance threshold in year 2. Beginning in year 3, the Agency will use the mean or median final score from a prior period.

ACP Comments:
The College commends CMS for setting the performance threshold for the transition year at a level that that allows most clinicians to be able to achieve at least a neutral payment adjustment. The flexibility in reporting options through "Pick Your Pace," coupled with reduction in the performance threshold, will be very helpful in providing multiple pathways for clinicians to begin to gain experience in reporting under the new QPP requirements. **In order to encourage continued participation, ACP strongly recommends that CMS make similar considerations in setting the performance threshold and allowing flexibility in reporting requirements in the second performance period.** A slow, incremental phase-in of requirements is crucial to keep clinicians engaged in future years. Therefore, ACP encourages CMS to use any flexibilities available to ensure that increases in the performance threshold in year three and subsequent years results in continued engagement and participation by clinicians, in particular those in small and rural practices.

D. Group Reporting

Background:
CMS finalized its definition of a group practice for reporting purposes as a Taxpayer Identification Number (TIN) with two or more eligible clinicians (including at least one MIPS eligible clinician), as identified by their National Provider Identifier (NPI), who have reassigned their Medicare billing rights to the TIN. CMS will use multiple identifiers for eligible clinicians that allow them to choose between being measured as an individual or collectively through a group's performance. The Agency finalized the use of the same identifier across all four performance categories, so if a group (identified through a TIN) chooses to submit information collectively for one performance category it must report collectively across all four performance categories. In order to have performance assessed as a group, individual MIPS eligible clinicians must aggregate their performance data across the TIN. CMS finalized using a TIN/NPI identifier for applying the payment adjustments, regardless of how a MIPS EC is assessed. Individual ECs who are part of several groups and associated with multiple TINs will be required to participate in MIPS for each TIN association unless the eligible clinician (NPI) is excluded from the MIPS.

ACP Comments:
The College continues to have significant concerns with CMS' policy to restrict group reporting to TIN-level identification. While some TINs may be representative of a group of clinicians that are solely primary care or focused on one specialty, many TINs represent many different specialties and subspecialists. Physicians may have elected to join together under a common TIN for billing purposes for a variety of reasons, but that does not necessarily equate to a TIN

being representative of common patient conditions, treatments, etc. Internal medicine physicians and subspecialists may have assigned their billing privileges to a TIN that includes 20 or more different specialties within it. And while many of these TINs prefer to elect the group reporting option, CMS reporting policies will force physicians in a multi-specialty group to report on a common set of general measures in order to find a measures set that can apply broadly across the different specialties within the group. Requiring groups with multiple specialties to report as a TIN also adds a layer of complexity and confusion to practices trying to find measures that are meaningful to each physician's scope of practice.

ACP strongly urges CMS to modify this policy to allow group practices additional reporting options when they choose to report at the group-level by allowing TINs to choose to subdivide into smaller groups for the purposes of being assessed for performance in MIPS. This option should be available to clinicians in addition to the finalized options that allow individual reporting or TIN-level group reporting. CMS could implement this subgroup by allowing TINs to identify smaller groups of NPIs that should be grouped together for performance assessment. In allowing for specialty-focused subgroups within TINs to report collectively, these smaller groups would have the flexibility to choose the performance activities that are most relevant to their scope of practice and patient population. Rather than choosing a general set of activities or a set that is focused around the dominant specialty within a TIN, each subgroup within the TIN would have the ability to report on the quality measures (including a more specialty-specific outcome or high priority area measure) and improvement activities that are most relevant to the specialty/subspecialty members.

This option of allowing small group reporting within TINs will also be in the best interest of the patients and families/caregivers. Limiting group reporting to the TIN-level only for multi-specialty practices will not create publicly reported data that is meaningful to consumers. For example, a patient or family/caregiver looking for information on Physician Compare might want to know how a cardiologist performed on quality measures related to managing heart diseases. Under the finalized TIN-level group reporting option, this patient or family/caregiver might be unable to find anything on measures related to heart disease management because the physician was in a multi-specialty group under TIN that had to report on measures with less of a specialty focus. By allowing smaller groups of clinicians within a TIN to be grouped together for assessment purposes, the cardiologists could form a group that reports on quality measures most relevant to their scope of practice and the patients that they treat.

E. Virtual Groups

Background:
Section 1848(q)(5)(I) of the Act establishes the use of voluntary virtual groups for certain assessment purposes. The statute requires the establishment and implementation of a process that allows an individual MIPS eligible clinician or a group consisting of not more than 10 MIPS eligible clinicians to elect to form a virtual group with at least one other such individual MIPS eligible clinician or group of not more than 10 MIPS eligible clinicians for a performance period

of a year. While the rule recognizes this requirement, CMS notes that the Agency chose to delay the onset of this provision until the 2018 performance year based on identified significant barriers regarding the development of a technological infrastructure required for successful implementation and the operationalization of provisions that would make this a conducive option for MIPS eligible clinicians or groups.

CMS is seeking additional comment on the following issues for future consideration: the types of requirements that could be established for virtual groups to promote and enhance the coordination of care and improve the quality of care and health outcomes; and the parameters (for example, shared patient population), if any, could be established to ensure virtual groups have the flexibility to form any composition of virtual group permissible under the Act while accounting for virtual groups reporting on measures across the four performance categories that are collectively applicable to a virtual group given that the composition of virtual groups could have many differing forms. The Agency believes that each MIPS eligible clinician who is part of a virtual group has a shared responsibility in the performance of the virtual group and the formation of a virtual group provides an opportunity for MIPS eligible clinicians to share and potentially streamline best practices.

CMS is seeking comment on the following issues for future consideration: the factors virtual groups would need to consider and address in order for the reporting and submission of data to be streamlined in a manner that allows for categorization of datasets and comparison capabilities; the factors an individual clinician or small practice who are part of a virtual group would need to consider in order for their CEHRT to have interoperability with other CEHRT if part of a virtual group; the advantages and disadvantages of having members of a virtual group use one form of CEHRT; the potential barriers that may make it difficult for virtual groups to be prepared to have a collective, streamlined system to capture measure data; and the timeframe virtual groups would need in order to build a system or coordinate a systematic infrastructure that allows for a collective, streamlined capturing of measure data.

ACP Comments:
The College believes that the implementation of the virtual groups provision is an important step towards establishing a viable and effective quality payment program. It will allow small practice clinicians to aggregate their data to allow for more reliable and valid measurement as well as serve as a platform to facilitate shared accountability and collaborative efforts. While we recognize and appreciate the barriers towards implementation in time for the 2017 performance period, ACP is not supportive of the planned delay in implementation.

Therefore, ACP strongly urges CMS to establish a pathway where clinicians/practices could attest to working together as a virtual group with all participants submitting an attestation to belong to a unique identified group. Collaborative efforts will be required in assisting small practice clinicians in identifying similar compatible practices/groups with which to attest. In keeping with the objectives of providing education about the program and maximizing participation, and as mandated by the MACRA, $100 million in technical assistance will be

available to MIPS eligible clinicians in small practices; a portion of these funds could be used to assist in the setup and organization of virtual groups. The College supports attestation that will assist in relieving the administrative burden issue that is having an increasing impact on physicians. This is a critical option that small practices should be offered in order to support greater assessment opportunities under MIPS. **The College requests that CMS issue a preliminary proposal for comment prior to including a policy in the next MACRA proposed rule.**

Along these lines, ACP has strongly championed the concept of encouraging connecting primary care medical homes with specialist medical homes that commit to coordinating care across both settings, including entering into formal agreements on sharing information seamlessly. This concept—which we call the Patient-Centered Medical Home Neighborhood[10]—came out of the work of our own Council of Subspecialty Societies, and was the basis for the development of ACP's High-Value Care Coordination Toolkit,[11] which provides resources to facilitate more effective and patient-centered communication between primary care and subspecialist doctors. This toolkit provides practical and actionable resources for primary care and specialist practices to more effectively coordinate care. Its use could be incentivized by CMS within the CPIA category of MIPS.

ACP's Patient-Centered Medical Neighborhood policy paper was also the basis for the NCQA's specialty medical home certification process. The College is aware that NCQA, in its comments on the proposed rule,[12] proposed an approach whereby CMS would "include guidance on:

- Identifying virtual group partners, such as recognized PCMH and/or PCSP [patient-centered specialty practices] that MACRA actively promotes. Recognized PCMHs and PCSPs have demonstrated commitments to well-coordinated, high-quality, patient-centered care and thus greater potential to improve MIPS scores. These could be:
    - Other PCMH and PCSP practices in the same community or geographic region; or
    - Groups of similar PCSPs likely to report the same specialty measures.
- Drafting written agreements to establish virtual groups and share accountability and financial risk;
- Developing skills and tools for group reporting that will be new to virtual groups;
- Developing skills and expertise in analyzing data and addressing any quality gaps in order to improve MIPS scores and succeed as virtual groups; and
- Developing further skills and expertise to maximize use of CEHRT, base pay on performance and take two-sided risk in order to become APMs."

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[10] American College of Physicians. The Patient-Centered Medical Home Neighbor: The Interface of the Patient-Centered Medical Home with Specialty/Subspecialty Practices. Philadelphia: American College of Physicians; 2010: Policy Paper. (Available from American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106.) Accessed at: https://www.acponline.org/system/files/documents/advocacy/current_policy_papers/assets/pcmh_neighbors.pdf

[11] https://www.acponline.org/clinical-information/high-value-care/resources-for-clinicians/high-value-care-coordination-hvcc-toolkit

[12] http://www.ncqa.org/public-policy/comment-letters/ncqa-comments-on-macra

While we are not endorsing the NCQA's proposal per se, we join with NCQA in encouraging CMS to consider the concept of making the PCMH and PCMH-Neighbor the basis for proposing a virtual group reporting option.

The College is also aware that URAC, in their comment letter on the proposed rule, stated that "CMS must protect against anti-trust issues that may arise regarding physician collaboration to recognize economies of scale. The Federal Trade Commission (FTC) has indicated that clinically integrated networks, formed to improve the quality and efficiency of care delivered to patients, is a network model compliant with federal laws." As with above, ACP is not formally endorsing URAC's specific proposal; however, we do agree that the development of virtual groups should be done "in a manner that incentivizes sustainable growth as integrated networks capable of long-term success under value-based reimbursement."

F. Low-volume Threshold

Background:
MACRA requires CMS to set a low-volume threshold at which clinicians who fall below are not considered eligible clinicians for the purposes of MIPS. CMS has the discretion to use one or more of the following criteria in determining this exclusion: 1) the minimum number of Part B-enrolled beneficiaries who are treated by the clinician during the performance period; 2) the minimum number of items and services provided to Part B-enrolled beneficiaries during the performance period; and 3) the minimum amount of allowed charges billed by the MIPS eligible clinician during the performance period. CMS proposed to define MIPS eligible clinicians or groups who do not exceed the low-volume threshold as those who have Medicare billing charges of less than or equal to $10,000 AND provide care for 100 or fewer Part B-enrolled beneficiaries during the performance period. However, in the final rule, CMS modified the low-volume threshold to include ECs and groups with $30,000 in Part B allowed charges OR 100 or fewer Part B patients. CMS intends to notify ECs and groups who fall below the low-volume threshold based on historical data in early 2017.

ACP Comments:
ACP thanks CMS for incorporating our recommendation that the Agency raise the threshold to $30,000 in Medicare Part B allowed charges OR require fewer than 100 unique Medicare beneficiaries be seen by the clinician, as this would help provide a better safety net for small practices and certain specialists/subspecialists with a small Medicare patient population. We also appreciate that CMS plans to notify ECs and group practices shortly after the start of the performance period of their status with regards to the low-volume threshold. We recommend that CMS provide additional guidance as to how group practices will be treated when a practice has previously reported as a group under a common TIN but may wish to be considered as individuals for the purposes of the low-volume threshold. ACP also encourages CMS to carefully consider to how individuals and groups that fall below the low-volume threshold will be treated when it comes to voluntary participation in virtual groups.

The College further recommends that CMS develop a hardship exceptions process for MIPS through which ECs can apply to CMS on a case-by-case basis with special circumstances that warrant exclusion from MIPS for a performance period. While the flexible reporting options are helpful in the transition year in allowing practices to avoid a negative payment adjustment through test participation, there may be some clinicians who would be unable to transition away from the current model of payment through no fault of their own; this might include ECs that are significantly impacted by a natural disaster such as a hurricane or earthquake, adoption of new technology that results in inability to report, hospital or practice closure, severe financial distress (bankruptcy), etc. In future years, it will be important to have an option for practices in exceptional circumstances to avoid being penalized.

1. Medicare Participation Status

Background:
The final rule states that "MIPS is a new program for certain Medicare-participating eligible clinicians."

ACP Comments:
The College reiterates its recommendation from our comments on the proposed rule that the Agency track the number and group size of participating clinicians that change their status to non-participating and make this data available, as this could cause access issues in the future.

G. Telehealth Services in MIPS

Background:
When defining different MIPS eligible clinicians (ECs), CMS finalized the inclusion of telehealth services within the definition of "patient-facing" or "face-to-face" encounters. In the past, telehealth services have not been included in the definition of patient-facing encounters when reporting quality measures through PQRS. The eligible telehealth services included in this definition of patient-facing encounters incorporate the use of telecommunications technology (e.g., real-time audio and video communication – or synchronous communications) as a substitute for a face-to-face encounter. Services provided with the use of telecommunications technology that do not use a real-time interactive communication between a patient and clinician (e.g., previously recorded audio and video – or asynchronous communications) are not considered telehealth services in this context.

CMS also finalized the inclusion of telehealth services within the Expanded Practice Access subcategory of the Improvement Activities performance category (previously called the Clinical Practice Improvement Activities performance category) with a "medium" weight as proposed.

ACP Comments:
The College appreciates CMS finalizing the inclusion of specific telehealth services within the definition of patient-facing encounters which aligns with recent ACP policy recommending "telemedicine be held to the same standards of practice as if the physician were seeing the patient in person." Moreover, the inclusion benefits ECs providing certain telehealth services who can now count these encounters towards the minimum threshold for patient-facing encounters when reporting on quality measures.

ACP also supports telehealth services being included within the Improvement Activities performance category – providing the opportunity to incentivize and expand the use of telehealth services. The College appreciates CMS' explanation regarding the weighting of these activities and how the designation of "high" weights are for "activities that directly address areas with the greatest impact on beneficiary care, safety, health, and well-being;" **however, we continue to recommend weighting the telehealth services activity under Expanded Practice Access as "high" to further incentivize the use of clinically relevant and appropriate telehealth services.** The College also supports the use of administrative claims data, when feasible, for reporting on this specific telehealth activity within the improvement activities performance category (e.g., an EC using the telehealth modifier GT code would receive automatic full credit for this activity without having to report it separately). **When this claims-based reporting option is available for ECs, it is a step towards lessening any unnecessary or duplicative reporting burden.**

Again, the College appreciates the addition of telehealth services to the provisions discussed above but recommends including additional language within future regulations that supports further expansion of telehealth services through lifting current telemedicine restrictions. ACP's letter of support[13] for the CONNECT for Health Act outlines some of the components necessary for continued meaningful expansion and incorporation of telehealth services within new health care models including the creation of demonstration projects that test lifting current telehealth restrictions for MIPS- and APM-ECs.

H. MIPS Performance Categories

1. Quality Performance Category

a. Measure Requirements

Background:
CMS finalized that MIPS eligible clinicians or groups that choose the full participation option must report at least six measures, including at least one outcome measure or other high priority area measure, during the initial performance period. The reporting period must be a minimum of 90 continuous days during 2017 for CMS to calculate the quality performance on a

[13] https://www.acponline.org/acp_policy/letters/acp_support_letter_connect_for_health_2016.pdf

measure. However, CMS is encouraging ECs and groups to report quality data for the full calendar year because some measures may require data that needs to be collected over a period of more than 90 days. If an applicable outcome measure is not available, then the clinician or group would be required to report on one high-priority measure (e.g., appropriate use, patient safety, efficiency, patient experience, and care coordination measures). The Agency did not finalize its proposal to require that one of the six measures be a cross-cutting measure.

The Agency expects ECs and groups to select measures for which they will be able to meet the case minimum requirements. The agency also states that if fewer than six measures apply to the EC or group, then the EC or group would be required to report on each measure that is applicable. In the case where a MIPS eligible clinician reports a measure that does not meet the required case minimum, he/she would not be scored on the measure but would receive three points for attempting to report on the measure. By receiving three points, the EC would meet the overall performance threshold and therefore avoid a downward payment adjustment. This three-point minimum is only finalized for the transition year, and CMS will revisit this policy in the future.

CMS will utilize a validation process to review and validate a MIPS eligible clinician's inability to report on the quality performance requirements that would function similar to the Measure Applicability Validity (MAV) process that occurred under PQRS, but with a few exceptions. This process will only be available for claims and qualified registry reporting. CMS expects ECs and groups to select a reporting mechanism in which they have six applicable measures to report. CMS also finalized using one population-based measure in the quality performance score, the all-cause hospital readmissions measure, for groups of 16 or more ECs. This measure will be calculated using claims data, so no additional data submission is required. CMS did not finalize use of the acute and chronic composite measures of Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQIs) in the quality performance score. However, this will be calculated for all ECs and included in feedback reports.

ACP Comments:
In our comments on the quality component of MIPS, it seems imperative to reiterate our call for CMS to use the opportunity provided through the new MACRA law to actively build a learning health and healthcare system. It is critically important that the new payment systems that are designed through the implementation of MACRA reflect the lessons from the current and past programs and also effectively allow for ongoing innovation and learning. **Overall, quality measurement must move toward becoming more relevant and accurate, and toward effective approaches of measuring patient outcomes.**

Additionally, as was noted in our comments to CMS on the draft Quality Measure Development Plan (MDP)[14], it is critically important to constantly monitor the evolving measurement system to identify and mitigate any potential unintended consequences, such as increasing clinician burden and burn-out, adversely impacting underserved populations and the clinicians that care for them, and diverting attention disproportionately toward the things being measured to the neglect of other critically important areas that cannot be directly measured (e.g., empathy, humanity). **Therefore, the College strongly recommends that CMS collaborate with specialty societies, frontline clinicians, patients, and EHR vendors in the development, testing, and implementation of measures with a focus on integrating the measurement of and reporting on performance with quality improvement and care delivery and on decreasing clinician burden.**

ACP appreciates that CMS finalized a reduction in the overall number of measures required for reporting from nine measures to six, as well as removing the requirement that these measures fall across all of the National Quality Strategy domains. However, the College would like to reiterate our overall concerns with the performance measures that are currently in use within the PQRS program, as well as many of those finalized for use within MIPS. To begin to address this issue in the short term, in our comments on the draft MDP, ACP called on CMS to utilize the core set of quality measures identified by the Core Quality Measures Collaborative. Therefore, we appreciate that the Agency has specifically identified those core measures within the proposed rule; however, the College believes that CMS could do more than simply include them in the overall list with identifying marks. At the very minimum, ACP recommends that the core measures be more clearly pulled out into their own table or set of tables so that clinicians do not need to wade through the entire list to find them.

Along these lines, the College recommends that any measures CMS proposes to use outside of the core set identified by the Core Quality Measures Collaborative be those recommended by the Measure Application Partnership (MAP). ACP remains concerned that a majority of new measures added to PQRS for the 2016 reporting year, and that remain on the proposed list of measures for the MIPS program, 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. Therefore, measures given the "encourage continued development" recommendation should be resubmitted to the MAP once the suggested development occurs.

Additionally, ACP continues to believe that it would be preferable for all measures, whenever possible and regardless of source, to go through a multi-stakeholder evaluation process—a role that is performed by the National Quality Forum (NQF). This process is important as it involves

14 https://www.acponline.org/acp_policy/letters/comments_cms_draft_quality_measures_development_plan_2016.pdf

measures being evaluated against four important criteria—importance to measure, scientifically acceptable, usable and relevant, and feasible to collect.

Given that the approaches outlined above could result in a fewer number of measures available overall, particularly for a number of internal medicine subspecialties and other specialties, **ACP also recommends that CMS take concrete actions to provide clear options for those specialties and subspecialties that may be most impacted by too few appropriate measures.** These actions, which are detailed in ACP's comments on the MACRA proposed rule,[15] should include:

- Developing a process to determine in advance of the reporting year which quality measures are likely applicable to each eligible clinician—and only holding them accountable for these relevant measures (i.e., weighting performance on the remaining measures higher, rather than penalizing them with a score of zero on unreported measures).
- Putting a process in place, for the short term, to address the significant issues of validity and ability to implement associated with using measures that are not MAP-recommended, NQF-endorsed, and/or ACP recommended.[16]
- Establishing safe harbors for entities that are taking on innovative approaches to quality measurement and improvement as was recommended in a recent article by McGlynn and Kerr. [17]
- Taking the recommendation regarding safe harbors a step further, the College also calls on CMS to provide clear protections for individual clinicians who participate in these types of activities—this could be done by having the entities register certain measures as "test measures." Eligible clinicians then would not be required to report a specific performance score on these test measures, but their participation testing these measures (as some established subset of the 6 required measures) would not count against them, and in fact could be given some level of points within the quality category and/or counted as an improvement activity.
- Ensuring that the flexibility for QCDRs to develop and maintain measures outside of the CMS selection process is protected (this recommendation is discussed further below).

The College also reiterates our recommendation, as outlined in our response to the draft MDP—that it will be critically important for CMS over the longer term to continue to improve the measures and reporting systems to be used in MIPS to ensure that they measure items of clinical relevance, move toward clinical outcomes and patient- and family-centeredness measures, and do not create unintended adverse consequences.

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[15] https://www.acponline.org/acp_policy/letters/comment_letter_macra_proposed_rule_2016.pdf
[16] https://www.acponline.org/clinical-information/performance-measures
[17] McGlynn, E.A. and E.A. Kerr. Creating Safe Harbors for Quality Innovation and Improvement. *JAMA.* 2016;315(2):129-130. http://jama.jamanetwork.com/article.aspx?articleid=2481012

i. Outcome Measures

Background:
CMS finalized its proposal that a MIPS EC or group will report at least six measures including at least one outcome measure to fully participate in the Quality Performance Category. If an applicable outcome measure is not available, the MIPS EC or group will be required to report one other high priority measure in lieu of an outcome measure. High priority measures address one of the following areas: appropriate use, patient safety, efficiency, patient experience, and care coordination.

ACP Comments:
The College reiterates our comments from the Quality Measure Development Plan regarding the use of outcome measures in the initial roll-out of MIPS. While ACP is strongly supportive of moving toward outcomes-based measures, as well as those focused on patient- and family-centeredness, care coordination, and population health and prevention, we do not recommend that CMS establish a minimum number of outcomes-based measures, at least initially. **Therefore, ACP is disappointed that CMS did not remove the mandate for clinicians to report on at least one outcome measure, even though we recognize there is flexibility in that a "high priority" measure may be used when an outcome measure is not available.** While the pick-your-pace reporting options are helpful in addressing this concern in the initial performance period, ACP recommends that CMS remove this as a requirement in subsequent years as ECs and groups are learning to ramp up their reporting capabilities. Clinicians that choose to use an outcome measure should be provided bonus points within the quality category in the interim as practices learn the basics of QPP reporting.

ii. Population-Based Measures

Background:
CMS proposed utilizing several population-based measures as part of the quality performance score. These measures would be calculated using claims data, so no additional submission is required by ECs. The Agency finalized the inclusion of the all-cause hospital readmissions (ACR) measure from the value-based modifier (VM) program, as CMS believes that this measure encourages care coordination. Groups with 16 or more clinicians who meet the 200-case volume will be evaluated on their performance on this measure, in addition to the six quality measures that are required for full participation.

CMS did not finalize its proposal to use acute and chronic composite measures of AHRQ PQIs that meet a minimum sample size in the calculation of the quality measure domain for the MIPS total performance score. The Agency believes that additional enhancements, including the addition of risk adjustment, need to be made to these measures prior to inclusion in MIPS. However, CMS will calculate these measures for all MIPS eligible clinicians and provide feedback for informational purposes as part of the MIPS feedback reports.

ACP Comments:
The College appreciates CMS' decision not to include the two AHRQ PQI measures in the quality performance score. However, ACP also recommends that CMS remove the ACR measure from the quality score for groups that meet the size and case minimum requirements. If CMS wants to continue to use this measure, ACP recommends that it be included in feedback reports as information only and excluded from the calculation of the quality performance score. We recognize that individual clinicians do have a responsibility to work collaboratively with their patients to address and mitigate, to the extent possible, population- and community-level issues that impact patient health and well-being. However, attributing population health measure outcomes to specific clinicians is not appropriate and, in fact, defeats the purpose of population health measures.

In order to move toward developing measures that are appropriate for individual clinicians, CMS must collaborate with clinicians and specialty societies to ensure that individuals are not held accountable for measures that are designed to assess community-level outcomes. However, recognizing that there is evidence that community-level interventions improve individual health outcomes, the College further recommends that CMS, and HHS more broadly, consider other approaches to support public health interventions and the work of the physicians involved in those efforts, including providing optional improvement activities points for the proposed population health measures and/or for participation in public health efforts within the improvement activities category of MIPS.

iii. Cross-Cutting Measures

Background:
Cross-cutting measures are measures that, for both individual and group reporting, are broadly applicable across multiple clinical settings and eligible clinicians within a variety of specialties. In order to reduce the complexity of the program, CMS did not finalize its proposal to require patient-facing clinicians to report at least one cross-cutting measure. However, the Agency seeks comments on what factors to consider regarding overall requirements for cross-cutting measures for future years.

ACP Comments:
While ACP is supportive of moving toward the use of cross-cutting measures, we appreciate that CMS did not finalize its proposal to require ECs to report on at least one cross-cutting measure in the initial performance period. As ECs and groups are learning to navigate the new reporting system under QPP, it is critical to allow them additional flexibility in choosing the types of measures that they report on to minimize the burden of reporting**. Therefore, ACP recommends that CMS hold off on requiring that a cross-cutting measure be mandatory for the Quality Performance Category for the early years of QPP implementation.** Only after CMS has determined that sufficient numbers of ECs, including those in solo and small practices and in rural areas, are able to satisfactorily report on the full amount of measures required in the

Quality Performance Category should the Agency consider adding in mandates as to the types of measure that must be included.

iv. Patient Experience Measurement (i.e., CAHPS for MIPS)

Background:
With regard to reporting on patient experience, CMS finalized its policies as proposed to allow registered groups of two or more ECs to voluntarily elect to participate in the Consumer Assessment of Healthcare Providers & Systems (CAHPS) for MIPS survey. Groups that choose to report via the CAHPS survey must use a CMS-approved survey vendor. The CAHPS survey counts as one of the six measures that must be reported for full participation in the Quality Performance Category. The CAHPS for MIPS survey counts in both the Quality Performance Category and as a high-weighted activity in the Improvement Activities Performance Category.

ACP Comments:
The College appreciates that CMS has now added this as an option in the Improvement Activities Performance Category. In line with the comments on the CMS Quality Measure Development Plan,[18] **ACP strongly recommends that reporting CAHPS for MIPS remain voluntary at a minimum in future years—and further recommends that this survey be removed from the quality component.**

Additionally, in order to more cohesively address the issue of patient experience, **the College recommends that CMS consider an approach recently outlined by McGlynn, Schneider, and Kerr,[19] which calls on measure developers to actively consider how to integrate patient preferences and goals into measure design**—this would involve investments in new methods and systems with a focus on having quality measurement be part of care delivery "rather than existing as a parallel."

As CMS considers developing additional patient experience measures such as patient-reported outcomes measures (PROMs), the College reiterates its recommendations from our letter on the draft Quality Measure Development Plan that CMS ensure that any PROMs being developed undergo substantive testing to ensure that they are valid and reliable, do not place additional burdens on physicians in the collection and reporting of data, are minimally burdensome on patients, and are actually shown to have an evidence base that indicates that they are measuring quality improvement.

Additionally, to decrease the burden on patients and physicians, CMS should make PROMs as flexible as possible by allowing for multiple methods and modes of administration to best fit

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[18] https://www.acponline.org/acp_policy/letters/comments_cms_draft_quality_measures_development_plan_2016.pdf

[19] Elizabeth A. McGlynn, Ph.D., Eric C. Schneider, M.D., and Eve A. Kerr, M.D., M.P.H. "Reimagining Quality Measurement." N Engl J Med 2014; 371:2150-2153. http://www.nejm.org/doi/full/10.1056/NEJMp1407883.

with the unique needs of both the patient and physician practice (i.e., computer/internet access, Smart phone technologies, computer software/programming, EHR interfaces, etc.). CMS should also ensure that patients and families/caregivers be included throughout the PROM development process. It is important that the patients and families who will be tasked with reporting any data be involved in providing input in any patient measures being developed to ensure that the burden on patients is minimized and the measures being developed are evaluating outcomes that matter to the patient.

v. Risk Adjustment of Quality Measures

Background:
CMS is required to take into account the relevant studies conducted and recommendations made in reports under the Improving Medicare Post-Acute Transformation (IMPACT) Act of 2014, which requires the Office of the Assistant Secretary for Planning and Evaluation (ASPE) to conduct studies on the issue of risk adjustment for sociodemographic factors on quality measures and cost as well as other strategies for including social determinants of health status evaluation in CMS programs. The Agency will closely examine the ASPE studies when they are available and incorporate findings as feasible and appropriate through future rulemaking. CMS will also monitor outcomes of beneficiaries with social risk factors, as well as the performance of the MIPS eligible clinicians who care for them to assess for potential unintended consequences such as penalties for factors outside the control of clinicians.

ACP Comments:
The College continues to believe that valid risk adjustment is essential for the success of MACRA implementation, particularly for outcome and population-based measures. It is critical that clinicians and practices not be penalized for taking care of patients in underserved areas and/or with characteristics that are more likely to lead to worse outcomes. This is true both under the MIPS pathway, within the Quality and Cost components, and within the Alternative Payment Model (APM) pathways as it affects benchmarking, quality calculations, and the adequacy of various upfront (e.g. care management payment under CPC+) and backend (MSSP shared savings) payments. As a result, **the College reiterates its recommendation that CMS use its resources in an active effort to continually improve the risk adjustment methodology employed within MACRA implementation.** The College believes that the current Medicare HCC risk adjustment approach is a significant improvement from previously used methodologies. We look forward to the completion of studies being conducted by ASPE on the issue of risk adjustment for socioeconomic status on quality measures and resource use, and the use of this information to improve further the risk adjustment methodology currently being applied.

Along these lines, ACP recommends that the Agency actively work to incorporate socioeconomic status (SES) into its risk adjustment methodologies given that there is existing literature on the impact of SES on the rates of hospitalizations, readmissions, and other factors—and the ASPE report, once available, can be additionally informative on this issue. Ideally, and perhaps over time, this adjustment would be patient-specific (e.g., based on his/her

specific income, education, etc.); however, in the short term an aggregate marker, such as ZIP code, could be used—particularly as recent data suggest that zip codes can be used to identify social determinants of health.

b. QCDRs

Background:
Quality measures that are used in QCDRs are excluded from many of the requirements that other measures utilized in MIPS must undergo. They do not need to go through notice and comment rulemaking; be published in the *Federal Register*; or be submitted for publication in specialty-appropriate, peer-reviewed journals. If a QCDR chooses to use non-MIPS measures (measures that are not part of the MIPS quality measures set), these measures must go through a rigorous approval process by the Agency. This includes a review and analysis of measure specifications for scientific rigor, technical feasibility, duplication pertaining to current MIPS measures, clinical performance gaps evidenced by background and/or literature review, and relevance to specialty practice quality improvement. While non-MIPS measures used by QCDRs are not required to be NQF-endorsed, CMS encourages QCDRs to select NQF-endorsed measures and measures that have been in use prior to MIPS.

ACP Comments:
While the College appreciates that MACRA requires the Secretary to encourage the use of QCDRs for quality reporting, ACP still has concerns with the more stringent approach that CMS has taken in reviewing QCDR measures that are not NQF-endorsed or PQRS measures recently. While the requirements in the rule pertaining to QCDR measures are consistent with what has been in place in the past, the College is concerned that it appears that CMS is trying to push QCDRs to limit their quality measures selections to those that are currently used in PQRS (and soon in MIPS) and those with NQF-endorsement. ACP supports the use of NQF-endorsed and MAP-recommended measures overall. However, the College emphasizes that QCDRs have been given special treatment under law that explicitly allows them to use measures that are that do not go through the vetting process that MIPS measures must undergo. Therefore, **the College continues to recommend that CMS ensure that the flexibilities that were given to QCDRs in law to develop and maintain measures that are outside of the CMS selection process are protected.**

The College was disappointed that CMS will continue to limit the number of non-MIPS measures that a QCDR can request to report on to 30 measures and limits each QCDR to only using its own non-MIPS measures but we were pleased that the Agency will evaluate the feasibility of adding additional measures in the future. These limits place unnecessary restrictions on QCDRs that may result in the inability of a QCDR to include sufficient numbers of measures to allow them to be used by all subspecialty and sub-subspecialty clinicians who may wish to utilize them due to a dearth of specialty-specific measures within the MIPS measure set. **ACP encourages CMS to remove the arbitrary restriction on the number of non-MIPS measures that a QCDR can utilize.** Further, the College recommends that CMS allow QCDRs to

utilize measures from other QCDRs (with permission). By allowing QCDRs to use more non-MIPS measures, including those from other QCDRs, multi-specialty practices will have more opportunities to select a QCDR with measures that are relevant to the different specialties and subspecialties in the practice.

In an effort to promote transparency and allow measure developers more insights into the measurement evaluation process, **the College continues to recommend that the Agency publish the specific criteria that they plan to use in evaluating QCDR measures moving forward.** Many internal medicine subspecialist organizations have invested in QCDRs and their own specialty measures development processes to specifically give subspecialists a broader array of quality measures that are specific to their scope of practice. These measures are difficult and costly to develop and maintain. Placing arbitrary limitations on or denying the use of these specialty-specific measures will leave many physicians with few options that are relevant to their practice. QCDRs also play an important role in the development and testing of new, more relevant measures. ACP recommends that CMS publish specific guidance on the criteria it will use in allowing QCDRs to select measures outside of the CMS and NQF processes. **If CMS decides to deny the use of a measure in a QCDR, the College also recommends that the Agency provide the measure developer/steward with specific information on what criteria were not met that led to a measure not being accepted for use and provide a process for immediate reconsideration when the issues have been addressed.** Again, we make this recommendation so that measure developers can quickly address CMS concerns.

c. Data Completeness Criteria

Background:
CMS did not finalize its proposal to increase the data completeness thresholds to 80 to 90 percent. Instead, the Agency finalized the following:

- For clinicians and groups reporting on quality measures using QCDRs, EHRs, or qualified registries, physicians/groups must report on at least 50 percent of the patients that meet the measure's denominator criteria, regardless of the payer. For the initial performance period, ECs who do not meet the data completeness threshold will receive 3 points for submitting the measure.
- For clinicians using claims reporting, at least 50 percent of the Medicare Part B patients for which the measure applies. For the initial performance period, ECs who do not meet the data completeness threshold will receive 3 points for submitting the measure.
- Groups submitting quality measures using the CMS Web Interface or the CAHPS for MIPS survey need to meet the data submission requirements on the sample of Part B patients that CMS provides.

CMS also finalized increasing the data completeness threshold to 60 percent in the second performance period (2018). The Agency plans to further increase the data completeness threshold in 2019 and subsequent years. The Agency believes that higher thresholds are appropriate to ensure a more accurate assessment of a MIPS EC's performance on the quality

measures and to avoid any selection bias. Additionally, CMS is requesting all-payer data for QCDR, EHR, and qualified registry submission mechanisms because the Agency believes it will provide a more complete picture of the scope of practice of each clinician as well as provide access to data about specialties and subspecialties that is not currently captured in PQRS. Submissions using these mechanisms must also contain a minimum of one quality measure for at least one Medicare patient.

The Agency also modified its proposal to allow ECs that report measures that fall below the data completeness threshold to receive three points rather than failing the quality component. This 3-point floor will ensure that ECs who attempt to report on a quality measure avoid a downward payment adjustment. Measures that fall below the data completeness threshold will not be scored for the transition year.

ACP Comments:
The College appreciates that CMS accepted our recommendation to maintain the current 50 percent data completeness requirements for quality reporting during the first performance period under MIPS. An increase in the data reporting requirements to 80 or 90 percent, as was proposed, would have placed a significant additional administrative burden on clinicians and practices at a time when they are trying to learn and understand the new, complicated requirements of QPP and navigate the varying reporting requirements in each performance category.

Given the flexible reporting options that are available in the transition year, the College urges CMS to maintain the 50 percent data completeness criteria in future years as ECs are learning how to report under QPP. Clinicians who choose the test participation or partial participation options are unlikely to be prepared to submit a full set of quality measures data for 60 percent of their patients for a full year in 2018. The data completeness criteria should remain stable at 50 percent for subsequent years as these clinicians are learning to successfully report. **ACP further recommends that that higher data completeness requirements are phased in only after review has determined that doing so is both appropriate and feasible and that CMS utilize a slow, incremental phase-in of any new data completeness requirements for quality reporting in MIPS.**

d. Topped-out Measures

Background:
A quality measure may be considered topped out if performance is so high and unvarying that meaningful distinctions and improvement in performance can no longer be made. For the purposes of this rule, CMS defines topped out non-process measure as a measure where the Truncated Coefficient of Variation is less than 0.10 and the 75th and 90th percentiles are within 2 standard errors and a topped out process measure as a measure with a median performance rate of 95 percent or higher.

CMS modified its proposal to allow measures that are in the first year of being identified as topped out to be treated in the same manner as other measures for that year. CMS is seeking feedback on how to treat a measure in the second year that the measure is identified as topped out. The Agency proposes to modify the benchmark methodology in the second year that a measure is topped out to set the maximum number of points for a topped out measure at the midpoint of the highest and lowest scores within a cluster. Alternately, CMS proposes to remove the topped out measure in its second year or apply a flat percentage to the benchmark.

ACP Comments:
ACP appreciates that CMS accepted our recommendation that measures in the first year of being identified as topped out will be treated in the same manner as other measures and maintain the 10-point maximum scoring standard. However, the College remains concerned that CMS is contemplating removing or reducing the maximum number of points for topped out measures in the second year without regard for the value of the quality actions that are being measured. Removing a measure from scrutiny, just because the measure is topped out, could actually lead to slippage in what had been consistently excellent performance. This approach could actually put patients at risk simply due to an exclusive focus on the data, rather than on the impact of the actions underlying the measure on patient care. We further recommend that CMS keep topped out measures under the same scoring standard as other quality measures for at least the first few performance periods under MIPS. As ECs and groups are learning to meet the new reporting requirements under QPP, it will be important to maintain stability in the program to reduce the burden on clinicians and avoid any added confusion in the measure selection process.

Additionally, ACP reiterates its recommendation that CMS publicly disclose any measures that are topped out prior to a performance period in advance. This can be done as part of the publication of the final quality measures each year, which must be published by November 1 of the year prior to the performance period. Along with this information, CMS should also publish the statistics of any measures that are nearing the topped out status prior to the performance period. Because physicians often select the same measures to report year-after-year, it will be important for them to know in advance which measures are close to topping out in advance of the performance period so that they have the opportunity to select alternate measures. Since credit can be given for improving on performance from year-to-year, information on topped out measures as well as those nearing topped out status is important as physicians select which measures to report on.

e. CEHRT Bonus for Quality Performance Category

Background:
CMS finalized their proposal to allow one bonus point for each reported quality measure under the Quality Performance Category score and also increased the CEHRT bonus point cap from the proposed five percent to ten percent of an EC's overall Quality Performance Category score. The ten percent bonus cap will be available through the first two years of the program with the

intention that the Agency will lower the cap through future rulemaking. The CEHRT bonus is available for all submission mechanisms except claims submissions. Therefore, MIPS ECs who report through qualified registries, QCDRs, EHR submission mechanisms, and CMS Web Interface in a manner that meets the "end-to-end electronic" reporting requirements may receive on bonus point for each reported measure up to a maximum of ten percent of their total Quality Performance Score.

CMS also expanded their proposed "end-to-end electronic" reporting requirements to a wider array of reporting pathways – including those pathways not yet capable of supporting *all* of the required standards for the necessary data elements outlined in the proposed rule.

ACP Comments:
The College applauds CMS for taking our recommendations into consideration and allowing ECs to obtain the CEHRT bonus for reporting to otherwise qualified registries that are not yet capable of supporting the required standards for the submission of *all* data elements. ACP is supportive of CMS' and The Office of the National Coordinator for Health IT's (ONC's) vision and goals for standards-based, interoperable methods for managing quality measurement data; however, in this case, if physicians see the clinical value and are willing to perform the additional work to report to such registries – they should not be penalized.

2. Cost (Resource Use) Performance Category

Background:
CMS initially proposed to use three types of measures for the cost performance category: total per capita cost, Medicare spending per beneficiary (MSPB), and episode-specific measures. These measures would be calculated using claims data, so no additional submission is required for this performance category. Each measure would be worth 10 points, and physicians would receive an average score of all cost measures that can be attributed. The average score of the measures was proposed to count for the 10 percent of the overall MIPS composite performance score. Through the transition year policies in the final rule outlined earlier in this letter, CMS modified these provisions and lowered the weight of the Cost Performance Category score to zero percent of the overall MIPS composite performance score.

Although cost measures will not be used to determine the final score in the transition year, the Agency still intends to calculate performance on measures of total per capita costs for all attributed beneficiaries and a Medicare Spending per Beneficiary (MSPB) measure during the 2017 "transition" performance year. CMS limited calculations to these measures because they have previously been included in the Value-based Modifier (VM) and/or the 2014 Supplemental QRUR (sQRUR) and have shown to be reliable measures for both individual and group reporting. CMS also finalized ten episode-based measures that met reliability standards and were previously made available to physicians through feedback reports. In performance year 2018, and as performance feedback on cost measures is available on at least an annual basis, CMS finalized that the cost performance category will account for ten percent of MIPS

composite performance score affecting physician payments in 2020. MACRA then requires that the Cost Performance Category account for 30 percent of the MIPS by the third MIPS payment year of 2021.

CMS will continue to develop care episode groups, patient condition groups, patient relationship categories, as well as codes associated with these groups, and provide the opportunity to comment on through future notice and rulemaking.

ACP Comments:
The College applauds CMS for reducing the Cost Performance Category down from 10 percent to zero percent of the overall MIPS composite score in the first performance period. As stated in our comments on the proposed rule, the cost measures have not proven to be reliable, validated measures in their application to physicians. Since CMS did not indicate that they will be using different claims measures to calculate the Cost Performance Category score in future performance years, the College would like to reiterate our concerns about the measures in general. The total per capita cost measure and the MSPB measure are carried over from the VM program. These measures inappropriately attribute broad-based costs to physicians for services that are outside of their control and that they do not have the ability to impact such as costs associated with hospitalizations and other care settings that occur outside of the physician's practice.

ACP also has concerns with the 20 case minimum that is being applied to cost measures. This minimum seems like an arbitrary number of cases that is not reflective of appropriate reliability and validity for factors such as practice size, specialty, etc. Additionally, ACP is concerned that CMS proposes to reduce the case minimum for the MSPB measure. CMS just increased the case minimum for the MSPB measure from 20 to 125 as a part of the FY 2016 Physician Fee Schedule, so it seems premature and arbitrary to drop this case minimum back down to 20 before there has been sufficient time for data collection and analysis to show that a reduction of this magnitude is warranted. At a minimum, additional transparency is needed from CMS as to how the Agency arrived at the 20-case minimum amounts for each cost measure and a variety of factors such as practice size and physician specialty would be impacted through various options if other approaches or factors were used in this determination.

The cost measures also lack proper risk adjustment methodologies such as adjustments for socioeconomic status. Failing to properly risk adjust creates a system that inappropriately penalizes physicians with higher numbers of lower income or frailer patients, which could cause physicians to cherry-pick the patients that will be less costly at the detriment of those most in need of care. While we realize that CMS is in the process of studying how socioeconomic status could be incorporated into risk adjustment methodologies, it is imperative that appropriate risk adjustment be factored into cost measures.

Given the remaining concerns with the cost measures, ACP recommends that CMS zero out the cost performance category in the second performance year as well and continue to focus

on the development and refinement of the new code sets to ensure than when cost is accounted for in the composite performance score, it is done in a more appropriate manner that factors in components such as patient condition and the costs associated with clinicians in the role in which they treat each patient.

3. Improvement Activities Performance Category

Background:
CMS defines an improvement activity as one that relevant MIPS eligible clinicians, organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes. CMS finalized allowing eligible clinicians or groups to select from a list of more than 90 activities listed in Table H of the rule. The activities are grouped in these 9 categories:

- Expanded Practice Access
- Population Management
- Care Coordination
- Beneficiary/Patient Engagement
- Patient Safety and Practice Assessment
- Participation in an Advanced APM
- Achieving Health Equity
- Emergency Response and Preparedness
- Integrated Behavioral and Mental Health

The Agency finalized a 90-day performance period for the Improvement Activities Performance Category, which must occur entirely during calendar year 2017 for the transition year. Year one will require a yes/no response from the eligible clinician or group on the improvement activity inventory.

Scoring: Activities have been weighted as high or medium based on alignment with CMS national priorities or requiring performance of multiple activities such as participation in the Transforming Clinical Practice Initiative. Activities weighed high are given 20 points each and those that are medium receive 10 points each. In order to receive the highest potential score of 100 percent (40 points), two high-weighted improvement activities (20 points each) or four medium-weighted improvement activities (10 points each), or some combination of high and medium-weighted improvement activities to achieve a total of 40 points. This is a reduction from the proposed rule, which required ECs to earn 60 points for full credit. To achieve a 50 percent score, one high-weighted or two medium-weighted activities are required for these MIPS eligible clinicians or groups.

Exception: For small group practices (consisting of 15 or fewer clinicians), groups located in rural areas or geographic health professional shortage areas (HPSAs), and non-patient-facing ECs or groups, point values are doubled. Therefore, in order to achieve the highest score of 100

percent, two medium-weighted or one high-weighted activity is required to achieve full points for the improvement activities category.

ACP Comments:
The College appreciates that CMS accepted our recommendation and reduced the number of activities that must be reported to earn full credit in the Improvement Activities Performance Category. We further thank the Agency for making accommodations for small, rural, and non-patient facing physicians to be able to meet reduced requirements to earn credit in this category. The requirement for the reporting period to be for 90 days is also greatly appreciated. ACP encourages CMS to continue to make sure that improvement activities are not too prescriptive to allow clinicians and practices to be innovative as they strive to transform their practices to improve quality for their patients. The College also reiterates the recommendation (outlined above) that CMS revise the number points and activities required for full credit in the Improvement Activities Performance Category to be more directly reflective of their weight in the overall performance score.

We applaud the requirement that only attestation is required for this Category. By requiring only attestation, this will relieve the issue of administrative burden that is having an increasing impact on physicians. The College also appreciates CMS accepting our recommendation that those participating in an APM receive full credit in the Improvement Activities Performance Category based on the requirements of their APM structure. Successful APM participation warrants that a practice is already performing many of the activities identified in in this Category and attesting to additional activities would be redundant. We further recommend that the Agency make permanent the full credit in the Improvement Activities Performance Category that is given to MIPS APMs in year 1 rather than undergoing a review each year.

The College strongly supports CMS' current inclusion of use of QCDRs in several improvement activities and the Agency's attempt to streamline some of these options with to allow dual credit opportunities under the Advancing Care Information Performance Category. This will incentivize physician participation in robust clinical data registries that provide feedback to participating clinicians and drives improvement in quality of care.

The College also reiterates our recommendations for adding certain programs to the improvement activities list, which are outlined in further detail in our comments on the proposed rule:[20]

- Inclusion of completing ACP Practice Advisor® modules as an Activity in the subcategory of Patient Safety and Practice Assessment.
- Inclusion of ACP's High Value Care resources,[21] which can be used by clinicians to implement optimal diagnostic and treatment strategies in their practice, including

[20] https://www.acponline.org/acp_policy/letters/comment_letter_macra_proposed_rule_2016.pdf
[21] https://www.acponline.org/clinical-information/high-value-care

Clinical Guidelines & Recommendations, a Pediatric to Adult Care Transitions Toolkit, the High Value Care Coordination Toolkit, as well as High Value Care Cases.

- Allowing credit for certain defined CME activities:
    - Accredited CME activities that involve assessment and improvement of patient outcomes or care quality, as demonstrated by clinical data or patient experience of care data.
    - Accredited CME that teaches the principles of quality improvement and the basic tenets of MACRA implementation, including application of the "three aims," the National Quality Strategy, and the CMS Quality Strategy, with these goals being incorporated into practice.

The College also recommends that CMS establish a clear and transparent process for adding new items to the list of improvement activities that facilitates broad stakeholder input. This process should be driven by evaluation of which activities are being reported in prior years. Efforts should be made for the activities to be applicable to a wide variety of clinicians and practice settings and, to the extent possible, be based upon evidence that they have an impact on improving patient outcomes. **Along these lines, ACP reiterates is recommendation that CMS permit practicing clinicians to submit alternative activities for credit and/or consideration for future credit, as this will help ensure that clinicians are able to identify and undertake quality improvement activities aimed at meeting their own specific goals, even if those activities are not yet included on the improvement activities list.** It is critical that the Improvement Activities Performance Category of MIPS facilitate ongoing improvement and innovation—and not become a stagnant list that, over time, could make clinicians feel overly frustrated or limited.

a. Patient-Centered Medical Homes within the MIPS Improvement Activities Performance Category

Background:
The MACRA law specifies that a MIPS eligible clinician or group that is certified as a patient-centered medical home (PCMH) or comparable specialty practice, as determined by the Secretary, with respect to a performance period must be given the highest potential score for the improvement activities performance category. CMS has defined a PCMH for the purposes of full credit within the CPIA category as one that "is a nationally recognized accredited patient-centered medical home, a Medicaid Medical Home Model, or a Medical Home Model."

CMS finalized its proposal that a MIPS eligible clinician or group as being a certified patient-centered medical home or comparable specialty practice if they have achieved certification or accreditation as such from a national program. The Agency expanded this definition in the final rule to also include a regional or state program, private payer or other body that administers patient-centered medical home accreditation and certifies 500 or more practices for patient-centered medical home accreditation or comparable specialty practice certification. The

finalized definition for the purposes of receiving full credit in the improvement activities category is as follows:

A practice is certified as a patient-centered medical home if it meets any of the following criteria:

(A) The practice has received accreditation from one of four accreditation organizations that are nationally recognized;
  (1) The Accreditation Association for Ambulatory Health Care;
  (2) The National Committee for Quality Assurance (NCQA);
  (3) The Joint Commission; or
  (4) The Utilization Review Accreditation Commission (URAC).

(B) The practice is participating in a Medicaid Medical Home Model or Medical Home Model.

(C) The practice is a comparable specialty practice that has received the NCQA Patient-Centered Specialty Recognition.

(D) The practice has received accreditation from other certifying bodies that have certified a large number of medical organizations and meet national guidelines, as determined by the Secretary. The Secretary must determine that these certifying bodies must have 500 or more certified member practices, and require practices to include the following:
  (1) Have a personal physician/clinician in a team-based practice.
  (2) Have a whole-person orientation.
  (3) Provide coordination or integrated care.
  (4) Focus on quality and safety.
  (5) Provide enhanced access.

For a definition of Medical Home Model and Medicaid Medical Home Model, see the background portion of the Advanced APMs comments below.

ACP Comments:

The College sincerely appreciates CMS' active implementation of this component of the law—as it is critically important to facilitate movement by all clinicians toward care that is truly patient-centered, coordinated, and comprehensive. ACP has been a leader in supporting the medical home model, particularly in light of the plethora of currently available research [22] linking the model to higher quality and lower costs. **ACP applauds CMS for incorporating our recommendation that the Agency broaden its definition of patient-centered medical home and comparable specialty practices for the purposes of full improvement activities credit to specifically be inclusive of programs that have a demonstrated track record of support by non-Medicare payers, state Medicaid programs, employers, and/or others in a region or state (but that do not yet meet all of the requirements to be deemed an advanced APM program**

[22] Patient Centered Primary Care Initiative. The Patient-Centered Medical Home's Impact on Cost and Quality. Annual Review of Evidence 2014-2015. Available at http://www.milbank.org/uploads/documents/PCPCC_2016_Report.pdf

per the recommendation later in this letter). The programs to be included should be clearly articulated by CMS in advance, along with transparent criteria and methodology for the addition of new PCMH programs.

Additionally, **ACP recommends that CMS carefully consider the 500-practice certification requirement that it has placed on those non-national recognition entities (e.g., state or regional, private payers, etc.) to determine the appropriateness of that threshold and allow flexibility as warranted.** The College is concerned that some entities with PCMH programs, such as those that are in areas largely or entirely rural, may meet all other requirements but fall short of the 500-practice threshold. CMS should be flexible in allowing programs that meet all requirements other than the arbitrary 500-practice threshold to meet the PCMH certification requirement and thereby allow practices it certifies to receive full credit in the improvement activities category. At a minimum, CMS should allow these certification entities to be considered on a case-by-case base while the Agency explores the appropriateness of setting a specified practice threshold.

4. Advancing Care Information Performance Category

Background:
CMS finalized that the Advancing Care Information (ACI) Performance Category (formerly the EHR Incentive Program or "Meaningful Use") be composed of two scores, each valued at half of the total score. The "base score" is intended to measure participation and reporting, and a "performance score" is intended to measure performance at varying levels above the base score.

The proposed measures within the ACI category, for both the base and performance scores, are revised from the Modified Stage 2 and Stage 3 of Meaningful Use (MU) program and focus on interoperability, digital patient engagement, information exchange, and security.

The ACI reporting requirements are lower than the thresholds established for Meaningful Use Modified Stage 2 and Stage 3 of the EHR Incentive Programs to provide flexibility for clinicians as they transition to the MIPS program in the first year. To avoid a negative payment adjustment in the first year of the program, clinicians need only do the five base measures.

To improve the ACI score, and thus optimize their overall MIPS Composite Score, clinicians can perform additional measures to raise the Performance Score. There are nine performance score measures, three of which are required measures in the base score and will be awarded a score for performance. For the three repeated base measures, the difference is what gets reported.

In addition to the base and performance scores for the ACI category, CMS finalized supplementary attestation requirements include cooperation with surveillance and direct review of CEHRT and prevention of information blocking.

The “Pick Your Pace’” program announced prior to the release of the final rule allows ECs flexibility in reporting requirements. A clinician can elect to report on a shorter performance period than the proposed full calendar year, under which they must report a minimum amount of data to avoid negative adjustments, partial submission of a performance period of any consecutive 90 days during 2017 or submit a full year.

ACP Comments:
ACP is encouraged by the improvements made from the proposed rule to the final rule with comment period around simplifying the reporting requirements and scoring methodology within the ACI category; however we still have concerns about its direction, complexity, and ability to be implemented. This will be discussed in more detail in later comments.

The Meaningful Use program (MU) has achieved its objective of near universal adoption of EHRs by physicians and hospitals. For that reason, the College would have liked to see the program sunset completely in 2019 with the understanding that other components within MIPS could provide a clearer direction for the use of EHRs and health IT (i.e., improving quality and reducing cost) without prescriptive measures. The College understands that CMS’ interpretation of the HITECH Act does not permit CMS to sunset the MU program. ACP recommends that MU should continue within MIPS as a vehicle for learning. This would be accomplished by re-crafting the program so that it demonstrates how doctors and hospitals use health IT in care delivery rather than through repeated use of the same EHR-functions regardless of how they practice.

Performing EHR functions simply to demonstrate ability to do so is not the best way to move health IT forward. While CMS has reduced the thresholds for the ACI measures to either “1” or “yes,” these are still thresholds (as discussed in further detail below). Given CMS’ continuation of these requirements, the ACP appreciates the change in the proposed rule requiring reporting on 11 base measures, reduced to four or five base measures (based on EHR edition) in the final rule. To avoid a negative payment adjustment in the first year of the program, clinicians need only perform the five base measures.

While we appreciate that three of the five base measures will be awarded credit in the performance categories) and thus allow clinicians to more readily comply with the program; we are concerned that CMS is using rulemaking to encourage performance where the evidence is lacking. Specifically, we challenge the underlying concept that simply triggering a process of EHR function results in better care. Some performance measures seem like good ideas, but have no actual evidence of value. There must be clear field-based evidence of clinical value and valid measure design so that clinicians and patients find the data useful. Medical research has repeatedly shown that it is dangerous to just assume that “more is better.” **We strongly recommend that CMS rethink their position on ACI Performance Scores in future rulemaking.**

Table 1: Comparison between CMS and ACP ACI Performance Category Proposal

CMS ACI Performance Category		ACP ACI Performance Category	
BASE SCORE		**BASE SCORE: Auto-Calculated from EHR**	
Protect Patient Health Information			
Measure	**Requirement**	**Measure**	**Requirement**
Security Risk Analysis	Yes/No Attestation **(YES required)**	Security Risk Analysis	Yes/No Attestation **(YES required)**
Electronic Prescribing			
Measure	**Requirement**	**Measure**	**Requirement**
ePrescribing	#/# **(at least 1)**	ePrescribing	#/# **(no minimum)**
Patient Electronic Access			
Measure	**Requirement**	**Measure**	**Requirement**
Patient Access	#/# **(at least 1)**	Patient Access	#/# **(no minimum)**
No longer Required for Base Measure		Patient Specific Education	#/# **(no minimum)**
Coordination of Care Through Patient Engagement			
Measure	**Requirement**	**Measure**	**Requirement**
No longer Required for Base Measure		View, Download or Transmit (VDT)	#/# **(no minimum)**
		Secure Messaging	#/# **(no minimum)**
		Patient-Generated Health Data	#/# **(no minimum)**
Health Information Exchange:			
Measure	**Requirement**	**Measure**	**Requirement**
Patient Care Record Exchange	#/# **(at least 1)**	Patient Care Record Exchange	#/# **(no minimum)**
Request/Accept Patient Care Record	#/# **(at least 1)**	Request/Accept Patient Care Record	#/# **(no minimum)**
Public Health and Clinical Data Registry Reporting			
No longer Required for Base Measure		**Measure**	**Requirement**
		Immunization Registry Reporting	Yes/No

PERFORMANCE SCORE	
Patient Electronic Access:	
Patient Access	Up to 10%
Patient Specific Education	Up to 10%
Coordination of Care Through Patient Engagement:	
View, Download or Transmit (VDT)	Up to 10%
Secure Messaging	Up to 10%
Patient-Generated Health Data	Up to 10%
Health Information Exchange:	
Patient Care Record Exchange	Up to 10%
Request/Accept Patient Care Record	Up to 10%
Clinical Information Reconciliation	Up to 10%
Public Health and Clinical Data Registry Reporting	
Clinical Data Registry Reporting	BONUS
Electronic Case Reporting	BONUS
Immunization Registry Reporting	BONUS
Public Health Registry Reporting	BONUS

HEALTH IT ACTIVITIES SCORE	
Proposed Activities:	
EHR/HIT Educational Activity	Points TBD
Patient Engagement Activity	Points TBD
Precision Medicine/Learning Health System Participation	Points TBD
Clinical Informatics Improvement	Points TBD
Quality, Safety, Value Improvement in HIT	Points TBD
Patient Safety and Near-miss Reporting	Points TBD
Development of eCQMs	Points TBD

For calendar year 2017, acknowledging that the final rule contains Performance Scores, the ACP is pleased that ECs have been given the ability to select among a longer list of health IT-specific activities that are appropriate to the specialty of the EC.

The ACP is happy to see that CMS finalized a policy to allow ECs to achieve bonus points when they use functions included in CEHRT to complete one of the activities listed in the new improvement activity performance category.

ACP strongly urges CMS to keep the "Pick Your Pace" level of reporting requirements for a minimum of years two and three of the MIPS program, and perhaps indefinitely. Since the passage of the HITECH Act in 2009, clinicians have constantly been in the process of adopting, implementing and upgrading EHR systems while simultaneously trying to navigate the continually changing landscape of reporting requirements for incentive programs. After 8 years of ongoing change, clinicians need a reprieve from the cycle of implementing new reporting requirements in order to give them time to become effective and efficient under the current MIPS landscape.

Maintaining the "Pick Your Pace" level of reporting requirements not only interrupts the status quo of regulation after regulation, but allows CMS to monitor the evolving measurement system to identify and mitigate any potential unintended consequences, such as increasing clinician burden and burn-out, adversely impacting underserved populations and the clinicians that care for them. This level of reporting would allow clinicians to reconnect with their patients; putting them back at the center of care and reassuring them that EHRs are tools to help provide an enhanced level of care, not a distraction.

More specifically, CMS has requested comment and feedback around a variety of initiatives within the ACI portion of the regulation—these comments are below.

a. Integration of ACI and Improvement Activities Performance Categories

Background:
CMS identifies a set of improvement activities from the improvement activities performance category that can be tied to the objectives, measures, and CEHRT functions of the ACI performance category and would qualify for the bonus in ACI. CMS will award a 10 percent bonus if a MIPS eligible clinician attests to completing at least one of the improvement activities specified. CMS is seeking comment on this integration of the improvement activities with the advancing care information performance category, and other ways to further the advancement of health IT measurement.

ACP Comments:
Because of the HITECH Act and the incentive programs, EHR adoption is almost universal. When looking at the learning healthcare system and exploring ways to further advance the use of health IT, there is an opportunity to be less prescriptive. This supports innovation and flexibility

in how EHRs and other health IT is built and used; in turn rewarding measurements of good care and outcomes. To do this in a post Meaningful Use health IT world, **ACP strongly recommends that CMS eliminate all thresholds and scores and reward clinicians for participation in the learning healthcare system.** An example of this is what CMS done with ePrescribing. ePrescribing is specifically mentioned in the HITECH Act and yet CMS has chosen to transform how ePrescribing is measured, from a "more is better" approach to using the capability it in the normal course of caring for patients and reporting that data to CMS.

The system needs to learn from its past in order to grow in the future. Quality measures are mandated for annual review whereas ACI measures can be codified forever simply by inertia. An engaged patient can be determined by measuring their perception and knowledge of their conditions and health status, as well as relevant quality measures. This has to be a superior method than simply measuring the frequency of clicking a box. Further, we waste clinician, staff, and health IT professionals time by having the focus on optimizing checkbox checking rather than improving care.

Overall, the integration of improvement activities with the ACI performance category seems to be an easy bar to incentivize physicians toward greater use of CEHRT. ACP appreciates the wealth of various intervention examples provided in Table 8 of the final rule. In one instance, this would require population health management techniques to generate lists of eligible patients, and then assess achievement of the requisite threshold number of patients. There is ambiguity in the case of required documentation standards, metrics, and interpretations should the Inspector General audit the attestations. The ACP suggests that CMS create clearer guidance for both ECs and auditors to avoid this potential problem.

b. ACI Group Reporting Threshold

Background:
CMS is finalizing the proposal to allow group reporting for the ACI performance category with the additional explanation of data aggregation requirements for group reporting. CMS did not impose a threshold for group reporting. For example, in future years they may require that groups can only submit their ACI performance category data as a group if 50 percent or more of the eligible patient encounters are captured in CEHRT. CMS is seeking comments on what would be an appropriate threshold for group reporting in future years.

ACP Comments:
It is critically important that the new payment systems that are designed through the implementation of MACRA reflect the lessons from the current and past programs and also effectively allow for ongoing innovation and learning. If the purpose of ACI is to advance electronic information (and not better patient care), one could see the justification of increasing the thresholds year-after-year. However, if the goal of EHRs and other health IT is to be an enabling infrastructure for improving care and outcomes, the number should be studied rather than arbitrarily determined. **The College recommends that measures and thresholds for ACI be**

based upon a scientific review process that involves four domains: purpose and importance to measure, clinical evidence base, measure specifications, and measure implementation and applicability. Applying unfounded and untested thresholds risks diverting attention disproportionately toward the things being measured to the neglect of other critically important areas that cannot be directly measured (ex. empathy, humanity).

c. ACI Scoring Methodology Policies

Background:
In the 2017 Advancing Care Information Transition objectives and measures, ECs will have the ability to earn up to 155 percentage points for the ACI performance category, which will be capped at 100 percent, regardless of which set of measures they report. In order to make up the difference in the number of measures included in the performance score for the Advancing Care Information Transition and the 2017 Advancing Care Information Transition measure sets, CMS has increased the number of percentage points available for the performance weight of the Provide Patient Access and Health Information Exchange measures (up to 20 percent for each measure), as these measures are critical to the goals of patient engagement and interoperability. CMS are seeking comment on final scoring methodology policies and future enhancements to the methodology.

ACP Comments:
While ACI is just a small portion of the QPP, the prescriptive detail of this one section is too complicated for the typical clinician to understand. Even physicians well versed in informatics find these provisions unclear and complicated to implement. Unless a practice was of sufficient size with sufficient Medicare business to invest in an administrative person dedicated to all these requirements, it is an overwhelming task for small practices to undertake. For primary care clinicians in many markets, one alternative would be to stop participating in Medicare than to try and untangle the many provisions. This would not be beneficial to the patient and the overall community the physician cares for and serves.

Continuing to rely on any scoring of EHR functional use will result in the expected negative consequence of clinicians and software engineers focusing on meeting the narrow definitions of EHR functional use; rather than beginning a new era in EHR design and use. That new era should permit flexibility in design and use, such that an EHR serve the patient and the care team rather than serving the interest of coding, billing, and functional use reporting. Clinicians need to focus on how to transform what is perceived as a source of distraction and dissatisfaction into the enabling infrastructure for value-based care and payment. Continuing prescriptive measurement of EHR functional use *regardless* of what is learned about how doctors and patients benefit from health IT is antithetical to a learning health and healthcare system.

5. MIPS APMs

Background:
The rule finalizes a scoring standard for MIPS eligible clinicians participating in certain types of APMs in order to reduce participant reporting burden by eliminating the need for eligible clinicians in such APMs to submit data for both MIPS and their respective APMs. These APMs are labeled as MIPS APMs, and are defined as APMs that meet the following criteria: (1) the APM Entity participates in the APM under an agreement with CMS; (2) the APM Entity includes one or more MIPS eligible clinicians on a Participation List; and (3) the APM bases payment incentives on performance (either at the APM Entity or eligible clinician level) on cost/utilization and quality measures.

ECs report under MIPS under the APM scoring standard for MIPS APMs if they do not reach qualifying participant status under the Advanced APM pathway or participate in certain APMs that did not meet CMS criteria to be considered an Advanced APM (i.e., due to not meeting financial risk standards). For the transition year, CMS finalized the following as MIPS APMs:

- Shared Savings Program ACOs (Tracks 1, 2 and 3)
- Next Generation ACO Model
- Comprehensive ESRD Care (CEC) Model (all arrangements)
- Oncology Care Model (OCM) (all arrangements)
- Comprehensive Primary Care Plus (CPC+) Model

ACP Comments:
The College continues to support the concept of the MIPS APMs and its goal to reduce reporting burden for eligible clinicians and alleviate duplicative and/or conflicting payment methodologies. The discussion of the concept of MIPS APMs in the final rule provides increased clarity compared to the proposed rule, and the changes finalized increase the likelihood of this approach achieving its stated goal. The College, in addition to the above stated support, continues to have several concerns that we recommend you address:

- There are a very limited number of APMs that qualify as MIPS APMs in the first performance period. We are particularly concerned with the lack of availability of viable MIPS APMs for many eligible specialty and subspecialty clinicians. ACP recommends that the Agency, through its authority under the Innovation Center and through the efforts of the Physician-Focused Payment Model Technical Advisory Committee (PTAC) process, expand MIPS APMs availability. This would have the effect of both reducing unnecessary reporting burden, but also provide additional pathways for practices to transition from traditional fee-for-service to more valued-oriented payment approaches.
- As recognized in the rule, the concept of MIPS APMs and their varied scoring protocols remains quite complex. The College strongly supports the Agency's stated goal to simplify and standardize these requirements and use its many educational and technical out-reach activities to provide necessary increased clarity.

- The College appreciates that the Agency fulfilled the statutory requirement in the final rule of providing participants within a MIPS APM Entity with credit for at least 50 percent of the potential points under the Improvement Activities Performance Category. We also support your establishing a review process for these participants to earn additional points within this component based on the nature of the APM. Nonetheless, we continue to recommend that participants within a MIPS APM receive 100 percent of the potential points under the Improvement Activities Performance Category to recognize and encourage their efforts to provide valued-oriented care.
- The College in general supports your decision to change the proposed method of determination of whether an eligible clinician is included in the APM Entity group for a MIPS APM from a one-time December 31 "snap shot" participation list review, to an approach in which participation lists will be reviewed on March 31, June 30 and August 31. We recommend the addition of a fourth review date, December 31st, to the process for identifying MIPS APMs participants to further ensure that those eligible clinicians that qualify for APM Entity group status are included.

V. Alternative Payment Models

A. Medical Home Model

Background:
In the final rule, CMS also modified the definition of Medical Home Model and Medicaid Medical Home Model (payment arrangement under title XIX) to emphasize the primary care focus and add Obstetrics and Gynecology to the list of primary care specialties, finalizing that these models require the following elements:

(1) Primary care focus with participants that include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services. For the purposes of this provision, primary care focus means involving specific design elements related to eligible clinicians practicing under one or more of the following Physician Specialty Codes: 01 General Practice; 08 Family Medicine; 11 Internal Medicine; 16 Obstetrics and Gynecology; 37 Pediatric Medicine; 38 Geriatric Medicine; 50 Nurse Practitioner; 89 Clinical Nurse Specialist; and 97 Physician Assistant;
(2) Empanelment of each patient to a primary clinician; and
(3) At least four of the following:
    (i) Planned coordination of chronic and preventive care.
    (ii) Patient access and continuity of care.
    (iii) Risk-stratified care management.
    (iv) Coordination of care across the medical neighborhood.
    (v) Patient and caregiver engagement.
    (vi) Shared decision-making.
    (vii) Payment arrangements in addition to, or substituting for, fee-for-service payments (for example, shared savings or population-based payments).

CMS finalized as proposed the requirements for a Medical Home Model to be determined an Advanced APM, which means that the qualifying participants in that medical home would not be included in the MIPS program and would receive the 5 percent bonus payments on their Medicare Part B reimbursements for several years. These requirements are generally aligned with those of all advanced APMs; however, CMS has outlined a different, reduced bar for Medical Home Models in terms of the financial risk standard and nominal amount standard that they need to take on. The Medical Home Model financial risk standard is proposed as follows:

> The following standard applies only for APM Entities that are participating in Medical Home Models, and, starting in the 2018 QP Performance Period, such APM Entities must be owned and operated by an organization with fewer than 50 eligible clinicians whose Medicare billing rights have been reassigned to the TIN(s) of the organization(s) or any of the organization's subsidiary entities. The APM Entity participates in a Medical Home Model that, based on the APM Entity's failure to meet or exceed one or more specified performance standards, which may include expected expenditures, does one or more of the following:
>
> (i) Withholds payment for services to the APM Entity or the APM Entity's eligible clinicians.
> (ii) Reduces payment rates to the APM Entity or the APM Entity's eligible clinicians.
> (iii) Requires the APM Entity to owe payment(s) to CMS.
> (iv) Causes the APM Entity to lose the right to all or part of an otherwise guaranteed payment or payments.

Further, the rule finalizes the following definition of nominal amount standard for the Medical Home Model as:

> For a Medical Home Model to be an Advanced APM, the minimum total annual amount that an APM Entity must potentially owe or forego under the APM must be:
> (A) In 2017, 2.5 percent of the APM Entity's total Medicare Parts A and B revenue;
> (B) In 2018, 3 percent of the APM Entity's total Medicare Parts A and B revenue;
> (C) In 2019, 4 percent of the APM Entity's total Medicare Parts A and B revenue;
> (D) In 2020 and later, 5 percent of the APM Entity's total Medicare Parts A and B revenue.

ACP Comments:
The College commends CMS for its recognition within the proposed rule regarding the unique status of the medical home within the APM portfolio. The College has been a leader in supporting the medical home model, particularly in light of the plethora of currently available

research[23] linking the model to higher quality and lower costs. *However, we remain greatly concerned the CMS did not meet Congress' intent that medical homes be able to qualify as [Advanced] APMs without being required to bear more than nominal risk (even via the less stringent Medical Home Model Standard for financial risk and nominal amount).* The following explains our interpretation of the Congressional intent of the law and proposes specific steps that should be taken to modify the proposed rule to meet this intent.

A reasonable reading and interpretation of the statute can lend one to understand what we believe to be the clear congressional intent—that CMS should allow a medical home to qualify as an [advanced] APMs, without bearing more than nominal financial risk; if it is a medical home that <u>meets criteria comparable to</u> medical homes expanded under section 1115A(c). While this language is included in the discussion of the all-payer option that begins in 2021 (which is when other payer payments can be counted toward the threshold to determine if one is a qualifying APM participant), it makes clear that the intent of the law is to incentivize medical homes that are aligned with Medicare initiatives—and therefore ACP sees no reason to unnecessarily limit the initial opportunities for practices to become Advanced APMs that are clearly meeting comparable criteria.

Criteria "comparable to medical homes expanded under section 1115A(c)" means:

(1) the Secretary determines that such expansion is expected to—
   - (A) reduce spending under applicable title without reducing the quality of care; or
   - (B) improve the quality of patient care without increasing spending;

(2) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce (or would not result in any increase in) net program spending under applicable titles; and

(3) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under the applicable title for applicable individuals. In determining which models or demonstration projects to expand under the preceding sentence, the Secretary shall focus on models and demonstration projects that improve the quality of patient care and reduce spending.

In sum, the congressional intent and even the statutory language and criteria clearly do not require medical homes to bear more than nominal financial risk in order to qualify for payments as [Advanced] APMs.

Nor does it require that the Secretary and the Chief Actuary determine/certify that medical homes would reduce net program spending—rather, the applicable standard is that the

[23] Patient Centered Primary Care Initiative. The Patient-Centered Medical Home's Impact on Cost and Quality. Annual Review of Evidence 2014-2015. Available at http://www.milbank.org/uploads/documents/PCPCC_2016_Report.pdf

Secretary determines they would "reduce spending . . . without reducing the quality of care" *or "*improve the quality of patient care without increasing spending" and the Chief Actuary certifies they "would reduce (or would not result in any increase in) net program spending." [Emphasis added]. The College believes that there is abundant evidence that medical homes, at the very least, can improve the quality of care without increasing spending (although there is growing evidence from the many PCMH programs around the country that can also bring about reductions in costs).

Therefore, ACP recommends that CMS take the following steps to provide multiple pathways for medical homes to be included in the advanced APM pathway, to be implemented in a timely enough basis for eligible medical homes to qualify as Advanced APMs within the first year of program implementation, if feasible, and no later than the second performance period (2018). See Table 2 for a summary of the following proposals.

Table 2: PCMH Pathways to Qualify as Advanced APMs

Model	Practice Eligibility	Require "More than Nominal" Financial Risk*	Medicare Payment Model	Medicare Advanced APM 5% FFS bonus
CPC+	CPC+ participating practices, 20 regions, up to 5000 practices	Yes	Risk-adjusted PBPM, FFS	Yes
CPCi "as expanded" (as specified in Section 1115 A [c] of MACRA)	Any PCMH practice that meets CPC+ participation requirements	No	Risk-adjusted PBPM, FFS, shared savings	Yes
A deemed PCMH program that: **a.** has a demonstrated multi-year track record of support by non-Medicare payers, state Medicaid programs, employers, and/or others in a region or state; **b.** shares data with participating practices to assist them in improving quality and lowering costs; **c.** provides financial support such as risk-adjusted prospective per enrollee; and **d.** submits sufficient data to the Secretary that the deemed program, based on the experience of the patient populations served by the program, can be expected to: i. reduce Medicare spending without reducing the quality of care; and ii. improve the quality of patient care without increasing Medicare spending.	The PCMH practice in a deemed program would need to provide patient-centered care to Medicare beneficiaries, as well as the other patient populations served by the deemed program, consistent with the requirements that are outlined for the Medical Home Model in the proposed rule	No	Usual FFS payments for Medicare population seen by the practices (each deemed program will have its own payment model for non-Medicare populations served)	Yes
Medical Home Model – inclusive of other medical home programs	PCMH practices that meet the Medical Home Model Standard for financial risk and nominal amount as outlined in the proposed rule	Yes	Usual FFS payment	Yes

1. **Immediately initiate plans to undertake an <u>expedited analysis</u> of the results of the Comprehensive Primary Care initiative (CPCi) to determine whether the statutory requirements for expansion by the Secretary are met (i.e., Section 1115A(c), cited above). This analysis should be completed no later than six months from promulgation of the final rule to allow for a determination to expand CPCi in time for medical home practices to qualify as Advanced APMs no later than the 2018 performance period.** The five comprehensive primary care functions that are required for practices participating in CPCi are clearly aligned with the definition of Medical Home Model that the Agency has described in the proposed rule. Additionally, ACP is very optimistic regarding the likelihood of this model to fulfill the requirements for expansion based on the first 2 years of CPCi results—that is, they ***"*improve the quality of patient care <u>without increasing spending</u>."** This clearly is a model that aligns well with the type of care our members desire to deliver, and their patients want to receive.

- **In parallel with this analysis, CMS should initiate advanced planning to develop their expansion approach for the CPCi program.** This expansion should take place nationally with regard to Medicare payments to those practices that apply, attest to the five comprehensive primary care functions, and are able to meet the milestones over the course of a given timeframe that is clearly articulated in advance. Other payers should be actively invited to apply to collaborate with Medicare; however, the expansion of this program should NOT be dependent upon additional payer participation. Practices should be fully informed in advance of finalizing their agreements with CMS to participate as to whether or not their other regional payers are participating.

2. **Establish a deeming program or process to enable practices enrolled in medical home programs run by states (including state Medicaid programs), other non-Medicare payers, and employers as being deemed to have met criteria "comparable to medical homes expanded under section 1115A(c)."**

- A deemed PCMH program is one that:
  a. has a demonstrated multi-year track record of support by non-Medicare payers, state Medicaid programs, employers, and/or others in a region or state;
  b. shares data with participating practices to assist them in improving quality and lowering costs;
  c. provides financial support such as risk-adjusted prospective per enrollee payments for care coordination to the practices and/or other types of support to such practices; and
  d. submits sufficient data to the Secretary that the deemed program, based on the experience of the patient populations served by the program, can be expected to:

i. reduce Medicare spending without reducing the quality of care; or
ii. improve the quality of patient care without increasing Medicare spending.

- The PCMH practice in a deemed program would need to provide patient-centered care to Medicare beneficiaries, as well as the other patient populations served by the deemed program, consistent with the requirements that are outlined for the Medical Home Model in the proposed rule.
  a. The PCMH practice in a deemed program would qualify as a Medical Home Model that is an advanced APM, without having to bear more than nominal financial risk (per both the intent of the law)—and therefore the participating practices in that program would be eligible to be qualifying participants (QPs) and not be part of the MIPS program, but rather would receive the 5 percent bonus payment on their Medicare fee-for-service payments, should their Medicare Part B payments meet the required threshold.
  b. Along those lines, ACP recognizes that, per the statute in the 2019 and 2020 payment adjustment years, at least 25 percent of the payments to the APM participant must come from Medicare Part B in order for that clinician to be determined to be a qualifying participant and receive the 5 percent advanced APM bonus on their Medicare Part B reimbursements. As per the law, this threshold to be a qualifying APM participant would then broaden to include payments from the other payers, starting with the 2021 payment adjustment period.

- This deeming process can use the five comprehensive primary care functions as its criteria, along the lines of how the Agency is expected to be able to expand the CPCi program. Newly deemed programs would not be eligible for the additional financial support that CPCi provides (i.e., care management fees and shared savings) provided by Medicare; however, they would still be able to receive any additional payment incentives being provided by the other payers and also the 5 percent bonus payment on Medicare fee-for-service reimbursements over the course of time that those bonuses are available.

3. **Allow inclusion of medical home programs as Advanced APMs that meet the Medical Home Model Standard for financial risk and nominal amount as outlined in the final rule.** While, as outlined above, the law specifically calls for medical home programs to be advanced APMs without taking on financial risk, ACP is supportive of the latitude that CMS has taken to establish separate financial risk and nominal amount standards for the Medical Home Model to be used as needed until such time as CMS completes an expedited review and expansion of CPCi, and creates a "deemed" PCMH program pathway for advanced APMs, as described above. This is particularly important given the very limited ability of most medical home

practices to take on any substantial financial risk above their significant investment in practice redesign and ongoing improvement.

Along these lines, ACP is appreciative of the Agency recently launching the new Comprehensive Primary Care Plus (CPC+) program—and allowing participating clinicians in the CPC+ to also participate in the Medicare Shared Savings Program (MSSP). However, the College is concerned that CPC practices that are in Track One MSSP ACOs could not be considered Advanced APMs and therefore could not qualify for the 5 percent bonus. This is problematic because it will likely cause CPC practices that are currently in Track One ACOs to leave the ACO program rather than allowing practices to participate in both CPC+ and MSSP Track One, which the College believes was the intent behind allowing practices to participate in both programs. Thus, ACP recommends that CMS consider any CPC+ practice that meets the threshold requirements to be a qualifying participant in an Advanced APM be eligible to receive the 5 percent bonus, regardless of whether the practice is also in MSSP Track One. We also recommend that practices in Track 1+ MSSP ACOs, when available, be permitted to also participate in CPC+ and be considered QPs in Advanced APMs.

Additionally, even though CPC+ does have a broader reach than CPCi, it is still limited to a maximum of 5000 practices in 20 regions of the country—and then the opportunity to be an advanced APM (and receive the 5 percent bonus on Medicare fee-for-service reimbursements) for those in CPC+ is proposed to be further limited to those practices with 50 or fewer eligible clinicians. ACP strongly believes that while the CPC+ model is tremendously important, the interpretation by CMS of CPC+ being the only Medical Home Model available as an advanced APM, even with financial risk, is too narrow and restrictive. **Therefore, the College strongly recommends that CMS use the Medical Home Model Standard for financial risk and nominal amount to allow additional PCMH practices to qualify as advanced APMs.**

- Under this option, practices would be required to meet at least the Track 1 requirements for those in the new CPC+ program and would be required to take on risk for their Medicare Part B payments that is aligned with the Medical Home Model Standard. They may also already be taking on some level of risk for their payments from other payers within a regional or state-based program, but this would not be required.
- These practices would not be eligible for the additional financial support that CPC+ provides (i.e., care management fees) provided by Medicare; however, they would still be able to receive any additional payment incentives being provided by the other payers and also the 5 percent bonus payment on Medicare fee-for-service reimbursements over the course of time that those bonuses are available.
- As noted above, in this case as well, it is understood that this approach would only be applicable to clinicians that meet the Medicare fee-for-service payment threshold for the initial years—with additional payer reimbursements and/or attributed patients counting toward that threshold beginning in year 2021.

- We also recommend consideration of the Independence at Home demonstration project as meeting the requirements of an Advanced APM within the Medical Home Model specifications.

1. Recommended Modifications to the Proposed Medical Home Model Risk Requirement

The final rule defines the nominal risk standard for the Medical Home Model as beginning at 2.5 percent of the APM Entity's total Medicare Parts A and B revenue in 2017 and ramping up to 5 percent by 2020. **The College, in recognition of the up-front costs of establishing the infrastructure required to deliver services within this model and the limited ability of most primary care practices to accept even minimal downside risk, reiterates its recommendation that the 2.5 percent risk requirement remain at that level until it is determined that a sufficient number of model participants have demonstrated the ability to succeed under even this minimal downside risk requirement.**

Further, the rule states that the special Medical Home Model nominal risk standard be limited, after the first performance year, to organizations with fewer than 50 clinicians. This limitation was created in recognition that larger entities would be more capable of accepting the standard nominal risk requirement. The College believes the 50-clinician limit is arbitrary and does not provide a meaningful distinction in the type or quality of care that patients would receive. Thus, we recommend that the clinician-based limitation be removed.

2. Recommendations on Medical Home Model Application to Specialty Practices

ACP strongly recommends that the Medical Home Model nominal risk standard also be applied to comparable specialty practice models. Given that the Agency is already able to award full credit in the Improvement Activities performance category to patient-centered medical homes as well as comparable specialty practices, it seems logical that similar treatment to models that are comparable in the Advanced APM pathway. Therefore, ACP urges the Agency to give careful consideration to specialty practice models that are comparable to Medical Home Models as Advanced APMs and apply the same nominal risk standards. Additionally, for Medical Home Models that are Advanced APMs and qualify as models without a risk-bearing requirement, similar treatment should be given to comparable patient-centered specialty practice models.

B. Availability of Alternative Payment Models and Advanced Alternative Payment Models to Non-Primary Care Specialists/Subspecialists

Background:
The rule defines the specific requirements for entities to be considered either as MIPS APMs for scoring purposes and Advanced APMs for the purposes of qualifying for the 5 percent Part B bonus and being exempt from MIPs reporting. The requirements reflect multiple components

including the entity's contractual relationship with CMS, the nature of the model implementation (e.g., was it a CMMI initiative?), and whether it meets specified performance measurement and nominal risk requirements. According to the Advanced APM lists that are currently available, only two programs, the Comprehensive ESRD Care (CEC) Model and the Oncology Care Model (OCM) (two-sided risk arrangement) are directly linked to services provided by specialist/subspecialists.

Factors specifically contributing to the limited number of specialty/subspecialty-related Advanced APMs include that few CMMI models related to these physicians are currently being tested through CMMI, and that, as opposed to the special status provided to Medical Home models both in the statute and rule that provides both no nominal risk and reduced nominal risk pathways for Advanced APM recognition, all other APMs must meet a very high risk standard. Nominal risk refers to the downside financial liability (risk) the entity has if it doesn't meet the specified benchmark of the payment model. For the second performance period, CMS does suggest in the final rule that the Agency intends to develop a new voluntary bundled payment as well as release details on how the proposed episode payment model for cardiac care and the Comprehensive Joint Replacement model can be considered Advanced APMs.

CMS finalized two ways that an APM can meet the Advanced APM nominal amount standard. An APM would meet the nominal amount standard if, the Qualifying APM Participant (QP) Performance Periods in 2017 and 2018, 8 percent of the average estimated total Medicare Parts A and B revenues of participating APM Entities (the "revenue-based standard") are at risk; or for all QP Performance Periods, 3 percent of the expected expenditures for which an APM Entity is responsible under the APM (the "benchmark-based standard") is at risk.

ACP Comments:
The College commends CMS for finalizing two ways that an APM can meet the Advanced APM nominal amount standard. One way: The College appreciates CMS' reducing the nominal risk standard for 2017 and 2018 as a potential downside of 3 percent (down from 4 in the Proposed Rule) of the expected expenditures for which the clinician is responsible under the APM itself. **The second way:** The College appreciates CMS allowing AMP entities for 2017 to calculate 8 percent of the average estimated total Medicare Parts A and B revenues of participating APM Entities (the "revenue-based standard") as a potential downside risk. This would allow for an APM's financial design to meet either of the two nominal amount standards, CMS would consider the nominal amount standard to be met.

However, the College continues to have major concerns with respect to the limited number of opportunities now accessible for non-primary care specialists /subspecialists participate in recognized Alternative Payment Models (APMs) and Advanced APMs. ACP makes the accompanying particular proposals to address this issue.

- **Along the lines of two ways that an APM can meet the Advanced APM nominal amount standard:**

    - **There must be a period of stability and predictability for Advanced APMs. The "more than nominal risk" standard of at least 8 percent of APM Entities' Medicare Parts A & B revenues, or 3 percent of the benchmark should remain in place for no less than a 3-year period. After an initial 3–year period that allows for stability and predictability, an assessment should be completed based on the data to assess whether the financial viability of the APM entities could support a modest incremental increase or not.** This standard will be the basis for the 5 percent APM incentive payments. These incentive payments are intended to assist physicians in transitioning to APMs. Physicians who are making this transition require a period of stability and predictability.

      Allow Other Payer APMs (includes private payers, Medicare Advantage and Medicaid) to meet the same Advanced APM required revenue and benchmark-based nominal risk standards as defined under the Medicare program.. This will enable the same APM financial risk structure to be used by all payers, rather than having different standards for Medicare APMs and Other Payer APMs, and will help facilitate the development of multi-payer models.

    - **The College urges CMS to make clear in regulation that the nominal amount standard is either 8 percent of Medicare Parts A and B revenues (the "revenue-based standard") or 3 percent of expected expenditures (the "benchmark-based standard"), whichever is more advantageous for the entity.** The nominal amount standard for the 2017 and 2018 QP Performance Periods further increases flexibility for APM Entities. This will allow APM Entities that do not meet the benchmark-based standard using a total cost of care benchmark be assessed by the revenue-based standard - calculating the total potential risk as a percentage of the average estimated Medicare Parts A and B revenue of the participating APM Entities. If an APM's financial design meets either of the two nominal amount standards, CMS would consider the nominal amount standard to be met.

- **Provide priority for consideration through the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and for CMMI testing for models involving physician specialty/subspecialty categories for which there are no current recognized APMs and Advanced APM options available. We further recommend that CMS provide a clear pathway for models recommended by PTAC to be implemented as APMs under MACRA.**

- The College is appreciative of CMS' plans to propose a Track 1+ for Accountable Care Organizations (ACOs) that will be able to qualify as an Advanced APM, initiating the

CPC+ model and work on additional options for 2018 in recognition of the very limited number of options available to non-primary care specialists/subspecialists groups. **However, the College continues to be concerned that there are such a low number of APMs and Advanced APMs available for non-primary care specialists/subspecialists groups. CMS must create a platform to accelerate the testing for APM acknowledgment of bundled payment and similar episodes of care payment models**. In collaboration with our related subspecialty societies, it is clear that bundled and episode of care payment models are best aligned with the type of services provided. This platform could possibly be accomplished by immediately extending the Bundled Payment for Care Initiative (BPCI) and expanding it beyond the current inpatient-based tracks, or instituting a new ambulatory-based bundled payment initiative.

A major problem faced by most bundled payment APMs being considered by members of our Council of Subspecialty Societies (CSS) is how participants in these developing payment models, which will likely meet the general requirements of an Advanced APM, will be able to meet the necessary payment amount or patient count thresholds. The bundled services within the developing models only cover a relatively small number of the overall patients within their panels. While it appears that the actual threshold amounts are defined by law and cannot be modified under current CMS authority, we believe that there may be alternative means of addressing this issue.

These include:

- Providing increased flexibility for eligible participants to participate in multiple Advanced APMs and combining payment/patient count amounts when determining whether the threshold has been obtained. CMS' recent decision to allow CPC+ practices to participate within the Medicare Shared Saving Program is an example of the type of flexibility that may assist physicians and other eligible health professionals to become QPs while engaged in a recognized bundled payment advanced payment model.
- Developing pathways using the "virtual group" language in the ACT to allow practices to combine their advanced APM activities and related payment/patient count amounts when determining whether the QP threshold has been obtained.

The College appreciates and supports the decision to change the proposed method of determination of the QP Performance Period and the timing of QP determinations. This change will allow eligible clinicians to know of their QP status prior to or near the beginning of the MIPS data submission period and know whether they should report to MIPS for the applicable year.

C. Treatment of Non-Fee-For-Service Payments

Background:
CMS finalized excluding financial risk payments when calculating the estimated aggregate payment amount for covered professional services upon which to base the APM Incentive

Payment amount. According to the Agency, financial risk payments are not for specific Medicare Part B covered professional services; rather they are for performance in an APM. Therefore, CMS believes their inclusion in the estimated aggregate payment amount would be inconsistent with the statutory language and stated policy principles. In addition, the Agency expresses the difficulty of disaggregating payments to individual QPs and the lagged timing of some financial risk payments creates significant policy and operational barriers that are in line with the objective of making APM Incentive Payments in a timely manner.

ACP Comments:
ACP continues to have very strong concerns with the Agency deciding on a case-by-case basis whether to exclude many payments made to physicians that are not traditional Medicare Physician Fee Schedule payments from calculations of the 5 percent lump sum payments to participants in Advanced APMs. It is completely inappropriate to declare that "financial risk payments" should not count as physician payments for services, since under CMS shared savings models, this is the only way that physicians can be compensated for services delivered that are not directly paid under the fee schedule. These payments are not "incentives," they are compensation contingent on performance. It is also inappropriate to indicate that monthly payments for patient care are merely "cash flow mechanisms," when in most cases, they are flexible payments designed to enable physicians to deliver a range of services, including services that are not directly paid for under the fee schedule. This proposal adds unnecessary complexity and uncertainty to the calculations and could provide a disincentive for physicians who want to transition away from a fee-for-service approach.

D. Medicare Shared Savings Program

Background:
CMS finalized that Medicare Shared Savings Program (MSSP) ACO Tracks 2 and 3 as well as the Next Generation ACO model would qualify under the Agency's criteria as MIPS APMs and Advanced APMs. Track 1 under the MSSP, while qualifying as a MIPS APM, would not qualify as an Advanced APM under the finalized criteria. As of December 2016, 95 percent of MSSP participants are in Track 1 of the program, and only 18 ACOs are participating within the Next Generation program. In the final rule, CMS notes its intention of developing an MSSP ACO Track 1+ model that would be available in the second performance period. This model would have some down-side risk associated with it but at a lower level than Tracks 2 and 3.

ACP Comments:
Comments from our members and the results of a recent survey study released by the National Association of Accountable Care Organizations (NAACOS)[24] continue to reflect the intensive capital outlay (which is "at risk" capital under most business definitions) to establish and

[24] National Association of Accountable Care Organizations. ACOs at a Crossroads:
Cost, Risk and MACRA. 2016 Available at https://www.naacos.com/news/ACOsataCrossroads-NAACOSWhitePaper060116.htm

maintain a viable ACO within the Medicare Shared Savings Program (MSSP). Furthermore, the ability to accept downside risk remains problematic for many MSSP entities, as reflected by the preponderance of MSSP involvement under Track One.

We strongly support the acceptance of ACP's recommendation that CMS develop a new MSSP track, which the Agency refers to as Track 1+, as an Advanced APM that meets a lower downside risk standard that will allow those in currently in ACOs and those thinking about joining the program a more palatable pathway into the acceptance of downside financial risk under the CMS standards. We make the following additional recommendations to improve MSSP—a program that we believe is a very important part of CMS APM portfolio and a crucial component in its overall efforts to transition Medicare payment towards value.

- **The College reaffirms its belief that Track One MSSP ACOs should qualify as meeting the nominal risk requirement for determining an advanced APM**. This is based on the significant "at risk" capital requirements necessary to start and maintain these programs. This position was more fully articulated in a joint comment letter signed-on by the College dated March 25, 2016, which is available at https://www.acponline.org/acp_policy/letters/joint_comment_mssp_aco_benchmarking_2016.pdf.
- **The College thanks CMS for taking the recommendation of ACP and others of adding a new track within MSSP that helps bridge the transition for one-sided to two-sided risk.** We further appreciate that CMS has announced its intention to make these new Track 1+ MSSP ACOs a new Advanced APM option for the 2018 performance period. **As the Agency develops the policies outlining the new Track 1+ ACOs, ACP urges CMS to consider the following recommendations and others that are discussed in further detail in a joint comment letter of which ACP is a part of**:[25]
    - Qualification as an Advanced APM: The College strongly supports including Track 1+ ACOs as Advanced APMs beginning with the 2018 performance period.
    - Risk levels: ACP recommends that CMS set the risk structure for Track 1+ ACOs at no more than the minimum levels of risk finalized in the rule (8 percent of Parts A and B revenues or 3 percent of expected expenditures).
    - Benchmarks for existing ACOs: For current Track 1 ACOs that choose to move into Track 1+, the College supports CMS setting the benchmarks under the new benchmarking methodology that incorporates a regional blend with national expenditure data.
    - Availability for participation: We support making Track 1+ a voluntary model that is available to both existing Track 1 ACOs and those new to the program. We further encourage the Agency to available to MSSP Tracks 2 and 3 as well as Next Generation ACOs and Pioneer ACOs. Current ACOs should be able to move into Track

25 https://www.acponline.org/acp_policy/letters/acp_comment_letter_to_cms_on_track_one_plus_medicare_shared_savings_programs_in_macra_2016.pdf

1+ at the beginning of any performance year rather than waiting until the start of a new agreement period.

- Length of agreement: ACP recommends that CMS utilize a three-year agreement period for Track 1+ ACOs, and we further urge the Agency to allow ACOs to remain in Track 1+ indefinitely and not be limited to a certain number of agreements in Track 1+.
- Beneficiary assignment: The College urges CMS to allow Track 1+ ACOs (as well as those in all other MSSP tracks) the option of choosing prospective or retrospective assignment of beneficiaries. We further encourage CMS to allow for voluntary beneficiary alignment as the Agency finalized for other MSSP ACOs in the 2017 physician fee schedule rule.
- Quality reporting: ACP supports allowing Track 1+ ACOs to use the same quality reporting requirements as with other MSSP tracks and further encourage the Agency to allow quality reporting and improvement to increase the payment of shared savings a Track 1+ ACO can earn from 60 to 70 percent.
- Waiver authority: We encourage CMS to extend to Track 1+ ACOs and all other ACO models waiver authority from legal and regulatory barriers (i.e., home heath homebound requirements, SNF 3-day stay rule, telehealth restrictions, primary care co-payments, etc.).

VI. Conclusion

ACP sincerely appreciates the opportunity to comment on CMS final rule with comment regarding the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) – Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models. The enactment of the MACRA law represented a rare situation where physicians, nurses, patient and consumer advocacy groups, and so many others, were able to come together with members of both political parties, in both chambers of Congress, to help craft legislation to create a better physician payment system. Therefore, we believe that CMS has an obligation to take into account the feedback from all of these stakeholders as it works toward implementation. Along these lines, we truly appreciate that the agency has initiated some promising approaches and ideas in this final rule, including but not limited to creating flexible reporting options in the transition performance period, reducing the overall number of quality measures required for reporting, stating an intent to ensure that meaningful use (now ACI) is no longer a pass/fail enterprise, initiating the Improvement Activities Performance Category of MIPS with a clear interest in flexibility, weighting the Cost Performance Category at zero percent in year 1, and making an effort to ensure that patient-centered medical homes are given special status within both MIPS and APMs. However, the College strongly believes that much more can and should be done to ensure that this new payment system is rolled out successfully.

Therefore, we urge CMS to actively consider all of our recommendations in this letter--and ACP has made every effort to provide the Agency with detailed rationales and a number of specific

alternative approaches. Additionally, we have articulated our top priority recommendations in several categories:

- Simplify the Implementation of the Quality Payment Program (QPP)
- Allow Flexibility in the Performance Period and Reporting Requirements
- Patient-Centered Medical Homes as Advanced APMs
- Advanced APM Options for Internal Medicine Subspecialists and other Medical Specialties
- Improve the Advancing Care Information Performance Category

Thank you for considering our 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 if you have questions or need additional information.

Sincerely,

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