



August 21, 2017

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS-5522-P
Room 445–G, Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: Medicare Program; CY 2018 Updates to the Quality Payment Program [CMS-5522-P]

Dear Administrator Verma:

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) notice of proposed rulemaking regarding the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) – Calendar Year (CY) 2018 Updates to the Quality Payment Program (QPP). The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 152,000 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 and expand on the following guiding principles that were included in our comments on the MACRA proposed¹ and final² rules for the 2017 performance period and the Draft CMS Quality Measures Development Plan:³

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

² https://www.acponline.org/acp_policy/letters/avp_comment_letter_to_cms_on_macra_final_rule_2016.pdf

³

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 strongly recommends CMS collaborate with specialty societies, frontline clinicians, patients, and electronic health record (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.

Third, 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 better align the numerous reporting and payment programs previously administered under Medicare Part B and truly improve care for Medicare beneficiaries. Thus, the policy that is developed to guide these new value-based payment programs must be thoughtfully considered in that context.

ACP's recent position paper, *Putting Patients First by Reducing Excessive Administrative Tasks in Health Care*⁴, outlines a cohesive framework for analyzing new and existing administrative tasks and provides detailed policy recommendations to reduce, streamline, or eliminate entirely excessive administrative tasks and requirements that take physicians away from providing high-value care to their patients. As CMS further implements the QPP, the College continues to have concerns regarding the potential administrative burden associated with participation in the program. **Therefore, as our fourth guiding principle, ACP strongly recommends that CMS consider the detailed recommendations to reduce administrative tasks and requirements outlined in our paper and summarized in our post-publication outreach letter to CMS,⁵ and continue to work with physicians and other key stakeholders to achieve the goals of putting patient care first by reducing administrative complexities and burdens.**

⁴ <http://annals.org/aim/article/2614079/putting-patients-first-reducing-administrative-tasks-health-care-position-paper>

⁵

https://www.acponline.org/system/files/documents/advocacy/where_we_stand/patients_before_paperwork/reducing-excessive-admin-tasks-cms.pdf

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 QPP can be improved prior to the 2018 performance period 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 Scoring Approach for the Quality Payment Program

- CMS must further simplify and standardize the scoring approach within MIPS in order to allow the point value for each measure or activity to be fully reflective of its value within in the overall composite performance score (CPS). Currently, 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.
- Alternatively, ACP proposes that CMS modify the point values to reflect a more unified approach:
 - The available points within the quality component should add up to a total of 60 points – counting for 60 percent;
 - The points within improvement activities 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 proposed 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).
- The College urges CMS to modify the base score component of ACI and remove the threshold requirements of 1 or “yes” for all proposed base measures except for the protecting patient health information attestation, which ACP believes is integral to the use of health IT. When considering our move to a value-based and learning healthcare system and exploring ways to further advance the use of health IT, there is an opportunity to be less prescriptive.
- ACP 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 that CMS remove the weighting of Improvement Activities, as it adds unnecessary complexity and it is unclear what evidence might indicate why certain activities might be considered medium versus highly weighted.

Priority Area #2: Performance Reporting Improvements

- The College strongly recommends that the Quality performance category be set at a 90-day reporting period (rather than 21 months) in order to align it with the other reporting categories of Advancing Care Information and Improvement Activities. This will allow clinicians to gradually prepare for full participation and for CMS to continue to facilitate the idea of a learning health care system focused on value over volume.
 - Revising the reporting period for Quality would also work well in conjunction with an opening of the data submission prior to the conclusion of the performance period if feasible. Practices that choose to submit data earlier should then be able to receive more timely feedback on their data submission and use that feedback to make improvements.
- ACP also recommends that CMS 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.
- CMS should prioritize moving the performance period closer to the payment adjustment year as soon as possible. This, combined with providing clinicians and practices with much more timely feedback on their data submission, will serve to better facilitate meaningful improvement--and an ability for clinicians to experience incentives in a timely and understandable manner.
- Further, as CMS continues to improve the program, and the complex patient bonus in particular, the College recommends that even more points be given to physicians who care for more complex patient panels.

Priority Area #3: Reduce Administrative Burden

- The College supports the proposal to allow eligible clinicians (ECs) and groups to use multiple data submission mechanisms to report a single performance category. However, reporting data via more than one submission mechanism also creates additional administrative burden and added cost for a practice. Therefore, ACP urges CMS to ensure that this option is strictly voluntary.
- ACP strongly recommends that CMS collaborate with specialty societies, frontline clinicians, patients, and EHR vendors in the development, testing, and implementation of quality measures with a focus on integrating the measurement of and reporting on performance with quality improvement and care delivery and on decreasing clinician burden.
- The College appreciates that CMS accepted our recommendation to maintain the current 50 percent data completeness requirements for quality reporting for the second performance period under MIPS. An increase in the data reporting requirements 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.

- With regard to topped out quality measures, when CMS does decide to begin proposing these measures for removal, the Agency must give consideration to the impact this will have on clinicians. Removing a large number of these measures simultaneously will leave many clinicians, especially specialists/subspecialists, without sufficient measures to report in a single reporting mechanism, causing them to look to multiple mechanisms to try to meet the 6-measure requirement. This will come at significant cost and added administrative burden.
- The College appreciates that CMS has proposed to allow ECs and certain third-party intermediaries can submit for the improvement activities performance category in all future years through attestation by designating a “yes” response. By requiring only attestation, this will relieve the issue of administrative burden that is having an increasing impact on physicians, particularly as they are still becoming educated about and initiating transition to the new Quality Payment Program.
 - ACP further requests that CMS consider allowing other third parties that may be collecting information that is indicative of completion of an improvement activity to submit lists to CMS that would allow credit to be awarded absent a submission by an EC, group, or third-party intermediary.
- ACP applauds CMS’ approach of allowing ECs to continue to use 2014 Edition certification criteria (or CEHRT) for their EHRs through CY 2018 and rewarding those who have adopted the new technology with bonus points. ACP believes this bonus should be available to all ECs, regardless of whether they are new to the MIPS program or not. These types of upgrades take a large amount of time and are a significant burden to roll out and can pose potential risks to patient health if done too suddenly.
 - However, it is important to note that the College does believe that there are health IT functionalities that can minimize administrative “paperwork,” double-documenting, or duplicate data entry burden for physicians and other clinicians-- and that these would alleviate some of the pain points of the Quality Payment Program.
- 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. However, ACP continues to have concerns there is a very limited number of APMs that qualify as MIPS APMs in the first performance period, particularly for many eligible specialty and subspecialty clinicians.

Priority Area #4: Provide Even More Opportunities for Small Practices to Succeed

- ACP is encouraged by CMS’ continued concern for small practices and certain specialists/subspecialists with a small Medicare patient population by providing a better safety net. Raising the low volume threshold to \$90,000 in Medicare Part B allowed charges OR require fewer than 200 unique Medicare beneficiaries seen, will provide relief to even more clinicians.
 - However, the College strongly recommends that clinicians below the proposed \$90,000 or 200-patient low-volume thresholds have the option of opting into MIPS and receiving payment adjustments associated with their performance.

- We would also like to note our concern that this proposal poses a risk of stalling these exempted practices in making progress toward value based payment, which is contrary to the Congressional intent of MACRA and the overarching movement toward value in the healthcare system.
- The College strongly recommends that CMS consider options for allowing practices that may not meet the strict definition of small practices under Agency rules but are otherwise similar in challenges, structure, etc. to qualify for the same exemptions and special rules as other small practices.
- There are many small practices that believe that they cannot afford the upfront investments in EHR technology and those who have not adopted EHRs due to the administrative and financial burden to maintain these systems. Therefore, the hardship exemption for small practices will provide significant relief. At the same time, we are concerned that some small practices are being left behind in the overall computerization of health care. In addition to a hardship exemption for those who choose to accept it, we urge CMS to provide more assistance to small practices that are willing to try to integrate information technology, but cannot accomplish the task without additional help.
- ACP appreciates the new 2018 QPP performance period proposal to offer a small practice bonus to those practices with 15 or fewer clinicians, as it will help promote participation and ease the burden on small practices. However, the College strongly recommends that CMS extend this bonus to those physicians practicing in rural and underserved areas.
- ACP strongly urges CMS to modify its policy of restricting group reporting to TIN-level identification and allow group practices the option of reporting at the subdivided TIN-level, where the group divides into smaller groups for the purposes of being assessed for performance in MIPS.
 - These smaller groups would have the flexibility to choose the performance activities that are most relevant to their scope of practice and patient population.
 - Further, this option of allowing small group reporting within the TINs will be in the best interest of the patients and families/caregivers, as it will create more meaningful publicly reported data.

Priority Area #5: Patient-Centered Medical Homes and Patient-Centered Specialty Practices

- PCMHs and PCSPs Within the MIPS Pathway:
 - The College appreciates the proposed expansion of the PCMH definition within MIPS to include both medical homes that are “certified” and those that are “recognized.” Including both terms better reflects the terminology used by various organizations, states, etc. that have PCMH programs that may qualify for full credit in the improvement activities performance category.
 - However, the College does not support the proposal to require that 50 percent of practice sites within a TIN be certified PCMHs or comparable specialty practices in order to receive full credit for improvement activities. A TIN may

have many practice sites under it but only a one or two that are primary care and therefore able to be recognized PCMHs. These practice sites would be penalized by not receiving full credit despite their efforts to improve their practice and patient care by making the transformation into a medical home.

- PCMHs and PCSPs Within the Advanced APM Pathway:
 - While the College commends CMS for its continued recognition within the proposed rule regarding the unique status of the medical home within the APM portfolio, 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).
 - 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).
 - Further, ACP recommends that CMS take the several specific steps (as outlined in this letter) 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 in the second performance period (2018), if feasible, and no later than the third performance period (2019).
 - Additionally, while the College appreciates that CMS proposes to exempt CPC+ Round 1 practices from the 50-clinician limit in the organizational entity, we urge CMS to broaden this proposal to remove any limitations on Medical Home Models based on the number of clinicians in the organization that owns and operates the practice site.
 - 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, strongly recommends that the 2 percent proposed risk requirement for the Medical Home Model 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 also strongly recommends that the Medical Home Model nominal risk standard also be applied to comparable specialty practice models.

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) (p. 16)

1. MIPS Performance Period for Year 2 (p. 16)

- The College appreciates that CMS continues to offer flexible reporting options in QPP Year 2 to protect ECs from downward payment adjustments. This proposal addresses ACP's previous recommendation that the Agency maintain similar flexible reporting options for the second QPP performance period.
- The College strongly recommends that CMS reduce the proposed reporting period requirement for the Quality performance category from 12 months to a 90-day reporting period.
- ACP strongly recommends that CMS move the performance period closer to the payment adjustment year.

2. QPP Performance Feedback (p. 17)

- Until a real-time mechanism exists, CMS should make feedback reports available as frequently as possible, on a quarterly basis at minimum, while working toward monthly reports as soon as possible. The College urges CMS to include patient-level data in feedback reports in an accessible and understandable manner.
- ACP recommends the Office of the National Coordinator for Health IT (ONC) add a single certification requirement that EHR vendors provide fully functional access to third-party tools, through the use of application programming interfaces (APIs), that could add these needed functionalities without further complicating the existing EHR system.

3. Low-Volume Threshold (p. 18)

- ACP is encouraged to see CMS' continued concern for small practices and certain specialists/subspecialists with a small Medicare patient population by providing a better safety net. Raising the low volume threshold to \$90,000 in Medicare Part B allowed charges OR require fewer than 200 unique Medicare beneficiaries seen, will provide relief to even more clinicians.
- The College strongly recommends that clinicians below the proposed \$90,000 or 200-patient low-volume thresholds have the option of opting into MIPS and receiving payment adjustments associated with their performance.

4. Virtual Groups (p. 20)

- ACP strongly urges CMS to finalize 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.
- ACP also urges CMS to allow ECs and group practices that fall below the low-volume threshold to opt in for virtual group participation if all other requirements are met.

5. Group Reporting (p. 21)

- 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.

6. Small Practice Definition (p. 22)

- The College strongly recommends that CMS consider options for allowing practices that may not meet the strict definition of small practices under Agency rules but are otherwise similar in challenges, structure, etc. to qualify for the same exemptions and special rules as other small practices.

7. Submission Mechanisms (p. 23)

- Recognizing the challenges associated with having multiple reporting mechanisms for a single performance category, ACP urges CMS to ensure that this option is strictly voluntary. If a clinician or group does not have sufficient quality measures to report six measures including an outcome measure in one submission mechanism and reports all of the measures that are available and applicable, that should be sufficient to meet the full data submission requirement for the quality performance category.

8. Submission Deadlines (p. 24)

- ACP also recommends that practices that choose to submit data earlier should be able to receive more timely feedback on their data submission.

9. Quality Performance Category (p. 25)

a. Measure Requirements (p. 25)

- 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.
- 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.

- The College further recommends that any measures CMS proposes to use outside of the ACP recommendations and core sets 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.
- The College 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 this as an option in the Improvement Activities Performance Category.
- 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, which calls on measure developers to actively consider how to integrate patient preferences and goals into measure design.

b. Data Completeness Criteria (p. 30)

- The College appreciates that CMS accepted our recommendation to maintain the current 50 percent data completeness requirements for quality reporting for the second performance period under MIPS.
- ACP further recommends 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.

c. Facility-based Measures (p. 31)

- ACP supports the concept of using a hospital or facility's quality measure scores to serve as a proxy in the MIPS Quality and Cost components for ECs and their groups.

d. Global and Population-based Measures (p. 32)

- ACP reiterates its recommendation that CMS remove the all-cause hospital readmissions (ACR) measure from the quality score for groups that meet the size and case minimum requirements.

e. Topped Out Measures (p. 33)

- ACP appreciates that CMS will allow measures in the first year of being identified as topped out to 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 appreciates that CMS accepted our recommendation that the Agency publicly disclose any measures that are topped out prior to a performance period in advance.

f. QCDRs (p. 35)

- The College continues to recommend 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 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.
- ACP recommends that CMS provide more clarity around the process for harmonization of QCDR measures in scenarios where multiple QCDRs submit similar measures.

g. Quality Measures Determined to Be Outcome Measures (p. 36)

- ACP encourages CMS to 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.

10. Cost Performance Category (p. 37)

- The College applauds CMS for reducing the Cost performance category down from 10 percent to zero percent of the overall MIPS composite score for the 2018 performance period.
- Given the remaining concerns with the proposed cost measures, ACP strongly urges CMS continue to delay the increase in weight of the Cost performance category for the overall MIPS performance score in future performance years.
- The College recommends that CMS use this authority to reweight the Cost performance category to zero percent in the third performance period and subsequent years due to the lack of adequate and relevant measures within the Cost performance category.
- ACP recommends that CMS conduct a voluntary pilot program on the episode-based cost measures once an operational set of episode groups and subgroups is fully ready for testing, no earlier than in 2018, that includes a representative sample of practice types, sites, geographic regions, etc.

11. Improvement Activities Performance Category (p. 39)

- ACP reiterates its recommendation that all improvement activities are weighted equally to allow time for CMS to establish a more evidence-based approach to weighting and simplify scoring as practices gain experience in the early years of MIPS.
- The College urges CMS to explicitly list ACP Practice Advisor and ACP Quality Connect within the description of the improvement activities where applicable.
- We further request that CMS consider allowing other third parties that may be collecting information that is indicative of completion of an improvement activity to submit lists to CMS that would allow credit to be awarded absent a submission by an EC, group, or third-party intermediary.
- ACP strongly supports CMS' proposal to award CPC+ Round 2 control group practices full credit for the improvement activities. We further encourage CMS to minimize the amount of practices that are selected for the control group as much as possible to maximize the number of practices who are able to participate in CPC+ as an Advanced APM.

12. Advancing Care Information Performance Category (p. 44)

- The College recommends that CMS 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.
- The College urges CMS to modify the base score component of ACI and remove the threshold requirements of 1 or "yes" for all proposed base measures except for the protecting patient health information attestation which ACP believes is integral to the use of health IT.
- ACP applauds CMS' approach, allowing ECs to continue to use 2014 Edition through CY 2018 and rewarding those who have adopted the new technology with bonus points.
- ACP strongly encourages CMS to allow for a 12-month notification period of any changes in weight and computation of MIPS scores to allow for the health IT ecosystem to adjust these alterations.
- In addition to a hardship exemption for those who choose to accept it, we urge CMS to provide more assistance to small practices that are willing to try to integrate information technology, but cannot accomplish the task without additional help.
- Rather than the approach CMS has taken to-date of rewarding a point for each measure submitted using end-to-end reporting, the College recommends that additional bonus points be available for reporting to additional entities – whether they are quality measurement organizations, clinical data registries, public health organizations, health information exchanges, or research organizations.
- ACP recommends that CMS and ONC partner with physicians that use direct EHR reporting specifically to gather instances of errors in value set logic and/or value set implementation. Incentives could include additional bonus points in the ACI category

and/or permitting this as an improvement activity that also rewards extra points in the ACI category.

13. APM Scoring Standard for MIPS ECs in MIPS APMs (p. 57)

- 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 the availability of MIPS APMs.
- The College continues 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.
- ACP recommends that CMS consider allowing leniency for these Other MIPS APMs to meet quality reporting requirements and deadlines given the adjustments that have been made to allow MIPS reporting.

14. MIPS Final Score Methodology (p. 60)

a. Complexity in MIPS Performance Scoring (p. 60)

- While CMS continues to propose to allow for flexibility in 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.
- ACP strongly 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 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.
- 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—this would serve to strengthen MIPS and make the program more comprehensive rather than siloed.
- The College also recommends CMS use the time during initial performance periods to refine the feedback mechanisms that will be utilized for QPP performance and allow for appropriate user feedback and end-to-end testing.

b. Scoring the Quality Performance Category (p. 63)

- ACP recommends that CMS maintain the 3-point floor for quality measures for all clinicians, including those who fail to meet the data completeness criteria, for the second performance period.
- While we understand the desire to provide incentives for meeting the full participation requirements for the quality performance category and support this goal, ACP recommends that CMS consider additional ways of incentivizing improvements for ECs and groups that are incrementally increasing performance toward the full quality measure requirements.

c. Scoring the Improvement Activities Performance Category (p. 72)

- ACP reiterates its recommendation that all activities be weighted equally for this category. This will help in simplifying the scoring methodology to allow clinicians to see more directly the impact that reporting an improvement activity will have on their overall performance score.

d. Complex Patient Bonus (p. 74)

- As CMS continues to improve the complex patient bonus incentive, the College recommends that more points be given to physicians who care for more complex patient panels.
- ACP recommends that CMS partner with physician societies and other stakeholders to provide education and support on how to properly code for HCCs so physicians are aware of where their patient's fall on the risk-adjustment spectrum and how they are being scored.

e. Small Practice Bonus (p. 75)

- The College strongly recommends that CMS extend the small practice bonus to those physicians practicing in rural and underserved areas.

B. Advanced APMs (p. 75)

1. Medical Home Model (p. 75)

- ACP remains 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).
- 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 in the second performance period (2018), if feasible, and no later than the third performance period (2019).
 - 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 2019 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 this proposed rule.
- 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.
- While the College appreciates that CMS proposes to exempt CPC+ Round 1 practices from the 50-clinician limit in the organizational entity, we urge CMS to broaden this proposal to remove any limitations on Medical Home Models based on the number of clinicians in the organization that owns and operates the practice site.

2. Nominal Amount of Risk (p. 82)

- The College recommends that a lower, revenue-based standard for small practices be set at the Medical Home Model nominal amount standard.
- We strongly recommend that CMS apply a lower, revenue-based nominal amount standard to all small and rural practices in APMs, regardless of whether they are part of a larger APM entity or part of a Medical Home Model.
- 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, strongly recommends that the 2 percent proposed 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.

C. Physician-Focused Payment Model Technical Advisory Committee (PTAC) (p. 88)

- The College recommends that CMS provide a clear pathway for models recommended by PTAC to be implemented as APMs under MACRA.
- ACP also urges CMS to make technical assistance available to stakeholders that are developing physician-focused payment models (PFPMs) for PTAC review.

IV. Merit-Based Incentive Payment System (MIPS)

A. MIPS Performance Period for Year 2

Background:

Similar to the “pick your pace” options in the 2017 QPP performance period, CMS proposes to offer continued flexibility in reporting and participation for clinicians in what the Agency has termed as “The Quality Payment Program Year 2.” The CMS proposals for the MIPS performance period in QPP Year 2 modestly increase the reporting requirements for the Quality performance category from 90 days to a full year (12 months) of data. CMS also proposes a performance period of 12 months for the Cost performance category; however, as discussed later in the Cost summary section, the Cost data does not require additional reporting by clinicians and CMS proposes not to use the Cost performance score in the final score determination for the QPP Year 2. The performance periods for the Advancing Care Information and Improvement Activities performance categories remain at a minimum of 90 days for the QPP Year 2.

ACP Comments:

The College appreciates that CMS continues to offer flexible reporting options in QPP Year 2 to protect ECs from downward payment adjustments. This proposal addresses ACP’s previous recommendation that the Agency maintain similar flexible reporting options for the second QPP performance period. It is not reasonable to expect that an EC or group that elected to test participation in MIPS by submitting one quality measure will be ready to move to the full reporting requirements in year two. **Therefore, the College strongly recommends that CMS reduce the proposed reporting period requirement for the Quality performance category from 12 months to a 90-day reporting period.** It is important to allow clinicians to gradually prepare for full participation and for CMS to continue to facilitate the idea of a learning health care system focused on value over volume. ACP believes CMS should continue to 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 to ensure that practices can

smoothly transition into more fully reporting in QPP while also providing understandable and actionable performance feedback.

The College thanks the Agency for maintaining the performance period of 90 days for the Advancing Care Information and Improvement Activities performance categories for QPP Year 2. 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 maintain stability to reporting on these performance categories as practices adapt to QPP requirements. The College also believes that a 90-day reporting period for ACI and IAs is a sufficient amount of time to capture the necessary information required for both categories while also allowing physicians the opportunity to update or implement new and innovative technology throughout the course of the performance period to ultimately improve quality and care delivery.

While ACP is advocating for incremental increases and a shorter 90-day reporting period for quality, IAs, and ACI during the MIPS Year 2 performance period we recommend CMS continue to review available data to determine the appropriate length of the performance period necessary for clinicians 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 cost 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.

Following a substantial transition period over the course of several years, and once an appropriate length of the performance period is determined, **ACP strongly recommends that CMS move the performance period closer to the payment adjustment year.**

B. QPP Performance Feedback

Background:

CMS proposes to provide QPP performance feedback to ECs and groups on an annual basis and in future program years aims to provide feedback more frequently in order to provide timely, actionable data for ECs to improve care. Over the past year, the Agency reached out to frontline clinicians and determined the following is necessary for user-friendly feedback reports:

- Timely performance data
- Understandable feedback to quickly assess how and why payments will be adjusted and how business will be affected
- Understandable feedback on how to improve performance
- Performance data over time to improve care of patients
- Peer comparisons

CMS has begun development of real-time feedback on data submission and scoring where technically feasible and will continue to gather information from frontline clinicians. Additionally, the Agency seeks comments on how health IT, either through an EHR or supplemental mechanism, could better support feedback reports related to QPP participation and quality improvement in general.

ACP Comments:

ACP is encouraged that CMS is reaching out to clinicians to gather feedback on specific needs of those participating in the program. It is imperative that CMS continue to move forward in development of a mechanism to provide real-time, actionable feedback to physicians and practices participating in QPP. **Until that real-time mechanism exists, CMS should make feedback reports available as frequently as possible, on a quarterly basis at minimum, while working toward monthly reports as soon as possible. The College urges CMS to include patient-level data in feedback reports in an accessible and understandable manner.**

Regarding questions of how health IT can better support feedback reports, ACP believes that there are multiple functional capabilities within EHR systems that could promote useful feedback mechanisms including workflow management, data analysis, data visualization, shared decision making, and data aggregation. Unfortunately, many of these functional capabilities are generally not available in existing EHR systems and not required by current EHR certification requirements. Instead of adding each of the specific functionalities described above to an already extensive list of EHR certification requirements, **ACP recommends the Office of the National Coordinator for Health IT (ONC) add a single certification requirement that EHR vendors provide fully functional access to third-party tools, through the use of application programming interfaces (APIs), that could add these needed functionalities without further complicating the existing EHR system.**

C. 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 has proposed to increase the low volume threshold from \$30,000 or less in allowed charges or 100 or fewer Part B patients to \$90,000 or less in allowed charges or 200 or fewer Part B patients in year 2.

ACP Comments:

ACP is encouraged to see CMS' continued concern for small practices and certain specialists/subspecialists with a small Medicare patient population by providing a better

safety net. Raising the low volume threshold to \$90,000 in Medicare Part B allowed charges OR require fewer than 200 unique Medicare beneficiaries seen, will provide relief to even more clinicians. However, while the College believes that the increased low-volume threshold is adequate to allow appropriate protections and burden relief for solo clinicians and small practices, **we strongly recommend that clinicians below the proposed \$90,000 or 200-patient low-volume thresholds have the option of opting into MIPS and receiving payment adjustments associated with their performance.** Because most reporting mechanisms require reporting quality data from all payers, clinicians with limited numbers of Part B payments or patients may still have sufficient sample size to report valid data when their broader patient population is incorporated—and some of these clinicians may already have been actively participating in MIPS in 2017 and would be frustrated to be excluded in 2018. Further, by significantly raising the low-volume threshold and prohibiting those below the threshold from opting into and having their payments adjusted under MIPS, CMS would prevent these practices from potentially receiving positive MIPS payment adjustments in future years.

We also appreciate that CMS plans to notify small practices of their status near the beginning of the performance period as it pertains to eligibility relating to technical assistance, applicable improvement activities criteria, the proposed hardship exception for small practices under the advancing care information performance category, and the proposed small practice bonus for the final score.

While ACP is supportive of the increased volume threshold as a means of protecting smaller practices from payment adjustments and excessive burden, those clinicians should be given the option of participating if they are able—however, we would also like to note our concern that this proposal poses a risk of stalling these exempted practices in making progress toward value based payment, which is contrary to the Congressional intent of MACRA and the overarching movement toward value in the healthcare system. The proposed changes in the low-volume thresholds would obstruct impacted practices from participating in virtual groups, which Congress expressly established in MACRA for solo and small groups to aggregate their data, in order to remove any methodology biases due to their potential small number of Medicare beneficiaries. **Therefore, ACP encourages CMS to carefully consider individuals and groups that fall below the low-volume threshold when creating policy for virtual groups, allowing them the option to opt-in to such groups for voluntary participation.**

Further, ACP is pleased CMS is proposing to reweight the advancing care information performance category to zero percent of the MIPS final score for ECs who qualify for the hardship exception that would become available beginning with the 2018 performance period and 2020 MIPS payment year. However, we continue to recommend 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.

D. Virtual Groups

Background:

Beginning in the 2018 performance year, solo clinicians and groups with ten or fewer MIPS eligible clinicians may establish a virtual group. For the quality and cost performance categories, the performance of individual members of the virtual group will be combined to determine the entire group's performance. Virtual groups must notify CMS of their intention to become Virtual Groups prior to the 2018 performance year.

ACP Comments:

Congress included language establishing virtual groups to provide a plausible mechanism for solo and small group practices to participate in the MIPS pathway alongside larger groups that would inherently benefit from larger numbers of beneficiaries, upon which CMS would calculate their evaluation. **ACP strongly urges CMS to finalize 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.**

The College appreciates that CMS proposes to allow significant flexibility in forming virtual groups by not limiting groups to ECs in the same geographic location or specialty or limiting the number of ECs or group practices that can join together virtually. It will be important to maintain the maximum flexibilities available in subsequent years to allow broader uptake of the virtual groups option and allow solo clinicians and small practices to find virtual groups compositions that best fit their needs.

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.**

ACP also urges CMS to allow ECs and group practices that fall below the low-volume threshold to opt in for virtual group participation if all other requirements are met. Excluding practices below the low-volume threshold is arbitrary given that the virtual group that they are joining will likely exceed the threshold when considered as an entire group. The College recommends that CMS allow any clinician or group that falls below the low-volume threshold the option of opting into MIPS and receiving payment adjustments based on their performance. It is important that virtual group participation is a reporting option for clinicians below the threshold that choose to participate.

E. Group Reporting

Background:

A group practice for reporting purposes is defined 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 uses 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. Groups are not required to register to report unless they are reporting via the CMS Web Interface or CAHPS for MIPS. CMS does not propose changes to group reporting. However, in recognition of concerns expressed by ACP and others that group reporting at the TIN level may not be appropriate for large, multispecialty practices, the Agency seeks comments on ways in which reporting at the subgroup level could be accomplished.

ACP Comments:

The College continues to have significant concerns with CMS' policy to restrict group reporting to TIN-level identification and appreciates that the Agency indicates in this rule that this may be addressed in the future. 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 are already forcing 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 for the 2018 performance period in addition to 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.

F. Small Practice Definition

Background:

For the purposes of virtual groups, a small practice is one with 10 or fewer ECs that have assigned their NPI billing to a TIN. Only small practices with 10 or fewer ECs and solo practices are able to join together to form a virtual group.

Elsewhere in the QPP regulations, a small practice is one that has 15 or fewer ECs with their NPI billing rights assigned to a TIN. The 15 or fewer clinician definition allows practices access to the small practice technical assistance, lower improvement activities requirements, and small practice bonus, among other things.

ACP Comments:

The College strongly recommends that CMS consider options for allowing practices that may not meet the strict definition of small practices under Agency rules but are otherwise similar in challenges, structure, etc. to qualify for the same exemptions and special rules as other small practices. We understand that the MACRA law specifies practices with 15 or fewer clinicians for certain policies, such as practices that are eligible for direct technical assistance. However, the law does not explicitly define a practice as a collective of clinicians under a single TIN. Therefore, we urge CMS consider broadening the small practice definition for certain practice structures. For example, multiple practices may be tied together loosely under an IPA with a shared TIN. While the IPA has more than 15 ECs that share a combined TIN, the practices under it do not have the benefit of sharing organizational and administrative resources in the same way that an organization that owns and operates the practice sites. In circumstances like

the IPA scenario, CMS should consider how to allow physical practice sites that meet the 15-clinician small practice definition but are loosely tied together under a TIN to be treated as a small practice under MIPS and thereby allowed the same benefits.

The number of clinicians in a physical practices site may be a better indicator of small practice needs when it comes to loosely held TINs that are not owned and operated as part of an organization. We urge CMS to allow physical practice sites under loosely held TINs as meeting the small practice definition if the physical location has 15 or fewer ECs. As such, these practice sites should also qualify to be treated under the same policies as those meeting the current TIN definition including access to direct technical assistance, the ACI hardship exemption, lower improvement activities requirement, and small practice bonus. We further ask that those physical practice sites that meet the 10-clinician limit that are under a TIN that is loosely held be permitted to join virtual groups.

G. Performance Category Measures and Reporting

1. Submission Mechanisms

Background:

CMS proposes to continue to allow clinicians to submit data using the same reporting mechanisms as finalized for the 2017 performance period. The Agency proposes to modify the requirement that ECs or groups use a single reporting mechanism for a performance category. Beginning with the 2018 performance period, CMS proposes to allow ECs and groups to submit data using multiple submission mechanisms for a single performance category. This flexibility is intended to address concerns that clinicians may not have sufficient quality measures available through a single submission mechanism, and enabling submission via multiple mechanisms may allow clinicians to report a full set of measures.

With regard to virtual groups, CMS proposes to generally apply finalized group practice policies to these groups. Virtual groups would be able to use a different submission mechanism for each performance category and submit quality via multiple submission mechanisms. However, they would be required to use the same submission mechanism for improvement activities and ACI. CMS does not propose any changes to MIPS APMs data submission policies.

ACP Comments:

The College supports the proposal to allow ECs and groups to use multiple data submission mechanisms to report a single performance category. This added flexibility will allow clinicians who might not have sufficient specialty-specific quality measures to have additional options when searching for appropriate measures. However, reporting data via more than one submission mechanism also creates additional administrative burden and added cost for a practice. **Recognizing the challenges associated with having multiple reporting mechanisms for a single performance category, ACP urges CMS to ensure that this option is strictly voluntary. If a clinician or group does not have sufficient quality measures to report six measures including an outcome measure in one submission mechanism and reports all of the**

measures that are available and applicable, that should be sufficient to meet the full data submission requirement for the quality performance category. ECs should not be penalized for failing to report additional measures via a second reporting mechanism to meet the 6-measure requirement. Simply reporting on all applicable measures within the data submission mechanism of choice, up to the six required measures, is all that should be required for the quality performance category.

2. Submission Deadlines

Background:

The data submission deadline is generally March 31 following the close of the performance period. Data submission generally begins on or around January 2 following the close of the performance period. For the 2018 performance period, CMS proposes to open data submission prior to January 2 if technically feasible. If opening the data submission period is not feasible, data submission will occur from January 2 – March 31, 2019. Claims with dates of service during the performance period must be submitted no later than 60 days following the close of the performance period. Additionally, the CMS Web Interface submission window will remain as an 8-week period occurring sometime between January 2 and March 31. CMS will publish the web interface window on its website.

ACP Comments:

The College supports opening the data submission prior to the conclusion of the performance period if feasible. **ACP also recommends that practices that choose to submit data earlier should be able to receive more timely feedback on their data submission.** This will help clinicians in the improvement activities and ACI performance categories determine whether they have met the requirements to receive full credit in the performance categories earlier in the process. We do have questions related to how opening the submission window early would impact the quality and cost performance categories given that CMS proposes a full-year performance period for each. This further demonstrates the need for CMS to reduce the proposed reporting period requirement for the Quality performance category from 12 months to a 90-day reporting period. ECs submitting quality data during the performance period should be able to get more frequent feedback throughout the year based on data submissions, enabling them to make more timely adjustments to improve performance.

If the Agency is able to open the data submission window during the performance period, the submission deadline should remain at March 31 of the year following the performance period to allow maximum time for submission following the conclusion of the year. Additionally, clinicians and practices that choose to submit data during the performance period should have the option of submitting additional data up to the March 31 deadline.

H. MIPS Performance Categories

1. Quality Performance Category

a. Contribution to Final Score

Background:

In the QPP final rule for 2017, CMS finalized that the Quality Performance Category would account for 60 percent of the weight in the composite performance score in the 2017 performance period and 50 percent in 2018. The final rule established a 10 percent weight for the Cost Performance Category for the 2018 performance period. In this rule, CMS proposes to reduce the weight of the Cost Performance Category at zero percent and increase the weight of the Quality Performance Category to 60 percent for the 2018 performance period. Additionally, under law, the quality and cost categories are both weighted at 30 percent for the 2019 performance period.

ACP Comments:

As detailed below in our comments on the cost performance category, the College appreciates that CMS accepted our recommendation to reduce the cost category weight to zero and reweight the quality performance category at 60 percent in the second performance period. We encourage CMS to consider ways of maintaining the quality and cost performance category weights at 60 percent and zero percent respectively in future years, as the measures that will be used for cost performance are still being developed and will need testing before they are implemented. We also reiterate our earlier recommendation that the reporting period for quality in the second performance period be a minimum of a 90-day continuous period within the performance period.

b. Measure Requirements and Data Submission Criteria

Background:

For the 2018 performance period, CMS proposes to continue to require individuals and groups to submit at least six quality measures including one outcome measure. If no applicable outcome measures are available, clinicians may report on a high priority measure instead. High priority areas include appropriate use, patient safety, efficiency, patient experience, and care coordination measures. If fewer than six measures apply, clinicians would be required to report on each applicable measure. CMS will only make determinations about whether a sufficient number of applicable measures were available for clinicians reporting via the claims or qualified registry submission mechanisms.

Clinicians may also choose to report their six measures from within a specialty measure set. If a measure set contains fewer than six measures, ECs must report all available measures in the set. If a measure set contains at least six measures, ECs are required to report on six measures within the set. Those choosing to report on a measure set are still required to report on at least one outcome measure, or, if no outcome measures are in the measure set, one high priority

measure within the set. Clinicians will not be penalized for choosing to report additional measures outside of the measure set as long as they follow the rules tied to measures reporting submission criteria.

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),⁶ 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.**

Along these lines, ACP's Performance Measurement Committee (PMC) has reviewed and provided detailed recommendations on performance measures that are particularly applicable to internal medicine—and soon will have recommendations available for all internal medicine-relevant MIPS measures.⁷ The PMC recommendations are 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. **Therefore, ACP strongly recommends that CMS look to these recommendations first when considering what measures to use for reporting by internal medicine specialists.**

The College further recommends that any measures CMS proposes to use outside of the ACP recommendations and core sets 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 MIPS for the 2018 reporting year have received only conditional support from the MAP, and the 2017 measures that remain on the list for the MIPS

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

⁷ <https://www.acponline.org/clinical-information/performance-measures>

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 all measures, whenever possible and regardless of source, should 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 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,⁸ 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 ACP recommended, MAP-recommended, and/or NQF-endorsed.
- 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.⁹
- 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).

⁸ https://www.acponline.org/acp_policy/letters/comment_letter_macra_proposed_rule_2016.pdf

⁹ 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>

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.

i. Cross-cutting Measures

Background:

CMS solicited feedback in previous rulemaking but did not require ECs to report on a cross-cutting measure as part of the quality performance category. A cross-cutting measure is considered to be any measure that is broadly applicable across multiple clinical settings and individual MIPS ECs or groups within a variety of specialties. Due to conflicting feedback received with regards to a cross-cutting measure requirement, CMS does not propose a cross-cutting measure requirement. The Agency will continue to accept comments on how to incorporate cross-cutting measures within MIPS in the future.

ACP Comments:

While ACP is supportive of moving toward the use of cross-cutting measures, we appreciate that CMS did not propose to require ECs to report on at least one cross-cutting measure in year 2. 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.

ii. CAHPS and Patient Experience Measures

Background:

Groups of 2 or more ECs may voluntarily elect to report on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey as one of their required quality measures. The CAHPS for MIPS survey may count as a high priority measure if no applicable outcome measure is available. At least five other measures must be submitted through a different reporting mechanism to meet the full quality reporting requirements. CMS proposes to shorten the survey administration period beginning in 2018 to an 8-week period concluding no later than February 28th of the year following the close of the performance period. The Agency also proposes to remove two summary survey measures (SSMs): “Helping You to Take Medication as Directed” and “Between Visit Communication.” These proposals are due to low reliability of the data for these SSMs and to better align CAHPS for MIPS with CAHPS for accountable care organizations (ACOs). CMS is seeking comments on the potential for including five open-ended questions for patient narratives such as those in the CAHPS Patient Narrative

Elicitation Protocol, which is currently in beta testing through AHRQ. These questions are designed to capture patient narratives in a scientifically grounded and rigorous way, unlike many of the patient narratives collected by health systems and patient rating sites. CMS also seeks comment on ways of incorporating other payer patient feedback into the CAHPS survey population.

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,¹⁰ **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.**

ACP supports the concept of including measures in the CAHPS for MIPS survey that capture patient narratives, such as the CAHPS Patient Narrative Elicitation Protocol measure undergoing beta testing through AHRQ, as this will add to the patient experience story. However, we caution that information needs to be carefully weighed with the survey data to ensure that outliers, such as individuals with a personal vendetta or who had a poor health outcome, aren't biasing the data set. Additionally, the added measures will entail an additional 5-7 minutes of patient time to complete. Given that CAHPS already has a low response rate, CMS should consider ways of streamlining or shortening components of the survey to ensure that the length of time necessary to complete the survey does not negatively impact the completion rate.

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,¹¹ 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.

¹⁰

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

¹¹ 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>.

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 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.

c. Data Completeness Criteria

Background:

In the final rule for performance year 2017, CMS finalized increasing the data completeness threshold from 50 percent in the transition year to 60 percent in the second performance period (2018). The Agency also finalized plans to further increase the data completeness threshold in 2019 and subsequent years based on the belief 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.

In this rule, CMS proposes to maintain the transition year data completeness threshold at 50 percent for an additional year (the 2018 performance period) and delay increasing the threshold to 60 percent until the 2019 performance period. The Agency notes that it is concerned that increasing the data completeness criteria too quickly will jeopardize the ability of ECs with minimal quality reporting experience to participate and perform well. CMS also proposes changes to the points available for failing to meet data completeness thresholds for certain clinicians.

Additionally, CMS is requesting all-payer data for the 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.

Under the proposed rule, the following data completeness criteria would apply in performance period 2018:

- 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.
 - Group practices with 16 or more ECs (including virtual groups) that do not meet the data completeness threshold will receive 1 point for submitting the measure rather than the 3 points available in the transition year;

- Individual reporters and small group practices with 15 or fewer ECs (including virtual groups) that do not meet the data completeness threshold will continue to 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. 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.

ACP Comments:

The College appreciates that CMS accepted our recommendation to maintain the current 50 percent data completeness requirements for quality reporting for the second performance period under MIPS. An increase in the data reporting requirements 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.

ACP further recommends 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. Given the flexibility in reporting options in the initial performance period, 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 participation options that do not entail submission of quality measures that meet the data completeness criteria 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 2019. The data completeness criteria should remain stable at 50 percent for subsequent years as these clinicians are learning to successfully report.

At a minimum, it may be appropriate to maintain the 50 percent data completeness threshold for small practices and those in rural areas and HPSAs for several years to allow CMS to analyze their uptake in full data reporting. Increasing the data completeness criteria before a significant amount of ECs are able to participate at the current levels will create substantial barriers while ECs are trying to learn the basics of the QPP requirements, including clinicians who may have chosen to test their participation or focus on other performance categories in the early years. Increasing the data completeness requirements will also add unnecessary administrative burden, especially given that CMS has already determined that the 50 percent data completeness standard is sufficient to attain a reliably valid performance score.

d. Facility-based Measures

Background:

The eligibility requirement for an EP to be classified as facility-based requires 75% of all their services to be rendered in the inpatient hospital or emergency room settings. For groups, 75%

of the EPs in the group, would need to meet the individual eligibility requirement criteria. Facility-based scoring would be optional and voluntary, aligned with the Hospital Value-Based Purchasing (VBP) program. This would mean that the hospital's fiscal-year 2019 Hospital VBP Total Performance Score would be applied to the EPs quality and cost performance categories. Scores would be derived using the data from the hospital facility where the EP treated the highest number of Medicare beneficiaries.

ACP Comments:

ACP supports the concept of using a hospital or facility's quality measure scores to serve as a proxy in the MIPS Quality and Cost components for ECs and their groups.

Models that were developed and tested for appropriate attribution that use facility-based measures may better capture the quality of care physicians and other clinicians provide to patients. Further, shared accountability measures may better incentivize collaboration among physicians and the facilities where they provide services.

Certain facility-based ECs face unique challenges meeting many of the MIPS reporting requirements. The current reporting methodology under MIPS may not be well-suited for ECs who provide care in a team-based environment. Although the EC's clinical actions meaningfully contribute to high quality outcomes and reduced resource use in a value-based environment, these contributions may not be easily captured by MIPS measures and objectives. Therefore, we believe facility-based measures, appropriately implemented, have the potential to capture the efforts of a larger number of clinicians who contribute to a patient's care.

ACP agrees with the proposal to allow for the voluntary reporting of hospital and facility-based quality measures until sufficient and objective data and benchmarks can be gathered and established. We urge CMS that any program that attributes facility-based measures to individual ECs or group practices be tested in a "hold-harmless" fashion. This approach will allow CMS to better understand the methodologies and implications of this policy across facility-based ECs.

Further, we urge CMS to give consideration to combining services furnished by ECs in both the hospital out-patient settings and qualifying hospital settings cumulatively for future exemptions applicable to facility-based physicians. If an EC furnishes a substantial number of services in a hospital out-patient and a substantial number in a qualifying hospital setting such that cumulatively the total number of services exceeds the 75 percent threshold, the physician should be treated as hospital- or facility-based for purposes of determining eligibility and exemptions.

e. Global and Population-based Measures

Background:

CMS does not propose changes to the global and population-based measures for the 2018 performance period. Therefore, group practices with 16 or more ECs will be scored on the all-

cause hospital readmissions (ACR) measure from the value-based modifier (VM) program, as CMS believes that this measure encourages care coordination. Group practices must meet a 200-case volume in order to have their performance evaluated on this measure, which will be in addition to the six quality measures that are required for full participation.

CMS will continue to calculate the acute and chronic composite measures of AHRQ PQIs that meet a minimum sample size, as finalized in the rule for 2017, and will provide informational feedback to applicable groups in reports. The Agency will not include these in the performance score, as CMS believes that they need additional enhancements including the addition of risk adjustment. As with other policies, the population-based measures will also be applied to virtual groups that meet the 16 EC-threshold and sample size requirements.

ACP Comments:

The College appreciates CMS' decision not to include the two AHRQ PQI measures in the quality performance score. **However, ACP also reiterates its recommendation 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. Further, at a minimum, the College urges CMS to keep the ACR measure out of the quality score for virtual groups with 16 or more clinicians. As these virtual groups are newly formed and are unlikely to have the same infrastructure and care coordination functionality that established groups under a single TIN may have in place, it is inappropriate to factor the ACR measure into their 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.

f. Topped Out Measures

Background:

A measure may be topped out if performance is so high and unvarying that meaningful distinctions and improvement in performance can no longer be made. CMS proposes a 3-year timeline for identifying and proposing to remove a topped out measure. After the third

consecutive year of being identified as topped out, CMS may remove a measure through notice and comment rulemaking in the fourth consecutive year it is identified as topped out. QCDR measures that are consistently identified as topped out will not be approved through the self-nomination process in the fourth year rather than be subject to removal via notice and comment rulemaking. CMS Web Interface measures will not be removed if they are topped out due to their alignment with the Medicare Shared Savings Program. CMS also proposes to use a special scoring standard for measures beginning with the second consecutive year in which they are identified as topped out.

ACP Comments:

ACP appreciates that CMS will allow measures in the first year of being identified as topped out to 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 on patient care of the actions underlying the measure. 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.

We further recommend that, when CMS does decide to begin proposing topped out measures for removal, consideration is given to the impact this will have on clinicians. As CMS notes, 70 percent of claims measures already meet the topped out definition, and 45 percent of registry/QCDR measures are topped out. Removing a large portion of these measures simultaneously will leave many clinicians, especially specialists/subspecialists, without sufficient measures to report in a single reporting mechanism, causing them to look to multiple mechanisms to try to meet the 6-measure requirement. This comes at significant cost and added administrative burden. When removing measures or reducing their maximum point value based on topped out status, CMS should ensure that sufficient measures are available to continue to allow ECs a choice of measures within each reporting mechanism to meet CMS requirements.

ACP appreciates that CMS accepted our recommendation that the Agency publicly disclose any measures that are topped out prior to a performance period in advance. Along with this information, we encourage CMS to 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.

g. 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.

In this rule, CMS proposes replace the term “non-MIPS measures” with “QCDR measures.” Beginning with the 2019 performance period, the Agency proposes to use a simplified process in which existing QCDRs or qualified registries in good standing may continue their participation in MIPS by attesting that their approved data validation plan, cost, approved QCDR measures (applicable to QCDRs only), MIPS quality measures, activities, services, and performance categories offered in the previous year’s performance period of MIPS have no changes. QCDRs and qualified registries in good standing would be those that are not on probation or disqualified. Substantive changes to QCDR measure specifications or new QCDR measures would be required to be submitted for CMS review and approval by the close of the self-nomination period.

While CMS only reviews MIPS quality measures if there are significant changes made, QCDR measures are reviewed annually, regardless of whether there is a significant change. The Agency seeks comment on whether to use different criteria for MIPS measures and QCDR measures. CMS is also considering how to encourage ECs to use third-party intermediaries that are able to support clinicians on both the MIPS and APMs sides. Advancing the role of intermediaries may ultimately reduce clinician burden by enabling a streamlined reporting and feedback system such as by enabling virtual care teams to receive longitudinal patient information for participating clinicians.

ACP Comments:

The College supports referring to “non-MIPS measures” as “QCDR measures” in the future. ACP strongly supports streamlining the QCDR and qualified registry self-nomination process for registries in good standing. The annual QCDR self-nomination applications should focus on changes in measures and reporting services rather than other application information that has not changed from previous years. Additionally, if CMS considers a multi-year approval option,

ACP recommends that QCDRs be given the flexibility to submit an abridged application on an annual basis to reflect changes in measures and/or services offered.

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.

Additionally, **the College recommends that CMS provide more clarity around the process for harmonization of QCDR measures.** If multiple QCDRs submit similar measures that CMS deems should be harmonized, QCDR sponsors should be promptly notified by CMS. The Agency should also be more transparency how CMS determines measures that should be harmonized and how the “accepted” measure is selected, which then must be licensed by the other QCDRs.

ACP supports adding incentives for use of third-party intermediaries (e.g., qualified registries, QCDRs, health IT vendors, CMS-approved survey vendors) that provide robust performance feedback mechanisms that drive quality improvement and improved patient outcomes. CMS should consider incentives for ECs participating with third-party intermediaries that include enhancements such as: ability to track clinical data overtime, timeliness of performance feedback reports (e.g., provided added incentive for using a QCDR that provides feedback more frequently than a quarterly basis), ability to benchmark across multiple specialties, and ability to develop patient outlier lists. The Agency should also ensure that any incentives provided for using certain third-party intermediaries do not inadvertently penalize clinicians who may not have access to advanced EHR systems that can seamlessly integrate with more advanced QCDRs.

h. Quality Measures Determined to Be 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. In this rule, CMS proposes to use the following to determine if a measure is an outcome measure:

- Measure steward and National Quality Forum (NQF) designation. If this is not clear, CMS will consider next step.
- CMS Blueprint definitions for outcome measures: An outcome of care is a health state of a patient resulting from health care. Outcome measures are supported by evidence that the measure has been used to detect the impact of one or more clinical interventions. Clinical analysts are utilized to evaluate the measure.

Patient-reported outcome measures will also be considered outcome measures. CMS seeks comment on whether there are additional criteria that should be considered in determining what qualifies as an outcome measure.

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 require the reporting of outcomes-based measures, at least initially. **Therefore, ACP encourages CMS to 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 flexible reporting options are helpful in addressing this concern in the first two performance periods, 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.

2. Cost Performance Category

Background:

For the 2018 MIPS performance period, or the QPP Year 2, CMS proposes to keep the weight of the Cost performance category at zero percent in 2018 and exclude the category from the final MIPS performance score which affects physician payments in 2020. Although the cost measures will not count in the final score, CMS proposes to continue evaluating cost performance based on the total per capita costs for all attributed beneficiaries measure and the Medicare Spending per Beneficiary (MSPB) measure as they did for the 2017 MIPS performance period. Both of these measures have previously been included in the Value-based Modifier (VM) program and/or the annual or mid-year Quality and Resource Use Reports (QRUR) between 2013 and 2016 and are calculated using administrative claims data requiring no additional reporting by ECs or groups. CMS does not propose any changes to the methodologies for payment standardization, risk adjustment, and specialty adjustment for these measures. Moreover, the

Agency will not use the 10 episode-based measures they finalized for the 2017 MIPS performance period and instead focus on the ongoing development of new episode-based cost measures. CMS intends on providing performance feedback to ECs and groups for the newly developed episode-based cost measure by the fall of 2017 for informational purposes only and will also provide feedback on the two claims-based measures by July 1, 2018.

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 for the 2018 performance period. As stated in our comments on the 2017 proposed and final QPP rules, ACP continues to have significant concerns with the claims-based measures as well as the newly developed episode-based measures that will be used to calculate the Cost performance category score. The total per capita cost measure and the MSPB measure lack sufficient attribution methodology and 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. Additionally, the College believes that the new episode-based measures developed by CMS and Acumen need further development and testing in order to determine their validity and reliability in measuring resource use for internal medicine physicians and subspecialists.

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, and also considering the incorporation of a "complex patient bonus" for MIPS participants, it is imperative that appropriate risk adjustment be factored into cost measures.

Given the remaining concerns with the proposed cost measures, ACP strongly urges CMS continue to delay the increase in weight of the Cost performance category for the overall MIPS performance score in future performance years. The College is aware of the statutory requirements outlined in MACRA to increase the weight of the Cost performance category to 30 percent in the 2019 performance year; however, under Section 1848 of the Social Security Act (42 U.S.C. 1395w-4), subsection (q)(5)(F) as added by the MACRA law gives the Secretary the authority to assign different scoring weights (including a weight of zero) in any year if there are not sufficient measures and activities applicable and available to each type of EC involved. **The College recommends that CMS use this authority to reweight the Cost performance category to zero percent in the third performance period and subsequent years due to the lack of adequate and relevant measures within the Cost performance category.** Any increase in the weight of the Cost performance category should be delayed until the cost measures and benchmarks can be properly implemented. Once the measures have met validity and reliability standards, CMS should phase in the weight of the cost performance category over several years until it ultimately reaches 30 percent.

ACP recommends CMS continue to focus on the refinement of the claims-based total per capita cost measure and the MSPB measure as well focus on providing performance feedback that includes specific patient-level data, individual physician and group-level information, and peer comparisons to allow clinicians to understand what areas they can take action in to improve their performance. Additionally, the methodology underlying the claims-based cost measure calculations should be clearly defined and disclosed to participating physicians within these feedback reports. Another area of focus for CMS should be on the continued development of new episode-based code sets to ensure that 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. Thorough education must be provided to clinicians on the new episode-based cost measures, any reporting requirements for new categories and code sets, as well as the impact of these episode-based measures on physicians' overall performance in the Cost performance category.

In order to address the above concerns, and in conjunction with the CMS' continued collection, review, and refinement of the claims-based cost measures, ACP recommends that CMS conduct a voluntary pilot program on the episode-based cost measures once an operational set of episode groups and subgroups is fully ready for testing, no earlier than in 2018, that includes a representative sample of practice types, sites, geographic regions, etc. Clinicians who volunteer to test the episode-based cost measures, which would also incorporate CMS' proposed patient condition groups and patient relationship categories, would receive feedback reports on the cost measures but it would not be counted toward their composite performance score in MIPS. Additionally, clinicians would receive full credit within the Improvement Activities performance category for participating in the pilot. The pilot would provide the opportunity for CMS to collect and review data over the course of a year (or multiple years) to help further answer some of the outstanding questions for how to best develop and implement these episode-based cost measures without inappropriately penalizing physicians. The outstanding questions of particular interest to ACP are available in our April 2017 comments to CMS on Episode-Based Cost Measure Development for the Quality Payment Program.¹²

3. Improvement Activities Performance Category

Background:

CMS defines improvement activities as an activity that relevant MIPS ECs, organizations, and other stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes. MIPS, ECs will

¹²

https://www.acponline.org/acp_policy/letters/acp_comments_on_cms_episode_based_cost_measure_development_for_macra_qpp_2017.pdf

be required to perform activities over a continuous 90-day period during 2018 to receive credit for the improvement activities performance category.

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.

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 is maintaining the 90-day performance period for the improvement activities performance category. We further recommend that the improvement activities performance period be established as any continuous 90-day period within the performance period for all future years. ACP supports allowing accommodations for small practices, those in rural areas or HPSAs, and non-patient facing clinicians. We also support the decision to continue to report improvement activities via attestation.

The College strongly supports CMS' current inclusion of use of QCDRs in several existing and proposed improvement activities and the Agency's attempt to streamline some of these options with to allow dual credit opportunities for bonus points 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.

ACP thanks CMS for indicating that several improvement activities that were submitted by the College through the Annual Call for Activities process are being proposed for inclusion in 2018. We also appreciate the Agency accepting our recommendation to allow certain continuing medical education (CME) programs that address performance or quality improvement receive credit as improvement activities. The College was informed that ACP Practice Advisor® modules as well as ACP's Quality Connect were included as proposed activities in year 2. However, we are disappointed that the proposed improvement activities listed do not explicitly state that ACP's programs are included in any of the activities. **ACP urges CMS to explicitly list ACP Practice Advisor and ACP Quality Connect within the description of the improvement activities where applicable.** If CMS is unable to explicitly list these programs in the activity descriptions, the College recommends that CMS list these programs in the improvement

activities data validation criteria documents so that practices are aware that using ACP Practice Advisor and ACP Quality Connect will count for credit.

Specifically, ACP believes that the following activities in Tables F and G of the proposed rule would allow credit for use these programs as follows:

- Completion of an Accredited Safety or Quality Improvement Program (IA_PSPA_XX) – Many ACP Practice Advisor modules have CME and MOC credits associated with them and incorporate elements of quality improvement, so practices therefore should receive credit when using these ACP Practice Advisor modules.
- Participation in Bridges to Excellence or Other Similar Programs (IA_PSPA_14) – Both ACP Practice Advisor and Quality Connect should receive credit under this activity.
- Participate in IHI Training/Forum Event; National Academy of Medicine, AHRQ Team STEPPS® or Other Similar Activity (IA_PSPA_3) – Both ACP Practice Advisor and Quality Connect should receive credit under this activity.
- Participation in MOC Part IV (IA_PSPA_2) – Both ACP Practice Advisor and Quality Connect should receive credit under this activity.

The College also recommends revisions to the following proposed improvement activity:

- Consulting AUC Using Clinical Decision Support when Ordering Advanced Diagnostic Imaging (IA_PSPA_XX) – ACP recommends that the description be modified to align with the appropriate use criteria (AUC) for advanced diagnostic imaging that is being implemented under the requirements in the Protecting Access to Medicare Act (PAMA). This description of this activity currently is so broad as to require use of AUC with every advanced diagnostic imaging order rather than the priority list in the regulations. Specifically, the College recommends that this activity require consultation with AUC for the same tests as expected in the AUC regulation for PAMA requirements and that the threshold be a relatively small percentage of those tests.

Additionally, the College has concerns with the proposed revisions to the following activities:

- Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record (IA_EPA_1) – CMS is considering reducing this activity to medium weight. We recommend that this be maintained as a high-weighted activity as many organizations have not been able to fulfill 24/7 access to care, creating barriers to care for many patients.
- TCPI Participation (IA_CC_4) – ACP recommends that participation in TCPi continue to receive the high-weighted designation. We do not understand the rationale behind reducing it to a medium weight, especially given that CMS notes that TCPi counts as an APM for improvement activities purposes and therefore participants automatically receive half credit in the performance category. Additionally, since CMS states that most TCPi participants are involved in other activities through the initiative that enable them to receive full improvement activities credit, ACP requests that TCPi be explicitly listed as an APM that qualifies for full credit in the improvement activities category.
- Completion of the AMA STEPS Forward Program (IA_PSPA_9) – CMS should modify this activity to explicitly include ACP Practice Advisor in the title and description.

Additionally, practices should be able to receive credit for using ACP Practice Advisor for any activities that AMA STEPS Forward is deemed appropriate.

The College also appreciates that CMS accepted our recommendation that those participating in an APM receive full credit in the Improvement Activities Performance Category in year 1 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. In the event that new APMs are added that do not include sufficient activities to receive full credit for improvement activities, CMS should separately point out that the specific APM receives only partial credit. In general, participants in MIPS APMs should be able to operate under the assumption that they will receive full improvement activities credit for their APM participation year-after-year unless CMS informs them otherwise.

a. Contribution to the Final Score

Background:

The Improvement Activities Performance Category accounts for 15 percent of the overall score. ECs in a certified patient-centered medical home (PCMH) or comparable specialty practice receive full credit in the improvement activities category. CMS is proposing to modify this definition to allow a “recognized” PCMH to be accepted as an equivalent term as a “certified” PCMH to ensure that terminology matches what is common in the medical community.

CMS does not propose changes to its system of weighting improvement activities as medium- or high-weighted activities. The Agency uses the high weighting for activities that directly address areas with the greatest impact on beneficiary care, safety, health, and well-being. CMS proposes to add new high-weighted activities.

ACP Comments:

The College appreciates the proposed expansion of the PCMH definition to include both medical homes that are “certified” and those that are “recognized.” Including both terms better reflects the terminology used by various organizations, states, etc. that have PCMH programs that may qualify for full credit in the improvement activities performance category. **ACP reiterates its recommendation that all improvement activities are weighted equally to allow time for CMS to establish a more evidence-based approach to weighting and simplify scoring as practices gain experience in the early years of MIPS.**

b. Submission Mechanisms

Background:

In addition to the transition year, CMS proposes that for future years all individual MIPS ECs or groups, or third party intermediaries such as health IT vendors, QCDRs and qualified registries

that submit on behalf of an individual EC or group, must designate a “yes” response for activities on the Improvement Activities Inventory. In order for a group to receive credit for an improvement activity, at least one clinician in the group must have performed the activity for a continuous 90-day period during the performance period. The Agency seeks comments on whether to establish a minimum amount of clinicians (i.e., 50 percent of clinicians in a group) must perform an activity for a group to get credit. CMS also requests comments on whether there should be different minimum thresholds based on group size. The Agency also wants feedback on ways of measuring performance and improvement without imposing additional burdens on clinicians, such as by using data captured in an EC’s daily work.

ACP Comments:

The College thanks CMS for proposing to allow ECs and third-party intermediaries to submit for the improvement activities performance category in all future years through attestation by designating a “yes” response. By requiring only attestation, this will relieve the issue of administrative burden that is having an increasing impact on physicians, particularly as they are still becoming educated about and initiating transition to the new Quality Payment Program.

We further request that CMS consider allowing other third parties that may be collecting information that is indicative of completion of an improvement activity to submit lists to CMS that would allow credit to be awarded absent a submission by an EC, group, or third-party intermediary. For example, an organization that awards CME credits that qualify as improvement activities could submit a list of ECs who received qualifying CME credit directly to CMS. Clinicians on this list would receive appropriate improvement activities credit without any additional attestation being submitted.

ACP does not support the establishment of a minimum amount of clinicians that must perform an activity for a group to get credit. Given that improvement activities is a new performance category that is not based on a legacy program, it is important to allow for the maximum amount of flexibility in determining and performing improvement activities, especially in the early years while clinicians are learning the requirements. If CMS does decided to implement a minimum number of clinicians that perform and activity to award credit, CMS should consider that there are varying circumstances that may not lend themselves toward a hard standard. For example, small practices may need a lower minimum. Large, multi-specialty groups may prefer to have smaller subsets perform activities that are relevant to their specialty. Virtual groups may have limitations due to geography or because clinicians do not share a single EHR system. Considerations such as these should be addressed in a proposed rule before an arbitrary minimum number of clinicians is established for improvement activities credit.

c. PCMH and Specialty Practices

Background:

In the transition year, CMS established a policy that allows a TIN to receive full credit as a PCMH or comparable specialty practice as long as at least one practice under the TIN meets the criteria. CMS proposes to modify this proposal for 2018 and future years to provide that, for a TIN to receive full credit as a recognized or certified PCMH or specialty practice, at least 50

percent of the practice sites must be recognized as a PCMH or specialty practice. If a group is unable to meet this threshold, an individual may still receive full credit based on PCMH or specialty practice recognition if he/she reports as an individual for all performance categories.

CMS has determined that the Comprehensive Primary Care Plus (CPC+) APM design satisfies the medical home model criteria and is therefore considered a certified or recognized PCMH. In the Round 2 of the CPC+ program, which begins in 2018, the Agency intends to randomly assign some practices that are accepted into an intervention group or control group. Because practices in the control group have been accepted and therefore meet the CPC+ eligibility criteria, CMS proposes to allow them to receive full credit in the improvement activities category in MIPS for being a recognized or certified PCMH. CPC+ control group practices would receive full credit in the improvement activities performance category for each performance period in which they are on the Participation Roster, which contains the official list of ECs that are in a CPC+ control group practice.

ACP Comments:

The College does not support the proposal to require that 50 percent of practice sites be certified PCMHs or comparable specialty practices in order to receive full credit for improvement activities. CMS relies on a study on physician-owned primary care groups, which is not a valid representation of the broader structure of physician practices as many groups have multiple specialties. A TIN may have many practice sites under it but only a one or two that are primary care and therefore able to be recognized PCMHs. These practice sites would be penalized by not receiving full credit despite their efforts to improve their practice and patient care by making the transformation into a medical home. The intent of the MACRA law was to give all practices that are recognized PCMHs or patient-centered specialty practices full credit in the improvement activities performance category. Placing an arbitrary minimum on the percent of practices that must be recognized PCMHs and comparable specialty practices to receive full credit is not consistent with the intent of Congress in including this policy.

ACP strongly supports CMS' proposal to award CPC+ Round 2 control group practices full credit for the improvement activities. Given that these practices met all of the qualifications of CPC+ practices and were placed in the control group solely as a result of randomization, they should be given appropriate credit for this role when possible. **We further encourage CMS to minimize the amount of practices that are selected for the control group as much as possible to maximize the number of practices who are able to participate in CPC+ as an Advanced APM.**

4. Advancing Care Information Performance Category

Background:

ACP appreciates proposals to update the Advancing Care Information (ACI) Category to include more flexibility for participating physicians as well as safeguards and hardship exemptions to protect clinicians should they find themselves in a scenario that would impose undue burdens when participating in ACI.

ACP appreciates proposals to update the Advancing Care Information (ACI) Category to include more flexibility for participating physicians as well as safeguards and hardship exemptions to protect clinicians should they find themselves in a scenario that would impose undue burdens when participating in ACI.

In commenting on the final rule for year one of QPP, the College urged CMS to minimize future changes to ACI. Any change, even if “beneficial,” results in additional work and expense to make the needed modifications within the practice and to the technologies to adapt to the changes. ACP applauds CMS for maintaining the same ACI measure set from 2017 into 2018, with modifications only to correct errors in the specifications. We hope that CMS will continue to weigh the value of any program changes with efforts that will be required by practices to accommodate them.

Whereas quality measures by their nature differ widely from each other, and typically apply to physicians based on specialty and scope of practice, ACI measures were developed predicated on the belief that the benefit of introducing health IT into any setting of care arose from using EHRs the same way – regardless of specialty and/or setting of care. CMS and other measure developers have developed and implemented rigorous processes to monitor changes to both the science behind quality measures and the results of reporting of those measures. There is no similar program to rigorously monitor the performance of the ACI measures. ACP calls on CMS to monitor the performance of the ACI measures just as it does with quality measures, and to demonstrate their value to the QPP with real evidence.

Based upon feedback from our members, the MU performance audit program has been fraught with challenges and irregularities. Auditors request documentation that is impossible to produce after the fact, but could have easily been produced earlier, had practices been aware of the requirements. CMS provides guidance on documentation production regarding audits of Medicare payments for clinical services. Along these lines, we urge CMS to provide specific audit documentation requirements for each ACI measure as part of the specification of each measure.

a. Reporting Period

Background:

For the improvement activities and advancing care information performance categories, CMS finalized for purposes of the MIPS payment year 2020, the performance period for the improvement activities and advancing care information performance categories is a minimum of a continuous 90-day period within CY 2018, up to and including the full CY 2018 (January 1, 2018, through December 31, 2018).

ACP Comments:

We thank the Agency for maintaining the performance period at 90 days for the advancing care information performance category for CY 2018 and CY 2019. **The College recommends that**

CMS 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. It also allows flexibility for physicians upgrading or replacing their EHR systems to be able to select the 90 days of data that reflects the highest utilization. As a practice continues to grow and change, having the ability to select and submit 90 days of the best performance allows for change and innovation without the fear of negatively impacted data that may inaccurately represent a practice or physician.

b. Base Score

Background:

For the CY 2018 performance period, CMS did not propose any changes to the base score methodology as established in the CY 2017 Quality Payment Program final rule. The current policy states that MIPS eligible clinicians must report a numerator of at least one for the numerator/denominator measures, or a “yes” response for the yes/no measure in order to earn the 50 percentage points in the base score. In addition, if the base score requirements are not met, a MIPS eligible clinician would receive a score of zero for the ACI performance category.

ACP Comments:

The College urges CMS to modify the base score component of ACI and remove the threshold requirements of 1 or “yes” for all proposed base measures except for the protecting patient health information attestation which ACP believes is integral to the use of health IT. The proposed base measures, which are the same measures that physicians have already found to be cumbersome and inappropriate within the Meaningful Use era, do little to help ECs move forward. Because of the HITECH Act and the incentive programs, EHR adoption is almost universal. When considering our move to a value-based and 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 are built and used, in turn rewards evidence of good care and outcomes.

c. Performance Score

Background:

In the CY 2017 Quality Payment Program final rule, CMS finalized that MIPS eligible clinicians can earn 10 percentage points in the performance score for meeting the Immunization Registry Reporting Measure. If a MIPS eligible clinician fulfills the Immunization Registry Reporting Measure, that clinician would earn 10 percentage points in the performance score. If a clinician cannot fulfill the Immunization Registry Reporting Measure, CMS proposes that he or she could earn 5 percentage points (up to a maximum of 10 percentage points) in the performance score for each public health agency or clinical data registry to which the clinician reports for the

following measures: Syndromic Surveillance Reporting; Electronic Case Reporting; Public Health Registry Reporting; and Clinical Data Registry Reporting.

CMS proposes similar flexibility for MIPS eligible clinicians who choose to report the measures specified for the Public Health Reporting Objective of the 2018 Advancing Care Information Transition Objective and Measure set. If a clinician fulfills the Immunization Registry Reporting Measure, then he or she would earn 10 percentage points in the performance score. If a MIPS eligible clinician cannot fulfill the Immunization Registry Reporting Measure, CMS is proposing that the clinician could earn 5 percentage points (up to a maximum of 10 percentage points) in the performance score for each public health agency or specialized registry to which the clinician reports for the following measures: Syndromic Surveillance Reporting and Specialized Registry Reporting.

ACP Comments:

The College understands the value of data reported to Public Health and Clinical Data registries but also understands that these registries may not always be prepared to receive electronic reports using preferred data standards. Therefore, ACP is supportive of the flexibility proposed in this rule, which would allow MIPS eligible clinicians to successfully complete this objective with resources available to him/her and earn 10 percentage points in the performance score. Because of this flexibility, ACP also supports closing the loophole so that an EC will not receive double credit under both a performance score and a bonus score for reporting to the same agency or registry.

d. Improvement Activities

Background:

In the CY 2017 Quality Payment Program final rule, CMS adopted a policy to award a bonus score to MIPS eligible clinicians who use CEHRT to complete certain activities in the improvement activities performance category based on the use of CEHRT in carrying out these activities. CMS adopted a final policy to award a 10 percent bonus for the ACI performance category if a MIPS eligible clinician attests to completing at least one of the improvement activities specified using CEHRT. In CY 2018, CMS has identified additional improvement activities that ECs can use CEHRT to receive a maximum of ten percentage bonus points.

ACP Comments:

ACP appreciates the Agency's efforts to align some of the program's improvement activities with ACI via bonus points in order to strengthen the MIPS program. The alignment of 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 CY 2017 final rule and Table 6 in this current rule. Using CEHRT to carry out improvement activities encourages physicians to expand their use of health IT and also serves to make the MIPS program more comprehensive rather than siloed. This will also allow physicians to better focus their efforts on the activities and measures that are most meaningful to their patients and practice.

However, the College would like to note concerns with the proposed appropriate use criteria (AUC) improvement activity, “Consulting AUC using clinical decision support when ordering advanced diagnostic imaging,” as specified in Table 6. As written, this activity presents significant challenges to implementation that may inhibit successful performance. The activity description requires consultation of a qualified mechanism “for all advanced diagnostic imaging services ordered.” This requirement is much broader than the AUC policies being implemented based on the provisions in the Protecting Access to Medicare Act (PAMA), which limit required consultation of AUC to only a priority list of advanced diagnostic imaging services. Given that the goal of including this as an improvement activity is to give practices credit for beginning to test implementation of the PAMA requirements, ACP recommends that CMS revise the description to allow ECs with little to no experience working with AUC to be successful should they choose to implement this activity. Specifically, the College recommends that this activity require consultation with AUC for the same tests as expected in the AUC regulation for PAMA requirements and that the threshold be a relatively small percentage of those tests.

e. Performance Period for ACI

Background:

In the CY 2017 Quality Payment Program final rule, CMS established a performance period for the advancing care information performance category to align with the overall MIPS performance period of one full year to ensure all four performance categories are measured and scored based on the same period of time. For the first and second performance periods of MIPS (CYs 2017 and 2018), CMS will accept a minimum of 90 consecutive days of data and encourage MIPS eligible clinicians to report data for the full year performance period. CMS maintains this policy as finalized for the performance period in CY 2018, and will accept a minimum of 90 consecutive days of data in CY 2018 and proposes the same policy for the advancing care information performance category for the performance period in CY 2019, Quality Payment Program Year 3, and will accept a minimum of 90 consecutive days of data in CY 2019.

ACP Comments:

We thank the Agency for maintaining the performance period at 90 days for the advancing care information performance category for CY 2018 and CY 2019 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, allowing a practice or physician to select the 90 days of data that reflect the best performance and allow the physician or practice to experiment with alternative performance measures, workflows and reporting measures to find those that best fit the practice or physician without negative repercussion.

f. Certification Requirements

Background:

For the CY 2017 performance period, CMS adopted a policy by which MIPS eligible clinicians may use EHR technology certified to either the 2014 or 2015 Edition certification criteria, or a combination of the two. For the CY 2018 performance period, CMS previously stated that MIPS eligible clinicians must use EHR technology certified to the 2015 Edition to meet the objectives and measures specified for the advancing care information performance category. CMS proposes that ECs may use EHR technology certified to either the 2014 or 2015 edition certification criteria, or a combination of the two for CY 2018. Also, to encourage new participants to adopt certified health IT and incentivize participants to upgrade technologies, CMS proposed to offer a bonus of 10 percentage points as a one-time bonus for those using only 2015 Edition CEHRT.

ACP Comments:

While the College encourages its members to start planning for and implementing the 2015 Edition CEHRT requirements, we understand the challenges of rapidly upgrading the technology. **Therefore, ACP applauds CMS' approach, allowing ECs to continue to use 2014 Edition through CY 2018 and rewarding those who have adopted the new technology with bonus points.** ACP believes this bonus should be available to all ECs, regardless of whether they are new to the MIPS program or not. These types of upgrades take a large amount of time to roll out, including effectively deploying the new technology, staff training, and workflow adjustments, and with a sudden switch, there is always the potential risk to patient health.

g. ACI Scoring

Background:

Twenty five percent of the MIPS final score shall be based on performance for the advancing care information performance category. CMS is considering modifications to the policy established in last year's rulemaking. In any year in which the Secretary estimates that the proportion of eligible professionals who are meaningful EHR users is 75 percent or greater, the Secretary may reduce the applicable percentage weight of the advancing care information performance category in the MIPS final score, but not below 15 percent, and increase the weightings of the other performance categories such that the total percentage points of the increase equals the total percentage points of the reduction.

CMS is considering modifications to the policy established in last year's rulemaking to base the estimation of physicians who are meaningful EHR users for a MIPS payment year (for example, 2019) on data from the relevant performance period (for example, 2017). CMS is concerned that if in future rulemaking CMS decides to propose to change the weight of the advancing care information performance category based on their estimation that such a change may cause confusion to MIPS eligible clinicians who are adjusting to the MIPS program and believe this performance category will make up 25 percent of the final score for the 2019 MIPS payment year. The earliest CMS would be able to make their estimation based on 2017 data and propose

in future rulemaking to change the weight of the advancing care information performance category for the 2019 MIPS payment year would be in mid-2018, as the deadline for data submission is March 31, 2018.

CMS is requesting public comments on whether this timeframe is sufficient, or whether a more extended timeframe would be preferable. They are proposing to modify existing policy such that they would base their estimation of physicians who are meaningful EHR users for a MIPS payment year on data from the performance period that occurs four years before the MIPS payment year. For example, CMS would use data from the 2017 performance period to estimate the proportion of physicians who are meaningful EHR users for purposes of reweighting the advancing care information performance category for the 2021 MIPS payment year.

ACP Comments:

ACP strongly encourages CMS to allow for a 12-month notification period of any changes in weight and computation of MIPS scores to allow for the health IT ecosystem to adjust these alterations. Any change to the MIPS program, specifically the possibility of a change in the weight of the advancing care information performance category, will have a domino effect on a variety of resources within the health IT space. Based on updated ACI weight guidance, which would change the overall computation of a MIPS score, health IT developers will need to make adjustments to their products and software accordingly. In turn, those products and software must be implemented by clinicians. For product and software lifecycles, there needs to be at least a 12 month notice given for all parties to adequately plan and execute these changes. This change will also have a ripple effect on other resources. For every measure whose weight decreases, the value of another category will increase to offset the total percentage points of the reduction. Given all of this, a 12 month notice would provide an EC time to plan for adjustments including education and allocation of office resources to respond to changes in emphasis of the various measures. The proposed timeline that CMS has outlined (for performance year 2017/adjustment year 2019, the earliest feedback would be in mid-2018 that would in turn effect the weight of performance year 2019/adjustment year 2021) would allow for notification of less than a year—and is therefore not sufficient.

h. Exclusions - Information Exchange and Electronic Prescribing

Background:

CMS is also proposing to add exclusions to the measures associated with the Health Information Exchange and Electronic Prescribing objectives required for the base score. CMS propose these exclusions would apply beginning with the CY 2017 performance period.

ACP Comments:

ACP applauds this exclusion policy for those who do not meet these criteria and would therefore receive a zero base score for ACI. Some MIPS eligible clinicians may not achieve a base score because they cannot fulfill the measures associated with the Health Information Exchange objective in the base score. For example, some clinicians may seldom refer or

transition patients thus making the implementation burden of that objective too high for them. Similarly, there are MIPS eligible clinicians who do not often write prescriptions in their practice or lack prescribing authority, and thus could not meet the E-prescribing Measure and would also fail to earn a base score. This exclusion allows them to continue to participate in the MIPS program without receiving a zero in the ACI category. 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. One way to reduce the negative impact of overly prescriptive measures is to eliminate the need to perform all of them – even if the threshold is only once. As stated earlier, ACP strongly recommends that CMS modify the base score component of ACI and remove the threshold requirements of 1 or “yes” for all proposed base measures except for the protecting patient health information attestation.

i. Hardship Exceptions – Significant Hardship

Background:

In the CY 2017 Quality Payment Program final rule, CMS recognized that there may not be sufficient measures applicable and available under the advancing care information performance category to MIPS eligible clinicians facing a significant hardship, such as those who lack sufficient internet connectivity, face extreme and uncontrollable circumstances, lack control over the availability of CEHRT, or do not have face-to-face interactions with patients. Additionally, CMS did not impose a limitation on the total number of MIPS payment years for which the advancing care information performance category could be weighted at zero percent, in contrast with the 5-year limitation on significant hardship exceptions under the Medicare EHR Incentive Program.

ACP Comments:

The College appreciates the extension past a five year limitation on hardships filed by clinicians with extenuating circumstances. In some instances, the hurdle that would cause a clinician the hardship may not be rectified within a five year span and would create undue burdens on the clinicians down the road. By assigning a zero percent weighting to the advancing care information performance category in the MIPS composite score for those who successfully demonstrate a significant hardship through the application process would provide significant relief.

j. Hardship Exceptions - Small Practices

Background:

CMS proposes a significant hardship exception for the advancing care information performance category for MIPS eligible clinicians who are in small practices. CMS would make eligibility determinations regarding the size of small practices for performance periods occurring in 2018 and future years and propose to reweight the advancing care information performance category to zero percent of the MIPS final score for MIPS eligible clinicians who qualify for this hardship exception.

ACP Comments:

ACP applauds CMS taking into consideration those facilities that face challenges based on their size and bandwidth. There are many small practices that believe that they cannot afford the upfront investments in EHR technology and those who have not adopted EHRs due to the administrative and financial burden to maintain these systems. We have heard personal stories from our members in which small group and solo practices are considering closing due to the potential negative payment adjustments under MIPS, and others looking to merge with larger facilities to help absorb the cost and administrative drains associated with EHR implementation and maintenance. This hardship exemption provides significant relief to those small practices. At the same time, we are concerned that some small practices are being left behind in the overall computerization of health care. **In addition to a hardship exemption for those who choose to accept it, we urge CMS to provide more assistance to small practices that are willing to try to integrate information technology, but cannot accomplish the task without additional help.** We were extremely disappointed to see the good work of the original HITECH REC program come to an end. Many of our small practices credit that program with their success in MU attestation.

k. Hardship Exceptions - Decertification**Background:**

CMS will provide an exemption to an eligible professional, subject to annual renewal, if the Secretary determines that compliance with the requirement for being a meaningful EHR user is not possible because the CEHRT used by such professional has been decertified under ONC's Health IT Certification Program.

ACP Comments:

While physicians and practices can take every precaution available to him/her in researching, evaluating and adopting CEHRT from a health IT developer, there are not many protections for the clinician should the developer fail to honor their certification obligations. ACP applauds CMS providing hardship protections to physicians who may find themselves with a decertified product through no fault of their own and subject to negative payment adjustments. The College supported the health IT provisions 21st Century Cures Act that included this particular safeguard and is pleased to see CMS implement this provision.

l. Calculating Total Measure Achievement and Measure Bonus Points**Background:**

In the CY 2017 Quality Payment Program final rule, CMS codified that 1 bonus point is available for each quality measure submitted with end-to-end electronic reporting, under certain criteria. They also finalized a policy capping the number of bonus points available for electronic end-to-end reporting at 10 percent of the denominator of the quality performance category percent score, for the first 2 years of the program. For example, when the denominator is 60, the number of measure bonus points will be capped at 6 points. CMS finalized that the CEHRT

bonus would be available to all submission mechanisms except claims submissions. Specifically, MIPS eligible clinicians who report via qualified registries, QCDRs, EHR submission mechanisms, or the CMS Web Interface for the Quality Payment Program, in a manner that meets the end-to-end reporting requirements, may receive 1 bonus point for each reported measure with a cap.

CMS specifically asked feedback on the following questions:

What other incentives within this category for reporting in an end-to-end manner could be leveraged to incentivize more clinicians to report electronically?

ACP Comments:

While the College is appreciative of CMS offering opportunities for bonus points for end-to-end reporting, we believe there is little additional value in end-to-end reporting for all measures vs. one measure, especially if the result is just sending more data to the same location using the same method. Solving interoperability at the practice level requires dealing with multiple reporting targets with varying requirements. **Therefore, rather than the approach CMS has taken to-date of awarding a point for each measure, the College recommends that additional bonus points be available for reporting to additional entities – whether they are quality measurement organizations, clinical data registries, public health organizations, health information exchanges, or research organizations.**

CMS and ONC should partner with physicians that use direct EHR reporting specifically to gather instances of errors in value set logic and/or value set implementation. Incentives could include additional bonus points in the ACI category and/or permitting this as an improvement activity that also rewards extra points in the ACI category.

As ideal as direct EHR reporting appears—and ACP is supportive of the option of direct EHR reporting overall—it still has issues with accuracy that are not readily apparent and need to be addressed. These issues are not present or as problematic with registry reporting or reporting from manual chart abstraction (that is then manually uploaded into a web form). The primary issues with EHR reporting are threefold:

- Lack of full transparency in measure specifications;
- Overly narrow specification of certain definitions; and
- No ability to appeal or manually override an EHR measure after a chart review finds what appears to be an error.

Unlike other means of reporting, EHR reporting is determined by coded rules ingested by the EHR. These rules are contained in value sets, which are not easy to find and hard to understand. As stated by the Value Set Authority Center, each value set consists of the numerical values (codes) and human-readable names (terms), drawn from standard vocabularies such as SNOMED CT®, RxNorm, LOINC and ICD-10-CM, which are used to define clinical concepts used in clinical quality measures (e.g., patients with diabetes, clinical visit).

As measures are defined by these value sets, the logic statements contained in the readily available eCQI Resource Center are too broad to be useful. This lack of full transparency of measure specifications makes it difficult, if not impossible, for an engaged clinician to accurately determine why he/she was not successful with any given patient for a measure, and thus not be able to use quality measurement for the purposes of quality improvement.

Additionally, narrow and/or overly specified definitions may be the cause of a clinician failing a measure – rather than lack of an appropriate activity. For example, the EHR reporting value set for medications for the quality measure for aspirin or antiplatelet drug and Ischemic Vascular Disease only includes aspirin with a specified dosage (i.e., 81 mg) or does not include all instances of aspirin at specified and appropriate dosages. This narrow or over-specification is not present with registry or web-interface reporting.

Further, when errors in a measure score are uncovered, there is typically no ability to report or remediate that error. For example, if a doctor found that he/she was not performing well on a quality measure for diabetes, and then researched the patients included in the diabetes value set, and determined that the issue was that a patient does not actually have diabetes, there is no course of action to rectify the problem.

Given these issues, ACP recommends that CMS and ONC partner with physicians that use direct EHR reporting specifically to gather use cases such as these in order to increase the accuracy and efficiency of direct EHR reporting. Incentives for this participation could include additional bonus points in the ACI category and/or permitting this as an IA activity that also rewards extra points in the ACI category.

Also, it is important that end-to-end reporting includes the proper use of health IT other than CEHRT. While use of CEHRT can be specified as a requirement, it cannot be the sole method for all steps in the process. It is not unusual for data to be collected, stored, analyzed, and reported using a variety of health IT tools, and the end-to-end reporting definition must acknowledge and accept this reality.

What format should these incentives take? For example, should clinicians who report all of their quality performance category data in an end-to-end manner receive additional bonus points than those who report only partial electronic data?

ACP Comments:

As outlined above, direct EHR reporting may not be ready for widespread adoption. CMS should incentivize those who attempt to participate in direct EHR reporting, whether or not all measures are reported electronically. Once the field matures, CMS could reconsider this position. ACP recommends that additional bonus points be available for reporting to additional entities – whether they are quality measurement organizations, clinical data registries, public health organizations, health information exchanges, or research organizations.

Are there other ways that HHS should incentivize providers to report electronic quality data beyond what is currently employed?

ACP Comments:

CMS could make EHR quality measure value sets readily transparent, and even point out where a value set may call for a numerator or denominator that is not intuitive. CMS also should work with EHR developers to make EHR reporting less costly and develop rolling 365-day quality reports that would better support ongoing quality improvement efforts.

m. Feedback Mechanisms

Background:

CMS may use one or more mechanisms to make performance feedback available, which may include use of a web-based portal or other mechanisms determined appropriate by the Secretary. For the quality performance category, the feedback shall, to the extent an eligible clinician chooses to participate in a data registry for purposes of MIPS be provided based on performance on quality measures reported through the use of such registries. For any other performance category (that is, cost, improvement activities, or advancing care information), the Secretary shall encourage provision of feedback through qualified clinical data registries (QCDRs).

CMS specifically asks for comments on how health IT, either in the form of an EHR or as a supplemental module, could better support the feedback related to participation in the Quality Payment Program and quality improvement in general.

ACP Comments:

Feedback is crucial to the success of any program, however accessing feedback and turning that into actions that improve value based care will rely on functional capabilities that are not universally available. These functional capabilities include workflow management, data analysis, data visualization, shared decision making, and data aggregation. These functions are not currently required by certification and are generally unavailable in existing EHR systems. It can be argued that the best way to encourage implementation of these necessary additional functions is not by adding to already bloated EHR certification requirements. In fact, the bloat of EHR systems is a cause of their poor usability. Until we address the needs for increased usability, it is crucial that CMS remain flexible by allowing both web access as well as the ability for information to be downloaded and presented in EHR. Another alternative would be to require that EHRs provide fully functional access to third party tools that could add the needed capabilities without further complicating existing EHR systems.

Specifically, CMS requested feedback on these outlined questions:

Are there specific health IT functionalities that could contribute significantly to quality improvement?

ACP Comments:

Historically, health IT vendors have responded to market forces and have built software that supports the existing business cases for health information management, namely documentation in support of billing. Few EHRs have built in tools that help doctors and patients see and take efficient actions on unmet care opportunities. Building in automation of many routine healthcare operations, smarter visualization of information and anticipatory decision support will make use of the EHR support more efficient care. While pop-up or alert fatigue is a concern, health IT functionalities that alert/remind the provider of under- and over-utilization of testing/prescribing could significantly contribute to quality improvement. There also is a role for alerts that notify clinicians about duplicate orders within the system. For example, the EHR might alert the provider to an EKG order recently done or testing recently done. Another example would be having an option within the EHR to default new lab orders to an “add to existing specimen” if such a specimen had been drawn earlier in the day. With increased decision support, a doctor’s time can be spent on viewing, interpreting, thinking, and discussing with the patient, rather than on unnecessary and burdensome documentation.

Are there specific health IT functionalities that could be part of a certified EHR technology or made available as optional health IT modules in order to support the feedback loop related to Quality Payment Program participation or participation in other HHS reporting programs?

ACP Comments:

Health IT functionalities that minimize administrative “paperwork,” double-documenting, or duplicate data entry burden for physicians and other clinicians would alleviate some of the pain points of the Quality Payment Program. Functionality includes actionable dashboards of unmet care opportunities with the ability to either take individual action or delegate actions to others. One example would be being able to catch and report “outliers” and reasons for such. Further, having a feedback loop that creates a virtual rolling 365 day trend report will provide direct EHR reports (formatted to a calendar year) more usable for taking appropriate actions.

In what other ways can health IT support clinicians seeking to leverage quality data reports to inform clinical improvement efforts? For example, are there existing or emerging tools or resources that could leverage an API to provide timely feedback on quality improvement activities?

ACP Comments:

Improving quality can mean achieving a higher score on a measure, which may or may not relate to higher actual quality. As an example, scoring well on smoking status and cessation counseling and BMI and follow-up is not necessarily associated with decreasing smoking use or obesity. One idea would be for those who are topped out on a process measure and have a particular interest in seeing quality improve in that area could join a community of interest quality improvement group, which would further count for extra credit or regular credit in the MIPS program.

Are there opportunities to expand existing tracking and reporting for use by clinicians, for example expanding the feedback loop for patient engagement tools to support remote monitoring of patient status and access to education materials?

ACP Comments:

Opportunities do exist to expand existing reporting and tracking. E-mail and texting have been used for a number of years to close that feedback loop. Mobile applications, wearables, and access to web portals are the next step in patient engagement. This territory has already begun to be explored and needs continual work.

Robust patient portals or other connected applications that permit the use of patient answered survey and screening questions should dramatically decrease the current click-box burden of clinicians and staff. The entire healthcare system is in need of a key set of data, such as patient-reported outcomes that can be captured through a patient portal. We cannot know what works for which patients without granular outcome data. Asking patients to rate their health status following each intervention, and then adding the responses to the EHRs would provide the start of this type of data set. Patient Portals also should serve as an educational resource to a patient. It would be useful to learn from our healthcare system which strategies related to information sharing, remote monitoring, and education are used by patients and found useful to patients. Clinicians would also benefit from knowing what information the patient has accessed and used for education.

The portal may also be the appropriate mechanism for encouraging increased patient engagement to review and verify data included in their health record. A patient should have the ability to report and request corrections to their EHR for physician review. For example, patients who are on multiple prescriptions may find it difficult to recall medication names and dosages during an office visit. Being able to update this information at their convenience through a functional patient portal, would increase the integrity of the data and be extremely helpful in reconciliation of data.

5. APM Scoring Standard for MIPS ECs in MIPS APMs

a. APM Scoring Standard for ECs in MIPS APMs

Background:

In the final rule for the 2017 performance period, CMS established a MIPS APM scoring standard for MIPS ECs 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 MIPS APMs 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). Additionally, partial qualifying participants in Advanced APMs that voluntarily opt to participate in MIPS to earn payment adjustments will be scored under the MIPS APMs standard.

MIPS APMs will be scored at the APM entity group level, and all ECs receive the APM entity group's final score, with payment adjustments applied at the TIN/NPI level for participants. In the transition year, MSSP and Next Gen ACOs were scored under the MIPS APM standard based on the following category weights: quality at 50 percent; cost at zero percent; improvement activities at 20 percent; and ACI at 30 percent. All other MIPS APMs had category weighting as follows: quality at zero percent; cost at zero percent; improvement activities at 25 percent; and ACI at 75 percent.

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. ACP continues to have concerns there is 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 the availability of MIPS APMs.** 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.

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 that CMS is 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.**

b. Assessment Dates for Inclusion in MIPS APMs

Background:

CMS currently uses three snapshot dates -- March 31, June 30, and August 31 -- for assessment to identify MIPS ECs who are on an APM Entity's Participation List and determine the APM Entity group that is used for purposes of the MIPS APM scoring standard. Beginning with the 2018 performance period, CMS proposes to add a fourth assessment date of December 31 to identify those MIPS eligible clinicians who participate in a full TIN APM. A full TIN APM is one in

which participation is determined at the TIN level, and all ECs who have assigned their billing rights to a participating TIN are therefore participating in the APM (e.g., MSSP ACOs). The fourth snapshot date will only be used in identifying additional full TIN APM participants for the MIPS APM scoring standard, not for QP status in an Advanced APM.

This additional date is being proposed for full TIN APMs to allow ECs who are added to the TIN late in the year to be assessed along with the rest of their group. Absent this additional date, late additions to a TIN would be required to report under the standard MIPS program separate from the rest of their TIN, which would be under the APM scoring standard. CMS considered but did not propose applying the fourth assessment date to MIPS APMs more broadly. The Agency believed that it may have allowed ECs to inappropriately use the additional date to avoid being scored under general MIPS standard when they were only in an APM for a short period of time.

ACP Comments:

The College appreciates that CMS accepted our recommendation to create a fourth snapshot date for the purposes of determining ECs that should be scored under the MIPS APMs standard. The additional December 31 snapshot date will ensure that clinicians who join a full TIN APM in the last four months of the performance period are not forced to report under the general MIPS standards while others in the group report and are assessed under the MIPS APMs standards. ACP encourages CMS to expand this fourth snapshot date to all MIPS APM participants rather than limiting it to only those models that require full TINs to participate. We do not agree with the assumption that ECs will attempt to use the December 31 snapshot solely to avoid participating under the general MIPS scoring standard. As CMS looks to promote physicians' movement into the value-based payment world and ultimately into Advanced APMs, it is important to maximize opportunities for clinicians to move into new payment models. MIPS APMs provide an important step toward this goal.

c. Quality Scoring for MIPS APMs

Background:

For Next Gen ACOs and MSSP ACOs that report quality using the CMS Web Interface, the Agency proposes to also include the CAHPS for ACOs survey as part of their quality performance score beginning in 2018. CMS is now able to operationalize the CAHPS for ACOs survey on the same timeline as the CAHPS for MIPS survey, allowing it to be included in the quality score. CMS also proposes to score improvements in quality performance under the standards generally used for MIPS beginning with the 2018 performance period.

Beginning with the 2018 performance period, CMS proposes changes to allow quality to be scored for "Other MIPS APMs," those that do not report using the CMS Web Interface. These include the Comprehensive ESRD Care Model, CPC+, and the Oncology Care Model. Operational constraints prohibited CMS from including quality performance in the score for Other MIPS APMs in the first performance period, resulting in a quality performance category weight of zero percent. CMS proposes to calculate the quality score using APM-specific quality measures.

The benchmark score used will be based on a benchmark for the MIPS APM when available. When a MIPS APM-specific benchmark is not available, scoring will be based off of the generally applicable MIPS benchmark. The minimum number of measures that need to be reported are the minimum measures required by the MIPS APM that are collected and available in time to be included in the score. An APM Entity that misses the MIPS submission deadline for certain measures would receive a zero score for those measures, and missing the MIPS submission deadline completely will result in a zero percent score for the quality performance category. Measures that do not meet the 20 case minimum or do not have benchmarks will not be counted against the quality score. Bonus points would be available for reporting using end-to-end CEHRT and reporting additional high priority measures. Topped out measures used as part of a MIPS APM will not be subject to a 6-point cap.

ACP Comments:

The College strongly supports the Agency's stated goal to simplify and standardize these requirements and use its many educational and technical outreach activities to provide necessary increased clarity. Given the complexity of the multiple scoring standards for MIPS APMs in the initial performance period, the College appreciates that CMS has determined a way to include quality performance in the scoring for the non-ACO MIPS APMs in year 2. As CMS notes, the Agency had to make a number of changes to how quality measures are reported in these Other MIPS APMs in order to allow for alignment with the general MIPS reporting requirements. Because these changes are being made to models under which ECs and APM entities have already been participating, there may be initial challenges in ensuring that the changing reporting deadlines, etc. are met. **ACP recommends that CMS consider allowing leniency for these Other MIPS APMs to meet quality reporting requirements and deadlines given the adjustments that have been made to allow MIPS reporting.** This includes consideration of allowing Other MIPS APMs to meet the general MIPS quality reporting requirements, meaning that only six measures would be required for quality performance category scoring.

6. MIPS Final Score Methodology

a. 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 through rulemaking; however, ACP still has continued concerns with the scoring structure for MIPS, including proposed revisions, 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 this rule, CMS proposes modifications to 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):

- Zero out the weight of the Cost Performance Category – which was initially set at ten percent of the overall CPS for 2018.
- Increase the weight of the Quality Performance Category from 50 to 60 percent of the CPS.
- Increase the overall performance threshold for the CPS from three points to 15 points, which fails to align sufficiently with most participation options for the 2018 performance period.
- Add a complex patient bonus of 1-3 points based on average HCC risk score.
- Add a small practice bonus of 5 points for practices with 15 or fewer ECs that submit data in at least one performance category.
- Propose a methodology for scoring improvement in the quality and cost performance categories.
- Create a lower scoring standard for quality measures that are identified as topped out, allowing them a maximum of 6 points rather than 10.
- Allow 1 point for failing to meet data completeness criteria for quality measures, while allowing small practices 3 points.

ACP Comments:

While CMS continues to propose to allow for flexibility in 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. Consistent with the policies finalized for the 2017 performance period, 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 proposed to be zeroed out for the 2018 performance period, the Quality Performance Category now accounts for 60 percent of a physician’s CPS. Advancing Care Information remains complex, with a base score of 50 points that must be met in order to achieve any credit, with an additional 90 points available for performance on other activities, and a total of 15 available bonus points—all of which adds up to a total of 155 possible points. However, the maximum points for full credit in the ACI Performance Category is 100 points (even though, as indicated, 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.

On top of these concerns, CMS now proposes to layer in even more complexity for the second performance period. Certain quality measures that are determined to be topped out are only eligible for a maximum of six points rather than 10. For quality measures that fail to meet data completeness criteria, ECs can only earn 1 point, unless they are small practices, in which case they earn 3 points. The Agency is also adding a complex patient bonus of 1-3 points based on average HCC risk score, and small practices may receive a 5-point bonus if they submit data in at least one performance category. In addition, CMS plans to layer in adjustments based on scoring improvement over the prior performance period for quality and cost.

Additionally, CMS proposes to increase the performance threshold from 3 points in 2017 to 15 points in 2018. 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. The increase in the performance threshold makes it even more difficult to determine how to combine reporting on measures and activities to avoid a negative payment adjustment. **ACP strongly 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 can and 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. 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 improvement activities would add up to 15 – counting for 15 percent; the points within ACI would add up to 25 – counting for 25 percent; 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.

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—this would serve 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 initial performance periods to refine the feedback mechanisms that will be utilized for QPP performance and allow for appropriate user feedback and end-to-end testing.**

b. Scoring Flexibility for ICD-10 Code Changes

Background:

CMS updates ICD-10 codes annually, with revisions effective October 1 through September 30. Because these changes are effective partway through the performance period, they could potentially impact scoring against a historic benchmark. Therefore, for measures that are significantly impacted by ICD-10 coding changes, CMS will assess only the first 9 months of data to determine performance. The Agency will use process to evaluate several factors to determine which measures are significantly impacted. These factors may include code changes that impact more than 10 percent of the codes in the measure numerator, denominator, exclusions, and exceptions. CMS will review the impact of ICD-10 code changes on measures and publish a list of which measures are considered to be significantly impacted by October 1 of the performance period if feasible, but no later than the start of the data submission period, which is January 1 currently.

ACP Comments:

The College supports making adjustments to benchmark when ICD-10 code changes may significantly impact the scoring of the measure.

c. Scoring the Quality Performance Category

Background:

CMS seeks feedback on whether to broaden the criteria for creating benchmarks to include PQRS and any data from MIPS including voluntary reporters that meet benchmark performance, minimum, and data completeness criteria. The Agency seeks comment on methods for stratifying benchmarks by specialty or place of service; also on how to stratify submissions by multi-specialty practices or practices that operate in multiple places of business. CMS proposes to retain the 3-point floor for measures that can be reliably scored against a benchmark based on the baseline period, consistent with transition year policy.

ACP Comments:

The College does not support including data from ECs who voluntarily report in MIPS but are not eligible for payment adjustments in the benchmarks. Including the data of people who are not being impacted based on performance against the benchmark may skew the benchmark in a way that it does not accurately reflect those who have their performance being scored.

i. Identifying and Assigning Achievement Points for Topped Out Measures

Background:

Topped out measures include process measures with a median performance rate of 95 percent or higher. For non-process measures, CMS uses a definition similar to the one used in the Hospital VBP Program: Truncated Coefficient of Variation is less than 0.10 and the 75th and 90th percentiles are within 2 standard errors. CMS will not use any special scoring methodology for quality measures that are topped out for the first performance period. Beginning with the 2018 performance period, the Agency will modify the benchmark methodology for topped out measures in the second year that they are identified as topped out.

CMS proposes a lifecycle for topped out measures under which a measure can be identified as topped out in the published benchmark for two years. In the third consecutive year that a measure is topped out, the Agency may propose removal of the measure through notice and comment rulemaking or the QCDR approval process. The measure could then be removed from the benchmark list in the fourth year.

The Agency proposes implement a special scoring standard to cap the score of a topped out measure at 6 measure achievement points. Topped out measures will continue to be eligible for bonus points if they meet the required criteria.

CMS proposes to only apply the topped out scoring standard to select measures in 2018 to ensure that any one specialty would not be overwhelmed. For 2018, CMS has identified six measures for scoring under the special scoring standard for topped out measures under select criteria that will be used for 2018 only. Starting with the 2019 performance period, the Agency would apply the topped out scoring standard to all topped out measures provided that they are in their second consecutive year of being identified as topped out.

- Year 1 (2017): Measure benchmarks are identified as topped out based on benchmarks as published for the most recent performance period, which is 2017 for the purposes of this proposed rule.
- Year 2 (2018): Measure benchmarks are identified as topped out based on benchmarks as published for the most recent performance period, which is the 2018 MIPS performance period. The six measures identified for the special scoring standard for 2018 are scored using the 6-point cap for topped out measures.
- Year 3 (2019): Measure benchmarks identified as topped out for the 2019 performance period. All measures in at least their second consecutive year of meeting the topped out standard are scored under the special scoring standard. The six measures scoring under the special standard for the 2018 performance period may be considered for removal through notice and comment rulemaking.
- Year 4 (2020): Measure benchmarks are identified as topped out in the benchmarks published for the 2020 performance period. Measures from 2018 that were scored under the special scoring standard and considered for removal in the 2019 rule are no longer available for reporting (if they continue to meet topped out criteria). Measure

benchmarks identified as topped out for at least the second consecutive year are scored under the special scoring standard.

The special scoring standard for topped out measures under the proposed rule will not apply to the CMS Web Interface measures. CMS Web Interface measures are reported in both MIPS and certain APMs (e.g., Shared Savings Program). ECs using the Web Interface must report on all measures within the submission mechanism, clinicians do not have the ability to choose other measures if a topped out measure was scored under the special scoring standard. Therefore, the Agency does not propose to apply the special scoring standard to topped out measures if they are reported through the CMS Web Interface.

ACP Comments:

As noted earlier, the College opposes removing or reducing the maximum number of points for topped out measures without regard for the value of the quality actions that are being measured. Many topped-out measures are focused on actions that impact patient care, and reducing the points available for reporting may result in significant declines in the number of clinicians reporting the measure. As clinicians look to report different measures, this will take the focus away from consistently performing actions, which may negatively impact patient care. ACP reiterates its recommendation 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. Stability in the measures that are available and the points available for reporting are critical as clinicians gain experience in MIPS. We also note that reducing the points for topped-out measures will likely impact a practice's ability to maximize scoring for improvements that are made year-to-year.

We further recommend that CMS reduce the points available for reporting topped-out measures only after at least one rulemaking cycle in which the Agency collects comments on the measure and its continued value in the MIPS program. As new measures are developed and added to MIPS, it might be appropriate to reduce the maximum score for some topped-out measures and ultimately phase them out. However, they should not be phased out or have their point value reduced without consideration of the value of the underlying action and whether other measures are available to fill a similar gap. If CMS does want to place limitations on topped-out measures, perhaps limiting the number of topped-out measures that can be reported by an individual or group would be more appropriate in the early years. For example, a clinician or group could report one topped-out measure and be scored under the 10-point maximum standard that is available for other quality measures. But each additional topped-out measure reported by the individual or group in the same performance period would be subject to the 6-point cap on topped-out measures.

ii. Case Minimum Requirements and Measure Reliability and Validity

Background:

CMS does not propose changes to the case minimum requirement. Therefore, a 20-case minimum is required for all measures other than the all-cause hospital readmissions measure, which only applies to groups of 16 or more ECs that meet a 200-case minimum.

Measures that are submitted but cannot be scored because they do not meet the case minimum, do not have a benchmark, or do not meet the data completeness criteria receive three points under the final rule policies. In order to be scored based on performance, measures submitted/calculated must meet the following criteria:

- The measure has a benchmark;
- Meets the case minimum (20 cases); and
- Meets the data completeness standard (50 percent).

Measures meeting all of the above criteria are eligible for 3 to 10 points based on performance compared with the benchmark. Under the final rule for 2017, data that failed to meet at least one of these criteria received a score of 3 points and could not be scored against a benchmark. In the 2018 proposed rule, the Agency proposes to maintain the 3-point floor with one exception. For measures that fail to meet the data completeness standard, which is 50 percent for 2018, CMS will award 1 point instead of the 3 points that are awarded for the 2017 performance period. The Agency believes that meeting the data completeness standard should be encouraged to ensure that data is reliable. Additionally, data completeness is under the direct control of the clinician unlike the other criteria. CMS notes that it plans to reduce the points awarded for failing to meet data completeness standards to zero points in the future. However, in recognition of the challenges that small practices may face meeting criteria due to their potential for smaller numbers of cases, etc., CMS will continue to award 3 points for a measure that fails to meet data completeness criteria. These policies would not apply to CMS Web Interface measures and administrative claims-based measures.

ACP Comments:

ACP recommends that CMS maintain the 3-point floor for quality measures for all clinicians, including those who fail to meet the data completeness criteria, for the second performance period. As ECs and groups are learning to meet the new requirements under MIPS, we believe that it is important to maintain stability in the policies under which they are being scored. Changing the point floor for quality measures for clinicians also adds complexity to a scoring methodology in MIPS that is overly complicated. The College does acknowledge that meeting certain requirements pertaining to what constitutes complete data for the purposes of scoring it against a benchmark is important. We agree that the case minimum and data completeness criteria should be met in order to receive a reliable score against a benchmark. ACP urges CMS to keep the floor for quality measure scoring 3 points for year 2 for all ECs and groups until the Agency has data to analyze that shows that sufficient numbers of clinicians are able the criteria to warrant a reduction in the quality measure points floor. Additionally, should CMS decide to

reduce the point floor to 1 point in the future, the Agency should consider maintaining the 3-point floor for small practices at a minimum.

iii. Scoring MIPS ECs That Do Not Meet Quality Performance Category Criteria

Background:

For ECs who do not report on six measures including one outcome or high priority measure, the Agency proposes to maintain its policy of assigning zero out of 10 points to each missing measure if there are measures that are applicable to the clinician that were not reported on. CMS proposes to retain its process for validating whether additional measures were applicable and available for clinicians submitting data claims and registry reporting only. Additionally, for clinicians using multiple submission mechanisms for a single performance category, as has been proposed for year 2, those using a combination of claims and registry submissions will also undergo the validation process. Because groups cannot report using claims, groups and virtual groups will only go through the validation process if they submit via a qualified registry. Availability and applicability will be evaluated through clinically related measure analysis based on patient type, procedure, or clinical action associated with the measure specifications.

ACP Comments:

We agree that ECs who do not report sufficient quality measures to meet the requirements should receive zero points for the measures that they fail to report if additional measures are applicable. However, we do have concerns that there may be situations in which a clinician reported, but did not report on all 6 measures as he/she was unaware that an additional measure or measures were applicable. In this instance, the clinician would receive zero points for each applicable measure not reported up to the 6-measure requirement. We encourage CMS to consider ways of addressing these situations by providing guidance on how clinicians could approach determining whether additional measures are applicable. This could be by providing lists of measures commonly reported by each specialty, lists of measures commonly applicable across many specialties, and the unreported measures that are commonly identified as applicable through validation process as well as information on how CMS determines applicable measures through the validation process.

iv. Scoring Improvement for the MIPS Quality Performance Category

Background:

CMS proposes to score quality for both achievement and improvement beginning in the 2018 performance period. For the quality performance category, CMS proposes to score improvement at a category level rather than a measure level. The Agency believes that will allow clinicians the flexibility to choose measures that are meaningful to their practice without being concerned that selecting a different measure will cause them to lose the ability to have improvement accounted for in their performance score. The proposed improvement percent score is capped at 10 percent, which will be added to the achievement percent score in a manner similar to the Shared Savings Program. CMS plans to monitor improvement scores to determine whether practices are actually improving or perceived as improving due to switching

to measures on which they perform better, and they will address any issues through future rulemaking.

CMS proposes to compare results when the same identifier has been used in two consecutive performance periods. For example, TIN/NPI for individual reporting, TIN for group reporting, APM entity, or virtual group. If CMS does not have an identifier used in consecutive years with which to compare performance for improvement scoring, the Agency proposes to use a hierarchy logic to determine a performance score to use for comparison. For a group or virtual group that did not have a previous group score, CMS will take an average of scores of the individuals in the group from the previous performance period to use as a comparison. For a group now reporting as individuals, the comparison would be based off of the group score associated with the TIN/NPI from the prior performance period.

In order to be scored for improvement, an individual or group must have met data sufficiency standards in the previous performance period. The standards are intended for all clinicians to be scored for improvement as long as they met data sufficiency standards in the prior performance period.

ACP Comments:

The College supports including points for improvement in the quality performance category in year 2 through category level improvements. Given that ECs and groups may report different measures year-to-year, especially in the early years of MIPS while clinicians are adjusting to the new requirements, scoring category-level improvements is important. ACP encourages CMS to consider how those ECs and groups that are consistently high achievers can still be adequately awarded for improvement relative to those who have more room to improve.

ACP supports the current approach to allow the maximum number of ECs to be able to receive a score for improvement in the quality performance category, regardless of a change in identifier from year-to-year. While we understand that it would be simpler to only score improvement for an EC or group with the same identifier in consecutive years, this will hinder clinicians' flexibility to make changes in practice composition, reporting choices, etc. As ECs move toward participation in virtual groups and APMs, maintaining the ability to have improvement scored despite a change in reporting identification is critical.

v. Full Participation Requirement to Measure Improvement

Background:

CMS proposes that clinicians may only receive an improvement percent score if they fully participate in the quality performance category. Full participation means that all required measures, including an outcome or high priority measure, have been submitted and data completeness criteria are met for all measures. Full performance is required for the current performance period only to account for the flexible transition year policies. CMS will assume a quality performance score of 30 percent for the 2017 performance period for ECs that received a score of less than or equal to 30 percent. Therefore, improvement can only be scored for the

2018 performance period if quality performance exceeds 30 percent. This is meant to ensure that practices that minimally participated in the transition year are rewarded for an increase in achievement performance rather than an increase in participation.

ACP Comments:

While we understand the desire to provide incentives for meeting the full participation requirements for the quality performance category and support this goal, ACP recommends that CMS consider additional ways of incentivizing improvements for ECs and groups that are incrementally increasing performance toward the full quality measure requirements. In addition to the maximum improvement score that CMS will calculate for ECs and groups that are fully participating in the quality performance category, CMS should create a separate improvement calculation or bonus for clinicians who do not meet this level for the early years of MIPS performance while ECs are learning how to meet the requirements. For example, an EC who reported one measure through the test participation option in 2017 and was able to report and meet data completeness requirements for a few measures in 2018 might be eligible for a smaller improvement score. The College believes that incentivizing incremental increases in performance in the early years will be an important way to encourage ECs and groups to participate in MIPS without adding too much administrative burden in a single year.

vi. Measuring Improvement Based on Achievement

Background:

CMS proposes to measure the improvement percentage score based on achievement scores without the addition of any bonus points. Their rationale is that bonus points may be awarded for reasons not directly related to performance (e.g., use of end-to-end electronic reporting). Bonus points or improvement adjustments to the score in the current or prior performance will not be taken into account when determining whether an improvement has occurred or can be part of the improvement percentage score.

ACP Comments:

The College supports basing the improvement percentage score based solely off of a comparison of the achievement scores from consecutive years in most scenarios. We agree that bonus points may not be directly linked to improvements in performance. In addition to the bonus for reporting using end-to-end electronic reporting, this would include scenarios in which a practice reported on additional outcome or high priority measures, but performance on those additional measures was not used as part of the performance score because only the top six measures are used in the score. The practice would receive bonus points for those additional measures even though it did not perform well on the measures. We encourage CMS to consider counting bonus points for scenarios where additional outcome or high priority measures are reported and are also counted toward the quality performance score. In this instance, the bonus point does have a stronger tie to performance and it may be appropriate to include it in calculating improvement. This will help provide incentives for ECs to move toward reporting of more outcome measures in the future.

vii. Improvement Scoring Methodology

Background:

The improvement percentage score will be calculated as the change in quality performance category achievement percentage from prior period to current period, divided by the achievement percentage from the prior period. This will then be multiplied by 10 percent to account for the 10 percent cap on the improvement score. CMS believes that this formula is easy to explain and incentivizes ECs with a low performance score in the previous period to improve at a higher rate because they will receive a higher improvement score. To earn the 10 percent maximum for improvement, an EC or group would essentially need to double its achievement score from the prior period. Improvement scores cannot be negative, so any reduction in performance from year-to-year would result in an improvement percentage score of zero. CMS also considered awarding improvement based on a band level methodology in which a low performance score in the prior period would be awarded improvement at a higher rate. The Agency also considered using an approach similar to the Shared Savings Program methodology for groups using the CMS Web Interface.

ACP Comments:

The College supports using the scoring methodology as proposed for the initial performance periods in MIPS. It is important to have scoring methodologies that can be easily explained as ECs and groups are learning the new program requirements and gaining experience reporting. CMS could consider making adjustments to the improvement scoring methodology in future years based on an analysis of the impact of the current formula on practices and their ability to ramp up to full reporting. For example, in order to incentivize practices at the lower end of the performance spectrum to improve, a formula that rewards a higher percentage for improvements by these practices may be necessary.

viii. Calculating the Quality Performance Category Score Including Improvement

Background:

CMS proposes to incorporate the improvement percent score into the quality performance category percent score, which includes bonus points, by adding the improvement percentage to the quality score. The quality performance category percent score cannot exceed 100 percent.

ACP Comments:

The College supports this methodology for calculating the quality performance category score including improvement.

d. Scoring the Cost Performance Category

Background:

Under the final rule for 2017, CMS established that ECs can receive 1 to 10 achievement points for each cost measure attributed to them based on performance compared to the measure benchmark. Cost measure benchmarks are based on claims from the performance period, so

CMS will not publish benchmarks in advance of the performance period. CMS will only develop benchmarks if at least 20 ECs and groups can be attributed the case minimum for the benchmark. Points are assigned based on which benchmark decile range the EC or group falls into. The cost performance category score is an equally weighted average of all cost measures that can be scored. For the 2018 performance period and future years, CMS proposes to add improvement scoring to the cost category score.

ACP Comments:

As mentioned previously, we appreciate that CMS has proposed weighting the cost performance category at zero percent in the second performance period. The College continues to have concerns with the proposed cost measures, and we urge CMS continue to delay the increase in weight of the cost performance category for the overall MIPS performance score in future performance years. ACP recommends that CMS revisit the cost performance category scoring once data is available on the episode groups and patient relationship codes that are under development to determine the most appropriate method of evaluating and scoring performance.

i. Measuring Improvement

Background:

CMS proposes to measure improvement in the cost performance category based on individual measure-level improvements rather than at the category level as proposed for quality. Because cost performance is based on claims data and ECs do not have the choice of which measure they are evaluated on, the Agency believes that ECs are likely to have the same applicable measures scored each year. In order to measure improvement in cost, ECs will need to be scored on a measure in two consecutive performance periods. Because the Medicare Spending Per Beneficiary (MSPB) and the Total Per Capita Cost measures are the only cost measures from 2017 that will in 2018, clinicians will only have improvement factored into scoring on these two measures for the second performance period. A clinician would also have to report MIPS using the same identifier for two consecutive years to receive a score for improvement.

ACP Comments:

The College supports scoring the cost performance category based on measure-level improvement for at least the initial performance periods. This approach seems logical in the early years of MIPS when only the MSPB and Total Per Capita Cost measures would have feedback from multiple performance periods under which to calculate improvement. ACP encourages CMS to revisit the methodology for calculation cost improvements once the episode groups and patient relationship codes are implemented and calculated as a part of the cost performance category score.

ii. Improvement Scoring Methodology

Background:

CMS proposes to use the Shared Savings Program methodology to reward improvement in the cost category because it is straightforward and only recognizes significant improvement. To calculate improvement for cost, CMS will subtract the number of measures with significant declines from the number of cost measures with significant improvement, then divide the result by the number of measures the EC/group was scored on in the current and previous performance periods. The result will be multiplied by the maximum cost improvement score. Significant improvement or decline will be determined using a common statistical test, a t-test, as is used in the Shared Savings Program. CMS acknowledges that many clinicians lack understanding of cost measures and are still learning about the scoring system overall. Therefore, they decided to limit the impact of improvement scoring in the cost category to avoid confusion. For the 2018 performance period, CMS will calculate the cost improvement score, but it will be weighted at zero percent along with the performance category weight. If CMS determines to weight the cost performance category greater than zero (i.e., at 10 percent) in finalizing this rule, the maximum amount that can be factored in for improvement is 1 out of the 100 percentage points available in the cost performance category.

ACP Comments:

ACP supports the decision to calculate the cost improvement score but weight it at zero percent for the 2018 performance period. Given that CMS has proposed to weight the cost performance category at zero percent in year 2, it is appropriate that the improvement score not be included in the performance category score but feedback be provided to ECs as applicable. Additionally, in line with our earlier comments that the cost performance category weight remain at zero percent in future years until adequate cost measures have been developed and tested and clinicians have received proper education on the measures, ACP encourages CMS to not include cost improvements in the score.

e. Scoring the Improvement Activities Performance Category

Background:

CMS does not propose any changes to the improvement activities performance category. Therefore, 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.

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 performance category.

Clinicians that are participating in an APM will automatically receive at least half credit for improvement activities. ECs participating in a MIPS APM may be assigned a score that is higher than one half based on the extent the model requirements meet activities included in the Improvement Activity Inventory. PCMHs and comparable specialty practices will receive full credit in the improvement activities performance category.

i. Self-identification for Attestation

Background:

CMS finalized in the 2017 rule that ECs and groups in APMs would not be required to self-identify their participation to get improvement activities credit because CMS would already have that information. However, ECs would be required to self-identify their participation if they are in a PCMH or comparable specialty practices, a non-patient-facing clinician, in a rural area or HPSA, a small practice, or a combination of any of these. Beginning with the 2018 performance period, CMS proposes to no longer require self-identification of non-patient facing clinicians or those in small practices, rural practices, or in a HPSA because it is technically feasible for the Agency to identify these clinicians during the attestation period. ECs in a PCMH or comparable specialty practice will still need to self-identify their participation and CMS will validate it as appropriate.

ACP Comments:

The College continues to have concerns with CMS' methodology for assigning weighting to improvement activities. It is also unclear what evidence base might indicate why activities should be considered medium versus high weighting. Some of the activities weighted "medium" require enough effort that they should be given "high" weighting and visa versa. CMS should consider ways of improving the weighting of the improvement activities performance category in future years based on an analysis of the activities being reported. **In the interim, ACP reiterates its recommendation that all activities be weighted equally for this category. This will help in simplifying the scoring methodology to allow clinicians to see more directly the impact that reporting an improvement activity will have on their overall performance score.**

ACP supports CMS' proposal to eliminate the requirement that small, rural, and HPSA practices and non-patient-facing clinicians self-identify for improvement activities category. This will help ease the burden on these groups of submitting information to CMS that can already be determined based on existing information. We encourage CMS to consider ways of eliminating the self-identification requirement for ECs in PCMHs and comparable specialty practices as well. This could be accomplished by requiring the certification and recognition organizations to submit lists of the ECs/groups that meet their standards and are certified/recognized to CMS, similar to how participation lists are utilized to determine the participants in certain APMs.

f. Complex Patient Bonus

Background:

For the 2018 QPP performance period, CMS proposes to provide one to three bonus points to MIPS ECs that take on more complex, sicker patients. The Agency's initial approach is to use physicians' average Hierarchical Condition Category (HCC) risk-adjustment score for their entire beneficiary population based on services provided during the previous 2017 calendar year. CMS anticipates that clinicians average HCC scores will fall within the one to three point range and these average scores will then be added to the physician's overall MIPS composite score as the "complex patient bonus." CMS already collects and calculates the information necessary for the HCC risk-adjustment scores so there would be no additional reporting requirements for the physician. Another potential approach to determine patient complexity and subsequent bonus points is discussed and includes using Medicare Medicaid dual-eligibility status. Under this alternative option, CMS would calculate the ratio of dual eligible beneficiaries to a physician's entire beneficiary population in order to determine the number of bonus points.

ACP Comments:

ACP commends CMS' efforts to encourage physicians to take on more complex beneficiaries while removing the concern that these sicker patients will negatively affect their overall performance score. While we understand this is the first step in implementing a more comprehensive plan to address the concerns with taking on complex patients in a value-based health system, the College believes that the three point maximum bonus towards an EC's composite MIPS score is not sufficient to account for medically complex patients. **As CMS continues to improve this incentive, the College recommends that more points be given to physicians who care for more complex patient panels.**

ACP is generally supportive of using the HCC risk-adjustment score approach to calculate the complex patient bonus because it is an established risk-adjustment model used in other Medicare programs. CMS mentions that there are no additional reporting requirements associated with the HCC scoring because CMS calculates these scores using claims data; however, the College believes there is a necessary educational component associated with the use of HCC scoring for ECs as risk-adjustment methodologies become more important in participating in value-based payment systems. **ACP recommends that CMS partner with physician societies and other stakeholders to provide education and support on how to properly code for HCCs so physicians are aware of where their patient's fall on the risk-adjustment spectrum and how they are being scored.** As a more general comment on risk-adjustment, the College believes that further refinements to the HCC risk-adjustment methodology is necessary as well as the incorporation of important risk factors associated with socioeconomic status to the overall risk-adjustment methodology is necessary. Examples of these types of risk factors include Medicare Medicaid dual eligibility, psychosocial factors, Supplemental Nutrition Assistance Program (SNAP) participation, high-risk zip codes, etc.

g. Small Practice Bonus

Background:

In 2018, CMS proposes to offer a “small practice bonus” of five points to an EC’s final MIPS score if they are in a small practice, virtual group, or MIPS APM entity with 15 or fewer clinicians (the entire virtual group or APM entity combined must include 15 or fewer clinicians to qualify for the bonus). Additionally, in order to qualify for the bonus, eligible clinicians must participate in the program by submitting data on at least one MIPS performance category and meet data submission requirements in order to receive the 5 point bonus. CMS discussed extending this bonus to rural practices but ultimately decided against a bonus for rural practices at this time.

ACP Comments:

ACP appreciates the new 2018 QPP performance period proposals from CMS that will promote participation and help ease the burden on small practices. **However, the College strongly recommends that CMS extend this bonus to those physicians practicing in rural and underserved areas.**

V. Advanced Alternative Payment Models (APMs)

A. Medical Home Model

Background:

In the final rule for 2017, CMS established 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 established 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 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 finalized 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.

In the proposed rule for 2018, CMS proposes small changes to the 50-clinician limit and the Medical Home Model nominal amount standard, as described below.

ACP Comments:

The College commends CMS for its continued 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 research¹³ 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 meets criteria comparable to 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.

¹³ Patient-Centered Primary Care Collaborative. The Impact of Primary Care Practice Transformation on Cost, Quality, and Utilization. Annual Review of Evidence 2016-2017. Available at: https://www.pccpc.org/sites/default/files/resources/pcmh_evidence_report_08-1-17%20FINAL.pdf

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 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 in the second performance period (2018), if feasible, and no later than the third performance period (2019).

- 1. 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 2019 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 3 years of CPCi results—that is, they “improve the quality of patient care without increasing spending.” 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 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 this proposed 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 is expanding the new Comprehensive Primary Care Plus (CPC+) program to Round 2 areas—and allowing participating clinicians in the CPC+ to also participate in the Medicare Shared Savings Program (MSSP). However, the College is remains concerned that CPC practices that are in Track One MSSP ACOs cannot be considered Advanced APMs and therefore cannot 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 reiterates its recommendation 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.

Additionally, even though CPC+ does have a broader reach than CPCi, it is still limited to fewer than 4,000 practices in 18 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 currently further limited to those practices with 50 or fewer eligible clinicians. While CMS proposes to eliminate the 50-clinician limit for Round 1 CPC+ practices, it would remain in place for Round 2 and all other Medical Home Models under the nominal risk standard. 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.

B. Medical Home Model EC Limit

Background:

In 2017 final rule, CMS established a policy that limited the Medical Home Model financial risk standard to APM entities with fewer than 50 ECs in the organization through which the APM entity is owned and operated. This policy prohibits medical homes that are part of a larger organization, one with at least 50 ECs, from meeting Advanced APM standards through their participation in a Medical Home Model. This policy would not apply to Medical Home Models that are expanded through 1115A(c), which allows the Secretary to expand models that maintain quality while reducing cost or improve quality without increasing cost. Medical Home Models expanded under 1115A(c) are not required to have a policy that an APM entity bears more than nominal financial risk.

The Comprehensive Primary Care Plus (CPC+) model is currently the only Medical Home Model that is considered an Advanced APM. CMS proposes to exempt CPC+ practices in Round 1 of the program from the requirement that they must have fewer than 50 clinicians in the organization to be considered an Advanced APM. Because the QPP final rule was issued after some CPC+ practices had signed agreements, the Agency believes that practices may not have been aware of the 50-clinician EC limit. All future APMs under the Medical Home Model financial risk standard will be held to the 50-clinician limit for the purposes of determining Advanced APM status. This includes practices in Round 2 of CPC+.

ACP Comments:

While the College appreciates that CMS proposes to exempt CPC+ Round 1 practices from the 50-clinician limit in the organizational entity, we urge CMS to broaden this proposal to remove any limitations on Medical Home Models based on the number of clinicians in the organization that owns and operates the practice site. 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.

C. Nominal Amount of Risk

1. Generally Applicable Revenue-based Nominal Amount Standard

Background:

In the final rule for 2017, CMS established a generally applicable revenue-based nominal amount standard for the first two QPP performance periods only (2017 and 2018). Under this standard, APMs with 8 percent of the average estimated total Medicare Parts A and B revenue at risk for participating entities would meet the nominal risk standards to be Advanced APMs. In this rule, CMS proposes to extend the 8 percent revenue-based standard for an additional two years, the 2019 and 2020 performance periods. For performance periods after 2020, CMS would address any changes to the revenue-based standard through rulemaking.

CMS seeks comments on whether the 8 percent revenue-based nominal amount standard is appropriate. The Agency also requests feedback on whether to consider a lower, revenue-based nominal amount standard for small practices and those in rural areas for practices that are not in a Medical Home Model for the 2019 and 2020 performance periods. Additionally, should this standard apply only to small and rural practices that are participants in an APM or also to small and rural practices that join larger APM entities to participate in APMs?

ACP Comments:

The College supports maintaining the option of maintaining the more than nominal risk standard of at least 8 percent of APM Entities' Medicare Parts A & B revenues for an additional two years. There must be a period of stability and predictability for Advanced APMs as additional models are introduced for participation and more clinicians are able to move into the APM track. After an initial period that allows for stability and predictability in nominal amount standards, 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.

ACP appreciates that CMS accepted our recommendation to allow Other Payer APMs (includes private payers, Medicare Advantage and Medicaid) to meet the Advanced APM revenue-based nominal amount standard, in addition to the benchmark-based nominal risk standard, as defined under the Medicare program. This will enable all payers to use the the same APM financial risk, rather than having different standards for Medicare APMs and Other Payer APMs, and will help facilitate the development of multi-payer models.

We appreciate that CMS acknowledges that clinicians in small and rural practices may have greater challenges accepting the risk level under the general nominal amount standard. ACP urges CMS to adopt a lower, revenue-based nominal amount standard for small practices and those in rural areas. We recommend that this lower, revenue-based standard be set at the Medical Home Model nominal amount standard. Further, we do not understand rationale

behind only allowing the lower, revenue-based standard for small and rural practices that are not part of a Medical Home Model. **We strongly recommend that CMS apply this lower, revenue-based nominal amount standard to all small and rural practices in APMs, regardless of whether they are part of a larger APM entity or part of a Medical Home Model.**

2. Medical Home Model Nominal Amount Standard

Background:

The final rule established 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.

CMS proposes to modify this policy to extend the increase in the nominal amount standards over an additional year. The Agency notes that they reconsidered the increases in nominal amount standard and proposed a more gradual increase in risk since this may be better suited to the APM entities in Medical Home Models, which often have little previous experience with risk. Under this proposal, the nominal amount standard for Medical Home Models would increase as follows:

- In 2018, 2 percent of the APM Entity's total Medicare Parts A and B revenue;
- In 2019, 3 percent of the APM Entity's total Medicare Parts A and B revenue;
- In 2020, 4 percent of the APM Entity's total Medicare Parts A and B revenue;
- In 2021 and later, 5 percent of the APM Entity's total Medicare Parts A and B revenue.

ACP Comments:

While ACP appreciates that CMS has slightly slowed the increase in the nominal amount standard, we continue to have concerns that a ramp up to 5 percent APM Entity's total Medicare Parts A and B revenue by 2021 may be too fast. **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, strongly recommends that the 2 percent proposed 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.**

3. 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.

D. Advanced APMs Starting or Ending During a Medicare QP Performance Period

Background:

CMS proposes to calculate QP Threshold Scores for Advanced APMs that are actively tested continuously for a minimum of 60 days during the Medicare QP Performance Period and start or end during the Medicare QP Performance Period using only the dates that APM Entities were able to participate in the Advanced APM per the terms of the Advanced APM, not the full Medicare QP Performance Period.

ACP Comments:

The College supports the proposal to calculate the QP Threshold Score for Advanced APMs that start or end during a QP performance period using only the dates that APM Entities were able to participate, as long as a minimum of 60 days of active testing occurred during the QP performance period.

E. Participation in Multiple APMs

Background:

CMS proposes to make QP determinations for ECs that are participating in multiple Advanced APMs using the full Medicare QP Performance Period even if the eligible clinician participates in one or more Advanced APMs that start or end during the Medicare QP Performance Period. The Agency also proposes that if an eligible clinician is determined to be a QP based on participation in multiple Advanced APMs, but any of the APM Entities in which the eligible clinician participates voluntarily or involuntarily terminates from the Advanced APM before the end of the Medicare QP Performance Period, the eligible clinician is not a QP.

ACP Comments:

The College supports the proposal to make QP determinations using the full Medicare QP Performance period in situations where ECs are in multiple Advanced APMs, even if one of the APMs starts or ends during the performance period. ACP opposes the proposal that an EC are not considered a QP if any of the APM entities in which the clinician participates voluntarily or involuntarily terminate the Advanced APM before the end of the QP Performance Period. This inappropriately penalizes potential QPs for decisions made at the APM entity level, which are typically out of the EC's control.

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

Background:

CMS does not propose any new Advanced APMs in Medicare for the 2018 or 2019 performance period. Only the models that are currently Advanced APMs for 2017 and Track 1+ MSSP ACO model, which is new for 2018, will be available. Absent any changes in APM status, the following models will be available for the 2018 performance period as Advanced APMs:

- Comprehensive ESRD Care (CEC) - Two-Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- Next Generation ACO Model
- Medicare Shared Savings Program - Track 1+
- Medicare Shared Savings Program - Track 2
- Medicare Shared Savings Program - Track 3
- Oncology Care Model (OCM) - Two-Sided Risk
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1- CEHRT)

ACP Comments:

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 APMs and Advanced APMs. ACP encourages CMS to consider the following recommendations to help address this issue:

- 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 indefinitely as models are being developed, proposed, and implemented. Setting a bar for the nominal amount standard that is uncertain in a few years will create a moving target as groups are trying to properly design and test proposals for submission through the PTAC process or direct implementation by CMMI.
- After 3-4 years under the current nominal amount standards, an assessment should be completed based on the data available to analyze whether the financial viability of the APM entities to support a modest incremental increase or not. Regardless of the outcome of the analysis of existing models and their participants' ability to take on additional risk, CMS should maintain the current standards for any new models being implemented for at least the initial years of implementation. It will be difficult to add new specialty/subspecialty models if the bar to entry into the Advanced APM track is raised.
- 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 QPP, as detailed below.

- The College is appreciative of CMS' plans to initiate a Track 1+ for Accountable Care Organizations (ACOs) that will be able to qualify as an Advanced APM, implement the CPC+ model and work on additional options for 2019 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 clinicians 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.

G. Other Payer Option for APM Participation

Background:

Starting in the 2019 QPP performance period, clinicians are able to qualify for advanced APM participation through the All-Payer Option, which considers participation in advanced APMs outside of the Medicare program. Those participating in "other payer" advanced APMs must

demonstrate that the APM meets the following Medicare advanced APM criteria: (1) use of CEHRT; (2) use of quality measures comparable to those in the Quality performance category under MIPS and; (3) the payment arrangement must either require the APM Entities to bear more than nominal financial risk or be a Medicaid Medical Home Model that meets criteria comparable to Medical Home Models expanded under section 1115A(c) of the Act.

CMS proposes to establish two distinct, voluntary processes for determining Other Payer Advanced APM status – payer-initiated or individual clinician/individual APM Entity-initiated determinations. These two processes allow for either payers or individual APM Entities or individual clinicians to request annual determinations for payment arrangements to be considered under the Other Payer Option. Those submitting requests would be notified by CMS whether their payment arrangement was accepted and a comprehensive list would be publically posted after each round of determination requests.

CMS also notes within the proposed rule that they have received feedback in support of creating a path, prior to the 2019 performance period and 2021 payment adjustments, for clinicians participating in advanced APMs through the Medicare Advantage program. Clinicians could receive credit for their participation in an advanced APM within the MA program under the patient count test for QP determinations under the Medicare Option – as long as their payment arrangement through the MA plan met the three criteria discussed above.

ACP Comments

The College supports incorporating Other Payer options in order to qualify for the advanced APM track in QPP during future performance years. ACP looks forward to more extensive review and analysis of the necessary information required for determining Other Payer advanced APM participation and will provide recommendations through future rulemaking opportunities.

Additionally, ACP supports the idea of allowing an additional pathway for QP determination through the patient count test for clinicians participating in advanced APMs in the MA program. The College recommends CMS use their authority to reconsider the types of beneficiaries included in the overall patient count for QP determination to include MA beneficiaries earlier than the proposed 2019 implementation of the Other Payer option. The College strongly supports physician participation in cost sharing and risk arrangements as well as creating alignment to reinforce value-based strategies to promote higher quality and more efficient care within the Medicare program. Therefore, ACP agrees that those physicians participating in advanced APMs through MA should be able to qualify for the advanced APM track in the 2018 performance year via the patient count test as long as they are able to clearly demonstrate they are participating in a qualifying payment arrangement that meets the three advanced APM criteria for the QPP. We recommend that CMS develop a simple and understandable attestation process that requires only the necessary information to determine advanced APM qualifications in order to minimize administrative burden for clinicians.

H. Other Payer Documentation Requirements for CEHRT Criterion

Background:

Other Payer APMs are required to meet the same basic criteria that Medicare APMs must meet. Therefore, Other Payer APMs must meet the requirement that at least 50 percent of the participants in the APM are using CEHRT. CMS proposes to initially presume that an other payer arrangement would satisfy the 50 percent CEHRT use criterion if the Agency receives information and documentation from the APM Entity or from an individual through the EC-Initiated Process showing that the other payer arrangement requires the requesting ECs to use CEHRT to document and communicate clinical information.

ACP Comments:

The College has concerns with how this proposal will be implemented based on the terminology used by other payers. For example, some payers may require the use of an “EHR” or “EMR” in contracts with physicians but not specifically require that it be Certified EHR Technology via ONC. While we understand that the 50 percent CEHRT criterion is a legislative requirement, we encourage flexibility in allowing payers to meet this requirement. The large majority of physicians using an EHR or EMR are using CEHRT as their electronic system. Therefore, ACP encourages CMS to allow Other Payer APMs with a contract requirement of use of “EHR,” “EMR,” or other similar terms to count as meeting the 50 percent CEHRT requirement given that well over 50 percent of clinicians using electronic records are using CEHRT. Alternatively, if the Agency is not able to be more flexible in accepting varying contract terminology, CMS should accept the EHR vendor’s CHPL identification number as verification of the use of CEHRT.

I. Physician-Focused Payment Model Technical Advisory Committee (PTAC)

Background:

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) is the federal advisory committee established under MACRA to review physician-focused payments models (PFPMs) proposed by stakeholders. The PTAC is charged with accepting and reviewing proposed PFPMs, preparing comments and recommendations on whether proposed models meet the PFPM criteria established by the HHS, and submitting those comments and recommendations to HHS. The Secretary is required to review the PTAC’s recommendations and post a detailed response on the CMS website. Currently, CMS has tasked the PTAC with reviewing proposed APMs in which Medicare is a payer, ECs are participants and play a core role in implementing the payment methodology, and the APM targets quality and cost of services provided by participants in the model or that participants can significantly influence. CMS is seeking comment on whether to broaden the PTAC’s charge to allow it to review proposals in which Medicaid and/or CHIP are payers but Medicare is not. This proposed expanded charge would not allow for consideration of private payer only models, including those aimed at Medicare Advantage. The Agency also seeks comment on stakeholders’ needs in developing PFPMs that meet the established criteria.

ACP Comments:

The College recommends that CMS provide a clear pathway for models recommended by PTAC to be implemented as APMs under MACRA. As a part of this process, CMS should establish a date by which the Secretary will post an initial response to recommendations received from the PTAC. On May 31, 2017, the PTAC sent the Secretary its recommendations on the first three models that have completed the review process, two of which it recommended for limited testing. CMS has yet to make an announcement on any potential plans for implementation or even post a response to any of the proposals. In order to maximize the availability of APMs to specialists and subspecialists, ACP recommends that CMS post a response within 60 days of the receipt of recommendations from the PTAC.

ACP also urges CMS to make technical assistance available to stakeholders that are developing PFPs for PTAC review. Organizations that seek to propose PFPs through the PTAC often lack sufficient expertise in at least a few areas that are needed to fully develop proposals for review, causing changes to be made throughout the PTAC process. For example, determining the specifics underlying the design of the payment structure can be challenging for some groups, as the PTAC points out in its recent letter to HHS.¹⁴ CMMI should offer technical assistance to organizations as needed throughout the development process based on expertise gained in the design and testing of other models. This would not only enable the stakeholders to submit a proposal to the PTAC that is more comprehensive, but also allow the PTAC conduct a more thorough review and recommendation to CMS. It also will make it easier for CMMI to take steps to test models recommended by the PTAC since the Innovation Center aided in development of components that are required for implementation.

Access to appropriate data that is needed to design the payment structure underlying a model also presents challenges. ACP encourages CMS to provide access to data and analytics to assist stakeholders in the process of developing APM proposals that can benefit from refinements prior to submission to the PTAC. For groups without sufficient resources to hire analytics consultants, CMS should consider providing the claims analysis that is necessary for submission with proposals to the PTAC.

VI. Conclusion

ACP sincerely appreciates the opportunity to comment on the CMS notice of proposed rulemaking regarding the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) – Calendar Year (CY) 2018 Updates to the Quality Payment Program (QPP). 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.

¹⁴PTAC Letter to the Secretary on Lessons Learned.
<https://aspe.hhs.gov/system/files/pdf/255906/PTACLetterSecPriceLessonsLearned.pdf>

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 Scoring Approach for the Quality Payment Program
- Performance Reporting Improvements
- Reduce Administrative Burden
- Provide Even More Opportunities for Small Practices to Succeed
- Patient-Centered Medical Homes and Patient-Centered Specialty Practices

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,

A handwritten signature in black ink that reads "Jacqueline W. Fincher MD". The signature is written in a cursive, flowing style.

Jacqueline W. Fincher, MD, MACP
Chair, Medical Practice and Quality Committee
American College of Physicians