



December 29, 2017

Seema Verma  
Administrator  
Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
Attn: CMS-5522-FC and IFC  
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; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year [CMS-5522-FC and IFC]**

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) final rule with comment regarding the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) – Calendar Year (CY) 2018 Updates to the Quality Payment Program (QPP) and interim final rule regarding the extreme and uncontrollable circumstance policy for the transition year. 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. 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 for 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 the overall composite performance score (CPS). 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.
- More specifically, for the basic scoring system, 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 all of the available points within the quality component would add up to a total of 50 points – counting for 50 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 under the current rule, cost would add up to 10 points if 10 percent; 30 points if 30 percent.
  - For physicians with reweighting exceptions or special circumstances, ACP urges CMS to develop an easy-to-use online tool that will allow ECs to input circumstances and receive a breakdown of how the point values for measures and activities translate to the CPS.
- The College continues to urge 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 CMS reduce the finalized reporting period requirement for the Quality performance category from 12 months to a minimum of a 90-day performance period 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.

- ACP also encourages CMS to maintain a 90-day performance period for the ACI and Improvement Activities in subsequent years, as it will be important to add stability to reporting on these performance categories as practices adapt to QPP requirements.
- 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.

### **Priority Area #3: Reduce Administrative Burden**

- 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 strongly opposes CMS' decision to finalize the 60 percent data completeness requirements for quality reporting for the second performance period (up from 50 percent, as proposed). Increasing the data completeness requirements on measures, many of which may not be focused on outcomes that are meaningful to physicians and patients, seems to directly contradict CMS' recent commitments to focusing on "Meaningful Measures" and "Patients over Paperwork."
- The College appreciates that CMS will 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.
- 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 two performance periods, 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 \$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 policy 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 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 policy that requires 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 and recommends that CMS reconsider this requirement in interim rulemaking. 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:**
  - ACP recommends that CMS take 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 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 continue to urge CMS to broaden this policy 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 2.5 percent risk requirement remain at that level until it is determined that a sufficient number of model participants have demonstrated the ability to succeed under even this minimal downside risk requirement.
  - ACP also strongly recommends that the Medical Home Model nominal risk standard also be applied to comparable specialty practice models.

## **II. Summary of ACP Recommendations by Section**

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

## **A. Merit-Based Incentive Payment System (MIPS)**

### **1. MIPS Performance Period for Year 2**

- The College appreciates that CMS addressed ACP's recommendation to continue to offer flexible reporting options in QPP Year 2 to protect ECs from downward payment adjustments.
- The College strongly recommends that CMS reduce the finalized reporting period requirement for the Quality performance category from 12 months to a minimum of a 90-day performance period.
- 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 in reporting on these performance categories as practices adapt to QPP requirements.
- 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 that will allow a significant majority of solo physicians and small practices (including specialist/subspecialist practices) to have data that will be reliable and valid under the performance period.
- ACP strongly recommends that CMS move the performance period closer to the payment adjustment year.

### **2. QPP Performance Feedback**

- 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**

- ACP is encouraged to see CMS' continued concern for small practices and certain specialists/subspecialists with a small Medicare patient population by providing a larger 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 some clinicians.
- 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. The College would propose that CMS consider using the attestation process to allow physicians or small practices to opt into MIPS.
- Further, ACP recognizes the concerns CMS raised about these practices having a valid and comparable data set for the quality and cost categories and therefore recommends

that CMS could instead only assess the performance of these practices based on ACI and IA, and simply provide them feedback on their quality and cost data.

#### **4. Virtual Groups**

- ACP 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**

- 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**

- The College thanks CMS for revising the small practice definition to only include “eligible clinicians” in the count of the 15-clinician limit.
- 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.

#### **7. Quality Performance Category**

- Overall, quality measurement must move toward becoming more relevant and accurate, and toward effective approaches of measuring patient outcomes. 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.
- 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 strongly opposes CMS’ decision to finalize the 60 percent data completeness requirements for quality reporting for the second performance period (up from 50 percent, as proposed).
  - ACP recommends that CMS reverse this policy in upcoming rulemaking and finalize a 50 percent data completeness requirement for the 2018 performance period and subsequent years.
  - 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.
  - Increasing the data completeness requirements on measures, many of which may not be focused on outcomes that are meaningful to physicians and patients, seems to directly contradict CMS’ recent commitments to focusing on “Meaningful Measures” and “Patients over Paperwork.”
- ACP strongly recommends that CMS provide more transparency regarding the evaluation criteria for QCDR measures and the data QCDRs must provide for these measures at the time of self-nomination.

#### **8. Cost Performance Category**

- The College is extremely disappointed that CMS did not finalize the proposed reduction in the Cost performance category weight from 10 percent down to zero percent of the overall MIPS composite score for the 2018 performance period.
- Given the remaining concerns with the proposed cost measures, ACP also strongly urges CMS to delay including a weighted Cost performance category for the overall MIPS performance score in future performance years.
- The College recommends that CMS use its 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.

#### **9. Improvement Activities Performance Category**

- ACP urges CMS to explicitly list ACP Practice Advisor and ACP Quality Connect within the description of the improvement activities where applicable in rulemaking for year 3.
- The College reiterates its 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.
- 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 and recommends that CMS reconsider this requirement in interim rulemaking.



- ACP applauds CMS for finalizing the 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 Advanced APMs.

## **10. Advancing Care Information Performance Category**

- 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.
- Along these lines, we urge CMS to provide specific audit documentation requirements for each ACI measure as part of the specification of each measure.
- The College continues to urge 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.
- 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.

## **11. Complexity in MIPS Performance Scoring**

- While CMS continues 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.
- More specifically, for the basic scoring system, 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, as detailed in ACP’s comments on the QPP Year 2 proposed rule.<sup>1</sup>
- For physicians with reweighting exceptions or special circumstances, ACP urges CMS to develop an easy-to-use online tool that will allow ECs to input circumstances and receive a breakdown of how the point values for measures and activities translate to the CPS.
- Additionally, ACP appreciates the Agency’s efforts to add some overlap with the performance categories but recommends that CMS continue to consider additional options in rulemaking to promote taking on quality improvement activities that

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[https://www.acponline.org/acp\\_policy/letters/cms\\_comment\\_letter\\_re\\_cy\\_2018\\_macra\\_qpp\\_proposed\\_rule\\_2017.pdf](https://www.acponline.org/acp_policy/letters/cms_comment_letter_re_cy_2018_macra_qpp_proposed_rule_2017.pdf)

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.

## **12. Complex Patient Bonus**

- 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.

## **13. Small Practice Bonus**

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

## **14. APM Scoring Standard for MIPS ECs in MIPS APMs**

- 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 further reiterates its recommendation that CMS expand the fourth snapshot date to all MIPS APM participants rather than limiting it to only those models that require full TINs to participate.

## **B. Advanced Alternative Payment Models (APMs)**

### **1. Medical Home Model**

- ACP recommends that CMS take 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 no later than the third performance period (2019).
- 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.
- The College strongly recommends that CMS use the Medical Home Model standard for financial risk and nominal amount to allow PCMH practices, outside of those that are CPC+, to qualify as Advanced APMs.

- While the College appreciates that CMS will exempt CPC+ Round 1 practices from the 50-clinician limit in the organizational entity, we continue to 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 2.5 percent risk requirement remain at that level until it is determined that a sufficient number of model participants have demonstrated the ability to succeed under even this minimal downside risk requirement.
- ACP reiterates its strong recommendation that the Medical Home Model nominal risk standard also be applied to comparable specialty practice models.

## **2. Nominal Amount of Risk**

- ACP recommends extending the 8 percent revenue-based nominal amount standard indefinitely to encourage broader availability of and participation in APMs.
- 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.

## **3. Other Payer Documentation Requirements for CEHRT Criterion**

- While we understand that the 50 percent CEHRT criterion is a legislative requirement for APMs, we encourage flexibility in allowing payers to meet this requirement.

## **4. Physician-Focused Payment Model Technical Advisory Committee (PTAC)**

- The College recommends that CMS provide a clear pathway for models recommended by PTAC to be implemented as APMs under MACRA.
- ACP also reiterates its recommendation that CMS to make technical assistance available to stakeholders that are developing PFPMs for PTAC review.

## **C. Extreme and Uncontrollable Circumstance Policy for the Transition Year**

- The College strongly supports CMS' development of an automatic extreme and uncontrollable circumstances hardship exception policy for the transition year (2017).
- ACP further urges CMS to establish a permanent extreme and uncontrollable circumstances hardship exceptions policy for future years to ensure that a process is in place to handle clinician and patient needs in future scenarios.

### III. 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 will offer continued flexibility in reporting and participation for clinicians in what the Agency has termed as “The Quality Payment Program Year 2.” The CMS finalized policies for the MIPS performance period in QPP Year 2 increase the reporting requirements for the Quality performance category from 90 days to a full year (12 months) of data. CMS also finalized 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. The performance periods for the Advancing Care Information (ACI) and Improvement Activities (IAs) performance categories remain at a minimum of 90 days for the QPP Year 2. CMS also finalized a year-long performance period for 2019 (Year 3) for the Quality and Cost performance categories while maintaining a minimum of a 90-day period for ACI and IAs.

##### **ACP Comments:**

**The College appreciates that CMS addressed ACP’s recommendation to continue to offer flexible reporting options in QPP Year 2 to protect ECs from downward payment adjustments.** However, we continue to believe that it is unreasonable 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 finalized reporting period requirement for the Quality performance category from 12 months to a minimum of a 90-day performance period.** CMS could make this change in an interim final rule or in the rulemaking for year 3, which would be consistent with prior CMS announcements that allowed a 90-day performance period for meeting the Medicare EHR Incentive Program (Meaningful Use) requirements. 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 for years 2 and 3. **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 in 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 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 for 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 that will allow a significant majority of solo physicians and small practices (including specialist/subspecialist practices) to have data that will 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.

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.** While we understand that CMS does not feel that it can operationalize this yet, the College notes that it is difficult for ECs to make meaningful changes to improve their performance when available data has a significant lag time.

## **B. QPP Performance Feedback**

### **Background:**

CMS finalized as proposed policies 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. The Agency notes that providing more frequent feedback on most performance categories will not be feasible given that data is submitted once annually. Cost data and quality data for ECs that are reporting using claims-based submissions could potentially be available more frequently given that it relies solely on information included on claims. 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. CMS intends to provide feedback on all four performance categories to ECs by July 1, 2018.

**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.

**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 finalized their proposal 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 larger 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 some 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 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. **Therefore, 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. The College would propose that CMS consider using the attestation process to allow physicians or small practices to opt into MIPS.**

**Further, ACP recognizes the concerns CMS raised about these practices having a valid and comparable data set for the quality and cost categories and therefore recommends that CMS could instead only assess the performance of these practices based on ACI and IA, and simply provide them feedback on their quality and cost data.**

#### **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:**

The College appreciates CMS establishing a pathway 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.

**However, ACP 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.

**ACP Comments:**

The College appreciates that CMS has indicated interest in making changes to the group practice reporting policy to allow TINs to report as multiple, smaller sub groups. This is aligned with concerns that ACP and others have expressed with restricting group reporting to TIN-level identification. While some TINs may be representative of a group of clinicians that are solely primary care or focused on one specialty, many TINs represent many different specialties and subspecialists. In fact, ACP member data indicates a growing trend of internal medicine physicians and subspecialists going into multispecialty practices, with the percent of single specialty practices decreasing. 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 forcing physicians in a multi-specialty group to report on a common set of general measures. Finding a measures set that can apply broadly across the different specialties within the group, adds unnecessary complexity and results in data that is not relevant to a 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 2019 performance period in addition to options that allow individual reporting or TIN-level group reporting. CMS could implement subgroups by allowing TINs to identify smaller groups of NPIs that should be grouped together for performance assessment via an attestation process. 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. Allowing physicians to form smaller groups under a TIN will also benefit patients and families/caregivers because the quality and cost data generated for subgroups will allow for measure selection that is specific to specializations, allowing for more meaningful consumer data comparisons.

**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 was defined as one that has 15 or fewer “clinicians” with their NPI billing rights assigned to a TIN. Because of inconsistencies in the definitions, CMS finalized a modification to limit small practices to 15 or fewer “eligible clinicians” rather than “clinicians,” as had been previously defined. The 15-or-fewer EC definition allows practices access to the small practice technical assistance, reduced improvement activities requirements, and the small practice bonus, among other things. CMS is also establishing a “small practice size determination period,” which is a 12-month period that spans from the last four months of the calendar year two years prior to the performance period through the first eight months of the year prior to the performance period.

**ACP Comments:**

**The College thanks CMS for revising the small practice definition to only include “eligible clinicians” in the count of the 15-clinician limit.** We believe that this is consistent with congressional intent and will ensure that practices aren’t arbitrarily excluded from utilizing the small practice-specific policies due to the inclusion of clinicians who are excluded from participation in MIPS.

Additionally, ACP appreciates that CMS acknowledges our concerns with regards to small practice size limitations as they pertain to 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. 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.

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. **Therefore, 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.** This approach can be validated via a simple attestation by each EC within the practice—and the reliability of this approach can be refined over time based on the data submitted by the practices. **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. MIPS Performance Categories

### 1. Quality Performance Category

#### a. Measure Requirements and Data Submission Criteria

##### **Background:**

For the 2018 performance period, CMS finalized its proposal 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:**

**Overall, quality measurement must move toward becoming more relevant and accurate, and toward effective approaches of measuring patient outcomes. 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 is encouraged about CMS' recent announcement of new "Meaningful Measures" and "Patients over Paperwork" initiatives that are aligned with our goals. The College highlighted its support for both initiatives in a recent letter<sup>2</sup> to CMS. We further encourage CMS to consider our framework for analyzing new and existing tasks outlined in ACP's recent position paper, *Putting Patients First by Reducing Excessive Administrative Tasks in*

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[https://www.acponline.org/acp\\_policy/letters/letter\\_to\\_administrator\\_verma\\_re\\_burden\\_and\\_measures\\_2017.pdf](https://www.acponline.org/acp_policy/letters/letter_to_administrator_verma_re_burden_and_measures_2017.pdf)

*Health Care*<sup>3</sup>, as the Agency looks to reform quality measures in the context of burden reduction and the value of measures to patients and clinicians.

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.<sup>4</sup> 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 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,<sup>5</sup> 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).

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<sup>3</sup> <http://annals.org/aim/article/2614079/putting-patients-first-reducing-administrative-tasks-health-care-position-paper>

<sup>4</sup> <https://www.acponline.org/clinical-information/performance-measures>

<sup>5</sup> [https://www.acponline.org/acp\\_policy/letters/comment\\_letter\\_macra\\_proposed\\_rule\\_2016.pdf](https://www.acponline.org/acp_policy/letters/comment_letter_macra_proposed_rule_2016.pdf)

- 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.<sup>6</sup>
- Taking the recommendation regarding safe harbors a step further, the College also calls on CMS to provide clear protections for individual clinicians who participate in these types of activities—this could be done by having the entities register certain measures as “test measures.” Eligible clinicians then would not be required to report a specific performance score on these test measures, but their participation testing these measures (as some established subset of the 6 required measures) would not count against them, and in fact could be given some level of points within the quality category and/or counted as an improvement activity.
- Ensuring that the flexibility for QCDRs to develop and maintain measures outside of the CMS selection process is protected (this recommendation is discussed further below).

The College also reiterates our recommendation, as outlined in our response to the draft Quality Measure Development Plan (MDP)<sup>7</sup>—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.

## **b. Data Completeness Criteria**

### **Background:**

In this rule, CMS did not finalize its proposal 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 instead reverted to the previously finalized 60 percent data completeness threshold for the 2018 performance period. Additionally, CMS finalized a 60 percent data completeness threshold for the 2019 performance period (Year 3) and plans to announce additional increases in the data completeness threshold in 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. CMS also finalized changes to the points available for failing to meet data completeness thresholds for certain clinicians.

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<sup>6</sup> 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>

<sup>7</sup> [https://www.acponline.org/acp\\_policy/letters/comments\\_cms\\_draft\\_quality\\_measures\\_development\\_plan\\_2016.pdf](https://www.acponline.org/acp_policy/letters/comments_cms_draft_quality_measures_development_plan_2016.pdf)

Under the final rule, the following data completeness criteria 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 60 percent of the patients that meet the measure's denominator criteria, regardless of the payer, including at least 1 Medicare patient.
  - 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 60 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 strongly opposes CMS' decision to finalize the 60 percent data completeness requirements for quality reporting for the second performance period (up from 50 percent, as proposed).** An increase in the data reporting requirements places 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.

**Therefore, ACP recommends that CMS reverse this policy in upcoming rulemaking and finalize a 50 percent data completeness requirement for the 2018 performance period and subsequent years.** This could either be implemented through an interim final rule or through rulemaking for the 2019 performance period. Given the flexibility in reporting options in the initial performance period, 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 2018.

**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.** 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. **Additionally, increasing the data completeness requirements on measures, many of which may not be focused on outcomes**

that are meaningful to physicians and patients, seems to directly contradict CMS' recent commitments to focusing on "Meaningful Measures" and "Patients over Paperwork."

### c. 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 replaces the term "non-MIPS measures" with "QCDR measures." Beginning with the 2019 performance period, the Agency finalized the use of 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.

#### **ACP Comments:**

The College supports a simplified self-nomination process for previously approved QCDRs in good standing. We strongly encourage CMS to provide more clarity regarding the criteria that will be used to evaluate each QCDR's standing. Are all QCDRs that are not on probation or disqualified considered to be in good standing? Or are there additional criteria that will be used to evaluate the QCDR's standing?

**ACP strongly recommends that CMS provide more transparency regarding the evaluation criteria for QCDR measures and the data QCDRs must provide for these measures at the time of self-nomination.** The College encourages CMS to provide more clarity regarding any changes in QCDR measure approval criteria from year to year, particularly for QCDR measures that did not undergo any changes in measure specifications and received full approval one year and were not approved the following year. In these instances, the College supports use of the

provisional approval process, in which CMS clearly communicates the requirements for these measures to receive full approval moving forward (e.g., measure harmonization, feasibility studies, addressing changes in clinical guidelines, etc.).

The College also recommends that there should be more transparency in the communication regarding decisions made for self-nominations and QCDR measures and more reasonable and standardized response expectations. QCDRs should be given more than 24 hours to respond to requests for information and/or approval from CMS, as QCDRs typically have their own governance structure and internal approval processes that require more time to respond appropriately (e.g, 48-72 hours). The College believes that the simplified self-nomination process for previously approved QCDRs will help address some of these issues. However, the process for reviewing QCDR measures on an annual basis needs more transparency and improved communication.

## **2. Cost Performance Category**

### **Background:**

For the 2018 MIPS performance period, or the QPP Year 2, CMS did not finalize its proposal to keep the weight of the Cost performance category at zero percent in 2018 and exclude the category from the final MIPS performance score. Rather, the Agency reverted back to its previously finalized policy of weighting the cost performance category at 10 percent for the 2018 performance period. CMS will evaluate cost performance based on two measures, both of which have previously been included in the Value-based Modifier (VM) program and/or the annual or mid-year Quality and Resource Use Reports (QRUR) as well as in feedback reports for the 2017 MIPS performance period. Cost measures calculated using administrative claims data requiring no additional reporting by ECs or groups. CMS did not make 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 will also provide performance feedback to ECs and groups on the newly developed episode-based cost measures for informational purposes only and will also provide feedback on the two claims-based measures that will comprise the weighted portion of the cost performance score by July 1, 2018. CMS intends to propose in future rulemaking the use of the new episode-based cost measures for the 2019 performance period.

### **ACP Comments:**

**The College is extremely disappointed that CMS did not finalize the proposed reduction in the Cost performance category weight from 10 percent down to zero percent of the overall MIPS composite score for the 2018 performance period.** As stated in our comments on the 2018 proposed QPP rule, 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. The College also 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. Additionally, the cost measures also lack proper risk adjustment methodologies and factors such as socioeconomic status, which creates a system that inappropriately penalizes physicians with higher numbers of lower income or frailer patients. Therefore, ACP strongly recommends that CMS issue subsequent rulemaking to revise the Cost performance category weight down to zero percent for 2018 and increase the Quality category weight to 60 percent.

**Given the remaining concerns with the proposed cost measures, ACP also strongly urges CMS to delay including a weighted 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. ACP continues to believe that the currently available measures are neither sufficient nor applicable to clinicians without further refinement and testing. Therefore, in addition to setting the Cost category weight at zero percent in year two, **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.

In the interim, ACP recommends CMS continue to focus on the refinement of the claims-based total per capita cost measure and the MSPB measure as well 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, CMS should continue 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 as well as the impact of cost measures on physicians' overall performance in the Cost performance category. We also recommend that the Agency consider the College's April 2017



letter on Episode-Based Cost Measure Development for the Quality Payment Program<sup>8</sup> related to the development of episode-based cost measures for chronic conditions as well, as a possible pilot to voluntarily test new cost measures and patient relationship codes.

### 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 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 ECs), 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 the Agency accepting our recommendation to allow certain continuing medical education (CME) programs that address performance or quality improvement receive credit as improvement activities. However, ACP is disappointed that, while CMS indicated that several improvement activities that were submitted by the College through the Annual Call for Activities process were being proposed for inclusion in 2018, none of these are explicitly referenced in the activities list or descriptions in the proposed or final rules. The College was informed that ACP Practice Advisor<sup>®</sup> modules as well as ACP's Quality Connect were included as proposed activities in year 2. **ACP urges CMS to explicitly list ACP Practice Advisor and ACP Quality Connect within the description of the improvement activities where applicable in rulemaking for year 3.** Until CMS is able to list these programs in the activity descriptions, the College recommends that CMS list these programs in the improvement activities data validation

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[https://www.acponline.org/acp\\_policy/letters/acp\\_comments\\_on\\_cms\\_episode\\_based\\_cost\\_measure\\_development\\_for\\_macra\\_gpp\\_2017.pdf](https://www.acponline.org/acp_policy/letters/acp_comments_on_cms_episode_based_cost_measure_development_for_macra_gpp_2017.pdf)

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 final rule would allow credit for use these programs as follows:

- Completion of an Accredited Safety or Quality Improvement Program (IA\_PSPA\_28) – 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 Quality Improvement Initiatives (formerly 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 thanks CMS for making our recommended revisions to the following improvement activity:

- Consulting AUC Using Clinical Decision Support when Ordering Advanced Diagnostic Imaging (IA\_PSPA\_29) – ACP appreciates that the description has been modified in the final rule to align with the appropriate use criteria (AUC) for specified advanced diagnostic imaging services that is being implemented under the requirements in the Protecting Access to Medicare Act (PAMA). The proposed description of this activity was so broad as to require use of AUC with every advanced diagnostic imaging order rather than the priority list in the regulations.

Additionally, the College has comments on the finalized 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) – We appreciate that CMS accepted our recommendation and did not finalize the proposal to reduce the weight of this activity to medium. This activity should 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 in future years 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.

Additionally, ACP reiterates its recommendation 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. Submission Mechanisms**

##### **Background:**

CMS finalized 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 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 reiterates its 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 will provide more detailed recommendations to the Agency with regard to how we believe this can be done in a supplemental letter.

#### **b. 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 finalized a modification to this policy 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 policy that requires that 50 percent of practice sites be certified PCMHs or comparable specialty practices in order to receive full credit for improvement activities and recommends that CMS reconsider this requirement in interim rulemaking.** 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 applauds CMS for finalizing the 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 Advanced APMs.**

#### **4. Advancing Care Information Performance Category**

**ACP Overall Comments:**

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. 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. There is no 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. Base Score**

##### **Background:**

For the CY 2018 performance period, CMS did not make 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 continues to urge 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 rewarding evidence of good care and outcomes.

#### **b. 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. 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.

**c. Hardship Exceptions - Small Practices**

**Background:**

CMS finalized a significant hardship exception for the advancing care information performance category for MIPS eligible clinicians who are in small practices. CMS will make eligibility determinations regarding the size of small practices for performance periods occurring in 2018 and future years and 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 small group and solo practices that 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.

## H. MIPS Final Score Methodology

### 1. Complexity in MIPS Performance Scoring

#### **Background:**

In this rule, CMS finalized 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). This methodology includes the following elements:

- Increases Cost performance category weight to 10 percent of the overall CPS for 2018.
- Decreases Quality from 60 percent weight in Year 1 to 50 percent in the second performance period due to the decision to weight Cost at 10 percent.
- Increases the overall performance threshold for the CPS from 3 points to 15 points.
- Adds a complex patient bonus of 1-5 points based on average HCC risk score and dual eligible status.
- Adds a small practice bonus of 5 points for practices with 15 or fewer ECs that submit data in at least one performance category.
- Adds a methodology for scoring improvement in the quality and cost performance categories.
- Creates a lower scoring standard for quality measures that are identified as topped out, allowing them a maximum of 7 points rather than 10.
- Allows 1 point for failing to meet data completeness criteria for quality measures, while allowing small practices 3 points.

#### **ACP Comments:**

**While CMS continues 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 appreciates that CMS acknowledges that simplification of the MIPS scoring methodology to allow MIPS ECs to easily understand the scoring calculation is a core goal. We also appreciate that CMS has layered in additional scoring policies such as bonuses, varying point values for quality, etc.; however, the Agency still has not addressed the underlying concerns. 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.

**More specifically, for the basic scoring system, 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, as detailed in ACP's comments on the**

**QPP Year 2 proposed rule.**<sup>9</sup> This means that all of the available points within the quality component would add up to a total of 50 points – counting for 50 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 under the current rule, cost would add up to 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. The proposed tool referenced below would utilize this basic scoring system to determine how point values translate for any special circumstances.

We understand the Agency’s concern that there are challenges in creating one scoring system that is simple, understandable, and applicable to each physician in every scenario. However, the College maintains its recommendation that the underlying basic scoring methodology for the physicians that do not have special circumstances to consider should allow each measure or activity to directly translate into its value in the CPS. **For physicians with reweighting exceptions or special circumstances, ACP urges CMS to develop an easy-to-use online tool that will allow ECs to input circumstances and receive a breakdown of how the point values for measures and activities translate to the CPS.** For example, if an EC met criteria to apply for an ACI hardship exception and reweighting of that category to zero percent, he/she could click a box and the tool would indicate how much each quality measure and improvement activity would be worth in the overall CPS. Or a group that only has three applicable quality measures to report on could indicate the circumstance in the tool and receive analysis of how much each measure would be worth in the overall CPS.

**Additionally, ACP appreciates the Agency’s efforts to add some overlap with the performance categories but recommends that CMS continue to consider additional options in rulemaking to promote taking on quality improvement activities that crossover into multiple performance categories—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. Alternately, practices that want to focus on opioid use could report on measures and activities targeted at pain management and opioid prescribing. **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.**

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[https://www.acponline.org/acp\\_policy/letters/cms\\_comment\\_letter\\_re\\_cy\\_2018\\_macra\\_qpp\\_proposed\\_rule\\_2017.pdf](https://www.acponline.org/acp_policy/letters/cms_comment_letter_re_cy_2018_macra_qpp_proposed_rule_2017.pdf)



The College further reiterates comments that are detailed in our letter on the QPP proposed rule for Year 2<sup>10</sup> on other scoring issues not addressed elsewhere in this letter:

- **Minimum requirements for quality measures scoring:** ACP recommends that CMS maintain the 3-point floor for quality measures for all clinicians, including those who report on measures that do not have benchmarks or fail to meet case minimum or data completeness thresholds, for the second performance period rather than creating separate standards based on practice size.
- **Topped-out measures:** While we appreciate that CMS increased the maximum points available for reporting topped-out measures from 6 to 7 points, 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. 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.
- **Improvement activities scoring:** 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.
- **Measuring improvement in the quality performance category:** We appreciate that CMS will be measuring ECs' improvement in quality performance year-to-year and adding an improvement score to the final composite performance score. However, CMS will only provide a score for improvement for clinicians who report on a full set of measures. While we understand and support the desire to provide incentives for meeting the full participation requirements for the quality performance category—and improving upon performance on those measures—many ECs have little prior experience reporting and may opt for test or partial participation in the transition year. ACP recommends that CMS consider additional ways of incentivizing ECs and groups that are incrementally increasing their participation toward the full quality measure requirements.

## 2. Complex Patient Bonus

### Background:

For the 2018 QPP performance period, CMS finalized an increase in the maximum amount of points available for the complex patient bonus. The complex patient bonus will be calculated by adding the average HCC risk score to the ratio of dual eligible, multiplied by five. ECs that submit data in at least one performance category will be eligible to have a complex patient bonus of 1 to 5 points added to their overall performance scores.

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[https://www.acponline.org/acp\\_policy/letters/cms\\_comment\\_letter\\_re\\_cy\\_2018\\_macra\\_qpp\\_proposed\\_rule\\_2017.pdf](https://www.acponline.org/acp_policy/letters/cms_comment_letter_re_cy_2018_macra_qpp_proposed_rule_2017.pdf)

**ACP Comments:**

The College appreciates that CMS accepted our recommendation to increase the amount of points available for the complex patient bonus. The increase from three to a maximum of five points will better encourage physicians to take on more complex beneficiaries while removing the concern that these sicker patients will negatively affect their overall performance score. ACP also appreciates the addition of adjustments based on dual eligible status to the average HCC risk adjustment score. Dual eligibility is an important step toward layering in additional risk adjustments based on socioeconomic status (SES). The College further calls for CMS to incorporate other social determinants of health in quality and performance measurement such as adjustments for inadequate housing and transportation, lack of access to healthy foods, and racial and ethnic health disparities, which are known to negatively impact patients' health, to reflect the increased risk associated with treating disadvantaged patient populations.

We also appreciate that CMS intends to provide an educational component associated with the new risk-adjustment methodology. **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.** Because HCCs are based on patient data from a prior period, it is important that educational material be available as soon as possible so that physicians can incorporate any necessary changes into their workflows to ensure accurate HCC coding moving forward.

### 3. Small Practice Bonus

**Background:**

CMS finalized its proposal to offer a "small practice bonus" of five points for ECs in small practices, those with 15 or fewer ECs in a TIN. This bonus will be added onto the composite performance score for ECs in small practices, including virtual groups and MIPS APM entities with 15 or fewer ECs (the entire virtual group or APM entity combined must include 15 or fewer ECs to qualify for the bonus). In order to qualify for the bonus, eligible clinicians must submit data on at least one MIPS performance

**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 continues to recommend that CMS extend this bonus to those physicians practicing in rural and underserved areas.**

## I. APM Scoring Standard for MIPS ECs in MIPS APMs

### 1. 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 to submit additional data for MIPS purposes. Rather, the data submitted by an APM entity on behalf of the MIPS APM participants will be used for scoring purposes in MIPS.

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. Beginning with the 2018 performance period, all MIPS APMs will be scored under the same scoring 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. This reflects a change from the transition year scoring in which "Other MIPS APMs"—defined as those that do not report using the CMS Web Interface (i.e., the Comprehensive ESRD Care Model, CPC+, and the Oncology Care Model)—received a quality category weight of zero percent due to operational constraints on the part of the Agency. These MIPS APMs received a composite performance score based on 25 percent improvement activities weight and 75 percent ACI weight in year 1.

#### **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 are a very limited number of APMs that qualify as MIPS APMs in the first two performance periods, particularly 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 value-oriented payment approaches.

ACP supports CMS' efforts to operationalize a 50 percent weight for the quality performance category for "Other MIPS APMs" in year 2. ACP also appreciates that CMS will weight the Cost performance category at zero percent for the 2018 performance period for all MIPS APMs. We understand that CMS has different waiver authority pertaining to APMs. However, we reiterate our recommendation that CMS use their authority to also weight the Cost performance category at zero percent for all other MIPS ECs. This will better align scoring across MIPS participants and allow time for the development and refinement of adequate cost measures to use for MIPS scoring.

## 2. Assessment Dates for Inclusion in MIPS APMs

### **Background:**

For the 2017 performance period, CMS 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 finalized the addition of fourth assessment date of December 31 to identify those MIPS eligible clinicians who participate in a full TIN APM. 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.

### **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 further reiterates its recommendation that CMS 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.

## IV. 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.

CMS also 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.

In terms of the Medical Home Model nominal amount standard, CMS finalized a modification to extend the increase in the nominal amount standards over an additional year and proposed a more gradual increase in risk as follows:

- In 2018, 2.5 percent of the APM Entity's total Medicare Parts A and B revenue (rather than 2 percent as proposed);
- 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.

Additionally, CMS finalized an exemption from the requirement that Medical Home Model entities 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:**

The College commends CMS for its continued recognition regarding the unique status of the medical home within the APM portfolio. The College has been a leader in supporting the medical home model, particularly in light of the plethora of currently available research<sup>11</sup> linking the model to higher quality and lower costs. The College also would like to re-iterate our strong support for the Comprehensive Primary Care Plus (CPC+) program. As indicated in our November 8, 2017 testimony before the Energy and Commerce Health Subcommittee on "MACRA and Alternative Payment Models: Developing Options for Value-based Care,"<sup>12</sup> ACP believes that CPC+ offers the potential of greatly strengthening the ability of internists and other primary care clinicians, in thousands of practices nationwide, to deliver high value, high performing, effective, and accessible primary care to millions of their patients.

However, we remain concerned that available Medical Home Models within the Advanced APM category, which is currently limited to CPC+, are restricted to only practices that are in the 18 regions in Rounds 1 and 2 of the program. That leaves the majority of primary care physicians throughout the country with no available medical home options in the APM pathway. Additionally, 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).

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<sup>11</sup> 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.pcpcc.org/sites/default/files/resources/pcmh\\_evidence\\_report\\_08-1-17%20FINAL.pdf](https://www.pcpcc.org/sites/default/files/resources/pcmh_evidence_report_08-1-17%20FINAL.pdf)

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[https://www.acponline.org/acp\\_policy/testimony/statement\\_house\\_energy\\_commerce\\_health\\_subcommittee\\_hearing\\_on\\_macra\\_and\\_apms\\_2017.pdf](https://www.acponline.org/acp_policy/testimony/statement_house_energy_commerce_health_subcommittee_hearing_on_macra_and_apms_2017.pdf)

Therefore, ACP recommends that CMS take 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 no later than the third performance period (2019). These steps are detailed in the College's comments on the QPP proposed rule for CY 2018<sup>13</sup> and in a number of our past letters to the Agency and we welcome the opportunity to discuss these ideas further.

Additional recommendations related to the Medical Home Model are as follows:

- **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.** This is because, under the current policy, CPC practices that are in Track One ACOs are now incentivized to leave the ACO program in order to become an Advanced APM as a CPC+ practice rather than participating in both CPC+ and MSSP Track One, which the College believes was the intent behind allowing practices to participate in both programs.
- **The College strongly recommends that CMS use the Medical Home Model standard for financial risk and nominal amount to allow PCMH practices, outside of those that are CPC+, to qualify as Advanced APMs.** Although 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, for Round 2 practices, to those practices with 50 or fewer eligible clinicians. Details as to how we believe this can be done were provided in our 2018 proposed rule letter.
- **While the College appreciates that CMS will exempt CPC+ Round 1 practices from the 50-clinician limit in the organizational entity, we continue to urge CMS to broaden this policy 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.
- **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 2.5 percent risk requirement remain at that level until it is determined that a sufficient number of model participants have demonstrated the ability to succeed under even this minimal downside risk requirement.** Additionally, any new models under the

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[https://www.acponline.org/acp\\_policy/letters/cms\\_comment\\_letter\\_re\\_cy\\_2018\\_macra\\_qpp\\_proposed\\_rule\\_2017.pdf](https://www.acponline.org/acp_policy/letters/cms_comment_letter_re_cy_2018_macra_qpp_proposed_rule_2017.pdf)

medical home model nominal amount standard should be able to qualify for the 2.5 percent revenue-based risk standard.

- **ACP reiterates its strong recommendation that the Medical Home Model nominal risk standard also be applied to comparable specialty practice models.** While we understand and agree with CMS' interpretation that medical home models are intended to be primary care-focused, 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.

## **B. 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 finalized an extension of 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.

The Agency also sought 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. CMS did not finalize any policies pertaining to nominal amount standards for small and rural practices but may do so in the future. Additionally, CMS sought comment on whether this potential standard should 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 thanks CMS for 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.

**Therefore, we recommend extending the 8 percent revenue-based nominal amount standard indefinitely to encourage broader availability of and participation in APMs.** The process for development and evaluation of potential models, both through the PTAC process and elsewhere, can take years before the first practices are able to apply to participate in models undergoing testing or implementation through CMMI. By only finalizing the revenue-based standard for another two years, CMS is creating a scenario where the specialty models currently under development may not qualify as Advanced APMs by the time they are ready for

testing. We strongly recommend that the 8 percent of Medicare Parts A & B revenue standard be available indefinitely, and any potential changes should be announced several years before they are effective to allow existing models to make changes to meet new financial risk standards and undergo any new contracting that may be necessary for model participants. If CMS is unable or unwilling to make the revenue based standard available to all models, at a minimum the College recommends that it be available to any new models as they become available for testing/implementation to allow models that are in development to have a stable risk standard to aim for.

After an initial, multi-year period that allows for stability and predictability in nominal amount standards in any models undergoing testing or implementation, 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.

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 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. CMS should also indefinitely extend the 8 percent revenue-based standard to other payers, which may also try to match CMS nominal amount standards for their own value-based contracts, to align risk standards across the payer spectrum and to allow for better multi-payer testing of 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.**

### **C. 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. Very few new models have been added or proposed since the enactment of MACRA, leaving most specialists with few to no options to join in the early years of QPP implementation. It is critical that CMS prioritize testing of new models for specialists and subspecialists, especially those specialties with no existing APM options, including by creating an expedited implementation pathway for models that are recommended by the PTAC for testing or limited scale testing. Additionally, in developing and identifying new APMs for testing, ACP encourages CMS to consider its recommendations on specialty APMs from our letter on the CMMI “New Direction” Request for Information,<sup>14</sup> which includes suggestions on the appropriate interface between primary care models and non-primary care specialist and subspecialist models.

**D. 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.

CMS established 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 that the Agency intends to develop a demonstration project to test the effects of expanding incentives for ECs that participate in MA payment arrangements that qualify as Advanced APMs. Under this demonstration, CMS would allow credit for participating in MA arrangements prior to 2019 and incentivizing participation in 2018 through 2024. This will allow CMS to test whether incentivizing clinicians for participating in Advanced APMs with MA alone

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<sup>14</sup> [https://www.acponline.org/acp\\_policy/letters/acp\\_comments\\_on\\_cmmi\\_new\\_direction\\_rfi\\_2017.pdf](https://www.acponline.org/acp_policy/letters/acp_comments_on_cmmi_new_direction_rfi_2017.pdf)

and no Medicare fee-for-service APM participation requirement encourages more clinicians to move to the APM pathway. MA plans would submit information to CMS on their qualifications as an other-payer Advanced APM along with their information through the annual bidding process (by the first Monday in June prior to payment/coverage year).

#### **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 thanks CMS for accepting the recommendation of the College and others that allows a pathway for QP determination for clinicians participating in Advanced APMs in the MA program. We appreciate that CMS will allow clinicians participating in MA payment arrangements that meet Advanced APM requirements to be incentivized in 2018 through 2024, which will allow clinicians to qualify prior to when the other payer APM combination option kicks in. 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. 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.

#### **E. 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 another 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 due to 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 suing 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.

#### **F. 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.** We are disappointed that CMS does not believe that they can create a formal process for responding that would establish a date by which the Secretary will post an initial response to recommendations received from the PTAC. While we understand that the volume of PTAC recommendations received at any given time is out of CMS' control, the Agency should make efforts to make timely responses (i.e., within 60 days of receipt of a proposal). At a minimum, we recommend that CMS prioritize proposals that receive a PTAC recommendation of implementation or limited scale testing, especially those that are applicable to specialists/subspecialists with no current APMs, should receive prompt review and response.

**ACP also reiterates its recommendation that CMS to make technical assistance available to stakeholders that are developing PFPMs for PTAC review.** Organizations that seek to propose PFPMs 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 letter to HHS.<sup>15</sup> We appreciate

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<sup>15</sup> PTAC Letter to the Secretary on Lessons Learned.

<https://aspe.hhs.gov/system/files/pdf/255906/PTACLetterSecPriceLessonsLearned.pdf>

that CMS notes that it will undertake a robust analysis of payment methodologies prior to testing, we believe CMMI should also offer technical assistance to organizations as needed throughout the development process based on expertise gained in the design and testing of other models to ensure that the PTAC can review comprehensive, robust models when making recommendations to CMS. Additionally, 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.

## **V. Extreme and Uncontrollable Circumstance Policy for the Transition Year**

### **Background:**

In this final rule, CMS included an interim final rule with comment period to create an extreme and uncontrollable circumstance policy for the transition year (the 2017 performance period). Under this policy, clinicians who are impacted by extreme and uncontrollable circumstances in 2017 such as Hurricanes Harvey, Irma, and Maria or the wildfires in California can qualify for an automatic hardship exception for MIPS. The areas that qualify for this exception are based off of the Federal Emergency Management Agency (FEMA)-designated major disaster areas. Clinicians who are in FEMA-designated areas are identified through PECOS as individuals located in affected counties.

CMS will apply a neutral payment adjustment for the 2017 performance period to clinicians who qualify for the automatic extreme and uncontrollable circumstances hardship exception. This policy will be applied automatically without the need for submitting any request because CMS did not have sufficient time to develop an application process based on the timing of the disasters. Clinicians who choose to submit data for MIPS will have their data scored and could potentially earn a positive payment adjustment. The policy is applicable to individual clinicians only, though all clinicians would be considered individuals unless they are part of a group that submits data as a group practice.

### **ACP Comments:**

The College strongly supports CMS' development of an automatic extreme and uncontrollable circumstances hardship exception policy for the transition year (2017). ACP has requested numerous times that the Agency develop a hardship exceptions policy that allows clinicians who are impacted by circumstances outside of their control, such as natural disasters, to apply for relief from MIPS reporting requirements. It is important that clinicians in areas impacted by major disasters such as hurricanes and wildfires be given flexibility from reporting requirements and other regulatory restrictions to allow them to focus their efforts on meeting patient care needs.

**ACP further urges CMS to establish a permanent extreme and uncontrollable circumstances hardship exceptions policy for future years to ensure that a process is in place to handle clinician and patient needs in future scenarios.** This future process may include a formal hardship exceptions application process for affected clinicians to apply for an exemption from MIPS reporting requirements. In addition to an application process, we recommend that CMS

also include a permanent automatic extreme and uncontrollable circumstances hardship exceptions policy for events that occur prior to the conclusion of the performance period. Major disasters that occur, particularly toward the end of the performance period, may leave practices with insufficient time to file an application or inability to report adequate or timely data to meet MIPS requirements. An automatic exception policy similar to the transition year policy with no requirement to submit an application should exist for these scenarios.

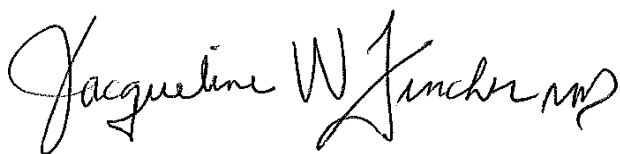
## **VI. Conclusion**

ACP sincerely appreciates the opportunity to comment on the CMS final rule with comment regarding the CY 2018 Updates to QPP and interim final rule on the extreme and uncontrollable circumstances policy for the transition year. 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. Therefore, we urge CMS to actively consider all of our recommendations in this letter as well as specific improvements that we intend to provide to the Agency prior to the next round of rulemaking. 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 Brian Outland, ACP Director of Regulatory Affairs, by phone at 202-261-4544 or e-mail at [boutland@acponline.org](mailto:boutland@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