



November 17, 2015

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

Re: Request for Information Regarding Implementation of the Merit-based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models [CMS-3321-NC]

Dear Acting Administrator Slavitt:

On behalf of the American College of Physicians (ACP), I am writing to share our comments on the Centers for Medicare and Medicaid Services' (CMS) request for information (RFI) regarding implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 143,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

I. Guiding Principles

ACP would like to call on CMS to use the opportunity provided through the new MACRA law to build a learning health and healthcare system. It is critically important that the new payment systems that are designed through the implementation of MACRA reflect the learnings from the current and past programs and also effectively allow for ongoing innovation and learning. The College recognizes that taking an approach such as this will require flexibility in design that will be extremely challenging to implement, particularly for a program that must be guided by federal regulations. Throughout our comments below, the College notes critical areas that should be built with considerable flexibility and an aim of understanding how to best refine the regulations over time based on the data and evidence that emerge, lessons learned, and best practices. ACP would

also point CMS to the extensive work that the Institute of Medicine has done in evaluating the issues and urgent actions necessary to foster a learning health care system in America.¹

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

ACP also would like to reiterate our support for the principles for MACRA implementation that were outlined in a recent sign-on letter² submitted to CMS by the American Medical Association (AMA). These principles include the following:

- **Support delivery system improvements.**
- **Avoid administrative and cost burdens for patients.**
- **Reduce administrative burdens for physicians.**
- **Improve current quality and reporting systems.**
- **Recognize patient diversity.**
- **Provide choice of payment models.**
- **Be equitable.**
- **Be relevant and actionable.**
- **Provide stability and resources.**
- **Be transparent.**

II. Summary of ACP Recommendations

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.

MIPS Eligible Professional (EP) Identifier and Exclusion

- The College urges CMS to use existing identifiers with which physicians are already familiar (i.e., a combination of taxpayer identification number (TIN) and National Provider Identifier (NPI) to identify EPs in MIPS).

¹ Institute of Medicine. “The Learning Healthcare System in America.” Accessed at:

<http://iom.nationalacademies.org/Activities/Quality/LearningHealthCare.aspx>.

² <http://www.ama-assn.org/resources/doc/washington/x-pub/macra-sign-on-letter-16nov2015.pdf>

Virtual Groups

- The College recommends that CMS ensure as much flexibility as possible in establishing a process to allow for MIPS EPs to elect to form a virtual group for a performance period.

Quality Performance Category

- The College strongly recommends that CMS actively work to improve the measures to be used in the quality performance category of MIPS. Along these lines:
 - In the short term, ACP encourages CMS to consider adopting a core set of measures that are methodologically sound and Measure Applications Partnership (MAP)-endorsed for use in the MIPS and APM programs. CMS should consider utilizing the core set of measures identified through the America's Health Insurance Plans (AHIP) coalition pending approval by the organizations involved, which includes both physician and consumer organizations and CMS.
 - Over the longer term, it will be critically important for CMS to continue to improve the measures and reporting systems to be used in MIPS to ensure that they measure the right things, move toward clinical outcomes and patient experience, and do not create unintended adverse consequences.
 - ACP is strongly supportive of filling the critical gaps in quality measurement; obtaining stakeholder input into the measure development process; and focusing on outcomes-based measures, patient and family experience measures, care coordination measures, and measures of population health and prevention. ACP also strongly recommends electronic specification of the measures as one of the top considerations for filling measure gaps.
 - It is critically important that the data collection and reporting burden related to the quality category (as with all of the MIPS categories) be minimized.
 - ACP recommends that CMS work to ensure that performance measurement and reporting becomes increasingly patient-focused.

Quality Performance Category: Reporting Mechanisms and Criteria

- ACP recommends that CMS begin MIPS with all current reporting options available in order to ease the transition.
- The College believes that the current nine-measure reporting requirement is arbitrary and does not contribute to the delivery of effective and efficient care. Practices should be required to report only measures within any National Quality Strategy (NQS) domain that are truly applicable to their patient population.
- ACP does not recommend that CMS establish a minimum number of outcomes-based measures, at least initially. Rather, CMS could incentivize clinicians to report on outcomes-based measures by assigning them more weight within the MIPS program.
- The College recommends that CMS remove the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey from the quality performance category and instead allow use of a CAHPS survey as one possible component of the clinical practice improvement activities performance category in the subcategory of beneficiary engagement.

- ACP recommends that a process be developed to determine in advance of the reporting year which quality measures are likely applicable to the EP.

Quality Performance Category: Data Accuracy

- Qualified Clinical Data Registries (QCDRs) should be required to submit data to CMS using Quality Reporting Data Architecture (QRDA) today, and CMS should be preparing all of its systems to support emerging standards in the near future, such as Fast Healthcare Interoperability Resources (FHIR).
- The College recommends that CMS provide feedback on errors in a detailed, informative, and actionable manner.
- The College strongly recommends that there should be no consequences for EPs who contract to use a data service for reporting purposes in good faith and who submit data as required.

Resource Use Performance Category

- ACP recommends that CMS consider additional modifying factors, including geography, site of service (e.g., facility v. outpatient), size of the physician/clinician group, sub specializations within subspecialties, etc. when measuring resource use to ensure that comparisons are truly between groups of like peers. The College strongly recommends that CMS work with specialty societies to improve the granularity for these comparisons.

Clinical Practice Improvement Activities Performance Category

- The College recommends that CMS begin considering and seeking feedback on the specific approaches that the Agency will employ to recognize Patient-Centered Medical Homes (PCMHs) and PCMH specialty practices under both the MIPS and APM tracks in the future—something that was not specifically inquired about within this RFI.
- In assessing the performance of EPs on clinical practice improvement activities, the College urges CMS to ensure that administrative burden associated with documentation of the activities, as well as the cost of performing the activities and submitting documentation is minimal and constructed to be extremely flexible in the early years as the Agency and the participating clinicians gain experience with this new reporting category.
- The College believes that any quality improvement activity that an EP is involved in should count toward the clinical practice improvement activities category.
- ACP recommends that CMS not initially establish overly prescriptive thresholds or quantities of activities.
- Given that the PCMH and PCMH specialty practice are two models that are designated by statute to achieve the highest score, the College recommends that CMS look closely at the activities that have been consistently identified as components of those models and consider giving them more weight.

Meaningful Use of EHRs Performance Category

- ACP urges CMS to avoid the use of process measures in Meaningful Use (MU) without a reexamination of their clinical value and appropriateness.

- CMS should reduce burden to EPs while, at the same time, push harder to improve the quality and value of electronic health records (EHRs) and other health information technology (IT).
- ACP strongly recommends that CMS transform MU from an all-or-nothing scoring system to a partial scoring system, with more points available for completion of an increasing number of activities, as was the intent of Congress in enacting MACRA.
- CMS should remove arbitrary thresholds from all objectives.
- ACP recommends that hardship exemptions be based on lack of ability to perform specific functions, whether due to system defect, unavailability of an exchange partner, or any other cause beyond the EP's control.

Feedback Reports

- CMS should make feedback reports available as frequently as possible, quarterly at a minimum, but working toward monthly reports as soon as possible.
- The College urges CMS to include patient-level data in feedback reports in a timely and easily accessible manner.

Alternative Payment Models

- ACP encourages the development of a regulatory framework that encourages innovation (i.e., is not overly prescriptive); recognizes the unique aspects of the various medical specialties including the services provided and the populations served; and is sensitive to the substantial financial and human equity costs required to succeed within this new payment environment.

Nominal Financial Risk

- The College recommends that CMS expand its definition of nominal financial risk to include recognition of non-billable costs that are currently overlooked (e.g., start-up and maintenance costs, and lost revenue to a system resulting from efforts to reduce unnecessary utilizations).

Medicaid: Medical Homes and Other State APMs

- The College supports the inclusion of Medicaid-recognized medical homes as eligible APM entities based on their comparability to medical homes expanded under the Center for Medicare and Medicaid Innovation (CMMI) authority.

Eligible APM Requirements

- The College recommends that CMS employ a very broad definition of entities that should be considered eligible APM (EAPM) entities as a means to promote innovation and recognize the heterogeneity of services and clinicians covered under Medicare.
- ACP recommends that selection of quality measures for an APM should be based on the goals and design of the specific APM and harmonized with those measures being used within the MIPS program—as well as across the multiple payers that are anticipated would be involved with APMs.

- The College strongly recommends that certified EHR technology (CEHRT) requirements for APMs be viewed as separate from requirements included under the Meaningful Use Incentive Program.

Physician-Focused Payment Models

- The process for approval of Physician-Focused Payment Models (PFPMs) must be clearly defined and implemented to be consistent with the Congressional intent that this approach be a pathway to encourage the development and approval of multiple valued-based payment models.
- There needs to be a clear understanding that models that are judged by the Physician-focused Payment Model Technical Advisory Committee (PTAC) to meet the established criteria will be tested on a fast-track basis through CMMI and, if determined to be successful, expanded and implemented as part of the APM track in line with the Agency’s authority.
- The College supports the concept of CMS using the PFPM pathway primarily (but not exclusively) to qualify payment models for physician and other healthcare professional specialties who are not eligible to broadly participate in current alternative payment models or models already under review or testing through CMMI.
- CMS should work collaboratively with medical societies and other organizations developing proposals to provide feedback on drafts and provide data up-front to help in modeling impacts. Furthermore, ACP encourages CMS to assist stakeholders through these processes in developing proposals that would qualify for the APM “bonus” payment contained in the statute.
- The College is particularly interested in the priority testing of the PCMH specialty practice model.

Technical Assistance to Small Practices and Practices in Health Professional Shortage Areas

- ACP recommends that CMS give consideration to the complexity of transforming to a value-based payment model and provide technical assistance to address identified needs specific to the practice setting.
- The College strongly recommends that CMS collaborate with the many specialty organizations—at the national, regional, and local levels—to use their established communication channels to provide a consistent message to their membership.

III. Detailed ACP Comments on the Request for Information

MIPS Eligible Professional (EP) Identifier and Exclusion

Background: CMS currently uses a variety of identifiers to associate an EP under different programs. For example, under the Physician Quality Reporting System (PQRS) for individual reporting, CMS uses a combination of a Taxpayer Identification Number (TIN) and National Provider Identifier (NPI) to assess eligibility and participation, where each unique TIN and NPI combination is treated as a distinct EP and is separately assessed for purposes of the program.

CMS will need to select and operationalize a specific identifier to associate with an individual MIPS EP or a group practice.

CMS Question: The Agency seeks comment on what specific identifier(s) should be used to appropriately identify MIPS EPs for purposes of determining eligibility, participation, and performance under the MIPS performance categories.

ACP Comments: **The College urges CMS to use existing identifiers with which physicians are already familiar.** Creating a new MIPS identifier would add to administrative burden. ACP recommends that CMS use a combination of TIN and NPI to identify EPs in MIPS.

The College also recommends that CMS decrease the burden on physicians by allowing them to validate and/or update their identifying information in the current Provider Enrollment, Chain, and Ownership System (PECOS) annually and not create a separate system.

Virtual Groups

Background: The Secretary is required to establish a process to allow an individual MIPS EP or a group practice of not more than 10 MIPS EPs to elect for a performance period for a year to be a virtual group with other such MIPS EPs or group practices. CMS quality programs, such as the PQRS, have used common identifiers such as a group practice's TIN to assess individual EPs' quality together as a group practice. The virtual group option under the MIPS allows a group's performance to be tied together even if the EPs in the group do not share the same TIN. CMS seeks comment on what parameters should be established for these virtual groups.

ACP Comments: In line with the principle of allowing for learning and innovation, **the College recommends that CMS ensure as much flexibility as possible in establishing a process to allow for MIPS EPs to elect to form a virtual group for a performance period.** This flexibility should be applied to:

- *The approaches that solo EPs and small group practices may use to decide how to join together.* Allowing different approaches may lead to greater validity and reliability of the data in the reporting process and facilitate collaboration toward more integrated and efficient care.
- *The number of virtual groups that can be formed in any given year.* Placing an arbitrary limit on the number of virtual groups that can be formed may prove detrimental to small practices and solo EPs who would be excluded from the virtual group option.
- *The size, location, and specialty mix of virtual groups.* In order to allow for the broadest participation in virtual groups, the College also opposes establishing a maximum or minimum size for virtual groups and restricting any virtual groups by specialty or geography.

Quality Performance Category

Background: There are two ways EPs can report under the PQRS, as either an individual EP or as part of a group practice, and for reporting periods that occur during 2015, there are collectively seven available mechanisms to report data to CMS as an individual EP and as a group practice participating in the PQRS Group Practice Reporting Option (GPRO). They are: (1) claims-based reporting; (2) qualified registry reporting; (3) Qualified Clinical Data Registry (QCDR) reporting; (4) direct EHR products; (5) EHR data submission vendor products; (6) Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS; and (7) the GPRO Web Interface. Generally, to avoid the PQRS payment adjustment, EPs and group practices are required to report for the applicable reporting period on a specified number of measures covering a specified number of National Quality Strategy domains. If data is submitted on fewer measures than required, an EP is subject to a Measure Applicability Validation (MAV) process, which looks across an EP's services to determine if other quality measures could have been reported.

ACP Comments: **The College strongly recommends that CMS actively work to improve the measures to be used in the quality performance category of MIPS. In the short term, ACP encourages CMS to consider adopting a core set of measures that are methodologically sound and Measure Applications Partnership (MAP)-endorsed for use in the MIPS and APM programs,** perhaps in line with the Brookings Institute recommendation quoted in italics below:

We recommend reducing the scope of reporting requirements for physicians under MIPS, which are built on existing requirements under PQRS, Meaningful Use, and the Value based Modifier. Instead, physicians in the MIPS program should be required to use patient experience and engagement measures at the individual physician level, as well as a limited number of core measures reflecting the patient conditions they treat. At present, physicians can generally use individual-level Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures; suitable outcome measures are not available for most specialties, but progress is occurring and should be accelerated. The measures should progress over time from appropriateness measures toward use of clinical outcome measures, patient-reported outcomes measures and total patient cost/resource use measures. Individual outcome measures should be used only for certain specialties and procedures/services in which it is feasible and appropriate to attribute the outcomes to a specific physician . . . We recommend that physicians in APMs be expected to measure a similar concise set of meaningful performance measures reflecting these same priorities: clinical outcomes, patient-reported outcomes, patient experience, and appropriateness. These key quality measures should be accompanied by total cost/resource use and efficiency measures. By 2018, such measures should reflect most of the patient care that they provide, as well as for care of their total patient population.³

³ <http://www.brookings.edu/~media/research/files/papers/2015/01/012715-medicare-physician-paymentreform-web.pdf>.

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

However, **over the longer term, it will be critically important for CMS to continue to improve the measures and reporting systems to be used in MIPS to ensure that they measure the right things, move toward clinical outcomes and patient experience, and do not create unintended adverse consequences.** A 2013 article by Berenson and Kaye,⁴ noted that “the current PQRS measures reflect a vanishingly small part of professional activities” and that there are currently many “overlooked aspects of physician performance that we would want to measure include[ing] making accurate diagnoses, avoiding overuse of diagnostic and therapeutic interventions, and caring for the growing number of patients with multiple chronic conditions and functional limitation.” The article also notes that patients care about “physicians’ confidence, empathy, humanity, personability, forthrightness, respect, and thoroughness” but that “available measures in PQRS and elsewhere are relevant to few of these professional qualities.” Improvements such as these must be made in an ongoing way as the MIPS program is implemented. The measurement targets must also remain patient centered and reflect potential differences in risk/benefit for specific populations. For example, targets for the frail elderly frequently differ from younger patients.

More recently, an article by McGlynn, Schneider, and Kerr⁵ states “that doing more of the same is misguided: the time has come to reimagine quality measurement.” The authors go on to lay out a set of goals for quality measurement, including that it should:

1. Be integrated with care delivery rather than existing as a parallel, separate enterprise;
2. Acknowledge and address the challenges that confront doctors every day — common and uncommon diseases, patients with multiple coexisting illnesses, and efficient management of symptoms even when diagnosis is uncertain;
3. Reflect individual patients' preferences and goals for treatment and health outcomes and enable ongoing development of evidence on treatment heterogeneity.

In the progression toward these goals, ACP is strongly supportive of filling the critical gaps in quality measurement; obtaining stakeholder input into the measure development process; and focusing on outcomes-based measures, patient and family experience measures, care coordination measures, and measures of population health and prevention. ACP also strongly

⁴ Berenson, Robert A. and Deborah R. Kaye. “Grading a Physician’s Value—The Misapplication of Performance Measurement.” *NEJM*. 2013. Accessed at: <http://www.nejm.org/doi/full/10.1056/NEJMp1312287>.

⁵ Elizabeth A. McGlynn, Ph.D., Eric C. Schneider, M.D., and Eve A. Kerr, M.D., M.P.H. “Reimagining Quality Measurement.” *N Engl J Med* 2014; 371:2150-2153. <http://www.nejm.org/doi/full/10.1056/NEJMp1407883>.

recommends electronic specification of the measures as one of the top considerations for filling measure gaps.

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

Additionally, it is critically important that the data collection and reporting burden related to the quality category (as with all of the MIPS categories) be minimized. Data collection should be driven by the needs of the physician and the patient at the point of care—with those data being reused for the purposes of reporting quality measures, as well as for quality improvement at the practice level. QCDRs can help significantly with reducing this burden—and their development and use should continue to be strongly encouraged by CMS. Payment, quality, public health, and other agencies should then have access to the appropriate data contained in these registries that are relevant to their needs.

Finally, related to the issue of data collection for quality measurement needing to be focused on the needs at the point of care and in line with the principle of ensuring that the new Medicare value-based payment approaches facilitate an ongoing learning health system, **ACP recommends that CMS work to ensure that performance measurement and reporting becomes increasingly patient-focused.** Particularly within a QCDR or other registry, the impact of patient characteristics on the effectiveness of an intervention should be tracked—such an approach will truly serve to put the patient at the center, not only of their health care, but of their health care quality.

Quality Performance Category: Reporting Mechanisms and Criteria

CMS Question: Should CMS maintain all PQRS reporting mechanisms currently available for MIPS?

ACP Comment: **CMS should begin MIPS with all current reporting options available in order to ease the transition.** The Agency then should move as quickly as feasible from measure reporting to registry reporting using specifications developed jointly with specialty societies. Acceptable registries could include QCDRs as well as other services that perform registry functions. This field is moving rapidly, and regulations should support and encourage innovation in this field.

CMS Question: Should we maintain the same or similar reporting criteria under MIPS as under the PQRS? What is the appropriate number of measures on which a MIPS EP's performance should be based?

ACP Comment: **The College believes that the current nine-measure reporting requirement is arbitrary and does not contribute to the delivery of effective and efficient care.** Currently, there are many specialties that realistically do not have nine applicable measures on which to report. Additionally, consideration should be given to measures that truly impact patient care and quality and should not be included solely to meet an arbitrary reporting threshold.

CMS Question: Should we maintain the policy that measures cover a specified number of National Quality Strategy domains?

ACP Comment: The College is supportive of the concept of National Quality Strategy (NQS) domains. However, **practices should be required to report only measures within any NQS domain that are truly applicable to their patient population.**

CMS Question: Should we require that certain types of measures be reported? For example, should a minimum number of measures be outcomes-based? Should more weight be assigned to outcomes-based measures?

ACP Comment: As is discussed earlier, the College is supportive of moving toward outcomes-based measures as well as those focused on patient and family experience, care coordination, and population health and prevention. However, **ACP does not recommend that CMS establish a minimum number of outcomes-based measures, at least initially. Rather, CMS could incentivize clinicians to report on outcomes-based measures by assigning them more weight within the MIPS program.**

CMS Question: Should CMS require that reporting mechanisms include the ability to stratify the data by demographic characteristics such as race, ethnicity, and gender?

ACP Comment: It is reasonable to seek the ability to stratify by fundamental, generally collected demographics such as race, age, and gender—as these data elements are typically considered relevant at the point of care. Attempting to go beyond these data elements will unnecessarily increase clinician workload without clear evidence of improving care quality or efficiency.

CMS Question: For the CAHPS for PQRS reporting option specifically, should this still be considered as part of the quality performance category or as part of the clinical practice improvement activities performance category? What consideration should be made as we further implement CAHPS for all practice sizes? How can we leverage existing CAHPS reporting by physician groups?

ACP Comment: **The College recommends that CMS remove CAHPS from the quality performance category and instead allow use of a CAHPS survey as one possible component of the clinical practice improvement activities performance category in the subcategory of beneficiary engagement.** As discussed earlier, ACP strongly agrees that evaluating patient experience is important to measure; however, the results of the data collected through CAHPS surveys are better suited to help practices determine practice improvements to make based on patient input (i.e., access to timely appointments and other information, communication with physicians and staff, etc.).

ACP would also like to note that there are several other methods for measuring patient experience including focus groups, comment cards, mystery shoppers, etc.; and while we recognize that these approaches do not have the same validity as the CAHPS survey, they are approaches that should be encouraged by CMS—possibly through inclusion as options within the clinical practice

improvement activities component—and their contributions to improved value should be evaluated over time.

Additionally, the term patient experience needs to be thoughtfully considered by CMS. It is a term that often appears in conjunction with the phrase “patient- and family-centered care.” The Beryl Institute describes patient experience as “the sum of all interactions, shaped by an organization’s culture, that influence patient perceptions across the continuum of care.”⁶ Other terms that are often used interchangeably with patient experience or patient- and family-centered are patient engagement and patient empowerment. Patient engagement is defined by the Center for Advancing Health as “actions individuals must take to obtain the greatest benefit from the health care services available to them.”⁷ Anderson and Funnell define patient empowerment as helping patients enhance and use their own innate ability to manage chronic conditions.⁸ Finally, related to all of these terms, but not typically used as interchangeably is “patient reported outcomes.” The confusion over these terms has therefore made it difficult for stakeholders to agree upon what patient- and family-centeredness truly is.

These differing terms also have an impact on performance measurement. Patient engagement, for example, could be measured by how often patients access a practice’s portal; however, this unfairly places accountability on the physician, without necessarily providing true benefit to the patient. Patient empowerment could be measured by a patient feeling ready to participate in a weight loss program—and this too could unfairly penalize a physician as this readiness is not fully under his/her control. Patient experience is typically measured by patient satisfaction (e.g. whether a patient liked the care they received), which is largely where the CAPHS survey is focused. Often, all of the components cited above are included when one talks about patient experience performance measures. All of these issues are important, but greater clarity is needed in terms of what and how each component is captured and used, with a strong eye toward identifying any unintended consequences that are not aligned with improving quality within a learning health care system.

CMS Question: How do we apply the quality performance category to MIPS EPs that are in specialties that may not have enough measures to meet our defined criteria? Should we maintain a Measure-Applicability Verification Process (MAV)? If we customize the performance requirements for certain types of MIPS EPs, how should we go about identifying the MIPS EPs to whom specific requirements apply?

ACP Comment: **ACP recommends that a process be developed to determine in advance of the reporting year which quality measures are likely applicable to the EP.** Perhaps this could be done through an analysis of the previous year’s claims data. The College strongly believes that EPs

⁶ <http://www.theberylinstitute.org/?page=Mission>

⁷ Center for Advancing Health. “A New Definition of Patient Engagement: What Is Engagement and Why Is It Important?” 2010. Accessed at: http://www.cfah.org/pdfs/CFAH_Engagement_Behavior_Framework_current.pdf

⁸ Funnell MM, Anderson RM, Arnold MS, Barr PA, Donnelly M, Johnson PD, Taylor-Moon D, White NH.

“Empowerment: an idea whose time has come in diabetes education.” *Diabetes Educ.* 1991 Jan-Feb; 17(1):37-41.

should not be vulnerable to situations where they are penalized after the fact for measures they were unaware that they could report on.

If CMS maintains the MAV process and this process determines that MIPS EPs could not report on enough quality measures to meet an arbitrary number of required measures, more weight should be assigned to the remaining reporting categories in order to account for the difference.

CMS Question: What are the potential barriers to successfully meeting the MIPS quality performance category?

ACP Comment: As is discussed extensively above, it is critically important that CMS continue to improve the measures and reporting systems to be used in MIPS to ensure that they measure the right things, moving toward clinical outcomes and patient experience, and do not create unintended adverse consequences. The College agrees that time has come to truly reimagine quality measurement. Critical gaps in quality measurement must be filled with a focus on outcomes-based measures, patient and family experience measures, care coordination measures, and measures of population health and prevention. ACP also strongly recommends electronic specification of the measures as one of the top considerations for filling measure gaps.

Another significant barrier is the data collection and reporting burden related to the quality category (as with all of the MIPS categories). Data collection should be driven by the needs of the physician and the patient at the point of care—with those data being reused for the purposes of reporting quality measures.

Quality Performance Category: Data Accuracy

CMS Question: Should registries and qualified clinical data registries be required to submit data to CMS using certain standards, such as the Quality Reporting Document Architecture (QRDA) standard, which certified EHRs are required to support?

ACP Comment: **Yes, QCDRs should be required to submit data to CMS using QRDA today, and CMS should be preparing all of its systems to support emerging standards in the near future, such as Fast Healthcare Interoperability Resources (FHIR).**

CMS Question: Should CMS require that qualified registries, QCDRs, and HIT systems undergo review and qualification by CMS to ensure that CMS' form and manner are met? (E.g., CMS uses a specific file format for qualified registry reporting. The current version is available at: <https://www.qualitynet.org/imageserver/pqrs/registry2015/index.htm>. What should be involved in the testing to ensure CMS' form and manner requirements are met?

ACP Comment: CMS and the Office of the National Coordinator for Health IT (ONC) should come to agreement on testing requirements and processes for all systems used in quality reporting. EHRs can be certified using these criteria, and other systems can be tested and qualified using precisely the same criteria. CMS should not establish any testing criteria beyond this jointly agreed upon

set. As an additional way to improve conformance, CMS should develop more robust implementation guides and enhance its validation tools.

CMS Question: What feedback from CMS during testing would be beneficial to stakeholders?

ACP Comment: **The College recommends that CMS provide feedback on errors in a detailed, informative, and actionable manner.**

CMS Question: Should CMS not require MIPS EPs to submit a calculated performance rate (and instead have CMS calculate all rates)?

ACP Comment: We would support this approach, but we note that most vendors will compute performance rates pursuant to provider-client's wishes to see them ahead of their submission time or alongside submission to CMS.

CMS Question: If a QCDR omits data elements that make validation of the reported data infeasible, should the data be discarded? What threshold of errors in submitted data should be acceptable?

ACP Comment: The College cannot offer a recommendation to this question, as we believe the answer will be variable depending on the nature of the error. At a minimum CMS needs to supply an error report, including specific information on which files were rejected and why they were rejected, and allow for data to be resubmitted.

CMS Question: If CMS determines that the MIPS EP (individual EP or as part of a group practice or virtual group) has used a data reporting mechanism that does not meet CMS data integrity standards, how should CMS assess the MIPS EP when calculating their quality performance category score? Should there be any consequences for the qualified registry, QCDR or EHR vendor in order to correct future practices? Should the qualified registry, QCDR or EHR vendor be disqualified or unable to participate in future performance periods? What consequences should there be for MIPS EPs?

ACP Comment: **The College strongly recommends that there should be no consequences for EPs who contract to use a data service for reporting purposes in good faith and who submit data as required.** If a QCDR or vendor fails to supply accurate data, then a standard process must be followed to potentially remove the entity from future participation—a process that also takes into account any unintended consequences on the EPs that use this vendor.

Quality Performance Category: Use of CEHRT

CMS Question: Under the MIPS, what should constitute use of CEHRT for purposes of reporting quality data?

Instead of requiring that the EHR be utilized to transmit the data, should it be sufficient to use the EHR to capture and/or calculate the quality data? What standards should apply for data capture and transmission?

ACP Comment: As a matter of general principle, if the quality data are compiled (recorded, calculated, etc.) using certified technology and the reporting requirements are built to only accept data compiled in a standardized way, then it should not matter if the submission technology is certified. Likewise, if the data are not compiled in a standardized way, but can be made standard through certified technology before submission, and meet the requirements set by CMS, then this should be acceptable.

In short, if certified technology is used during the recording, calculation, reporting, importing or exporting of quality data – and the data can be accepted by CMS – the requirement to use CEHRT should be satisfied.

Resource Use Performance Category

Background:

The resource use performance category under MIPS is described as the measurement of resource use for such period, using the methodology as appropriate, and, as feasible and applicable, accounting for the cost of drugs under the Medicare Prescription Drug Program (Part D). Costs shall be evaluated, to the extent practicable, based on a composite of appropriate measures of costs for purposes of the VM under the PFS. The Secretary must go through a series of steps and deliverables to develop “care episode and patient condition groups and classification codes” and “patient relationship categories and codes” for purposes of attribution of patients to clinicians, and provides for the use of these in a specified methodology for measurement of resource use. Under the MIPS, the Secretary must evaluate costs based on a composite of appropriate measures of costs using the methodology for resource use analysis specified that involves the use of certain codes and claims data and condition and episode groups, as appropriate. CMS’ experience under the VM will help shape this performance category. Currently under the VM, CMS uses the following cost measures: (1) Total Per Capita Costs for All Attributed Beneficiaries measure; (2) Total Per Capita Costs for Beneficiaries with Specific Conditions (Diabetes, Coronary artery disease, Chronic obstructive pulmonary disease, and Heart failure); and (3) Medicare Spending per Beneficiary (MSPB) measure.

ACP Comment: The current approaches used by CMS to determine episode-based costs are fraught with problems in terms of attribution, variation for low frequency events, variation in results with different methodologies, and placing an undue burden upon primary care physicians in contrast to other specialties. Therefore, the concept of CMS developing care episode and patient-condition codes was included in the MACRA legislation in order to more directly involve the public and clinicians in the process of resource use measurement—an approach that ACP supports. Further, the development of these additional processes is intended to address concerns that current algorithms and patient attribution rules fail to accurately link the cost of services to a clinician and are not appropriate to compare peer groups within specialty alone. **Additional**

modifying factors, including geography, site of service (e.g., facility v. outpatient), size of the physician/clinician group, sub specializations within subspecialties, etc. also need to be considered by CMS when measuring resource use to ensure that comparisons are truly between groups of like peers. Therefore, as the legislation intended, the College strongly recommends that CMS work with specialty societies to improve the granularity for these comparisons.

CMS Question: How should we incorporate Part D drug costs into MIPS? How should this be measured and calculated?

ACP Comments: The College recommends that CMS not include Part D drug costs, at least initially, and then work with specialty societies to modify the cost attribution for drug costs to ensure that the cost calculation does not unfairly disadvantage certain EPs or cause undue cost burden on beneficiaries. For certain drugs (i.e., biologics) that are covered under both Parts B and D, the resource costs for Part B drugs that are incurred by EPs are significant even though the out-of-pocket costs associated with the drugs for the beneficiary are lower than they are under Part D. The higher out-of-pocket costs to the beneficiary for these Part D drugs serve as a barrier for many beneficiaries that keeps them from accessing Part D drugs. ACP recommends that CMS modify the drug cost attribution structure to ensure that beneficiaries have access to the best quality care rather than having these decisions be based on cost.

Clinical Practice Improvement Activities Performance Category

Background: The measures and activities for the clinical practice improvement activities performance category must include at least the following subcategories of activities: expanded practice access, population management, care coordination, beneficiary engagement, patient safety and practice assessment, and participation in an APM. The Secretary has discretion under this provision to add other subcategories of activities as well. The term “clinical practice improvement activity” is defined as an activity that relevant EP organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes. In this RFI, we seek comment on other potential clinical practice improvement activities (and subcategories of activities), and on the criteria that should be applicable for all clinical practice improvement activities.

ACP Comments: First and foremost, ACP would like to reiterate our appreciation that Congress recognized the value of the Patient-Centered Medical Home (PCMH) by mandating in MACRA that PCMHs and PCMH specialty practices receive full credit for the clinical practice improvement activities performance category. **Therefore, the College recommends that CMS begin considering and seeking feedback on the specific approaches that the Agency will employ to recognize PCMHs and PCMH specialty practices under both the MIPS and Alternative Payment Model (APM) tracks in the future—something that was not specifically inquired about within this RFI.** Along these lines, ACP believes that multiple pathways to PCMH or PCMH specialty practice should qualify to achieve full credit in this category, including certification as a PCMH through a national recognition or accreditation program; by a private payer and/or state government program,

including state Medicaid programs; as well as those developed by national specialty societies, state medical societies, county medical societies, community-based physician groups, or other entities as deemed appropriate.

In assessing the performance of EPs on clinical practice improvement activities, the College urges CMS to ensure that administrative burden associated with documentation of the activities, as well as the cost of performing the activities and submitting documentation is minimal and constructed to be extremely flexible in the early years as the Agency and the participating clinicians gain experience with this new reporting category.

CMS should use existing data whenever possible to verify EPs completion of clinical practice improvement activities. The College recommends that CMS work with specialty societies to deem their relevant programs as meeting the requirements of MIPS, and CMS should accept society-supplied records as evidence of completion of appropriate activities with no additional burden on EPs to report completion of clinical practice improvement activities to CMS. Practice improvement is generally well defined and understood by practices and by their specialty societies, which have developed mature programs focused on the needs of the specialty. By allowing specialty societies to report completion of clinical practice improvement activities by their members, CMS can both minimize the reporting burden on EPs and allow societies to develop practice improvement activities that are better tailored to the unique needs of their specialty members. The College recommends that EPs should be able to work with their specialty societies and boards to determine appropriate clinical practice improvement activities, report appropriate levels of participation in those activities, and also establish appropriate validation of completion.

Additionally, any practice participating in practice improvement activities under CMMI-sponsored models such as the Transforming Clinical Practices Initiative (TCPI) and the State Innovation Models (SIM) should automatically get full credit for the clinical practice improvement activities category, and no further reporting by the practice should be necessary. CMMI should report to CMS on which practices are participating in these models.

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

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

- Documented preventive screenings and vaccinations;
- Participation in quality improvement programs such as Bridges to Excellence;

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

CMS Question: What threshold or quantity of activities should be established under the clinical practice improvement activities performance category? For example, should performance in this category be based on completion of a specific number of clinical practice improvement activities, or, for some categories, a specific number of hours? If so, what is the minimum number of activities or hours that should be completed? How many activities or hours would be needed to earn the maximum possible score for the clinical practice improvement activities in each performance subcategory? Should the threshold or quantity of activities increase over time? Should performance in this category be based on demonstrated availability of specific functions and capabilities?

ACP Comment: **Consistent with the guiding principle of a learning health and health care system outlined at the beginning of this letter, ACP would recommend that CMS not initially establish overly prescriptive thresholds or quantities of activities.** The clinical practice improvement activity category, in particular, should be used to gain a better understanding of exactly what activities—and in what quantity—truly contribute to increasing value. Practices should in no way be penalized if they are taking on activities in good faith and with a goal of quality improvement and should, in fact, be encouraged to take on innovative approaches that “count” in order to further the goal of learning. Until the Agency and the practices, working together with ongoing interaction with specialty societies, are better able to determine their capacity for conducting, documenting, and quantifying these activities (and their impact on value) in the most effective and efficient manner, greater flexibility should be applied.

However, **given that the PCMH and PCMH specialty practice are two models that are designated by statute to achieve the highest score, CMS should look closely at the activities that have been consistently identified as components of those models and consider giving them more weight.** This approach would serve to incentivize movement toward achievement of these more comprehensive models over time. Some examples of these activities include setting up a system for after-hours patient care, engaging in shared decision-making approaches⁹, using high-value care coordination resources¹⁰, and adopting specific population health management approaches¹¹.

An additional consideration with regard to the number of activities or hours that should be completed—if CMS determines that some level of specificity is needed—is that the Agency must take into account the size, structure, location, and patient population of the practices. Practices of greater size and/or organization will likely have significantly increased ability to take on a larger number of activities; whereas smaller, independent, and rural practices will be significantly

⁹ <http://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/index.html>.

¹⁰ https://hvc.acponline.org/physres_care_coordination.html.

¹¹ <https://www.pccpc.org/resource/managing-populations-maximizing-technology>.

hampered in this regard, particularly if their patient populations include those with multiple chronic conditions.

Meaningful Use of EHRs Performance Category

Background: The measures and activities for the meaningful use of certified EHR technology (CEHRT) performance category under the MIPS are the requirements established under in Medicare for determining whether an EP is a meaningful EHR user of CEHRT. In MACRA, 25 percent of the composite performance score under the MIPS must be determined based on performance in the meaningful use of certified EHR technology performance category. The Secretary has the discretion to reduce the percentage weight for this performance category (but not below 15 percent) in any year in which the Secretary estimates that the proportion of EPs who are meaningful EHR users is 75 percent or greater, resulting in an increase in the applicable percentage weights of the other performance categories. CMS seeks comment on the methodology for assessing performance in this performance category. Additionally, CMS notes that the Agency is only seeking comments on the outpatient departments, except in the case of items and services furnished by emergency physicians, radiologists, and anesthesiologists. CMS seeks comment on how to could best use this authority.

ACP Comment: **ACP urges CMS to avoid the use of process measures in Meaningful Use without a reexamination of their clinical value and appropriateness.** It is not appropriate to require process measures in all circumstances, and physicians should not be required to perform activities that are not clinically appropriate and desired by the patient. If a physician is using a certified EHR system to report patient data to a specialty registry, provide appropriate data to patients and other clinicians according to the receiver's preferences, and incorporate appropriate data from external sources, nothing more needs to be required.

CMS should reduce burden to EPs while, at the same time, push harder to improve the quality and value of EHRs and other health IT. The certification process should be improved by removing the requirements to collect data for process measures and increasing their ability to perform clinical tasks that doctors and patients need, such as support for care coordination and shared decision-making. Our more specific comments include:

- The use of thresholds in MU measures is not an appropriate way of determining successful performance. At this point in MU, the value of counting the number of times specified process activities are performed should not be for measuring compliance to a threshold, but rather for supplying information to the learning health care system that the MU program should support. In that fashion, MU can lead to a legacy of embedded and continuous learning, rather than an inflexible and overly prescriptive set of process measures.
- A major concern with the public reporting requirements (both public health and clinical reporting) is that, with the exception of immunizations, they are all one-way in terms of data and information sharing. EPs and Eligible Hospitals (EHs) must collect and supply data to target agencies, but there is no requirement for these agencies to report back to the EPs

and EHs. The definition of “active engagement” must be expanded to require that all health data exchanges be bidirectional. Otherwise, these reporting measures demonstrate clerical data entry rather than meaningful use. Patients and their doctors will benefit greatly from requirements that public health agencies report back in a timely manner and with meaningful data, such as intelligence about what is happening in the community.

- ACP is also concerned that there is an expectation that public health reporting will require duplicative documentation in an electronic form, rather than the reporting system accepting the export of a Summary of Care Document (SoCD). In order to decrease the public health reporting burden, all public health authorities must be compelled to coordinate and simplify reporting requirements.

CMS Question: Should the performance score for this category be based solely on full achievement of meaningful use? (For example, an EP might receive full credit (e.g., 100 percent of the allotted 25 percentage points of the composite performance score) under this performance category for meeting or exceeding the thresholds of all meaningful use objectives and measures; however, failing to meet or exceed all objectives and measures would result in the EP receiving no credit (e.g., zero percent of the allotted 25 percentage points of the composite performance score) for this performance category).

ACP Comment: **ACP strongly recommends that CMS transform MU from an all-or-nothing scoring system to a partial scoring system, with more points available for completion of an increasing number of activities, as was the intent of Congress in enacting MACRA.**

CMS Question: What alternate methodologies should CMS consider for this performance category?

ACP Comment: As is indicated above, **CMS should remove arbitrary thresholds from all objectives.** Successful reporting of each objective, no matter what the numerator is, should count as success for that objective. The goal should be 100 percent reporting from all EPs, even if they report a zero numerator on particular measures. Due to the threshold requirements, CMS only gets data from the relatively few successful attesters and is therefore not able to learn anything from those who failed to attest. If thresholds were not required, data would be available from far more practices. These data could provide volumes of information about what works, what does not work well, and what are possible causes of variation.

CMS Question: How should hardship exemptions be treated?

ACP Comment: **ACP recommends that hardship exemptions be based on lack of ability to perform specific functions, whether due to system defect, unavailability of an exchange partner, or any other cause beyond the EP’s control.** EPs who are granted hardship exemptions should be counted as successfully completing that component of the MU program. For example, if an EP is unable to report public health measures and is awarded a hardship exemption for this function, the EP would receive the points allotted to this function in the MU program.

Other Measures for Quality and Resource Use

Background: CMS is seeking comments on other measures that should be included in the quality and resource use performance categories including hospital inpatient quality measures, global and population-based measures, and measures for non-patient-facing EPs.

CMS Question: What types of measures (that is, process, outcomes, populations, etc.) used for other payment systems should be included for the quality and resource use performance categories under the MIPS?

ACP Comment: ACP recommends using all types of measures and that the measures should have, at a basic level, parity between settings. Initial use of basic Healthcare Effectiveness Data and Information Set (HEDIS) and process measures may be beneficial to include during the early years of the MIPS implementation process because clinicians are already familiar with these measures.

CMS Question: How could CMS leverage measures that are used under the Hospital Inpatient Quality Reporting Program, the Hospital Value-Based Purchasing Program, or other quality reporting or incentive payment programs? How should we attribute the performance on the measures that are used under other quality reporting or value-based purchasing programs to the EP?

ACP Comment: As referenced in our earlier comments, the College recommends that CMS consider adopting a core set of measures that are methodologically sound and can be utilized across all federal programs as well as by private payers such as those measures that are pending approval through the AHIP Core Quality Measures Collaborative. Additionally, CMS should use a TIN/NPI identifier to reflect performance on the measures used under other quality reporting programs

CMS Question: What types of global and population-based measures should be included under MIPS? How should we define these types of measures?

ACP Comment: The College recommends that CMS consider including in MIPS measures that are focused on health and well-being, chronic conditions, preventive services, care coordination, patient safety, infection control, and re-hospitalization. CMS should consider a measure's likelihood to contribute to progress, interoperability, and utility in multiple clinical settings when selecting measures.

Global and population-based measures are difficult to define while considering the heterogeneity of service availability between low and higher income areas/HPSAs vs non-HPSAs. However, these could include process measures for high quality evidence. ACP hopes that future research can look at the effect on other time-sensitive interventions and surgeries to see how similar networks can improve time to care (such as time to thrombolytics, time to hip fracture repair, time to completion of the Surviving Sepsis bundles, etc). State-based registries for immunizations and

reporting data from practices and hospitals could provide this information, but these are not presently easily accessible sources of data.

Development of Performance Standards

Background: In establishing performance standards with respect to measures and activities for the MIPS performance categories, the Secretary is required to consider: historical performance standards, improvement and the opportunity for continued improvement.

ACP Comments: The College recommends that CMS compare EPs to peer groups based on specialty and regional variations. The Agency should also consider additional modifying factors including site of service (e.g., facility v. outpatient), sub specializations within subspecialties, etc. to ensure that comparisons are truly between groups of like peers. The College encourages CMS to work with specialty societies to improve the granularity for these comparisons.

ACP also recommends that CMS stabilize benchmarks for at least two years at a time to ensure that EPs are not caught in a system that is constantly in flux. Setting a performance threshold that is constantly moving leaves EPs little opportunity to predict where the benchmark will be set and make improvements in performance accordingly. However, CMS should retain the ability to lower the benchmark in a year where it should have remained stable if it appears that a substantial number of EPs will fall below the benchmark in the prior year so that EPs are not adversely impacted by a benchmark that was set too high.

The College urges CMS to take into account risk factors when determining performance standards. The Agency should release clear guidance on what the risk adjustment factors are that CMS is evaluating and how the risk factors are being applied. The risk adjustment criteria should be released sufficiently in advance to give EPs an opportunity to comment before the risk adjustment factors are finalized and implemented.

Flexibility in Weighting of Performance Categories

Background: If there are not sufficient measures and activities applicable and available to each type of EP, the Secretary is required to assign different scoring weights (including a weight of zero) from those that apply generally under the MIPS. The total possible composite performance score must still add up to 100.

CMS Question: Are there situations where certain EPs could not be assessed at all for purposes of a particular performance category? If so, how should we account for the percentage weight that is otherwise applicable for that category? Should it be evenly distributed across the remaining performance categories? Or should the weights be increased for one or more specific performance categories, such as the quality performance category?

ACP Comment: There are situations where EPs will not be able to be assessed on performance in a performance category. However, the College can provide no definitive answer on how to handle

these situations. We provide two options for consideration. One would be to evenly distribute the weight across the remaining performance categories. A second possible approach would be to give a score equal to the average score achieved by EPs in the performance category that could not be assessed.

CMS Question: Generally, what methodologies should be used as we determine whether there are not sufficient measures and activities applicable and available to types of EPs such that the weight for a given performance category should be modified or should not apply to an EP? Should this be based on an EP's specialty? Should this determination occur at the measure or activity level, or separately at the specialty level?

CMS Question: What case minimum threshold should CMS consider for the different performance categories?

ACP Comment: ACP cannot give a definitive response to this question; however, we recommend that CMS gather data working with private insurance plans to see if there is evidence to determine minimum thresholds.

CMS Question: What safeguards should we have in place to ensure statistical significance when establishing performance thresholds? For example, under the VM one standard deviation is used. Should we apply a similar threshold under MIPS?

ACP Comment: It may be difficult to determine physician and other EP attribution within this new system, and, therefore, the College recommends that the threshold should be wide—perhaps using two standard deviations may be a better way to account for potential inaccuracies of this system.

Composite Performance Score

Background: The Secretary is required to develop a methodology for assessing the total performance of each MIPS EP based on performance standards with respect to applicable measures and activities in each of the four performance categories. The methodology is to provide for a composite assessment for each MIPS EP for the performance period for the year using a scoring scale of 0 to 100. The Secretary is required to compute a performance threshold to which the MIPS EP's composite performance score is compared for purposes of determining the MIPS adjustment factor for a year. The performance threshold must be either the mean or median of the composite performance scores for all MIPS EPs with respect to a prior period specified by the Secretary.

CMS Question: For the quality and resource use performance categories, should we use a methodology (for example, equal weighting of quality and resource use measures across National Quality Strategy domains) similar to what is currently used for the VM?

ACP Comment: As discussed earlier, the College is supportive of the concept of National Quality Strategy domains. However, practices only should be required to report measures within any NQS

domain that are truly applicable to their patient population. CMS needs to further investigate and provide more evidence and background information on the weighting for the National Quality Strategy domains that has been used to date and whether these weights have been perceived as valid.

CMS Questions: How should we use the existing data on quality measures and resource use measures to translate the data into a performance threshold for the first two years of the program?

What minimum case size thresholds should be utilized? For example, should we leverage all data that is reported even if the denominators are small? Or should we employ a minimum patient threshold, such as a minimum of 20 patients, for each measure?

ACP Comment: ACP recommends that to establish thresholds for the first two years, the sample size should be large enough to demonstrate meaningful differences between clinicians. The 20 patient minimum is not well validated. ACP supports cautiously employing a 20 patient minimum threshold, however, CMS should further investigate and provide more evidence to support minimum threshold validity. Additionally, patient populations should be stratified in well-defined risk groups to provide accurate comparisons. The College emphasizes the importance of physicians and other health care professionals having timely access to performance information, including the thresholds that will be used, and given a fair chance to examine and appeal potential inaccuracies in advance.

Public Reporting on Physician Compare

Background: CMS is seeking comments on thresholds for public reporting of MIPS quality measures on the Physician Compare website as well as the reporting of data that is stratified.

CMS Question: Should CMS include individual EP and group practice-level quality measure data stratified by race, ethnicity and gender in public reporting (if statistically appropriate)?

ACP Comment: ACP believes that including quality measure data that is stratified by race, ethnicity, and gender could be important to share for health equity purposes. However, we are concerned that the data may not be appropriately adjusted for socioeconomic factors. This type of data should only be included in public reporting if it can be measured fairly and presented in a way that consumers can understand.

Feedback Reports

Background: Beginning July 1, 2017, the Secretary is required to provide confidential feedback on performance to MIPS EPs. Specifically, we are required to make available timely confidential feedback to MIPS EPs on their performance in the quality and resource use performance categories, and we have discretion to make available confidential feedback to MIPS EPs on their performance in the clinical practice improvement activities and meaningful use of certified EHR

technology performance categories. This feedback can be provided through various mechanisms, including the use of a web-based portal or other mechanisms determined appropriate by the Secretary.

ACP Comments: **CMS should make feedback reports available as frequently as possible, quarterly at a minimum but working toward monthly reports as soon as possible.** Receiving data more than six months after it is reported, as is currently done with the QRURs, has little value to physicians and impedes their ability to use the data to make necessary changes to their practice to improve the quality of care for their patients.

Additionally, all EPs should have a customizable dashboard available in their system that is refreshed with data from all reporting sources on a daily basis. CMS can look to what many private payers have already done with dashboards as examples of how to design dashboards that include usable and useful data that is available on demand for physicians. All available information should be available to the EP by query to an open API.

The College urges CMS to include patient-level data in feedback reports and accessible from the dashboard. Having access to patient-level data allows EPs to drill down and determine patients who are outliers and may require additional care or follow-up. Additionally, including a list of patients that are attributed to the EP/practice is important to include in any data made available to physicians.

For the clinical practice improvement activities and meaningful use of certified EHR technology performance categories, ACP recommends that EPs should be alerted to the potential applicability of each activity to any given patient at the time of care or at any other time chosen by the EP.

Also, the College believes that it is reasonable for practices to provide some demographic data for stratification purposes. However, ACP is concerned that the data requirements must be truly the minimum necessary and easy for practices to collect. As with many of the components of MIPS, this activity should begin simply, using existing classifications, and submissions should be monitored carefully for indications of problems with accuracy or excessive burden.

Alternative Payment Models

Background: An EP may be determined to be a Qualifying Participant in APM (QP) through:

- (1) beginning for 2019, a Medicare payment threshold option that assesses the percent of Medicare Part B payments for covered professional services in the most recent period that is attributable to services furnished through an eligible alternative payment model (EAPM) entity; or
- (2) beginning in 2021, either a Medicare payment threshold option or a combination all-payer and Medicare payment threshold option. The combination all-payer and Medicare payment threshold option assesses both: (1) the percent of Medicare payments for covered professional services in the most recent period that is attributable to services

furnished through an EAPM entity; and (2) the percent of the combined Part B Medicare payments for covered professional services attributable to an EAPM entity and all other payments made by other payers made under similarly defined arrangements (except payments made by the Department of Defense or Veterans Affairs and payments made under Medicaid in a state in which no medical home or alternative payment model is available under the State program).

These arrangements must be arrangements in which:

- (1) quality measures comparable to those used under the MIPS apply;
- (2) certified EHR technology is used; and
- (3) either the entity bears more than nominal financial risk if actual expenditures exceed expected expenditures or the entity is a medical home under Title XIX (Medicaid) that meets criteria comparable to medical homes expanded under section 1115A(c) (CMMI).

ACP Comment: The College strongly supports the transition towards value-based payments within traditional Medicare and through APMs and further supports efforts by CMS to develop multiple pathways for physicians and other health care professionals to qualify for these payments. Towards this goal, **ACP encourages the development of a regulatory framework that encourages innovation (i.e., is not overly prescriptive); recognizes the unique aspects of the various medical specialties including the services provided and the populations served; and is sensitive to the substantial financial and human equity costs required to succeed within this new payment environment.** ACP's comments on APMs attempt to be consistent with the above framework.

Payment Incentive for APM Participation

Background: For 2019 – 2024, EPs who meet the thresholds to be considered a QP for APMs are eligible for a five percent incentive payment. The statute also specifies that partial qualifying participants are those who would be QPs if the threshold payment percentages for the year were lower (i.e., 20 percent instead of 25 percent, 40 percent instead of 50 percent). Partial QPs are not eligible for incentive payments for APM participation. Partial QPs who, for the MIPS performance period for the year, do not report applicable MIPS measures and activities are not considered MIPS EPs. Partial QPs who choose to participate in MIPS are considered MIPS EPs and will be subject to payment adjustments under MIPS.

CMS is seeking comments to help establish criteria and a process for determining whether an EP is a QP or partial QP.

ACP Comment: The College recommends that CMS use already existing identifiers (i.e., NPIs, TINs) in the process of determining whether an EP is a QP or partial QP and avoid establishing new identifiers whenever possible. Given that the transition from fee-for-service Medicare to APMs requires practices to undergo significant changes, maintaining the use of identifiers that the physician community already understands is important. Using existing identifiers will avoid the administrative burden associated with introducing new elements within their practice infrastructure.

ACP recommends that CMS allow for de minimis variance when determining whether an EP meets any threshold requirement (i.e., thresholds for determining qualifying and partial qualifying APM participants). For example, if a 25 percent threshold is required to be considered a QP, an EP should be considered to have met the requirement if he/she can document achieving at least 23 percent rather than 25 percent). This recognizes the inherent inaccuracy of any revenue aggregation approach that is implemented and ensures that any small variation in an EP's patient population from year to year would not penalize the EP. Allowing de minimis variance when meeting thresholds would be in line with the de minimis range of +/- 2 percent that HHS allows for when calculating whether a plan meets the actuarial value targets for qualified health plans in the exchanges.

Patient Approach

Background: In determining APM participation, the Secretary has the authority to use percentages of patient counts in lieu of percentages of payments to determine whether an EP is a QP or partial QP.

ACP Comment:

The College recommends that all qualifying and partial qualifying APM participants have the option to choose between threshold service calculations based upon revenue or patient counts. This will allow EPs to select the approach that best suits their unique situation.

Nominal Financial Risk

Background: Eligible APM entities must either bear financial risk of monetary losses under an APM that are in excess of a nominal amount or be a medical home that is expanded under CMMI authority in section 1115A(c). CMS seeks comments on the types of financial risk that should be considered an appropriate level of financial risk to be in excess of a nominal amount.

ACP Comment: **The College recommends that CMS expand its definition of nominal financial risk to include recognition of non-billable costs that are currently overlooked (e.g., start-up and maintenance costs, and lost revenue to a system resulting from efforts to reduce unnecessary utilizations).** The definition of risk should not solely be based from the CMS perspective (e.g., on CMS-determined losses compared to a historic or regional benchmark), but also on the actual capital the entity has at risk. One concrete result of this recommendation would be allowing Track One Medicare Shared Savings Programs (MSSPs) to qualify as APMs, recognizing that the costs (capital outlays) are particularly onerous in the early years. According to data from CMS and that National Association of Accountable Care Organizations (NAACOs), MSSP start-up costs on average are between \$1.8 – 2.0 million. ACP is concerned that the very narrow definition of risk being employed by CMS in its current projects would significantly limit physician participation within APM under MACRA.

Medicaid: Medical Homes and Other State APMs

Background: In determining whether EPs meet the combination all-payer and Medicare APM threshold, the non-Medicare APM must either be an entity that bears more than nominal financial risk if actual expenditures exceed expected expenditures or an entity is a medical home under Title XIX (Medicaid) that meets criteria comparable to medical homes expanded under section 1115A(c) (CMMI). CMS seeks comments on criteria for determining which Medicaid medical homes should qualify as APMs by meeting criteria similar to the CMMI medical home expansion criteria.

ACP Comments: **The College supports the inclusion of Medicaid-recognized medical homes as eligible APM entities based on their comparability to medical homes expanded under the CMMI authority.** Sources that the Secretary can use to establish comparability between Medicaid and CMMI expanded medical home models include the Joint Principles of the Patient-Centered Medical Home¹² and the key functions required by participants within the Comprehensive Primary Care (CPC) initiative.

Eligible APM Requirements

Background: An eligible alternative payment model (EAPM) entity is defined as an entity that

- (1) participates in an APM that requires participants to use certified EHR technology (as defined in Medicare) and provides for payment for covered professional services based on quality measures comparable to measures under the performance category quality performance category); and
- (2) bears financial risk for monetary losses under the APM that are in excess of a nominal amount or is a medical home expanded under section 1115A(c) (CMMI).

CMS Question: What entities should be considered EAPM entities?

ACP Comment: **The College recommends that CMS employ a very broad definition of entities that should be considered EAPM entities as a means to promote innovation and recognize the heterogeneity of services and clinicians covered under Medicare.** Entities to consider should include single and multi-specialty practices without limit in size of practice; independent practice associations (IPAs); clinically integrated networks; accountable care organizations (ACOs); health systems; critical access hospitals; rural hospital centers; and federally qualified health center (FQHCs).

Quality Measures

CMS Questions: What criteria could be considered when determining “comparability” to MIPS of quality measures used to identify an EAPM entity? Please provide specific examples for measures,

¹²

https://www.acponline.org/running_practice/delivery_and_payment_models/pcmh/demonstrations/jointprinc_05_17.pdf

measure types (for example, structure, process, outcome, and other types), data source for measures (for example, patients/caregivers, medical records, billing claims, etc.), measure domains, standards, and comparable methodology.

What criteria could be considered when determining “comparability” to MIPS of quality measures required by a non-Medicare payer to qualify for the Combination All-Payer and Medicare Payment Threshold? Please provide specific examples for measures, measure types, (for example, structure, process, outcome, and other types), recommended data sources for measures (for example, patients/caregivers, medical records, billing claims, etc.), measure domains, and comparable methodology.

ACP Comments: **ACP recommends that selection of quality measures for an APM should be based on the goals and design of the specific APM and harmonized with those measures being used within the MIPS program—as well as across the multiple payers that are anticipated would be involved with APMs.** Along those lines, ACP encourages CMS to consider adopting a core set of measures that are methodologically sound and MAP-endorsed for use in the MIPS and APM programs—with consideration given to those that are expected to be identified through the AHIP coalition. It is critically important that quality measure reporting for an APM be no more burdensome than under MIPS. Further, as was recommended earlier, ACP is strongly supportive of filling the critical gaps in quality measurement; obtaining stakeholder input into the measure development process; focusing on outcomes-based measures, patient and family experience measures, care coordination measures, and measures of population health and prevention. ACP also strongly recommends electronic specification of the measures as one of the top considerations for filling measure gaps.

Use of Certified EHR Technology

CMS Question: What components of certified EHR technology as defined in Medicare should APM participants be required to use? Should APM participants be required to use the same certified EHR technology currently required for the Medicare and Medicaid EHR Incentive Programs or should CMS other consider requirements around certified health IT capabilities?

ACP Comment: **The College strongly recommends that certified EHR requirements for APMs be viewed as separate from requirements included under the Meaningful Use Incentive Program.** While all EHRs should meet the base EHR definition and related functionalities mandated under the Health Information Technology for Economic and Clinical Health (HITECH) Act, vendors should have a pathway to certify a “laundry-list” of specific additional functionalities of their choice—those functionalities that best meet their perceived needs of the health care market place. Thus, entities wanting to develop or engage in a particular APM, would be able to choose a system that has the unique set of certified functionalities required for successful participation within that model. The recently released 2015 ONC Final Rule provides such a pathway, and the regulations developed to support MACRA implementation should be consistent with and support this approach.

CMS Question: What are the core health IT functions that providers need to manage patient populations, coordinate care, engage patients and monitor and report quality? Would certification of additional functions or interoperability requirements in health IT products (for example, referral management or population health management functions) help providers succeed within APMs?

ACP Comment: The College recommends that both ONC and CMS work closely with the various medical societies to develop a broad list of functionalities to be certified by ONC to meet the varied needs of the healthcare community. As a preliminary list, the Agency should consider certifying functionalities that can:

- Maintain directories of clinicians and other healthcare professionals, behavioral health services, social and public health services, health homes, and Medicaid Managed Care plans;
- Classify patients and identify patient cohorts for health risks, care management, levels of engagement, and unexpected outcomes;
- Collect and support analysis of quality and performance data in order to develop, implement, and maintain protocols for care, care transitions, risk factor reduction, chronic care, and patient experience;
- Create, manage, share, update, and track changes in multidisciplinary, individualized care plans including all participants in care and support; and
- Measure and compare performance for individual clinicians, groups, and system performance on any arbitrary data point.

CMS Question: How should CMS define “use” of certified EHR technology as defined in Medicare by participants in an APM? For example, should the APM require participants to report quality measures to all payers using certified EHR technology or only payers who require EHR reported measures? Should all professionals in the APM in which an eligible alternative payment entity participates be required to use certified EHR technology or a particular subset?

ACP Comment: ACP recommends that practices should be able to use any software or services they choose to address reporting functions. The functions should be certified, however they do not need to be included in CEHRT.

Physician-Focused Payment Models

Background: MACRA adds a new subsection entitled, Increasing the Transparency of Physician-Focused Payment Models (PFPMs). This section establishes an independent “Physician-focused Payment Model Technical Advisory Committee” (the Committee). The Committee will review and provide comments and recommendations to the Secretary on PFPMs submitted by stakeholders. The Secretary must establish, through notice and comment rulemaking following an RFI, criteria for PFPMs, including models for specialist physicians, that could be used by the Committee for making its comments and recommendations. In this RFI, CMS is seeking input on potential criteria that the Committee could use for making comments and recommendations to the Secretary on PFPMs proposed by stakeholders.

ACP Comments: The process for approval of Physician-Focused Payment Models must be clearly defined and implemented to be consistent with the Congressional intent that this approach be a pathway to encourage the development and approval of multiple valued-based payment models. This is particularly important to specialty areas that currently do not have access to existing APMs as options. As mentioned previously, the time and cost of developing these new models is substantial; thus it is important that stakeholders both have a clear understanding of the requirements (criteria) that have to be met for their proposal to be recognized as a Physician-focused Payment Model (PFPM) and are assured of recognition if these criteria are fully met. We believe this conceptual foundation is necessary to promote the type of substantial payment model development activity envisioned by the agency.

The College makes the following broad recommendations aligned with this general statement:

- Clear and robust criteria should be established to inform the review by the Physician-focused Payment Model Technical Advisory Committee (PTAC).
- **There needs to be a clear understanding that models that are judged by the PTAC to meet the established criteria will be tested on a fast-track basis through CMMI and, if determined to be successful, expanded and implemented as part of the APM track in line with the Agency’s authority.** Along these lines, the activities taken on by those participants in the initial testing of these new models should be given additional weight within the clinical practice improvement activities component of the MIPS program. This will help to incentivize practices to participate in the testing of APMs.
- The criteria used should promote innovation and not focus on the development of any specific forms of payment models (e.g., shared savings, bundled payments).
- Payment models should consider impact upon patient care and populations and ensure that there are no unintended consequences for specific patient populations.
- As “physician-focused payment models,” these models should target payments primarily directed to physicians and physician led-entities rather than to facilities.
- **The College supports the concept of CMS using the PFPM pathway primarily (but not exclusively) to qualify payment models for physician and other healthcare professional specialties who are not eligible to broadly participate in current alternative payment models or models already under review or testing through CMMI.**
- **CMS should work collaboratively with medical societies and other organizations that are developing proposals to provide feedback on drafts and provide data up-front to help in modeling impacts. Furthermore, ACP encourages CMS to assist stakeholders through these processes in developing proposals that would qualify for the APM “bonus” payment contained in the statute.**
- **The College is particularly interested in the priority testing of the PCMH specialty practice model¹³, which would reward specialty/subspecialty practices that demonstrate specific functionalities linked to the delivery of effective and efficient patient-centered care. These functionalities include processes to increase patient engagement, access, referral planning,**

¹³ American College of Physicians. “The Patient-Centered Medical Home Neighbor: The Interface of the Patient-Centered Medical Home with Specialty/Subspecialty Practices.” 2010. Accessed at: https://www.acponline.org/advocacy/current_policy_papers/assets/pcmh_neighbors.pdf.

care coordination, effective population management, and the delivery of quality care. The National Committee for Quality Assurance (NCQA) currently has a recognition program¹⁴ to identify these practices, and related payment approaches are already being tested by a number of private payers (e.g. Anthem, Blue Cross/Blue Shield).

Technical Assistance to Small Practices and Practices in Health Professional Shortage Areas (HPSAs)

Background: MACRA provides for technical assistance to small practices and practices in HPSAs. In general, the Secretary is required to enter into contracts or agreements with entities such as quality improvement organizations, regional extension centers and regional health collaboratives beginning in Fiscal Year 2016 to offer guidance and assistance to MIPS EPs in practices of 15 or fewer professionals. Priority is to be given to small practices located in rural areas, HPSAs, medically underserved areas, and practices with low composite scores. The technical assistance is to focus on the performance categories under MIPS, or how to transition to implementation of and participation in an APM.

ACP General Comment: **ACP recommends that CMS give consideration to the complexity of transforming to a value-based payment model and provide technical assistance to address identified needs specific to the practice setting.** The College is pleased that priority is being given to small and rural practices, as they will likely face significant challenges of having sufficient staff, clinician time, adequate health information technology capabilities, and experience with quality improvement activities.

CMS Question: What kind of support should CMS offer in helping providers understand the requirements of MIPS?

ACP Comment: **The College strongly recommends that CMS collaborate with the many specialty organizations—at the national, regional, and local levels—to use their established communication channels to provide a consistent message to their membership.**

CMS Question: Should such assistance require multi-year provider technical assistance commitment, or should it be provided on a one-time basis?

ACP Comment: ACP recommends that the technical assistance be provided via a multi-year commitment to address the needs of these practices as they move through the phases of transformation. Best practices and lessons learned that are identified by the practices that are receiving these services should be disseminated widely.

CMS Question: Should there be conditions of participation and/or exclusions in the providers eligible to receive such assistance, such as providers participating in delivery system reform initiatives such as the Transforming Clinical Practice Initiative (TCPI);

¹⁴ <http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredSpecialtyPracticePCSP.aspx>

<http://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/>), or having a certain level of need identified?

ACP Comment: Every effort should be made to align the technical assistance available to practices receiving this support with the other CMS/CMMI initiatives, including TCPI, to prevent duplication of effort and also to develop mechanisms for sharing lessons learned and best practices across all efforts. Additionally, it would be preferable to have assistance based upon identified level of need and matched to the appropriate assistance.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Robert McLean MD, FACP, FACR". The signature is fluid and cursive, with the letters "R", "M", and "L" being particularly prominent.

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