



December 21, 2018

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

Re: Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2019 (CMS-1693-F)

Dear Administrator Verma,

On behalf of the American College of Physicians (ACP), I am pleased to share our comments on the Centers for Medicare and Medicaid Services' (CMS) final rule with comment regarding Revisions to Payment Policies under the Medicare Physician Fee Schedule (PFS), Quality Payment Program (QPP) and Other Revisions to Part B for CY 2019. The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 154,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

I. Summary of ACP's Top Priority Recommendations:

Physician Fee Schedule:

- **Additional refinements are needed to the final E/M documentation and payment policies to provide for immediate documentation relief, ensure the needs of complex patients are appropriately addressed, and avert negative downstream consequences.** ACP appreciates the additional time to engage with CMS to address these concerns before the single payment rate is implemented.
- **The College supports separate payment for technology-based communication services but urges the Agency to reconsider patient cost sharing and burdensome consent polices which may prevent uptake of these critical services.**

- **ACP appreciates the burden relief that will result from allowing physicians to delegate Appropriate Use Criteria (AUC) consultations to appropriate clinical staff, but reiterates AUC is burdensome. We urge the Agency to pursue additional changes** including reimbursing clinicians for the additional time required to conduct these consultations and pilot testing AUC in limited clinical priority areas before deploying on a larger scale to prevent widespread payment disruptions.

Quality Payment Program (QPP):

- **More needs to be done to streamline reporting and scoring for the Merit-Based Incentive Payment System (MIPS) to lessen burden on clinicians. ACP calls on CMS to: simplify MIPS scoring by basing point values for individual measures on their relative value to the total MIPS score, taking every opportunity to award cross category credit, and instituting a consistent minimum 90-day reporting period across all categories.**
- **The College urges CMS to expediently develop more Advanced APMs, particularly for small and specialty practices.** We encourage the Agency to test and adopt new physician-focused payment models (PFPMs) that have been tested in the private sector and come recommended by the PFPM Technical Advisory Committee (PTAC).
- **ACP strongly opposes the use of cost measures that are deemed unreliable or inaccurate and urges CMS not to increase the weight of the Cost Category until every measure meets rigorous reliability and accuracy standards.**
- **The College calls for new policies that will help to address the gap in QPP performance and level the playing field between small and large practices,** including establishing separate Advanced APM Qualified Participant (QP) and MIPS performance thresholds.
- **The College supports increased oversight of third party intermediaries** to help ensure clinicians' MIPS performance is not adversely impacted by technological glitches or functional shortcomings beyond their control.
- **The College strongly urges CMS to reduce the overall number of quality measures and use only those deemed valid, relevant, and reliable, such as those recommended by ACP's Performance Measurement Committee.** Any measures outside the scope of these recommendations and core measure sets identified by the Core Quality Measures Collaborative should be recommended by the Measure Application Partnership (MAP).
- **ACP supports required use of 2015 Certified Electronic Health Record Technology (CEHRT). However, we recommend CMS allow at least six months, if not a full year, for implementation before clinicians are graded on their use of the new technology.** Moving to more up-to-date standards and functions is important, but it is important physicians have adequate time to train clinical staff, and test and implement the upgrades once the 2015 CEHRT is available from their vendors to help ensure a smooth transition to the new technology.
- **ACP appreciates changes to streamline scoring within the Promoting Interoperability Performance Category but encourages the Agency to consider additional refinements to further improve flexibility and reduce burden,** including expanding the number of available measures and eliminating the use of required "all-or-nothing" measures.

II. Recommendations by Section:

Physician Fee Schedule

Evaluation and Management (E/M) Service Codes

ACP appreciates CMS delaying by two years E/M single payment rate policies to consider additional feedback from stakeholders and further refine the policies before they are implemented. It is vitally important the Agency take the necessary time to get it right and appropriately value cognitive care. Sufficient time must be allowed to engage the physician community to develop and pilot-test alternatives that preserve the principle that more complex and time-consuming E/M services must be paid appropriately more while simplifying E/M documentation and ensuring program integrity. The College looks forward to working with the Agency and other stakeholders in this process.

ACP appreciates the several positive changes to the single rate payment proposal that recognize the intense nature of services needed for the most complex patients, including retaining separate payment for Level 5 visits. However, additional refinements are needed to ensure the needs of complex patients are appropriately addressed and potential downstream effects are properly mitigated. For example, the current flattened payment structure financially incentivizes a higher volume of shorter patient visits, which disadvantages primary care clinicians or certain subspecialties such as geriatrics that treat and often manage care for complex patients with a range of overlapping conditions. To keep their practices financially viable and more on par with specialists, some physicians may be forced to schedule additional face-to-face time with more complex patients over the course of multiple visits, which interrupts patient care and is time-consuming, costly and potentially harmful to patients. Additionally, the payment policies leave many lingering questions related to how benchmarks or performance-based payments under certain APMs will be impacted. For example, in Track 2 of the Comprehensive Primary Care Plus (CPC+) Model, there is partial capitation based on an assumed amount of patient visits tied to prospective payment. The remainder of the visit fee is paid if the patient requires an E/M visit. It remains unclear how a collapsed E/M payment rate would be taken into account in such models. The College is exploring additional refinements and potential alternative approaches that we look forward to sharing with the Agency as it engages with stakeholders over the course of the coming months and years.

The College reasserts its strong recommendation that documentation options outlined for 2021, with some improvements, be decoupled from E/M payment policies and implemented immediately. ACP supports finalizing the three options for E/M documentation (current 1995 or 1997 guidelines, medical decision-making (MDM), and time). However, physicians need immediate relief from outdated documentation guidelines that burden clinicians with paperwork, take them away from direct patient care, and are inconsistent with current medical practice. While we appreciate the Agency's program integrity concerns, the College has recommended several specific revisions to the documentation proposal that would allow it to be fully decoupled from the proposed payment structure while preserving program integrity.

Understanding that updates to the auditing requirements may not be feasible in time for implementation in 2019, ACP supports maintaining current 1995 and 1997 MDM documentation guidelines to ensure program integrity in the short-term as it works with stakeholders to further improve auditing guidelines and procedures for the long-term. Further, CMS should immediately remove the auditing requirements associated with the history and physical exam elements of the 1995 and 1997 E/M documentation guidelines.

Documenting the history and physical exam should continue to be a key component of the patient visit, but they should not be associated with auditing requirements. This is aligned with CMS' proposal to address redundancy that will allow clinicians to focus their documentation on what has changed since the last visit or on pertinent items that have not changed, rather than re-documenting a predefined list of required elements such as review of systems and family/social history. Our recommendation would further expand on this policy. Once these elements are no longer required for auditing purposes, the level of service would be determined by the complexity of the MDM for that encounter and would thus allow physicians to focus on documenting what is necessary based on the unique needs of individual patients.

CMS must immediately work to ensure that the auditing guidelines and procedures are updated and aligned to focus on the MDM elements of the visit and applied consistently by all auditing organizations. A key concept to consider when addressing documentation reform is that the guidelines themselves are burdensome, but there is also a great deal of burden associated with the lack of clarity and differing interpretations on what is required. To that end, CMS must recognize one transparent standard for auditing that can be universally applied.

To summarize, ACP's recommendation to immediately implement newly finalized documentation options while maintaining current MDM auditing requirements without the history and physical exam elements would allow CMS to decouple implementation of documentation and payment policies and provide immediate administrative burden relief to physicians while preserving program integrity and providing time for CMS to further engage with ACP and other stakeholders to develop more effective long-term solutions.

ACP appreciates CMS finalizing payment add-on codes for internal medicine physicians and subspecialists to recognize that the current E/M code structure does not adequately account for the intense cognitive nature of visits provided by these clinicians. We appreciate CMS' responsive to stakeholder concerns by raising the value of the primary care add-on from \$5 to \$13 to equal the value of the specialty add-on, which more appropriately values this important work. ACP further appreciates positive changes to the code descriptions in that the primary care codes can now be billed with new patient visits in addition to established patient visits and the specialty code description has been broadened to include additional relevant specialties and allow non-procedural specialty care visits to utilize these codes. We applaud these changes and CMS' overall responsiveness to stakeholder concerns. We remind CMS that it is critical to make documenting these add-on codes as minimally burdensome as possible.

ACP appreciates CMS finalizing a new "extended visit" add-on (code GPRO1) for prolonged services. However, ACP calls for the implementation to be sooner than 2021 given that this

codes fills a gap that already exists. The existing “first hour” time threshold in the descriptor for CPT code 99354 and 99355 is difficult to meet and is an impediment to using these services.

ACP requests clarification regarding how time is used with E/M code Levels 2-4 when the extended service code is not added-on. The Agency finalized a code descriptor for the extended visit code that describes a single range of minutes that applies to the overall duration of face-to-face time during the visit, without regard to which level visit was reported. According to the descriptor, starting in 2021 the typical time for new and established patient visit Levels 2-4 will be 23 minutes and 19 minutes respectively. CMS must clarify whether these times will be used regardless of the extended service add-on code or if the typical times as recorded in CPT for E/M Level 2-4 visits will be required. Further, CMS must clarify if it intends to use the CPT convention of counting time once 50% of the required time has been met. In other words, once 10 minutes has been spent with an established patient, would the clinician be able to bill a Level 2-4 visit based on time?

Communication Technology-Based Services

The College applauds CMS’ move to recognize the value of communication technology-based services by offering separate payment for these services. New interprofessional telecommunications consultation codes 99446, 99447, 99448, 99449, 99451, and 99452 recognize the value of primary care physicians’ knowledge and skills when consulting hospitalists and other specialists throughout the continuum of care while new G-codes G2012 for “virtual office visits” and G2010 for remote evaluation of pre-recorded video and/or images offer patients more access to clinicians, particularly in rural areas.

However, ACP is concerned that the requirement to obtain and document the patient consent every time a service is performed coupled with patient-cost sharing may hinder uptake of these critical services. If implemented as finalized, these policies will result in unnecessary burden, undue stress on the clinician patient relationship, and may even put the clinician at unnecessary risk of triggering the Self-Referral e.g. “Stark” Law. The College urges CMS to reconsider patient cost sharing, which could eliminate the need to obtain patient consent altogether. CMS could also consider a blanket patient consent that would be documented in the patient record once a year similar to the requirement for chronic care management, which would be equally as effective in protecting program integrity while being significantly less burdensome and avoiding compliance-related complications. Regardless of how often documenting patient consent occurs, the process to do so must be transparent and minimally burdensome, so as not to dissuade uptake of these valuable services.

Clinical Laboratory Fee Schedule (CLFS)

While the College welcomes CMS’ efforts to expand the pool of applicable laboratories to capture more hospital outreach laboratories and laboratories with a significant population of MA patients, this does not do enough to address the flawed payment rates. Larger laboratories enjoy economies of scale and have lower per patient operating costs. Because they make up the bulk of “applicable laboratories,” they skew “average” rates that are often

unattainable for lower volume facilities. As a result, the College is very concerned that absent a revision in how data is collected and rates are established, physician office laboratories and smaller, independent laboratories that often serve rural or underserved areas will not be able to provide their services at these rates and will be forced to close, resulting in access shortages to lifesaving tests and interruptions to patient care.

CMS must conduct targeted market segment surveys (reference laboratories, physician office-based laboratories, independent laboratories, and hospital outreach laboratories) to ensure payment rates accurately reflect the full spectrum of private market laboratory rates. While the survey is being conducted, CMS should revert back to 2017 CLFS rates.

Appropriate Use Criteria (AUC)

ACP appreciates CMS allowing physicians to delegate AUC consultations to clinical staff, which will alleviate burden on physicians while ensuring the authorized individual is knowledgeable and able to communicate advanced diagnostic imaging orders, interact with clinical decision support mechanisms (CDSMs), and engage with ordering physicians. We request CMS clarify that “clinical staff” in this circumstance would be the CPT definition.

That said, AUC remains a duplicative and burdensome regulation and we urge CMS to consider additional changes to the program in future rulemaking. Specifically, billing services that require AUC should cover the additional time for the required consultation and communication. Additionally, education and awareness of AUC consultations continues to be low. To avoid mass payment disruptions and cause unnecessary and potentially dangerous delays in patient care, CMS should initially pilot the program in a smaller subset of priority clinical areas to allow furnishing physicians to familiarize themselves with fulfilling AUC requirements before fully implementing the program on a larger scale.

Quality Payment Program

Low Volume Threshold

ACP appreciates CMS responding to stakeholders by finalizing an option for those who were previously automatically excluded under the low volume threshold to “opt-in” to MIPS. Doing so expands participation in the program and moves more practices toward value-based reimbursement, particularly small and rural practices, while minimizing administrative burden. Additionally, incorporating having more small groups participate in MIPS will lead to more accurate average and median MIPS performance scores, which will be critical for setting future performance thresholds and measure benchmarks more appropriately.

Minimum Performance Period

ACP is disappointed that despite repeated objections from the vast majority of stakeholders including the College, CMS continues to require a full year of quality and cost data. We urge CMS in the strongest possible terms to reconsider this policy and reconsider instituting a

consistent, minimum 90 consecutive day minimum reporting period across all MIPS performance categories. Lowering the minimum reporting period to 90 consecutive days would drastically reduce reporting burden, allow time to implement EHRs or other innovative technologies without risk of compromising MIPS reporting or performance, allow for more timely performance feedback, and reduce the two-year lag between performance and payment. Moreover, 90 days would be a minimum; while 90 days is a sufficient length of time to capture reliable data for the majority of measures, individual measures could have their own separate minimums so that data accuracy would not be compromised.

Quality Category

The College continues to reiterate the need for more relevant, accurate, and effective quality measurement, particularly measures based on patient outcomes. ACP is encouraged by CMS' ongoing "Meaningful Measures" and "Patients Over Paperwork" initiatives that are aligned with these goals. We encourage the Agency to consider ACP's framework for analyzing new and existing tasks outlined in ACP's recent position paper [Putting Patients First by Reducing Excessive Administrative Tasks in Health Care](#) as the Agency continues to reform quality measures in the context of burden reduction and clinical value.

The College implores CMS to consider the findings and recommendations of ACP's Performance Measurement Committee (PMC) when considering internal medicine measures. The committee has assessed and provided [detailed recommendations](#) on many MIPS performance measures with a focus on those applicable to internal medicine. The recommendations are based upon a scientific review process that involves five domains: importance, appropriateness, clinical evidence, specifications, and feasibility/applicability. Of measures considered relevant to general internal medicine, 37% were rated as valid, 35% as not valid, and 28% as of uncertain validity. The PMC [assessed](#) a number of additional performance measures reaching similarly mixed reviews. Based on these findings, the committee made several recommendations to improve the measure development process so that measures can drive high quality patient care without creating adverse unintended consequences.

The College further recommends that any measures outside the scope of these recommendations be included in the [consensus core sets](#) of the Core Quality Measures Collaborative (CQMC) and/or recommended by the Measure Application Partnership (MAP). ACP remains concerned that a majority of new MIPS measures finalized for 2019 have received only conditional support from the MAP, and previously adopted measures remain despite being recommended for "continued development" by the MAP, a designation reserved for measures that lack evidence of strong feasibility and/or validity. The College further recommends that any measure recommended for continued development be resubmitted to the MAP once redevelopment is initiated.

It is imperative CMS ensure that a transparent, multi-stakeholder process is used to evaluate all measures used in its programs. The National Quality Forum (NQF), for instance, evaluates measures against four critically important criteria: importance to measure, scientifically acceptable, usable and relevant, and feasible to collect. CMS should also collaborate with

specialty societies, frontline clinicians, patients, and EHR vendors in the development, testing, and implementation of new quality measures with a focus on integrating performance measurement and reporting within existing care delivery protocols to maximize clinical improvement while decreasing clinician burden. Further, the criteria and processes CMS uses to make its final decisions regarding which measures to remove from the program and which to continue using should also be fully transparent. This would allow stakeholders to better plan their efforts in terms of measure development and review and provide more meaningful feedback to the Agency in the future.

The College continues to strongly recommend CMS reduce the number of measures required for full participation in the Quality Category from six to three measures, especially given that the approaches outlined above could result in a fewer number of available measures for a number of internal medicine subspecialties and other specialties. Reducing the number of quality measures required for full MIPS participation is an essential precursor to moving toward clinically relevant, outcomes-based, and patient-centered measures that are more meaningful to clinicians and their patients. This will also help to ensure specialists and subspecialists have a sufficient set of measures relevant to their specialty and scope of practice, which ACP has addressed in [detailed recommendations](#).

As CMS develops their approach to removing process measures in 2019, ACP encourages the Agency to allow for stakeholder comments through proposed rulemaking. Process measures can be valuable to improving patient care. Arbitrarily and unilaterally removing one type of measures from MIPS or reducing their point value without regard to the specific value of each measure could lead to adverse impacts on quality performance. We urge CMS to approach removal of process measures cautiously and in a clear and transparent manner, taking into account ACP recommendations.^{1,2}

While the College supports the proposal to allow small practices to use the claims-based reporting option for group reporting, we are disappointed claims based reporting is being limited to small practices. CMS defines small practice as Tax Identification Numbers (TINs) with 15 or fewer eligible clinicians (ECs). Under this strict definition, many clinicians are excluded from policies intended to help small practices despite operating as small practices in all other respects, including small practices that join independent practice associations (IPAs) organized under a shared TIN. Additionally, there may be circumstances where reporting via claims as individuals is the best option for clinicians in larger multispecialty practices to allow each EC to focus on quality measures most relevant to his/her specialty and scope of practice.

The College continues to be concerned with artificially capping the maximum points that a “topped out” quality measure can earn. CMS should score topped out measures the same as other quality measures for a minimum of two years. Creating separate scoring standards for different subsets of measures adds unnecessary complexity to scoring the Quality Category and disregards the actual value of the quality actions being measured.

¹ <https://www.nejm.org/doi/full/10.1056/NEJMp1802595>

² <https://www.acponline.org/clinical-information/performance-measures>

Cost Category

ACP appreciates CMS' repeated efforts to engage stakeholders in the measure development process. However, the College has serious concerns about moving forward with eight new episode-based cost measures that have low average reliability and have not yet been given an adequate opportunity to be fully vetted by stakeholders. While we appreciate CMS' efforts to conduct national field testing, we do not support CMS moving forward with finalizing measures that had only been conditionally approved by the MAP and not yet submitted to the NQF at the time this final rule was issued. These bodies provide critical stakeholder input and are necessary to a sound, transparent measure development process that yields clinically valid and statistically reliable measures. Rushing this process will only lead to inaccurate measurement. Further, measure validity and reliability should never be sacrificed in the interest of adopting more measures or having the measures apply to more clinicians. CMS should independently establish a robust minimum average reliability rating and evaluate all future episode-based measures based on that same standard, not pre-determine a set of measures the Agency wishes to use then selecting whatever low reliability standard allows them to adopt all of those measure without raising case minimums. This sets a dangerous precedent. **CMS should institute a minimum average reliability rating of no less than 0.75 for all current and future episode-based cost measures, which is considered by experts the minimum for "good" reliability.**³ Notably, only three of eight episode-based measures would meet this standard.

The College appreciates CMS soliciting input from stakeholders on possible revisions to the Medicare Spending Per Beneficiary and Per Capita Cost Measures, which have been subject to longstanding criticism for their patient attribution and risk adjustment methodologies that can lead to misleading characterizations of utilization and result in adverse consequences including patient "cherry picking." **However, ACP urges CMS to make refinements to improve the reliability and accuracy of Cost measures before further increasing the weight of the Cost Category. CMS should not sacrifice accurate cost measurement for the sake of meeting a timeline that is years off and could change.** While we appreciate CMS' point that they are required under current statute to increase the weight of the Cost Category to 30% by performance year 2022, Congress could revise the timeline to afford CMS additional flexibility just as it did with the Bipartisan Budget Act. Moreover, given that the revisions under consideration are substantial, the primary measures composing the score may hardly resemble their earlier iterations, which would completely change scoring for this category. Accordingly, ramping up the weight of the Cost Category in an effort to familiarize clinicians with being evaluated on cost metrics is less urgent. ACP shares the Agency's goal to reward clinicians who are delivering high-quality, efficient care, but this only works with accurate cost and quality measurement. Otherwise, a host of unintended consequences could ensue, such as clinicians being penalized for treating sicker or older patients that may require more expensive care. The Agency should instead focus on updating these measures with all due speed and only after they are confident in the methodology and reliability for every cost measure should they look to increase the weight of the Cost Category.

³ Koo, Terry K., and Mae Y. Li. "A Guideline of Selecting and Reporting Intraclass Correlation Coefficients for Reliability Research." *Journal of Chiropractic Medicine* 15, no. 2 (June 2016): 155-63. doi:10.1016/j.jcm.2016.02.012.

Promoting Interoperability (PI) Category

ACP is encouraged by CMS' focus on interoperability and improving patient access to health information. The renaming of the PI performance category, along with the scoring and measure proposals, aligns the structure of this PI program with that of the hospital program which is helpful for those physicians participating in multiple Medicare programs. **However, we remain deeply concerned about a number of other aspects of the PI Category and PI Program.**

The College supports required use of 2015 CEHRT in 2019. Moving to more up-to-date standards and functions is important, especially in an effort to better support the exchange of health information. However, we continue to emphasize the need for CMS to allow for at least six months, if not a full year, for physicians to implement the upgrades once the 2015 CEHRT is ready and available from their vendor before they are graded on their use of the technology. We reiterate concerns with the significant cost associated with implementation and the time these types of system upgrades take to roll out, including deploying the new technology, training staff, and adjusting workflows, which all could cause risks to patient health.

ACP appreciates CMS' attempt to simplify the PI scoring methodology with the removal of the different base, performance, and bonus categories and to align MIPS PI measure and scoring with the recently finalized PI Program for hospitals. This alignment is helpful for clinicians participating in multiple Medicare reporting programs and the scoring changes are a meaningful step forward to simplify scoring for the PI category and for MIPS as a whole. **However, these simplifications fall far short of addressing the many shortcomings of the PI category.** ACP has several specific comments and concerns about the proposed PI objectives and measures set which are outlined in our original comments to the proposed rule.

The College is disappointed in particular to see six measures remain "required" and continue to be scored on an "all-or-nothing" basis. CMS actually increased the number of required measures from 2018. The College does not support the idea that a single misstep by a clinician should eliminate any opportunity to score well in the category. ACP has called for removal of the thresholds in previous comments on Meaningful Use Stage 3⁴ and the PI Category^{5,6} and urged CMS to evaluate clinicians on how much they use EHRs and health IT (HIT) instead of how they use the technology. Unfortunately, the updates to the 2019 PI scoring methodology and measures follow the same fundamentally flawed logic as previous EHR reporting programs.

The College continues to recommend that the PI Category not be limited to a small set of required measures. As a way to provide more flexibility within the PI Category, ACP urges CMS to incorporate a broader list of optional HIT activities from which clinicians can choose that are most appropriate to their scope of practice and specialty. The PI Program should be used as a vehicle to help practices make the needed transitions with the end goal of improving patient care. A potential unintended consequence of removing the performance category under PI is that there will be less flexibility to achieve a higher PI score based on what is

⁴ [ACP Comments on Meaningful Use Stage 3 Final Rule](#)

⁵ [ACP Comment Letter to CMS on MACRA Proposed Rule](#)

⁶ [ACP Comment Letter to CMS Regarding CY 2018 Medicare Physician Fee Schedule Proposed Rule](#)

relevant to the clinician’s specialty or practice. If CMS intends to move beyond the burdensome reporting elements of the legacy EHR reporting programs that have hindered HIT and EHR innovation and left physicians dissatisfied with their EHR systems, CMS must move away from focusing on churning out numerators and denominators for a rigid set of required measures toward allowing clinicians to select from a larger list of clinically focused measures that hones in on the areas of HIT-related improvements that would be most beneficial to their practice and patients. This will actually be more effective in progressing CMS’ goals of increasing the use of HIT and improving patient care because practices can focus on the HIT-related areas of improvement that are specific to the needs of their practice and patients, rather than satisfying a series of check-the-box requirements. Moreover, this will create more synergy between the PI Category and the Quality and Improvement Activities Categories, which each feature a list of menu measures or activities to choose from. We recommend CMS reference the list of HIT activities described in detail in ACP’s previous [recommendations](#) and continue to look for opportunities to synergize care improvement objectives and award credit across MIPS performance categories, including PI. Doing so would allow participants to focus on key strategic areas for meaningful improvement in care delivery while reducing reporting burden, promoting interoperability, and promoting the use of HIT to improve patient care. Effective development of these types of multi-category measurement models will require input from all stakeholders including practicing clinicians. ACP looks forward to continuing to support CMS and offer our feedback towards these important endeavors.

ACP continues to call for the PI Category to be re-conceptualized into a program that promotes the use of HIT to improve care and support practical interoperability. Management and sharing of the clinical narratives is integral to interoperability and ACP strongly recommends that CMS focus on this key aspect or we fear the industry will never achieve true, practical interoperability. When looking at clinical data exchange in the context of routine care delivery, CMS’ policies are on the right track, specifically policies that allow physicians to constrain the information in the summary of care record to support transitions of care, allow physicians to use their judgment in deciding which items to present on the problem list, medical history list, or surgical history list, and allow hospitals to use any document template within the consolidated clinical document architecture (C-CDA) standard to ensure that relevant information is included. The College believes these policies should apply in all routine care delivery situations as an industry-wide best practice and should not be restricted to participation in the PI Program or any other Medicare program. The clinical note is still not coded in a way that can be easily carried over and shared, even within the Fast Healthcare Interoperability Resources (FHIR) standard. The push to structure and code clinical data has resulted in a decline in the ability of HIT systems to manage what clinicians feel is most important, the narrative text. Clinicians need to be able to easily find and read the clinical narratives, such as the history of present illness and the Assessment and Plan.

Interoperability should not be measured by volumes of data transferred; it should focus on ability to incorporate clinical perspective and query health IT systems for up-to-date information related to specific, relevant clinical questions. When discussing interoperability more broadly, including other purposes of clinical data exchange outside of routine care delivery (e.g., Health Information Exchange [HIE] repositories, clinical data registries, private

payer billing and payment requests, and patient requests), there is a fundamental misconception that indiscriminately sending data is promoting or enhancing interoperability and improving patient care. From a technical perspective, once the full set of clinical data is sent from the source, it is considered historical data. A critical piece of information may have changed since the latest copy was received that could completely change a medical decision. Accordingly, it would be dangerous to make clinical decisions based upon the latest C-CDA without checking the original source for relevant updates. Unfortunately, a system in which systems are graded on their ability to consistently, securely, and electronically transfer an abundance of clinical information at one point in time does not meet this needs, nor does it recognize that accessing every aspect of a patient's information can sometimes actually hinder a clinician's ability to find useful and actionable information in a timely manner.

The College supports hardship exceptions for uncontrollable circumstances, including vendor issues. CMS must clearly communicate hardship options to physicians and make the application process as simple and streamlined as possible. In addition to a hardship exception for those who choose to accept it, we urge CMS to provide more assistance to small practices willing to try to integrate information technology, but cannot do so without additional support.

Improvement Activities Category

ACP supports CMS' continued efforts to be responsive to more clinical improvements as the industry evolves. In particular, we applaud the Agency's responsiveness to stakeholder calls to place more emphasis on behavioral and mental health, patient engagement, care coordination, patient safety, population management, and addressing public health emergencies. In line with our advocacy priorities to increase transparency and streamline scoring across MIPS, ACP urges CMS to release more details regarding the criteria it uses to evaluate whether an activity should be "high-" or "medium-weighted" and to consider updating this process based on stakeholder feedback. Further, ACP does not support CMS' decision to remove credit for reporting certain improvement activities via CEHRT. We disagree that it would add undue complexity to the PI Category and encouraging use of CEHRT and awarding cross-category credit are both critical to the future success of MIPS. This is a step in the wrong direction and we urge CMS to reconsider.

MIPS Scoring

The College reiterates our previous concerns that the separate reporting requirements and scoring methodologies for each category are confusing for clinicians and counter to CMS' efforts to minimize burden and create a unified program. One simple solution would be to assign point values for each measure proportionate to their overall value relative to the MIPS composite score. The total points in the PI Category would total 25 for example, and so on. This methodology has the support of a number of physician groups, and also would allow CMS to continue distinguishing high-priority measures and categories with more value while creating a more intuitive, streamlined scoring approach. **We encourage CMS to take every opportunity to award cross category credit.** Doing so will create synergy between the various performance categories and align incentives to drive meaningful improvement in critical priority areas, rather

than spreading practices too thin across too many metrics. This will lead to better patient outcomes, and less burden on clinicians and practice staff.

ACP urges CMS to reconsider ACP's alternative offered in our [comments](#) in response to the proposed rule to hold harmless clinicians who switch practices at any point during a given performance year. Doing so would have a minimal impact on overall MIPS payment adjustments as most clinicians will only switch practices a handful of times over the course of their careers, and would create a straight forward standard that is evenly applied. It would also allow clinicians a transition period to adjust to new data collection types and reporting approaches at their new practice. While CMS' approach to hold harmless from MIPS payment adjustment clinicians who, in the final quarter of a MIPS performance period, switch to a practice that is either not participating in MIPS as a group or was newly formed during those final three months is a definite improvement over past policy, we worry this approach sets arbitrary distinctions in scoring based on what could be switching practices on Sept. 30 versus Oct. 1 and whether a group happens to report as a group or individually as clinicians and is unnecessarily complex.

MIPS Facility-Based Scoring Option

ACP commends CMS for developing and finalizing the new facility-based scoring option. By using data that is already being reported through the Hospital Value-Based Purchasing Program towards MIPS Cost and Quality scores, CMS is reducing burden on practices while still holding them to rigorous quality and cost standards. Moreover, the College supports CMS' approach to automatically count this data unless other MIPS data is submitted that would result in a higher score. This approach minimizes burden on clinicians by not having to separately attest or report data, but allows the opportunity for clinicians to be recognized for their efforts to deliver high-quality, cost-effective care if they do choose to submit data.

Third Party Intermediaries

ACP supports CMS' decision to allow third party intermediaries to report directly on behalf of participating clinicians and groups and fully supports new policies that require CMS-certified survey vendors and qualified clinical data registries (QCDRs) to meet more rigorous standards and be subject to more oversight by CMS. The College has received numerous accounts of clinicians who are being held at the whim of substandard vendors that fail to deliver on the functionalities they promise altogether or report inaccurate or incomplete data (or both). Requiring vendors to meet more rigorous standards on the front-end coupled with enforcing the integrity of data reported on the backend will help to improve the accuracy of cost and quality data and protect the integrity of the MIPS Program.

CMS should support and promote increased collaboration between QCDRs in measure development and harmonization without mandating QCDR measure owners to license use rights to any approved QCDR. QCDRs should also not be required to license a measure from original QCDR measure owners in lieu of developing their own measure. Instead, CMS should develop a resource that allows QCDR vendors to search for measures under development.

QCDRs could use this resource to identify other vendors developing similar QCDR measure concepts. Vendors could collaborate earlier in the development phase to co-create measures or license measures to increase more broad adoption of QCDR measures across multiple QCDRs. CMS' approach to require QCDR measure owners to license measures to approved QCDRs may unintentionally result in de-incentivizing QCDR measure development. QCDR measure owners invest significant resources into measure development, data collection, and validation. Additionally, QCDR measure owners develop these measures for use beyond MIPS reporting (e.g., research, guideline development, quality improvement, etc.).

Advanced APMs

ACP commends CMS for extending the current 8% revenue-based nominal amount (e.g. risk) standard through the 2024 Qualified Participant (QP) performance period, which will create necessary stability and predictability to foster development and participation in APMs.

However, the College is disappointed that to date, there are only eight distinct types of Advanced APMs. Even accounting for models expected in the coming weeks, the number of available models falls well short of the robust pathway to value-based reform that Congress had envisioned for APMs and does not support the Agency's own stated goal of shifting clinicians into APMs.

The Agency is not fully leveraging the Physician-Focused Payment Model Technical Advisory Committee (PTAC), which could be an invaluable tool to facilitating the implementation of innovative new physician-led APMs but to date has unfortunately been underutilized. Of now 11 models recommended for limited scale testing or full-scale implementation, CMS has adopted zero. Many of these models have a proven track record of working in the private sector; it is to CMS' benefit to capitalize on the substantial investment and testing that has already gone into these models. Moreover, we have already seen a decline in the number of submissions to PTAC. The longer CMS goes without adopting any models, what could be a great launching pad for a variety of innovative new payment models could cease to serve any practical purpose as enthusiasm wanes and developers cease to invest the resources and time into developing models without a realistic chance of those models ever being adopted.

Medicare Shared Savings Program

ACP supports CMS allowing an option for current participants whose agreements expire at the end of 2018 an optional six-month extension so as not to interrupt their participation in the program. However, as explained more thoroughly in our [comments](#) in response to the *Pathways to Success* proposed rule, we continue to have major logistical concerns with methodologies for calculating cost and quality performance on the full year and reconciling it based on the partial-year performance. It remains unclear for example what would occur in the case of an ACO that chose to extend their current contract through June 30, 2019 but then failed to report quality data for the latter half of 2019. ACP appreciates additional flexibilities in data reporting such as allowing PI data to be reported at the individual clinician level in addition to the TIN-level, and for performance feedback to be accessible at the TIN-level. This gives participants more options to comply with program requirements and more ways to monitor

their performance which allows them to better target areas for improvement to achieve more optimal results. We also CMS' continued efforts as part of its Meaningful Measures Initiative to reduce the number of quality measure in the ACO quality measure dataset, which further reduces the burden on participating practices.

Small and Rural Practices

ACP does not support CMS' relocating the small practice bonus to the Quality Category, which reduces its relative worth. This bonus is critical to offset the unique challenges small practices face and we do not feel the Agency offers sufficient explanation for this move.

CMS must do more to support small and rural practices and level the playing field in the QPP. According to [2017 MIPS performance data](#), the average and median MIPS scores for small practices lagged far behind large practices; the difference in average scores was more than 30 points, and the median was more than 50. This cannot continue. Small practices have a desire to participate in clinical practice transformations and drive meaningful quality improvement, but they often lack the sophisticated infrastructure, financial reserves to purchase CEHRT, QCDRs, or other supporting technologies, and ability to take on risk that immediately puts them on uneven ground when it comes to participating in Advanced APMs and being compared against much larger systems in MIPS. **We implore CMS to consider the following policies:**

- Split small and large practices in two separate pools for MIPS performance evaluation.
- Establish a separate, lower MIPS performance threshold for small and/or rural practices.
- Establish separate MIPS measure benchmarks for small and/or rural practices.
- Establish a separate, lower Advanced APM nominal amount standard to encourage participation by small and/or rural practices.
- Offer small/rural practices greater APM-specific rewards to participating such as lower minimum savings rates or higher sharing rates.
- Extend the 5% lump sum bonus for substantial participation in Advanced APMs for clinicians in small/rural practices beyond when it expires for larger practices.

III. Conclusion

Thank you for considering our comments. The College looks forward to continuing to work with CMS to make improvements to our healthcare payment system that reduce unnecessary cost and burden on physicians while continuing to drive the evolution toward value-based reimbursement. Please contact Brian Outland, PhD, Director, Regulatory Affairs, at 202-261-4544 or boutland@acponline.org with questions or for additional information.

Sincerely,

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