December 29, 2015

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

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016 [CMS–1631–FC]

Dear Acting Administrator Slavitt:

On behalf of the American College of Physicians (ACP), I am writing to share our comments on the final rule for the Calendar Year (CY) 2016 Medicare Physician Fee Schedule (PFS). 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. <u>Summary of ACP Recommendations</u>

ACP is pleased with the changes the Agency made in a number of areas, such as accepting the code for Advance Care Planning, relieving the administrative burden surrounding the Transitional Care Management (TCM) code, retaining the Refinement Panel, and others. Throughout this letter, the College provides a number of recommendations to the Centers for Medicare and Medicaid Services (CMS) in order to improve the Medicare PFS. Our top priority recommendations are summarized below and discussed in greater detail within this letter.

Determination of Practice Expense (PE) Relative Value Units (RVUs)

- ACP urges CMS to conduct a new Physician Practice Expense Information Survey (PPIS) to validate the PE component of the RVUs.

Potentially Misvalued Services under the PFS

- Moderate Sedation: ACP recommends that there be a standard Resource-Based Relative Value Scale Update Committee (RUC) survey to determine the work and direct PE inputs

of moderate sedation. Codes that contain moderate sedation should have the work value and direct PE inputs removed, which would allow the moderate sedation to be separately reported.
- Surgical Global Periods: ACP recommends that CMS use the additional time from the delay in collecting data on global periods to develop a methodology to fairly re-allocate malpractice RVUs for services converting from a 90- or 10-day to a zero-day global period.

Target for Relative Value Adjustments for Misvalued Services

- ACP continues to strongly recommend that CMS review their approach to determine if there are other methods that can be employed to come closer to reaching the target established by the law.
- Additionally, ACP urges CMS to establish a transparent process in calculating the "target for relative value adjustments for misvalued services."

Improving Payment Accuracy for Primary Care and Care Management Services

Improved Payment for the Professional Work of Care Management Services

- ACP recommends that CMS investigate the adequacy of payment for physician services that typically take place outside of a face-to-face patient encounter. The College urges CMS to recognize non-face-to-face services that enable primary care physicians who provide chronic disease management and care coordination to provide valuable and timely care to their patients.

Collaborative Care Models for Beneficiaries with Common Behavioral Health Conditions
Establishing Separate Payment for Collaborative Care

- The College supports CMS' recognition of the need to value the delivery of behavioral health services within the PFS.
- The College recommends the immediate inclusion of changes within the PFS to recognize the importance of non-face-to-face consultations between primary care physicians and consulting specialists—in this case a behavioral health specialist—by providing coverage of e-consultation codes.
- The College also recommends that CMS create a code and provide reimbursement for e-consultations both between hospitalists and primary care physicians and between specialists and primary care physicians.

Chronic Care Management (CCM) Code

- ACP strongly recommends that CMS develop add-on codes for time increments greater than 20 minutes such as 21-40 min; 41-60 min; and greater than 1 hour.

Advance Care Planning Services

- ACP applauds CMS for its decision to allow Medicare reimbursement for advance care planning services. This is an important step to improve care for Medicare patients with serious illness.

- The College applauds the language CMS uses in describing who may bill for advance care planning services and encourages CMS to include this same language for the annual wellness visit (AWV): "Accordingly we expect the billing physician or non-physician providers (NPP) to manage, participate and meaningfully contribute to the provision of the services." Adding this language to the AWV may limit the potential misuse of the Medicare AWV by commercial entities that do not manage, participate, and meaningfully contribute to the provision of the services provided to patients, which is a concern to the College.
- ACP recommends that CMS establish a National Coverage Determination (NCD) for Advance Care Planning to provide consistency in coverage of these important services.

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Services

- ACP strongly recommends that CMS roll-out this project with an initial focus on a limited number of clinical conditions and related AUC.
- The College further recommends that the roll-out begin with health systems and large group practices—along the lines of how the Medicare Value-Based Payment Modifier (VM) Program has been rolled out—and, over time, be expanded into the small, independent practice-size setting.

Physician Compare

- The College supports the overall goals of the Physician Compare Website and supports efforts to improve transparency in the health care system.
- ACP appreciates that CMS accepted the College's recommendation to hold off on including check marks for the VM Program until a more adequate system can be implemented that indicates eligible professionals (EPs) who received no VM adjustment because they are classified as average.
- The College recommends that CMS consider noting on the profile pages of affected physicians that they successfully reported quality data but it could not be analyzed due to circumstances beyond their control.
- ACP recommends that CMS be transparent with regard to the methodology used to calculate these scores and ensure that scores are accurately and appropriately risk adjusted.
- The College recommends that CMS look at additional cross-cutting measures for future reporting on Physician Compare (i.e., measures pertaining to influenza, pain assessment and treatment, depression screening, etc.).

Physician Payment, Efficiency, and Quality Improvements – Physician Quality Reporting System (PQRS)

- The College appreciates that CMS did not make significant changes to PQRS reporting requirements for CY 2016. Given that this is the final reporting period prior to implementation of the Merit-based Incentive Payment System (MIPS), maintaining stability in requirements is important as practices prepare for selecting which track to

participate in under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

- ACP strongly recommends that CMS engage in additional outreach to all practices to encourage them to participate in the PQRS program and work to increase PQRS participation rates in order to increase readiness for MIPS.
- ACP appreciates that the Agency maintained the application of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) requirement for only those groups with 100 or more EPs for performance year 2016.
- The College recommends that CMS implement the requirement to report data on race, ethnicity, sex, primary language, and disability status through a phased-in approach by starting with a subset of measures so that obstacles can be identified and corrected before the policy is more broadly applied.
- ACP strongly recommends that CMS only select measures for PQRS that receive a Measure Applications Partnership (MAP) recommendation of "support." Measures given the "encourage continued development" recommendation should be resubmitted to the MAP once the suggested development occurs.

Electronic Clinical Quality Measures (eCQM) and Certification Criteria and Electronic Health Record (EHR) Incentive Program— Comprehensive Primary Care (CPC) Initiative and Medicare Meaningful Use (MU) Aligned Reporting

- The College supports the change from certifying the capability to calculate and report individual eCQMs to certifying the capability to support the underlying eCQM standards (Quality Reporting Document Architecture [QRDA] I and III as well as CMS specified "form and manner").
- ACP appreciates that CMS changed the certification process from one focused on certifying for individual measures to one focused on certifying the ability to produce the measure reporting formats. However, ACP is concerned that EPs reporting MU for the first time who choose to use the CPC group reporting for the eCQMs will be penalized in 2017 for not meeting MU requirements in 2016. While the College understands that the timing of reporting for EPs in this situation makes it difficult for CMS to follow its normal procedure, ACP recommends that CMS refund the 2017 penalty for these EPs at a later date.

Potential Expansion of the CPC Initiative

- ACP strongly supports the expansion of the CPC initiative both to additional geographic regions, as well as in existing CPC initiative areas. The College also supports continued support and evaluation of the model with the current CPC initiative participants. It is imperative that practices continue to receive support as they further refine their processes to cut costs and improve quality.
- The College is in agreement with the supporting comments suggesting matters to consider in a potential future expansion of the CPC initiative including:
    - Engagement of EHR vendors;
    - Coaching on leadership and change management;

- Documentation;
    - Beneficiary cost-sharing;
    - Care management;
    - Further testing of the CPC initiative model;
    - Eligibility for incentive payments for participation in Alternative Payment Models (APMs) under MACRA;
    - Auditing requirements;
    - Aggregation of payer and clinical data; and
    - Engagement with clinicians across the broader medical neighborhood.
- The College offers the following additional comments addressing the expansion:
    - ACP believes that it is not appropriate to require the use of a currently certified EHR system as a condition of participation in any program other than the CMS EHR Incentive Program. The current certification program is designed to meet the needs of the EHR Incentive Program only. It specifies functionality that is not required for the purpose of this CPC initiative, and it fails to address the numerous functionalities required for the delivery of true comprehensive primary care (such as functions required for care planning and care management).
    - Given the large number of patients with behavioral health needs that present themselves within the primary care setting, the College recommends addressing behavioral health issues as an additional milestone. This milestone could be added as the next phase for current CPC initiative participants.
    - ACP strongly urges consideration of ways to minimize what has been described as the “immense” reporting burden associated with meeting the milestones.
    - The College recommends that CMS carefully analyze the policy prohibiting CPC initiative participants from billing the CCM to determine if they would be put at a disadvantage compared to their colleagues that are not participating in these models but who can bill for the CCM code.

Value-Based Payment Modifier (VM) and Physician Feedback Program

- The College supports transitioning our health care system to a value-based payment approach. Additionally, we appreciate that CMS made only minimal changes to the VM Program for performance year 2016 given that this is the final performance period prior to the implementation of MIPS.
- The College supports allowing groups in which at least 50 percent of the EPs meet the criteria to avoid the PQRS payment adjustment as individuals to be classified in category 1, regardless of whether the group registers for PQRS group practice reporting option (GPRO). ACP appreciates that CMS is able to extend this policy to the 2017 VM as well.
- The College is disappointed that CMS did not reduce the maximum payment at risk in the VM to 2.0 percent for group practices with 10 or more EPs or continue to hold solo EPs and small group practices (2-9 EPs) harmless from downward payment adjustments for an additional year.

II. Detailed ACP Comments on Final Rule

Determination of Practice Expense (PE) Relative Value Units (RVUs)

The Centers for Medicare and Medicaid Services (CMS) finalized refinement modifications to two steps in calculating the Direct Cost PE RVUs methodology. In Step 2, CMS will calculate the aggregate pool of direct PE costs for the current year. For Step 7 of the PE methodology, CMS will refine this step to use an average of the three most recent years of available Medicare claims data to determine the specialty mix assigned to each code.

ACP Comment:

ACP is pleased that CMS understands there is a need to make modifications in calculating the Direct Cost PE RVU methodology. The College agrees with the idea of using an average of three years of the most recent available Medicare claims data. The College is hopeful that the modifications in Step 2 and 7 will result in greater stability in the relationship between the work and PE RVU components and mitigate code-level fluctuations for the full range of Physician Fee Schedule (PFS) codes. However, the College does not feel these changes to Steps 2 and 7 alone will stabilize the entire relationship among the relative shares of work, PE, and malpractice (MP) RVUs. We reiterate our comment that since it has been almost ten years since CMS conducted its last Physician Practice Expense Information Survey (PPIS), much of the data on PE is outdated. **Therefore, ACP urges CMS to conduct a new PPIS to validate the PE component of the RVUs. As we move into a new era of physician payment models, the College believes that revalidation of the PE RVUs will be beneficial to the overall structure of physician reimbursement.** ACP believes that accurate valuation of PFS services is essential, as the Medicare Payment Advisory Commission (MedPAC) and other researchers have described the effect of pricing on the availability and utilization of services.

Potentially Misvalued Services under the PFS

Valuing Services that Include Moderate Sedation as an Inherent Part of Furnishing Procedures

The College understands the difficulty in establishing an approach to valuation for all Appendix G services. The valuation must be based on the best data about the provision of moderate sedation and must determine the extent of the misvaluation for each code.

ACP Comment:

ACP recommends that there be a standard Resource-Based Relative Value Scale Update Committee (RUC) survey to determine the work and direct PE inputs of moderate sedation. Codes that contain moderate sedation (appendix G codes) should have the work value and direct PE inputs removed, which would allow the moderate sedation to be separately reported.

ACP also recommends explicit recognition that several different code sets would be required:

- Option 1 – The physician performing the procedure provides moderate sedation. In this situation, provision of moderate sedation could be more intense work than if the same sedation was performed by a different clinician, dedicated solely to the moderate

sedation. This possibility highlights the importance of proceeding with the RUC process for evaluating the physician work.

- Option 2 – A different clinician performs the moderate sedation. That clinician may or may not be an anesthetist.
- Option 3 – An anesthesiologist provides deep sedation (i.e., propofol or other sedatives).

There must be a distinction between moderate sedation and deeper levels of anesthesia (deep sedation or other forms of monitored anesthesia care). Recognizing that greater than 50 percent of colonoscopies, for example, now involve anesthesia care, the current inappropriate distribution of work RVUs and PE needs to be corrected. Such variation in anesthetic care for many endoscopies (respiratory as well as gastrointestinal) and other procedures highlights the need for the three different types of coding outlined above to ensure proper relative valuation and payments for the differing types of services.

The College is confident that the Agency will implement these recommendations as CMS continues to review and consider recommendations through notice and comment rulemaking.

<u>Improving the Valuation and Coding of the Global Package</u>

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to develop, through rulemaking, a process to gather information needed to value surgical services from a representative sample of physicians, and requires that the data collection shall begin no later than January 1, 2017.

Beginning in CY 2019, CMS must use the information collected, as appropriate, along with other available data to improve the accuracy of valuation of surgical services under the PFS. MACRA authorizes the Secretary, through rulemaking, to delay up to 5 percent of the PFS payment for services for which a physician is required to report information until the required information is reported.

ACP Comment:

The College is pleased that CMS will continue to use the information from public comments to help develop a proposed approach for the collection of this information in future rulemaking. **ACP continues to recommend that CMS use the additional time from the delay in collecting data on global periods to develop a methodology to fairly re-allocate malpractice RVUs for services converting from a 90- or 10-day to a zero-day global period.**

The College is pleased that CMS has acknowledged our comments. ACP urges the Agency to carefully weigh and implement the following recommendations in developing a methodology to fairly re-allocate malpractice RVUs for services converting from a 90- or 10-day to a zero-day global period:

- Collect and examine large group practice data for Current Procedural Terminology (CPT) code 99024 (postoperative follow-up visit).

- Review Medicare Part A claims data to determine the length of stay of surgical services performed in the hospital facility setting.
- Prioritize services that the Agency has identified as high-concern subjects.
- Review postoperative visit and length of stay data for outliers.

Refinement Panel

ACP Comment:

The College applauds CMS for retaining the refinement panel. We appreciate the interest of CMS in maintaining a transparent process with public accountability in establishing values for physician services. ACP physician members have had the opportunity to serve in an advisory capacity to the Multi-Specialty Refinement Panel, providing an independent and unbiased primary care physician voice to the process.

Target for Relative Value Adjustments for Misvalued Services

The Affordable Care Act (ACA) instructed CMS to identify "misvalued codes" in the PFS, which CMS does through the annual rulemaking process.

In the Protecting Access to Medicare Act of 2014 (PAMA), Congress set a target for adjustments to misvalued codes in the PFS for CY 2017 through 2020, with a target amount of 0.5 percent of the estimated expenditures under the PFS for each of those four years. Subsequently, the Achieving a Better Life Experience Act of 2014 (ABLE) accelerated the application of the target by specifying it would apply for calendar years 2016 through 2018, and increasing the target to 1.0 percent for 2016. If the estimated net reductions in PFS expenditures resulting from changes in values for misvalued codes in 2016 are not equal to or greater than the target, a reduction equal to the percentage difference between target and the estimated net reduction in expenditures resulting from misvalued code reductions must be made to all PFS services.

In this rule, CMS is adopting a methodology to implement this provision, including how net reductions in misvalued codes would be calculated. Based on that methodology, CMS has identified changes that achieve 0.23 percent in net reductions. This will require a 0.77 percent reduction to all PFS services, as required by the statute.

ACP Comment:

ACP finds it very disappointing that CMS was unable to reach or even come close to the target amount. The current approach used by CMS has resulted in a net reduction that impacts the newly established transitional care management and chronic care management services, as well as the advance care planning services. ACP continues to strongly recommend that CMS review their approach to determine if there are other methods that can be employed to come closer to reaching the targets established by the law.

ACP continues to urge CMS to establish a transparent process in calculating the "target for relative value adjustments for misvalued services." Establishing and publishing an estimated dollar amount as well as the estimated impact on the net target reduction would be an important step in the transparent process. The combined impact and/or the impact of each

family of services should be published by CMS. Each year CMS should publish the exact target reduction number and individual service-level impacts; this would ensure that the stakeholder community can fairly and accurately calculate the published reduction.

Improving Payment Accuracy for Primary Care and Care Management Services

Improved Payment for the Professional Work of Care Management Services

ACP is encouraged that CMS remains committed to supporting primary care and recognizing care management as one of the critical components of primary care that contributes to better health for individuals and reduced expenditure growth. Patient care is evolving and becoming increasingly more complex. Caring for patients with chronic illness requires care outside of the office visit, much of which is not captured in statistical data or separately reimbursed under current Medicare guidelines.

The College was pleased to see the Agency's continued interest in receiving comments for future rulemaking on ways to recognize different resources (particularly in cognitive work) involved in delivering broad-based, ongoing treatment – beyond those resources already incorporated in the codes that describe the broader range of Evaluation and Management (E/M) services.

ACP Comment:

The College appreciates the need for CMS to be cautious in considering ways to recognize different resources to facilitate broader input from stakeholders regarding details of implementing such codes – including their structure and description, valuation, and any requirements for reporting. It is understandable this may require a multi-year approach.

However, as an immediately achievable step towards CMS' goal of managing chronic disease, the College recommends that CMS employ tools that already exist in CPT by establishing Medicare payment for existing CPT codes that describe non-face-to-face E/M services. ACP recommends that CMS investigate the adequacy of payment for physician services that typically take place outside of a face-to-face patient encounter. The College urges CMS to recognize non-face-to-face services that enable primary care physicians who provide chronic disease management and care coordination to provide valuable and timely care to their patients. ACP strongly recommends CMS reimburse the following non-face-to-face services, which have been surveyed and valued by the RUC:

Existing non-face-to-face services that ACP feels should be paid by CMS:

- Anticoagulant Management (99363 and 99364);
- Medical Team Conference (99366 - 99368);
- Care Plan Oversight Hospice/Home Care NH (99374 - 99380);
- Interprofessional Consultation (99446 - 99449);
- Telephone Services (99441 - 99443);
- Prolonged Service without Direct Patient Contact (99358 and 99359);
- On-line Medical Evaluation (99444);

- Education and Training for Patient Self-Management (98960 - 98962); and
- Review of Data/Preparation of Special Reports (99090 and 99091).

Collaborative Care Models for Beneficiaries with Common Behavioral Health Conditions
Establishing Separate Payment for Collaborative Care

E-consultation Codes

The RUC has surveyed and valued codes for Interprofessional Consultation (99446 - 99449) for the use of the consultant.

ACP Comment:

It is disappointing that CMS does not provide support for e-consultation within the PFS. The College continues to stand by the recommendation for CMS to create a code and provide reimbursement for e-consultations both between hospitalists and primary care physicians and specialists and primary care physicians. CMS could use the existing codes and create a modifier, or use an existing modifier such as modifier 27, to allow the primary care clinician to bill and be reimbursed for such consultation services – or create a separate code for the primary care clinician.

Patients with chronic conditions often also require consultations and care from specialty/ subspecialty physicians. Recent studies[1] reflect that many of these specialist/subspecialist visits can be avoided and care effectively provided through the use of e-consultations between the primary care and referred to specialty/subspecialty physician. This approach speeds up the delivery of care (long waiting-list time is avoided), allows the patient to obtain needed care without unnecessarily taking off from work or other responsibilities, and is a cost savings to the payer.

Behavioral Health Services

One potential code specifically described in this rule recognizes the importance of addressing behavioral health issues in the provision of comprehensive primary care -- the provision of behavioral health care within the "Collaborative Care" model. "Collaborative Care" is an evidence-based approach to caring for patients with common behavioral health conditions. Collaborative Care is typically provided by a primary care team, consisting of a primary care physician and a care manager, who works in collaboration with a psychiatric consultant. The psychiatric consultant provides regular consultations to the primary care team to review the clinical status and care of patients and make recommendations.

ACP Comment:

The College supports CMS' recognition of the need to value the delivery of behavioral health services within the PFS. **ACP finds it truly disappointing that CMS did not take this opportunity to provide support for the integration of behavioral health services into primary care within the PFS.** The College reiterates the following recommendation:

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[1] A. Chen and H. Yee. Improving Primary Care–Specialty Care Communication ARCH INTERN MED/VOL 171 (NO. 1), JAN 10, 2011. http://archinte.jamanetwork.com/article.aspx?articleid=226311&resultClick=3

- **ACP recommends the immediate inclusion of changes within the PFS to recognize the importance of non-face-to-face consultations between primary care physicians and consulting specialists—in this case a behavioral health specialist—by providing coverage of e-consultation codes (as referenced in the College's comments above).** This would have the effect of immediately supporting the efforts of primary care physicians in addressing behavioral health needs -- particularly for patients who are not progressing or for whom the intensity of the problem is beyond the competencies of the treatment team. This is consistent with our comments above regarding establishing separate payment for collaborative care more generally between primary care and other specialty physicians.

<u>Chronic Care Management (CCM) Code</u>
In CY 2013, CMS implemented separate payment for transitional care management (TCM) services, and in CY 2015, implemented separate payment for CCM services. Both have many service elements and billing requirements that the physician or non-physician clinicians must satisfy in order to fully furnish these services and to report these codes. These elements and requirements are relatively extensive and generally exceed those for other E/M and similar services. Since the implementation of these services, it has become apparent that some of the service elements and billing requirements are too burdensome.

The original CCM code that the RUC recommended to CMS was for 1 hour of non-face-to-face services; however, CMS ultimately approved only 20 minutes of services per month in the 2015 physician fee schedule final rule.

ACP Comment:
The College was disappointed to see that no changes were made to CCM in CY 2016. ACP urges the Agency, in its development of subregulatory guidance, to clarify the intersection of fax transmission and certified EHR technology (CEHRT) for purposes of CCM billing. The Agency should also consider the following changes in payment and coding related to CCM, including:

- **Establishing separate payment amounts and making Medicare payment for CPT codes, such as the complex care coordination codes, CPT codes 99487 and 99489; and**
- **Developing add-on codes for CCM for time increments greater than 20 minutes such as 21-40 min; 41-60 min; and greater than 1 hour.**

Finally, ACP remains concerned about the issue of a patient co-payment for the CCM code, as it is widely recognized as a barrier to code utilization and causes additional burden. However, the College understands that CMS believes that the Agency lacks the authority to change this requirement absent a change in statute.

<u>Transitional Care Management (TCM)</u>
ACP is pleased that CMS is adopting the suggestions that the required date of service reported on the TCM claim be the date of the face-to-face visit and submission of the claim may be the date when the face-to-face visit is completed (but not required).

Advance Care Planning

CMS is establishing separate payment and a payment rate for two advance care planning services provided to Medicare beneficiaries by physicians and other clinicians. The Medicare statute currently provides coverage for advance care planning under the "Welcome to Medicare" visit available to all Medicare beneficiaries, but they may not need these services when they first enroll. Establishing separate payment for advance care planning codes to recognize additional clinician time to conduct these conversations provides beneficiaries and clinicians greater opportunity and flexibility to utilize these planning sessions at the most appropriate time for patients and their families. CMS is also finalizing payment for advance care planning when it is included as an optional element of the Annual Wellness Visit (AWV).

The College applauds the language CMS uses in describing who may bill for advance care planning services: "We note that the CPT code descriptors describe the services as furnished by physicians or other qualified health professionals, which for Medicare purposes is consistent with allowing these codes to be billed by the physicians and non-physician providers (NPPs) whose scope of practice and Medicare benefit category include the services described by the CPT codes and who are authorized to independently bill Medicare for those services. Therefore only these practitioners may report CPT codes 99497 or 99498. Accordingly we expect the billing physician or NPP to manage, participate and meaningfully contribute to the provision of the services, in addition to providing a minimum of direct supervision." **The College strongly encourages CMS to include this same language for the AWV. Adding this language to the AWV may limit the potential misuse of the Medicare AWV by commercial entities that do not manage, participate, and meaningfully contribute to the provision of the services provided to patients.**

ACP Comment:

ACP applauds CMS for its decision to allow Medicare reimbursement for advance care planning services. This is an important step to improve care for Medicare patients with serious illness. However, ACP continues to recommend that CMS establish a National Coverage Determination (NCD) for Advance Care Planning to provide consistency in coverage of these important services.

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Services

In PAMA, Congress required that clinicians that order advanced diagnostic imaging services consult with AUC via a clinical decision support mechanism. To implement the first component of this section of the PAMA, CMS is required to specify AUC from among those developed or endorsed by national medical professional specialty societies and other provider-led entities. Additional components also required by the PAMA include CMS approval of clinical decision support mechanisms, collection of additional information on the Medicare claim form, and the development of a prior authorization program based upon the claims information.

CMS is implementing the first component of this program in this PFS final rule by establishing which organizations are eligible to develop or endorse AUC, the evidence-based requirements

for AUC development, and the process the Agency will follow for qualifying provider-led entities.

ACP Comment:
The College continues to have significant concerns regarding the effective roll-out of this project by January 2017. As a result, ACP continues to strongly recommend that CMS roll-out this project with an initial focus on a limited number of clinical conditions and related AUC. The CMS-defined process to identify priority clinical areas, as outlined within this final rule, appears to be an appropriate approach to identify these initial limited number of conditions. **The College further recommends that the roll-out begin with health systems and large group practices—along the lines of how the Medicare Value-Based Modifier (VM) Program has been rolled out—and, over time, be expanded into the small, independent practice-size setting.** These large entities have the infrastructure to implement more effectively and efficiently the required consultation and reporting procedures and are more likely to have previous experience (particularly the large health systems) in employing AUC approaches. These recommendations will help address potential problems associated with the required rapid implementation of the program.

ACP looks forward to the opportunity to address the large number of additional aspects of importance to this program as they are released for comment through the rulemaking process.

Physician Compare
This section of the rule continues the phased-in approach to developing the Physician Compare Website, which includes information on physicians and other eligible professionals (EPs) enrolled in the Medicare program. CMS plans to make a broader set of quality measures available for publication on the website.

CMS did not finalize the proposal to expand the section on each individual EP and group practice profile page to include a green check mark to indicate those EPs and groups who received an upward adjustment for the VM. CMS noted that because the VM as a standalone adjustment will end after CY 2018 (based on performance year 2016) due to implementation of MACRA, including the VM indicator for such a short period of time may be confusing to consumers since it will be replaced by a an indicator related to Merit-based Incentive Payment System (MIPS) in future years.

CMS will continue to make available for public reporting on Physician Compare on an annual basis the performance rate for all PQRS group practice reporting option (GPRO) measures (across all reporting mechanisms), all measures reported by Shared Savings Program accountable care organizations (ACOs), and all Physician Quality Reporting System (PQRS) measures for individual EPs (across all reporting mechanisms).

The Agency will also continue to make available for public reporting individual EP-level qualified clinical data registry (QCDR) PQRS and non-PQRS measure data (that have been collected for at least a full year). CMS finalized its proposal to make available for public

reporting group practice-level QCDR PQRS and non-PQRS measure data that have been collected for at least a full year. Each QCDR will be required to declare during self-nomination whether it plans to post data on its own website and allow Physician Compare to link to it or if it will provide data to CMS for public reporting on Physician Compare.

ACP Comment:
The College supports the overall goals of the Physician Compare Website and supports efforts to improve transparency in the health care system. Transparent health care information is useful for a wide range of stakeholders, and can help patients and their families make more informed health care choices. The College supports alignment with the PQRS reporting and using nationally recognized performance measures and data collection methodology in the Physician Compare Website. Furthermore, ACP supports increased efforts to determine and employ the most effective means of presenting performance information to patients/consumers and to educate these information users on the meaning of performance differences among clinicians, and on how to use this information effectively in making informed health care choices. Therefore, ACP is supportive of the policy to have all measures be available for download and to only include a select group of measures on the website. ACP supports working with consumer groups to identify the meaningful measures for consumers and encourages CMS to ensure that measures on the website remain patient-centered and reflect potential differences in risk/benefit for specific populations.

ACP appreciates that CMS accepted the College's recommendation to not finalize the proposal to include a check mark only for those EPs who receive an upward adjustment for the VM as it may be confusing to patients. The selective use of a check mark could have caused beneficiaries to inappropriately assume that every EP without the check mark received a negative adjustment even though the majority of EPs fall into the average group.

The College remains concerned that CMS' review of the CY 2014 submission data and identified errors or inaccuracies in the Quality Reporting Document Architecture (QRDA) I, QRDA III and QCDR data. These errors included missing or incorrect performance rates, missing or invalid numerator data, missing or invalid denominator data and calculation errors. Due to these findings, CMS is unable to use these data to determine quality performance and/or establish benchmarks for the 2014 reporting year and therefore cannot include it on Physician Compare or analyze it for purposes of the VM. ACP is concerned with how consumers might interpret these missing data when using the Physician Compare Website as there might be negative connotations associated with physicians who lack quality data on their profile pages. **The College recommends that CMS consider noting on the profile pages of affected physicians that they successfully reported quality data but it could not be analyzed due to circumstances beyond their control.**

Additionally, in light of concerns with the CY 2014 data errors and inaccuracies, ACP also echoes strong support for the recent American Medical Association recommendation that CMS "apply a broad 'hold harmless' policy that would automatically exempt all physicians who attempted to comply with the 2014 PQRS requirements from any PQRS or VM penalties in 2016.

Alternatively, at the very least, CMS should extend the Informal Review deadline into the next calendar year so that physicians can see the impact of any PQRS and/or VM adjustments on their payments and file for a review if appropriate."[2] The College believes that this flexibility is necessary given the data submission errors and inaccuracies and the lack of physician awareness of the penalties that they are facing.

New Benchmarking Methodology

CMS finalized the proposal to report publicly on Physician Compare an item- or measure-level benchmark derived using the Achievable Benchmark of Care (ABC™) methodology[3] annually based on the PQRS performance rates most recently available (i.e., in 2017 report a benchmark derived from 2016 PQRS performance rates). This will only apply to measures deemed valid and reliable and that are reported by enough EPs or group practices to produce a valid result.

ACP Comment:

The College is supportive of CMS calculating composite scores for measures as they often are easier for consumers to understand and give a broader picture of clinical quality. **However, ACP recommends that CMS be transparent with regard to the methodology used to calculate these scores and ensure that scores are accurately and appropriately risk adjusted.** Given that CMS finalized the ABC methodology for benchmarking, it is crucial that the methodology be subjected to ongoing research and monitoring to ensure that it supports the patient-physician relationship, contributes positively to adoption of best practices, and does not unintentionally undermine patient care, such as by contributing to disparities by penalizing hospitals or physicians who care for poorer or sicker patients.

Future Rulemaking Considerations

For future rulemaking, CMS sought comment on:

- The types of quality measures that will help fill gaps and meet the needs of stakeholders and would benefit future reporting on Physician Compare;
- Adding Medicare Advantage (MA) information to group and individual EP profile pages (specifically which MA plans are accepted with a link to more information on the medicare.gov plan finder site);
- Including additional VM cost and quality data on Physician Compare (i.e., an indicator for downward or neutral VM adjustments and cost composite or other VM cost measure data);
- Including open payments data on individual EP profile pages; and
- Including EP and group practice-level quality measure data stratified by race, gender, and ethnicity if feasible and appropriate.

[2] American Medical Association Letter to CMS. December 1, 2015. Accessed at: https://download.ama-assn.org/resources/doc/washington/x-pub/physician-quality-reporting-system-value-modifier-letter-01dec2015.pdf.

[3] Kiefe CI, Weissman NW, Allison JJ, Farmer R, Weaver M, Williams OD. Identifying achievable benchmarks of care: concepts and methodology. International Journal of Quality Health Care. 1998 Oct; 10(5):443-7. http://intqhc.oxfordjournals.org/content/10/5/443.

ACP Comment:
The College recommends that CMS look at additional cross-cutting measures for future reporting on Physician Compare (i.e., measures pertaining to influenza, pain assessment and treatment, depression screening, etc.). These broader measures have the potential to provide consumers with better information to compare across clinicians than condition-specific measures, which can be problematic, especially in the context of patients with multiple chronic conditions. The College supports adding MA information to the group and individual EP profile pages on Physician Compare as well as including open payments data on individual EP pages. Giving patients/consumers additional information on clinicians is important in allowing them to make informed health care choices. ACP does not believe that providing quality measure data stratified by race, gender, and ethnicity is appropriate at this time. The College also recommends that CMS consider utilizing the Physician Compare website to begin educating patients on the upcoming changes to Medicare physician quality, cost, and payment data as the MIPS program is implemented.

Physician Payment, Efficiency, and Quality Improvements – PQRS
CMS will include the following reporting mechanisms for PQRS performance year 2016 consistent with previous policy: claims; qualified registry; electronic health record (EHR) (including direct EHR products and EHR data submission vendor products); the GPRO web interface; certified survey vendors, for Consumer Assessment of Healthcare Providers and Systems (CAHPS) and for PQRS survey measures; and QCDRs. Beginning in 2016, CMS will also allow QCDRs to submit quality measures data for group practices.

The Agency did not finalize its proposal to require group practices with 25 - 99 EPs that register to participate in the PQRS GPRO and select the web interface as the reporting mechanism to select a CMS-certified vendor to collect CAHPS for PQRS data for 2016. However, groups with 100 or more EPs that participate in GPRO will be required to collect CAHPS for PQRS data, as was required in 2015. Smaller group practices may voluntarily elect to use the CAHPS for PQRS survey in 2016. Group practices that are required or voluntarily elect to report CAHPS will need to select and pay a CMS-certified vendor to administer the surveys.

ACP Comment:
The College appreciates that CMS did not make significant changes to PQRS reporting requirements for CY 2016. Given that this is the final reporting period prior to implementation of MIPS, maintaining stability in requirements is important as practices prepare for selecting which track to participate in under MACRA. ACP also supports the policy allowing QCDRs to submit quality measures data for group practices.

Additionally, due to continuing low participation rates in PQRS among physicians,[4] **ACP strongly recommends that CMS engage in additional outreach to all practices to encourage them to**

[4] Centers for Medicare and Medicaid Services. 2013 Physician Quality Reporting System and eRx Reporting Experience and Trends. Accessed at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2013_PQRS_eRx_Experience_Report_zip.zip

participate in the PQRS program and work to increase PQRS participation rates in order to increase readiness for MIPS. It is crucial to engage clinicians and practices in quality reporting in 2016 to ease their transition to MIPS in 2017.

ACP supports measuring patient care experiences. The College appreciates that CMS accepted our recommendation that the CAHPS requirement not be expanded to practices with 25 or more EPs. Given that CMS requires practices to cover the cost of the administration of the CAHPS survey; this could present a significant financial burden on practices, especially the smaller groups. CMS is requiring the largest group practices (those with 100 or more EPs) to select a certified vendor and take on the financial costs of administering CAHPS for PQRS for the first time in 2015. **Maintaining the application of the CAHPS requirement for only those groups with 100 or more EPs for performance year 2016 is critical given that we have not yet seen the financial impact or results of this requirement for 2015 yet.**

Additionally, upon implementation of MACRA, the College recommends that CMS remove the CAHPS survey from the quality performance category of MIPS 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 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.).

Future Rulemaking Considerations

The ACA requires CMS to report data on race, ethnicity, sex, primary language, and disability status. CMS intends to require collection of these data elements within each PQRS reporting mechanism in the future. CMS sought comments on the facilitators and obstacles clinicians and vendors may face in collecting and reporting these attributes and on preference for a phased-in approach (i.e., starting with a subset of measures versus requiring across all possible measures and reporting mechanisms) but did not make or finalize any proposals.

ACP Comment:

The College reiterates our recommendation that CMS implement this requirement through a phased-in approach by starting with a subset of measures so that obstacles can be identified and corrected before the policy is more broadly applied. ACP believes that it would be helpful if this information can be pulled out of EHRs. We also note that ethnicity and language preference are data that might not be readily available in many cases.

Selection of Quality Measures for 2016 and Beyond

In selecting measures, CMS is required to select measures that have been endorsed by a consensus organization that has a contract with CMS, which is currently the National Quality Forum (NQF). However, in the case of a specified area or medical topic determined appropriate by CMS for which a feasible and practical measure has not been endorsed by NQF, the Agency may consider measures that have not been endorsed as long as due consideration has been

given to measures that have been endorsed or adopted by a consensus organization. The statute is silent as to how measures that are submitted to the contracted consensus organization (NQF) are developed. The steps for developing measures may be carried out by a variety of different organizations, and CMS does not believe that there need to be specific restrictions on the makeup of organizations doing measures development (i.e., that they are physician-controlled organizations).

Additionally, CMS must establish a pre-rulemaking process under which certain steps occur including convening multi-stakeholder groups to provide input on the selection of measures. This is currently done by NQF through the Measure Applications Partnership (MAP).

ACP Comment:
The College is very concerned that a majority of the new measures that CMS added to PQRS were given a MAP recommendation of "encourage continued development." This MAP designation is reserved for measures that often lack strong feasibility and/or validity data. Additionally, very few of the measures are NQF-endorsed or have been submitted to NQF. CMS is required to select measures that are NQF-endorsed unless special circumstances dictate that there is a gap in which NQF-endorsed measures do not exist. **ACP strongly recommends that CMS select measures for PQRS that receive a MAP recommendation of "support." Measures given the "encourage continued development" recommendation should be resubmitted to the MAP once the suggested development occurs.**

Additionally, ACP encourages CMS to consider adopting a core set of measures that are methodologically sound and MAP-endorsed for use in the MIPS and alternative payment model (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 as well as 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.

Electronic Clinical Quality Measures (eCQM) and Certification Criteria and EHR Incentive Program— Comprehensive Primary Care (CPC) Initiative and Medicare Meaningful Use Aligned Reporting

Certification Requirements for Reporting Electronic Clinical Quality Measures (eCQMs) in the EHR Incentive Program and PQRS

Physicians and other EPs participating in PQRS and the EHR Incentive Programs under the 2015 Edition must possess EHRs that have been certified to report eCQMs according to the format that CMS requires for submission. To allow EPs to upgrade to 2015 Edition CEHRT before 2018, CMS finalized the proposal to revise the CEHRT definition for 2015 through 2017 to require that EHR technology is certified to report eCQMs, in accordance with the optional certification, in the format that CMS can electronically accept. Rather than requiring certification for each

eCQM, this would require technology to be certified to use the HL7 QRDA Category I and III standards and the optional CMS "form and manner." CMS also finalized the proposal to revise the CEHRT definition for 2018 and subsequent years to require that EHR technology is certified to report eCQMs using the same standards. The CEHRT definition for 2015 through 2017 included in the current Stage 3 rule allows EPs to use 2014 Edition or 2015 Edition certified EHR technology. These policies apply to EPs, eligible hospitals, and critical access hospitals (CAHs). CMS made these amendments to ensure that EPs participating in PQRS and the EHR Incentive Programs under the 2015 Edition possess EHRs that have been certified to report eCQMs according to the format that CMS requires for submission.

ACP Comment:
The College appreciates that CMS finalized the change from certifying the capability to calculate and report individual eCQMs to certifying the capability to support the underlying eCQM standards (QRDA I and III as well as CMS specified "form and manner").

EHR Incentive Program-Comprehensive Primary Care (CPC) Initiative Aligned Reporting
Under this initiative, CMS pays participating primary care practices a care management fee to support enhanced, coordinated services. Simultaneously, participating commercial, state, and other federal insurance plans are also offering enhanced support to primary care practices that provide high-quality primary care. CPC practice sites are required to report to CMS a subset of the CQMs that were finalized in the EHR Incentive Program Stage 2 final rule for EPs beginning in CY 2014. For 2016, CMS finalized the proposal to require CPC practice sites to submit at least 9 CPC CQMs that cover 3 domains (rather than the current requirement of 2 domains). CMS believes that reporting across 3 domains is reasonable given the increased number of measures in the CPC eCQM set, the sufficient time that CPC practices have had to upgrade their systems, and the fact that this requirements aligns with what is required for the Medicare EHR Incentive Program CQM reporting.

CMS also finalized its proposal that for CY 2016, EPs who are part of a CPC practice site and are in their first year of demonstrating MU may use the CPC group reporting option to report their CQMs electronically instead of reporting CQMs by attestation though the EHR Incentive Program's Registration and Attestation System. However, EPs who choose this CPC group reporting option must use a reporting period for CQMs of one full year (not 90 days), and the data must be submitted during the submission period from January 1, 2017 through February 28, 2017. This means that EPs who elect to electronically report through the CPC practice site cannot successfully attest to meaningful use prior to October 1, 2016 (the deadline established for EPs who are first-time meaningful users in CY 2016) and therefore will receive reduced payments under the PFS in CY 2017 for failing to demonstrate meaningful use if they have not applied and been approved for a significant hardship exception under the EHR Incentive Program.

ACP Comment:
The College supports changing the certification process from one focused on certifying for individual measures to one focused on certifying the ability to produce the measure reporting

formats. However, ACP is concerned that EPs reporting MU for the first time who choose to use the CPC group reporting for the CQMs will be penalized in 2017 for not meeting MU requirements in 2016. **While the College understands that the timing of reporting for EPs in this situation makes it difficult for CMS to follow its normal procedure, ACP reiterates the recommendation that CMS refund the 2017 penalty for these EPs at a later date.**

<u>**Potential Expansion of the Comprehensive Primary Care (CPC) Initiative**</u>

To show CMS's commitment to supporting advanced primary care, the Comprehensive Primary Care (CPC) Initiative was launched by the Center for Medicare and Medicaid Innovation (CMMI) on October 1, 2012. This four-year multi-payer initiative is a collaboration between public and private health payers to test a payment model consisting of non-visit based, risk-adjusted, per-beneficiary-per-month care management payments and shared savings opportunities. The payment model is designed to support practices in the provision of these five comprehensive primary care functions: 1) Risk-Stratified Care Management; 2) Access and Continuity; 3) Planned Care for Chronic Conditions and Preventive Care; 4) Patient and Caregiver Engagement; and 5) Coordination of Care across the Medical Neighborhood. Participating practices in the seven states or regions must demonstrate progress by meeting nine annual Milestones: 1) budget; 2) care management for high risk patients; 3) access and continuity; 4) patient experience; 5) quality improvement; 6) care coordination across the medical neighborhood; 7) shared decision-making; 8) participate in learning collaborative; and 9) health information technology.

CMS is seeking public comments about issues surrounding a potential expansion of the CPC initiative. The Agency would use additional rulemaking in the future if CMS decides to expand the CPC initiative. Areas that the Agency has identified for potential issues in the expansion are:

- Practice readiness;
- Practice standards and reporting;
- Practice groupings;
- Interaction with state primary care transformation initiatives;
- Learning activities;
- Payer and self-insured employer readiness;
- Medicaid participation;
- Quality reporting;
- Interaction with the CCM fee; and
- Provision of data feedback to practices.

ACP Comment:

The College provides the following comments for the requested input pertaining to expansion of the CPC initiative. These comments are reflective of previous comments provided by the College in response to the CMMI Request for Information on Advanced Primary Care Model

Concepts.[5] **ACP strongly supports the expansion of this initiative both to additional geographic regions, as well as in existing CPC initiative areas. The College also supports continued support and evaluation of the model with the current CPC initiative participants. It is imperative that practices continue to receive support as they further refine their processes to cut costs and improve quality. The College offers the following additional comments addressing the expansion issues specifically identified within the final rule:**

Practice Readiness: The College supports baseline requirements for practice participation within any expansion of the CPC initiative provided that those requirements are built upon a demonstrated ability to deliver and perform defined aspects of comprehensive primary care (as reflected by recognition as a patient-centered medical home (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) and the ability to monitor and report defined practice-level eCQMs.

However, ACP believes it is not appropriate to require the use of a currently certified EHR system as a condition of participation in any program other than the CMS EHR Incentive Program. The current certification program is designed to meet the needs of the EHR Incentive Program only. It specifies functionality that is not required for the purpose of this CPC initiative, and it fails to address the many functionalities required for the delivery of true comprehensive primary care (such as functions required for care planning and care management).

The College, based on reports from our members, believes that to accomplish the five comprehensive primary care functions required within the CPC initiative, practices will need significant technical and financial support from CMS and other payers. These functions consist of 1) Risk-Stratified Care Management; 2) Access and Continuity; 3) Planned Care for Chronic Conditions and Preventive Care; 4) Patient and Caregiver Engagement; and 5) Coordination of Care across the Medical Neighborhood. The need to provide multi-payer support to practices to make it possible for them to accomplish these comprehensive primary care functions should be available independent of the size or configuration of the primary care practice.

Practice standards and groupings: The College, in general, supports the current CPC milestone approach. Current milestones relate to 1) budget; 2) care management for high risk patients; 3) access and continuity; 4) patient experience; 5) quality improvement; 6) care coordination across the medical neighborhood; 7) shared decision-making; 8) participation in a learning collaborative; and 9) health information technology. **We recommend the addressing of behavioral health issues as an additional milestone -- given the large number of patients with**

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[5] https://www.acponline.org/acp_policy/letters/acp_comments_cms_rfi_advanced_primary_care_payment_2015.pdf.

behavioral health needs that present themselves within the primary care setting. This milestone could be added as the next phase for current CPC initiative participants.

ACP strongly urges consideration of ways to minimize what has been described as the "immense" reporting burden associated with meeting the milestones. One approach to address this problem would be to work toward increased harmonization of the reporting required by CMS and the different payers participating within a CPC initiative geographic region. The College also emphasizes that meeting these milestones requires substantial use of financial and human resources on the part of the participating practices -- thus, it is important that the timelines used to gauge progress adequately recognize the required effort.

Practice Groupings: Given the very promising early data[6] recently released regarding the CPC initiative, the College recommends a hybrid approach to expansion–one that allows expansion within existing CPC regions and expansion to new regions where the required payer and physician interest exists. In considering new regions, the College suggests increased efforts to develop contractual agreements with participating payers that ensures their involvement throughout the full length of the initiative (the College has heard that this has been a problem in some existing regions) and preference given to those regions that have the infrastructure (e.g., a health information exchange, additional (non-CMS) sources of technical support for practice transformation, etc.) to promote comprehensive primary care. As CMS considers expansion of the CPC initiative, consideration should be given to the impact of geography and health care delivery patterns. For purposes of calculating shared savings, consideration should be given to grouping practices that have comparable attribution of risk severity. This could encourage practices to continue to provide services to beneficiaries with multiple chronic conditions and high severity of illness.

Interaction with state primary care transformation initiatives: The College would support efforts to expand the CPC initiative in regions that are already engaged in a separate primary care transformational effort -- such an approach has the potential to mutually benefit both efforts through a sharing of resources and preventing duplication. For example, practices in states that have State Innovation Model grants to integrate behavioral health in primary care would have focused tools and resources already available to supplement what is offered through CPC initiative participation. Nonetheless, we agree that such an expansion may encounter a number of issues with aligning goals and reporting requirements and should be initially approached in a very limited way. Over time, as the CMMI gains experience with this type of situation, fuller expansion in such regions can occur. Obviously, preference should be given to those areas where the requirements and goals of the different programs are maximally aligned and collaboration is occurring.

Learning Activities: ACP supports the learning activities that are occurring in the current CPC initiative practices -- reports from our participating members have been generally quite positive. **The College recommends increased opportunities within the program (and in any**

[6] https://innovation.cms.gov/Files/reports/CPCI-EvalRpt1.pdf

expansion) for the sharing of best practices and opportunities to collaborate and network to address barriers encountered by participating practices.

Besides the learning activities inherent to the CPC initiative, resources scheduled to be provided through the Transforming Clinical Practices Initiative, the continued efforts of quality improvement organizations (QIOs) and HIT Regional Extension Centers in various areas, various related state funded initiatives, and the $100 million included in MACRA for small practice technical assistance can help complement CPC initiative efforts. The College recommends that CMS give some consideration on how best these additional resources can be used and leveraged.

Payer (including Medicaid) and self-insured employer readiness: From the perspective of our members, the crucial issue is the total amount of "penetration" within their patient panels provided by the multi-payers involved in a given region. Regions in which the penetration of participating payers is low would make necessary transformation difficult. As mentioned above, the College further encourages efforts by CMS to develop contractual agreements with participating payers that ensure their involvement throughout the full length of the initiative. Furthermore, the contracts (agreements) with payers should, as much as possible, attempt to align reporting requirements expected from the participating practices, and ensure the delivery of crucial health care utilization information to the participating practices from the payers in a usable and timely manner.

Quality reporting: A requirement for CPC initiative participation should be a practice's ability to aggregate quality data at the practice level for submission --- this should be a component of the readiness assessment. **Quality data aggregation functionality required by this program may not be available in certified EHR systems, as this is not a requirement of the EHR Incentive Program. Therefore, practices will have to acquire this functionality either as an add-on from their vendor or as a service provided by third parties, and both approaches will result in additional costs to the practices. The College recommends that consideration be given to the additional burden and cost.** As mentioned above, every effort should be made to harmonize the reporting requirements for all payers.

Interaction with the CCM payment: The College supports CMS' efforts to not provide duplicative payments. However, ACP does not agree that the services provided in the CPC initiative are necessarily duplicative of those provided under the CCM code. The workflows that practices currently need to put into place to be successful in the CPC initiative (and other PCMH programs) and to bill the CCM code are not aligned and thus, do not allow the CCM code to be an ideal "on ramp" for practices towards APM participation. Currently, the uptake of the CCM code has been quite limited due to its (overly) strict and burdensome billing requirements. We expect uptake in use of this code to increase over time as CMS refines the code criteria and practices develop effective and efficient ways of meeting the billing criteria. As practices increase the use of the CCM code, at some point it may become a "business decision" regarding whether to participate within the CPC initiative or continue to have the capability to bill for the CCM code. **The College recommends that CMS carefully analyze** the policy prohibiting CPC

initiative participants from billing the CCM code **to determine if they would be put at a disadvantage compared to their colleagues who are not participating in these models but who can bill for the CCM code.**

Provision of data feedback to practices: The College emphasizes the importance of participating practices receiving timely and actionable data from all payers involved in a geographic region. This includes CMS developing mechanisms to deliver the quarterly feedback reports in a more efficient manner, and increasing efforts to help these practices understand and apply the information included within these reports to deliver more value-oriented comprehensive primary care. In order to inform these suggested improvements, we suggest that CMS make a more intensive effort to elicit feedback from the current CPC initiative practices on the usability of the current reports and on the additional technical support required to turn the data from the reports into action.

Value-Based Payment Modifier (VM) and Physician Feedback Program

Continuing its policy established in the final rule for 2015, CMS will continue to apply the VM to all physicians based on performance data from payment year 2016. Quality reporting data for performance year 2016 will be used to calculate each EP or group practice's VM for payment adjustment year 2018. In addition to applying the VM in 2018 to all physicians, CMS finalized expanding the group of EPs subject to the VM in 2018 to include physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNSs), and certified registered nurse anesthetists (CRNAs) in addition to all physicians.

The Agency finalized the use of CY 2016 as the performance period for the CY 2018 VM, consistent with policy in previous years. This will be the final performance period under the current VM and PQRS structures, as the first performance period for MACRA may begin in CY 2017. CMS will continue to include all PQRS GPRO and PQRS individual reporting mechanisms in the VM for payment adjustment year 2018. All of the quality measures that are available to be reported will be used to calculate a group or solo EP's VM to the extent that data on these measures are submitted. Additionally, CMS will not recalculate the VM upward payment adjustment factor after it is made public unless there was a significant error made in the calculation of the adjustment factor.

ACP Comment:

The College supports transitioning our health care system to a value-based payment approach, and ACP looks forward to working with CMS through the Health Care Learning and Payment Action Network to help achieve this goal. The College believes that a new value-based system should facilitate coordinated, comprehensive, longitudinal care provided by physicians working in collaboration with other clinicians. ACP recognizes that CMS is required by law to apply the value modifier to all physicians in 2017. The College appreciates that CMS made only minimal changes to the VM program for performance year 2016 given that this is the final performance period prior to the implementation of MIPS.

Quality Tiering

CMS will continue to use a two category approach for the CY 2018 VM based on participation in PQRS by groups and solo EPs during performance year 2016, as outlined below.

Category 1:

- Solo EPs that meet the criteria to avoid the PQRS payment adjustment;
- Groups that meet the criteria to avoid the PQRS payment adjustment as a group practice participating in PQRS GPRO; and
- Groups that have at least 50 percent of the EPs meet the criteria to avoid the PQRS payment adjustment as individuals, regardless of whether the group registers for PQRS GPRO. In previous years, this option was only available to groups that did not register to participate in PQRS GPRO. In this rule, CMS also finalized its proposal to extend this flexibility to group practice reporting for the 2017 VM (based on performance year 2015 PQRS reporting).

Category 2: groups and solo EPs that are subject to the 2018 VM and do not fall in Category 1 (e.g., those that do not meet the PQRS satisfactory reporting/participation criteria).

Consistent with policy for the previous year, CMS finalized the proposal to apply to Category 2 EPs (i.e., non-PQRS reporters) an automatic 4.0 percent downward payment adjustment VM to groups of 10 or more EPs and a 2.0 percent downward adjustment VM for solo EPs and groups of 2-9 for payment adjustment year 2018. These VM payment adjustments are in addition to the 2.0 percent downward payment adjustment for failing to satisfactorily report PQRS data for payment adjustment year 2018 (performance year 2016).

CMS finalized the proposal to apply the quality-tiering methodology to groups and solo EPs in Category 1. For the CY 2018 VM (based on performance in CY 2016), solo EPs and groups in category one could receive a maximum upward adjustment under the quality-tiering methodology for the CY 2018 VM to: +4.0 times an upward payment adjustment factor (to be determined after the performance period has ended) for groups with 10 or more EPs; +2.0 times an adjustment factor for groups with between 2 to 9 EPs and physician solo EPs; and +2.0 times an adjustment factor for groups and solo EPs that consist of non-physician EPs who are PAs, NPs, CNSs, and CRNAs. The amount of payment at risk under the CY 2018 VM is 4.0 percent for groups with 10 or more EPs, 2.0 percent for groups with between 2 to 9 EPs and physician solo EPs, and 0 percent for groups and solo clinicians that consist only of non-physician EPs who are PAs, NPs, CNSs, and CRNAs.

ACP Comment:

The College supports allowing groups in which at least 50 percent of the EPs meet the criteria to avoid the PQRS payment adjustment as individuals to be classified in category 1, regardless of whether the group registers for PQRS GPRO. ACP appreciates that CMS was able to extend this policy to the 2017 VM as well.

The College is disappointed that CMS did not reduce the maximum payment at risk in the VM to 2.0 percent for group practices with 10 or more EPs. When combined with the 2.0 percent PQRS penalty, the total amount of combined payment at risk for PQRS and the VM would be 4.0 percent for larger group practices. Because this is the last performance year under the current programs prior to the implementation of MIPS, we believe it makes sense to make the policy for 2016 consistent with the 4.0 percent maximum downward adjustment in the first year of MIPS (2017). **Additionally, ACP recommends that CMS continue to hold solo EPs and small group practices (2-9 EPs) harmless from downward payment adjustments for an additional year.** Due to the ongoing low PQRS participation rate for small practices and solo EPs as cited earlier, CMS should focus over the next year on communication with and education of these practices and clinicians to help them learn about the quality reporting system and prepare so that they can ultimately be successful in the transition to MIPS.

Policies Related to ACOs, CPCi, and other Innovation Center Models
Beginning with the CY 2017 payment adjustment period, CMS finalized a number of policies impacting EPs participating in ACOs, CPCi, and other CMS Innovation Center models including waiving application of the VM for groups and solo EPs, as identified by TIN, if at least one EP who billed for PFS items and services under the TIN during the applicable performance period for the VM participated in the Pioneer ACO Model, CPC Initiative, or other similar Innovation Center models during the performance period (e.g., Next Generation ACOs, Oncology Care Model, Comprehensive ESRD Care Initiative).

ACP Comment:
The College appreciates CMS' decision to waive application of the VM if at least one EP (in a group or solo) billed for PFS items and services and participated in a Pioneer ACO, CPC initiative, or similar Innovation Center model during the performance period. **ACP further encourages CMS to consider extending the waiver of application of the VM to practices if an EP participated in a Medicare Shared Savings Program ACO.**

Modifications to Evaluation of Quality and Resource Use
CMS finalized the proposal to modify the benchmarking policy to separately benchmark the PQRS eCQMs beginning with the CY 2018 VM. CMS notes that there are several factors that differentiate eCQMs from other equivalent PQRS measures including the inclusion of all-payer data for eCQMs and the different annual update cycle. This change will be made beginning with the CY 2016 performance period, for which the eCQM benchmarks will be calculated based on CY 2015 performance data.

The Agency finalized the proposal to reclassify a Taxpayer Identification Number (TIN) as Category 1 when PQRS determines on informal review that at least 50 percent of the TIN's EPs meet the criteria for satisfactory reporting of data on PQRS quality measures as individuals for the relevant CY PQRS payment adjustment, or in lieu of satisfactory reporting, satisfactorily participate in a PQRS QCDR for the relevant CY PQRS payment adjustment.

CMS uses a minimum episode count for the Medicare Spending per Beneficiary (MSPB) measure for inclusion in a TIN's cost composite. In previous years, the Agency used a 20 episode case minimum that was non-specialty adjusted. However, based on more recent analysis CMS has found this to have lower reliability when specialty adjusted. Therefore, CMS finalized an increase in the minimum to 125 episodes beginning with the CY 2017 payment adjustment period and CY 2015 performance period.

ACP Comment:
The College appreciates the policy change to separately benchmark eCQMs from other equivalent PQRS measures because the factors that differentiate them create a situation where they cannot be accurately compared with each other directly. The College supports CMS' proposal to reclassify a TIN as Category 1 when the Agency determines on informal review that at least 50 percent of the associated EPs meet the criteria for satisfactory reporting. The College supports the CMS increasing the minimum episode count for the MSPB measure to 125 episodes. ACP does not believe that EPs should be arbitrarily given downward payment adjustments based on a measure for which they reported too few episodes to have reliable data to analyze.

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,

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