



June 27, 2016

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

**Re: Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models [CMS-5517-P]**

Dear Acting Administrator Slavitt:

On behalf of the American College of Physicians (ACP), I am pleased to share our comments on the Centers for Medicare and Medicaid Services' (CMS) notice of proposed rulemaking (NPRM) regarding the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) – Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule and Criteria for Physician-Focused Payment Models. The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 143,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

## **I. Guiding Principles**

**First, as outlined in our comments on the CMS Quality Measure Development Plan, ACP reiterates its call for CMS to use the opportunity provided through the new MACRA law to build a learning health and healthcare system.** It is critically important that the new payment systems that are designed through the implementation of MACRA reflect the lessons from the current and past programs and also effectively allow for ongoing innovation and learning. **Also important is the need to constantly monitor the evolving measurement system to identify and mitigate any potential unintended consequences,** such as increasing clinician burden and burn-out, adversely impacting underserved populations and the clinicians that care for them,

and diverting attention disproportionately toward the things being measured to the neglect of other critically important areas that cannot be directly measured (e.g., empathy, humanity).

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

**Third, the College strongly recommends that CMS collaborate with specialty societies, frontline clinicians, and EHR vendors in the development, testing, and implementation of measures with a focus on integrating the measurement of and reporting on performance with quality improvement and care delivery and decreasing clinician burden.**

## **II. Summary of ACP's Top Priority Recommendations**

Throughout this letter, the College makes a significant number of specific recommendations to the Agency of ways we believe the proposed rule can be improved prior to implementation. We believe all of these recommendations are important for CMS to consider, but below have summarized a subset of them that reflect our top priority areas (detailed explanations for each recommendation are included in the main text of the letter). This approach is intended to ensure that these key issues for the ACP and internal medicine as a whole are not lost within the more detailed and thorough discussions that follow.

### **Priority Area #1: Patient-Centered Medical Homes**

- CMS should broaden the definition of patient-centered medical home for the purposes of full Clinical Practice Improvement Activity (CPIA) credit within MIPS to specifically be inclusive of programs that have a demonstrated track record of support by non-Medicare payers, state Medicaid programs, employers, and/or others in a region or state (but that do not yet meet all of the requirements to be a deemed advanced APM program per the recommendation later in this letter). (page 43)
- A reasonable interpretation of the statute supports our view that Congress clearly intended for medical homes to qualify as [advanced] APMs, without bearing more than nominal financial risk; if it is a medical home that meets criteria comparable to medical homes expanded under section 1115A(c). (page 43)
- CMS should take the following actions to provide multiple pathways for medical homes to be included in the advanced APM pathway, to be implemented in a timely enough

basis for eligible medical homes to qualify as advanced APMs within the first year of program implementation (2019). (page 63)

- Immediately initiate plans to undertake an expedited analysis of the results of the Comprehensive Primary Care initiative (CPCi) to determine whether the statutory requirements for expansion by the Secretary are met (i.e., Section 1115A(c)). This analysis should be completed no later than six months from promulgation of the final rule to allow for a determination to expand CPCi in time for medical home practices to qualify as advanced APMs in 2019.
  - In parallel with this analysis, CMS should initiate advanced planning to develop their expansion approach for the CPCi program.
- Establish a deeming program or process to enable practices enrolled in medical home programs run by states (including state Medicaid programs), other non-Medicare payers, and employers as being deemed to have met criteria “comparable to medical homes expanded under section 1115A(c)”
- Allow inclusion of medical home programs as advanced APMs that meet the Medical Home Model Standard for financial risk and nominal amount as outlined in the proposed rule.
- ACP recommends that CMS retain the 2.5 percent risk requirement for Medical Home Models in the initial performance period at the same level in subsequent years until it is determined that a sufficient number of model participants have demonstrated their ability to succeed under even this lower downside risk requirement. (page 68)

## **Priority Area #2: Advanced Alternative Payment Model (APM) Options for Internal Medicine Subspecialists and other Medical Specialties**

- CMS should provide priority for consideration through the Physician-Focused Payment Models Technical Advisory Committee (PTAC) and for Center for Medicare and Medicaid Innovation (CMMI) testing for models involving physician specialty/subspecialty categories for which there are no current recognized APMs and Advanced APM options available. We further recommend that CMS provide a clear pathway for models recommended by PTAC to be implemented as APMs under MACRA. (page 69)
- CMS should reduce the nominal risk requirement for potential advanced alternative payment models other than the Medical Home Model. (page 69)
- CMS should create a platform to expedite the testing for APM recognition of bundled payment and similar episodes of care payment models. (page 69)
- The College reaffirms its belief that Track One Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs) should qualify as meeting the nominal risk requirement for determining an advanced APM. (page 71)
- The College recommends the addition of a new Track within the MSSP that helps bridge the transition for one-sided to two-sided risk. (page 71)

### **Priority Area #3: Simplify the Implementation of the Quality Payment Program (QPP)**

- CMS should simplify and clarify MIPS performance scoring in the final rule to allow physicians to better assess the scoring and weighting within each category. (page 17)
  - Therefore, the College strongly recommends that CMS modify the point values within the overall MIPS performance scoring to reflect a more unified approach by making the points available for performance on each category and measure reflective of the value it has in the overall composite performance score (CPS).
- Given the significant need for simplification, as well as other improvements in the rule (as outlined throughout all of ACP's recommendations), the College calls on CMS to release an interim final rule with comment period as soon as possible to address a number of critical issues that would benefit from additional discussions with key stakeholders, including specialty societies, frontline clinicians, patients, other payers, vendors, and others. (page 18)
- CMS should allow group practices additional reporting options when they choose to report at the group-level by allowing taxpayer identification numbers (TINs) to choose to subdivide into smaller groups for the purposes of being assessed for performance in MIPS. (page 20)
- CMS should use its authority to adjust resource use down from 10 percent in the first performance period by setting resource use at zero and increasing the quality performance category by 10 percent to make up for the difference. (page 38)

### **Priority Area #4: Provide Better Opportunities for Small Practices to Succeed**

- CMS should carefully consider the performance threshold for MIPS in the first performance period to take into account the impact that it will have on various types of clinicians, in particular weighing how small practices will be affected. (page 19)
- CMS should include in the final rule for the 2017 performance period a policy that allows small practices to join together as virtual groups for the purposes of MIPS assessment in the initial performance period. As noted above, CMS could address this and other critical, yet unresolved or addressed issues via an interim final rule with comment period. (page 21)
  - If the Agency is unable to provide a virtual group option through rulemaking for the first year, then, as a back-up, ACP recommends that CMS treat small practices in a manner similar to how they were treated in the phase-in of the Value-based Payment Modifier (VM) program. Under this option, CMS would allow solo clinicians and groups of 2-9 ECs that report under MIPS to be held harmless from any potential downward adjustments until such time that a virtual groups option is made available.
- ACP recommends that CMS raise the threshold to \$30,000 in Medicare allowed charges OR require fewer than 100 unique Medicare patients be seen by the clinician, as this would help provide a better safety net for small practices. (page 23)

## Priority Area #5: Improve Quality Measurement

- It is imperative that CMS use the opportunity provided through the new MACRA law to actively build a learning health and healthcare system. Overall, quality measurement must move toward becoming more relevant and accurate, and toward effective approaches of measuring patient outcomes. (page 27)
- CMS should collaborate with specialty societies, frontline clinicians, and EHR vendors in the development, testing, and implementation of measures with a focus on decreasing clinician burden and integrating the measurement of and reporting on performance with quality improvement and care delivery. (page 27)
- Any measures that CMS proposes to use outside of the core set identified by the Core Quality Measures Collaborative need to be endorsed by the Measure Applications Partnership (MAP). (page 27)
- CMS should consider the recommendations made by ACP's Performance Measurement Committee with regard to measure selection within MIPS (see the ACP website<sup>1</sup> and the Appendix at end of this letter). (page 28)
- CMS should take concrete actions to provide clear options for those specialties and subspecialties that may be most impacted by too few appropriate measures. (page 28)
- The College also reiterates our recommendation, as outlined in our response to the draft Measures Development Plan (MDP) —that over the longer term CMS must continue to improve the measures and reporting systems to be used in MIPS to ensure that they measure items of clinical relevance, move toward clinical outcomes and patient- and family-centeredness measures, and do not create unintended adverse consequences. (page 30)
- CMS should remove the mandate for clinicians to report on at least one outcome measure, even though we recognize there is flexibility in that a “high priority” measure may be used when an outcome measure is not available. Clinicians that choose to use an outcome measure should be provided bonus points within the quality category of MIPS. (page 31)
- CMS should remove the three population health measures from the quality category. However, recognizing that there is evidence that community-level interventions improve individual health outcomes, the College further recommends that CMS, and HHS more broadly, consider other approaches to support public health interventions and the work of the physicians involved in those efforts, including providing optional CPIA points for the proposed population health measures and/or for participation in public health efforts within the CPIA category of MIPS. (page 31)
- ACP strongly recommends that reporting Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS should remain voluntary at a minimum—and further recommends that this survey be removed from the quality component and instead be identified as one of the optional clinical practice improvement activities (CPIA), within the subcategory of beneficiary engagement. (page 32)

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<sup>1</sup> <https://www.acponline.org/clinical-information/performance-measures>

- CMS should use its resources in an active effort to continually improve the risk adjustment methodology employed within MACRA implementation. (page 32)
  - Along these lines, ACP recommends that the Agency actively work to incorporate socioeconomic status (SES) into its risk adjustment methodologies.
- CMS should ensure that the flexibilities that were given to QCDRs in law to develop and maintain measures that are outside of the CMS selection process are protected. (page 34)
- CMS should publish the specific criteria that it plans to use in evaluating QCDR measures moving forward. (page 34)
  - If CMS decides to deny the use of a measure in a QCDR, the College also recommends that the Agency provide the measure developer/steward with specific information on what criteria were not met that led to a measure not being accepted for use and provide a process for immediate reconsideration when the issues have been addressed.
- CMS should maintain the current 50 percent data completeness requirements for quality reporting during the first performance period under MIPS. (page 35)
  - CMS should utilize a slow, incremental phase-in of any new data completeness requirements for quality reporting in MIPS.
- For measures that reach the topped out threshold during the performance period, ACP urges CMS to hold harmless physicians who report on these measures from any downside adjustment in the maximum points that the measure is worth by maintaining the 10-point maximum value of the measure for that performance period. (page 36)
  - Additionally, ACP recommends that CMS publicly disclose any measures that are topped out prior to a performance period in advance.

#### **Priority Area #6: Improve the Advancing Care Information (ACI) Category**

- CMS should simplify the reporting requirements and scoring methodology within the proposed ACI category and not require the volume and complexity specified in the base and performance scores. (page 46)
- For the 2017 performance period, ACP recommends that the ACI measurement period should be 90 days instead of the full calendar year as done previously with the EHR Incentive Program performance period. (page 47)
- CMS should modify the base score component of ACI and remove the threshold requirements of 1 or “yes” for all proposed base measures except for the protecting patient health information attestation which ACP believes is integral to the use of health IT. (page 48)
- Within the performance score component of ACI, ACP recommends that eligible clinicians (ECs) be given the ability to select among a longer list of health IT-specific activities that are appropriate to the specialty of the EC. (page 48)
- CMS should focus the review and improvement of ACI measures on the value of the measures and whether they assist practices in applying health IT to improve the quality and value of care and not focus on the performance levels of the measures. (page 59)

## **Priority Area #7: Change the Start Date for the First Performance Year**

- CMS should delay start of the initial performance period under QPP to July 1, 2017 rather than the proposed January 1, 2017, start date. (page 16)
- The length of the initial performance period should remain as a full year unless CMS releases analysis indicating that a shorter performance period will not have a negative impact on clinicians including those in small practices and specialists/subspecialists. (page 16)

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

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

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

##### **1. MIPS Performance Period (page 15)**

- The College urges CMS to delay start the initial performance period under QPP to July 1, 2017 rather than the proposed January 1, 2017, start date.
- The length of the initial performance period should remain as a full year unless CMS releases analysis indicating that a shorter performance period will not have a negative impact on clinicians including those in small practices and specialists/subspecialists.

##### **2. Complexity in MIPS Performance Scoring (page 17)**

- ACP recommends that CMS simplify and clarify performance scoring in the final rule to allow physicians to better assess the scoring and weighting within each category.
- The College strongly recommends that CMS consider modifying the point values within the overall MIPS performance scoring to reflect a more unified approach by making the points available for performance on each category and measure reflective of the value it has in the overall CPS.
- ACP recommends that CMS consider additional options in rulemaking to promote performance of quality improvement activities that crossover into multiple performance categories to strengthen MIPS and make the program more comprehensive rather than siloed.

##### **3. Performance Threshold (page 19)**

- ACP recommends that CMS carefully consider the performance threshold for MIPS in the first performance period to take into account the impact that it will have on various types of clinicians, in particular weighing how small practices will be affected.

#### **4. Group Reporting (page 19)**

- ACP strongly urges CMS to allow group practices additional reporting options when they choose to report at the group-level by allowing TINs to choose to subdivide into smaller groups for the purposes of being assessed for performance in MIPS.

#### **5. Virtual Groups (page 21)**

- ACP strongly urges CMS to include in the final rule for the 2017 performance period a policy that allows small practices to join together as virtual groups for the purposes of MIPS assessment in the initial performance period.
- If the Agency is unable to provide a virtual group option in through rulemaking for the first year, then as a backup, ACP recommends that CMS treat small practices in a manner similar to how they were treated in the phase-in of the Value-based Payment Modifier (VM) program.

#### **6. Low-Volume Threshold (page 23)**

- ACP recommends that If CMS would raise the threshold to \$30,000 in Medicare allowed charges OR require fewer than 100 unique Medicare patients be seen by the clinician, as this, would help provide a better safety net for small practices.
- The College recommends that CMS develop a hardship exceptions process for MIPS through which ECs can apply to CMS on a case-by-case basis with special circumstances that warrant exclusion from MIPS for a performance period.

#### **7. Telemedicine in MIPS (page 24)**

- ACP recommends weighting the telehealth services activity as “high” (more specifics on ACP’s weighting recommendations for CPIA are further described later in this letter).

#### **8. Quality Performance Category (page 25)**

##### **a. Measure Requirements (page 25)**

- ACP reiterates our call for CMS to use the opportunity provided through the new MACRA law to actively build a learning health and healthcare system. Overall, quality measurement must move toward becoming more relevant and accurate, and move toward effective approaches of measuring patient outcomes.
- The College strongly recommends that CMS collaborate with specialty societies, frontline clinicians, and EHR vendors in the development, testing, and implementation of measures with a focus on integrating the measurement of and reporting on



performance with quality improvement and care delivery and on decreasing clinician burden.

- ACP recommends that ideally any measures CMS proposes to use outside of the core set identified by the Core Quality Measures Collaborative be endorsed by the Measure Application Partnership (MAP).
- The College recommends that CMS consider the recommendations made by ACP’s Performance Measurement Committee with regard to measure selection within MIPS.
- ACP also recommends that CMS take concrete actions to provide clear options for those specialties and subspecialties that may be most impacted by too few appropriate measures. These actions should include:
  - Developing a process to determine in advance of the reporting year which quality measures are likely applicable to each eligible clinician—and only holding them accountable for these relevant measures (i.e., weighting performance on the remaining measures higher, rather than penalizing them with a score of zero on unreported measures).
  - Putting a process in place, for the short term, to address the significant issues of validity and ability to implement associated with using measures that are not MAP-endorsed, National Quality Forum (NQF)-endorsed, and/or ACP recommended.
  - Establishing safe harbors for entities that are taking on innovative approaches to quality measurement and improvement as was recommended in a recent article by McGlynn and Kerr.<sup>2</sup>
  - The College also calls on CMS to provide clear protections for individual clinicians who participate in these types of activities—this could be done by having the entities register certain measures as “test measures.”
  - Ensuring that the flexibility for QCDRs to develop and maintain measures outside of the CMS selection process is protected.
- The College also reiterates our recommendation, as outlined in our response to the draft MDP—that it will be critically important for CMS over the longer term to continue to improve the measures and reporting systems to be used in MIPS to ensure that they measure the right things, move toward clinical outcomes and patient- and family-centeredness measures, and do not create unintended adverse consequences.
- ACP calls on the Agency to remove the mandate for clinicians to report on at least one outcome measure, even though we recognize there is flexibility in that a “high priority” measure may be used when an outcome measure is not available. Clinicians that choose to use an outcome measure should be provided bonus points within the quality category of MIPS.
- In order to move toward developing measures that are appropriate for individual clinicians, CMS must collaborate with clinicians and specialty societies to ensure that individuals are not held accountable for measures that are designed to assess community-level outcomes.

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<sup>2</sup> McGlynn, E.A. and E.A. Kerr. Creating Safe Harbors for Quality Innovation and Improvement. *JAMA*. 2016;315(2):129-130. <http://jama.jamanetwork.com/article.aspx?articleid=2481012>

- The College recommends that CMS remove the three population health measures from the quality category.
- The College further recommends that CMS, and HHS more broadly, consider other approaches to support public health interventions and the work of the physicians involved in those efforts, including providing optional CPIA points for the proposed population health measures and/or for participation in public health efforts within the CPIA category of MIPS.
- ACP recommends that CMS not remove Physician Quality Reporting System (PQRS) #110 and PQRS #111 as cross-cutting measures, which will help ensure that eligible clinicians in a variety of care settings will be incentivized to offer immunization services in the course of providing care to patients.
- ACP strongly recommends that reporting CAHPS for MIPS should remain voluntary at a minimum—and further recommends that this survey be removed from the quality component and instead be identified as one of the optional clinical practice improvement activities (CPIA), within the subcategory of beneficiary engagement.
- The College recommends that CMS consider an approach recently outlined by McGlynn, Schneider, and Kerr,<sup>3</sup> which calls on measure developers to actively consider how to integrate patient preferences and goals into measure design.
- The College recommends that CMS use its resources in an active effort to continually improve the risk adjustment methodology employed within MACRA implementation.
- ACP recommends that the Agency actively work to incorporate socioeconomic status (SES) into its risk adjustment methodologies given that there is existing literature on the impact of SES on the rates of hospitalizations, readmissions, and other factors—and the ASPE report, once available, can be additionally informative on this issue.

#### **b. Qualified Clinical Data Registries (QCDRs) (page 33)**

- The College recommends that CMS ensure that the flexibilities that were given to QCDRs in law to develop and maintain measures that are outside of the CMS selection process are protected.
- ACP encourages CMS to remove the arbitrary restriction on the number of non-MIPS measures that a QCDR can utilize. Further, the College recommends that CMS allow QCDRs to utilize measures from other QCDRs (with permission).
- ACP recommends that the Agency publish the specific criteria that they plan to use in evaluating QCDR measures moving forward.
- If CMS decides to deny the use of a measure in a QCDR, the College also recommends that the Agency provide the measure developer/steward with specific information on what criteria were not met that led to a measure not being accepted for use and provide a process for immediate reconsideration when the issues have been addressed.

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<sup>3</sup> Elizabeth A. McGlynn, Ph.D., Eric C. Schneider, M.D., and Eve A. Kerr, M.D., M.P.H. “Reimagining Quality Measurement.” *N Engl J Med* 2014; 371:2150-2153. <http://www.nejm.org/doi/full/10.1056/NEJMp1407883>.

**c. Data Completeness (page 34)**

- The College recommends that CMS maintain the current 50 percent data completeness requirements for quality reporting during the first performance period under MIPS.
- ACP recommends that CMS utilize a slow, incremental phase-in of any new data completeness requirements for quality reporting in MIPS, and that higher data completeness requirements are phased in only after appropriate review has determined that doing so is both appropriate and feasible.

**d. Topped-out Measures (page 36)**

- For measures that reach the topped out threshold during the performance period, ACP urges CMS to hold harmless the physicians who report on these measures from any downside adjustment in the maximum points that the measure is worth by maintaining the 10-point maximum value of the measure for that performance period.
- ACP recommends that CMS publicly disclose any measures that are topped out prior to a performance period in advance.

**e. CEHRT Bonus for Quality Performance Category (page 37)**

- ACP recommends that ECs should be eligible for the extra point for reporting to otherwise qualified registries that are not yet capable of supporting the required standards for the submission of all data elements.

**9. Resource Use Performance Category (page 37)**

- The College urges CMS to use its authority to adjust resource use down from 10 percent in the first performance period by setting resource use at zero and increasing the quality performance category by 10 percent to make up for the difference.

**10. Clinical Practice Improvement Activities Performance Category (page 39)**

- ACP recommends that all activities be weighted the same at 5 points per activity to make the total be 15 points for this Category. Full scoring would be accomplished by attesting to 3 activities or attesting as being PCMH recognized or participating in an APM.
- The College strongly recommends inclusion of completing ACP Practice Advisor® modules as an Activity in the subcategory of Patient Safety and Practice Assessment.
- ACP recommends that CMS specifically include ACP's High Value Care resources as clinical practice improvement activities.

- The College urges CMS to recognize credit for certain defined Continuing Medical Education (CME) activities:
  - Accredited CME activities that involve assessment and improvement of patient outcomes or care quality, as demonstrated by clinical data or patient experience of care data.
  - Accredited CME that teaches the principles of quality improvement and the basic tenets of MACRA implementation, including application of the “three aims,” the National Quality Strategy, and the CMS Quality Strategy, with these goals being incorporated into practice.
- The College also recommends that CMS establish a clear and transparent process for adding new items to the list of CPIA that facilitates broad stakeholder input.
- ACP calls on CMS to permit practicing clinicians to submit alternative activities for credit and/or consideration for future credit, as this will help ensure that clinicians are able to identify and undertake quality improvement activities aimed at meeting their own specific goals, even if those activities are not yet included on the CPIA list.

**a. PCMHs within the CPIA Performance Category (page 42)**

- ACP recommends that CMS broaden their definition of patient-centered medical home for the purposes of full CPIA credit to specifically be inclusive of programs that have a demonstrated track record of support by non-Medicare payers, state Medicaid programs, employers, and/or others in a region or state (but that do not yet meet all of the requirements to be deemed an advanced APM program per the recommendation later in this letter).
- With regard to “comparable specialty practice,” ACP also recommends that CMS also broaden its definition to not only include those practices recognized by NCQA, but also those practices that may be certified in some manner by other nationally recognized accreditation bodies or programs implemented by non-Medicare payers, state Medicaid programs, employers, and others in a region that may become available.
- The College recommends that specialty practices should be able to attest directly to CMS and document that they meet standards comparable to those for primary care medical homes, as recognized through an accreditation body, other certification process, or direct application to CMS or one of its carriers.

**11. Advancing Care Information Performance Category (page 45)**

- ACP recommends that CMS simplify the reporting requirements and scoring methodology within the proposed ACI category and not require the volume and complexity specified in the base and performance scores.
- For the 2017 performance period, ACP recommends that the ACI measurement period should be 90 days instead of the full calendar year as done previously with the EHR Incentive Program performance period.

- The College recommends that CMS modify the base score component of ACI and remove the threshold requirements of 1 or “yes” for all proposed base measures except for the protecting patient health information attestation which ACP believes is integral to the use of health IT.
- Within the performance score component of ACI, ACP recommends that ECs be given the ability to select among a longer list of health IT-specific activities that are appropriate to the specialty of the EC.
- The College recommends that ONC clearly label on the envelope, subject line, or phone message with the official nature of the Surveillance and Direct Review request so as to differentiate itself from the abundance of other types of communications.
- ACP recommends that ONC Surveillance tests be performed on EHR test systems using test data, and involve the same test scripts that ONC uses during the EHR certification process. Further, the College recommends that ECs who participate in the Surveillance and Direct Review testing and attestation should receive ACI bonus points for successful participation.
- The College recommends that the second and third statements for the Health Information Exchange and Prevention of Information Blocking Attestation be struck or revised so that ECs are not held accountable for factors beyond their control.
- ACP recommends that CMS provide ECs with cost estimates for electronic submissions through registries and EHRs as well as time estimates for submission of attestations through CMS Web Interface to provide as much upfront information on which submission method would be the least burdensome and most cost effective.
- The College recommends that CMS focus the review and improvement of ACI measures on the value of the measures and whether they assist practices in applying health IT to improve the quality and value of care and not focus on the performance levels of the measures.

## **12. MIPS APMs (page 59)**

- ACP makes the following recommendations to improve MIPS APM participation:
  - Expand the number of reporting categories potentially reportable through the MIPS APM entity to all four performance components within the program.
  - Provide participants within a MIPS APM Entity with credit for 100 percent of the potential points under the Clinical Practice Improvement Activity (CPIA) component for their participation in a recognized MIPS APM.
  - Develop expedited “glide paths” to facilitate, where appropriate, the transitioning of MIPS APMs to Advanced APMs.

## **B. Alternative Payment Models (page 60)**

### **1. Medical Home Models (page 60)**

- A reasonable reading and interpretation of the statute can lend one to understand what we believe to be the clear congressional intent—that CMS should allow a medical home to qualify as an [advanced] APMs, without bearing more than nominal financial risk; if it is a medical home that meets criteria comparable to medical homes expanded under section 1115A(c).
- ACP recommends that CMS take the following steps to provide multiple pathways for medical homes to be included in the advanced APM pathway, to be implemented in a timely enough basis for eligible medical homes to qualify as advanced APMs within the first year of program implementation (2019):
  1. Immediately initiate plans to undertake an expedited analysis of the results of the Comprehensive Primary Care initiative (CPCi) to determine whether the statutory requirements for expansion by the Secretary are met (i.e., Section 1115A(c), cited above). This analysis should be completed no later than six months from promulgation of the final rule to allow for a determination to expand CPCi in time for medical home practices to qualify as advanced APMs in 2019. In parallel with this analysis, CMS should initiate advanced planning to develop their expansion approach for the CPCi program.
  2. Establish a deeming program or process to enable practices enrolled in medical home programs run by states (including state Medicaid programs), other non-Medicare payers, and employers as being deemed to have met criteria “comparable to medical homes expanded under section 1115A(c)”
  3. Allow inclusion of medical home programs as advanced APMs that meet the Medical Home Model Standard for financial risk and nominal amount as outlined in the proposed rule. The College strongly recommends that CMS use the Medical Home Model Standard for financial risk and nominal amount to allow additional PCMH practices to qualify as advanced APMs.
- In recognition of the up-front costs of establishing the infrastructure required to deliver services within this model and the limited ability of most primary care practices to accept even minimal downside risk, ACP recommends that the 2.5 percent risk requirement remain at that level until it is determined that a sufficient number of model participants have demonstrated the ability to succeed under even this minimal downside risk requirement.

### **2. Availability of Alternative Payment Models and Advanced Alternative Payment Models to Non-Primary Care Specialists/Subspecialists (page 68)**

- ACP recommends that CMS:
  - Provide priority for consideration through the Physician Focused Payment Models Technical Advisory Committee (PTAC) and for CMMI testing for models

involving physician specialty/subspecialty categories for which there are no current recognized APMs and Advanced APM options available. We further recommend that CMS provide a clear pathway for models recommended by PTAC to be implemented as APMs under MACRA

- Reduce the nominal risk requirement for potential advanced alternative payment models other than the Medical Home model.
- Create a platform to expedite the testing for APM recognition of bundled payment and similar episodes of care payment models.

### **3. Medicare Shared Savings Program (MSSP) (page 70)**

- The College reaffirms its belief that Track One MSSP ACOs should qualify as meeting the nominal risk requirement for determining an advanced APM.
- The College recommends the addition of a new Track within the MSSP that helps bridge the transition for one-sided to two-sided risk.

### **4. Other APM Issues (page 71)**

- The College recommends that CMS delay the start day for the first performance period for MIPS APMs and Advanced APMs until January 1, 2018, with the payment adjustment year remaining 2019.
- ACP recommends that CMS withdraw its proposal to decide on a case-by-case basis whether to exclude many payments made to physicians that are not traditional Medicare Physician Fee Schedule payments from calculations of the five percent lump sum payments to participants in Advanced APMs.

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

### **A. MIPS Performance Period**

#### **Background:**

CMS proposes to establish the performance period for the 2019 payment adjustment period and subsequent years as the calendar year two years prior to the year in which the MIPS adjustment is applied. This is the same lag time between performance and payment adjustment periods that exists under current programs such as PQRS and Meaningful Use. CMS proposes establishing the initial performance period to be one year beginning on January 1, 2017. CMS notes that the Agency also considered a performance period that would begin on July 1 and end on June 30. CMS believes that this approach allows for both a full year of measurement and sufficient time to base adjustments on complete and accurate information.

Under MACRA, CMS is required to establish a performance period that begins and ends prior to the year that the MIPS payment adjustment takes place, beginning with the initial 2019 MIPS

payment adjustment year. The performance period must be as close as possible to the payment adjustment year. There is not a requirement that the performance be a specified length or one that requires it to begin by any specific date.

**ACP Comments:**

**The College urges CMS to delay start the initial performance period under QPP to July 1, 2017 rather than the proposed January 1, 2017, start date.** The performance period should remain as one year in length overall, ending on June 30, 2018. ACP believes that this later start date for the performance period better matches Congressional intent that the performance period be as close to the payment adjustment period as possible, while still allowing for the related payment adjustments to take place in 2019 as mandated by MACRA.

Given that the final rule implementing the initial performance period for MACRA will likely not be issued until October 2016 at the earliest, CMS, physician organizations, ECs, and other affected parties would have less than three months to prepare for implementation of an entirely new Medicare payment system, QPP. While it may be feasible for the physician fee schedule to be issued and implemented in a short time frame, the MACRA rule is different because it is not simply issuing revisions to a rule that has previously been implemented. Rather the MACRA rule entails digesting long, complex policies on MIPS and APMs that have never been in existence. Significant efforts will be required by CMS, physician organizations, and others to prepare educational materials and tools and provide practices opportunities to learn how they can succeed in QPP and best meet the needs of their patients. CMS should also use the time between the issuance of the final rule and the later July 1, 2017, start date to refine the feedback mechanisms that will be utilized for QPP performance and allow for appropriate user feedback and end-to-end testing.

Additionally, ACP recommends that CMS retain the proposed one-year performance period. The College believes that a year of quality reporting data is necessary to ensure that solo and small practices have sufficient data to be reliable and valid. The College also encourages CMS to maintain the CPIA performance requirement of any 90 days within the performance period and allow for this same 90-day requirement for ACI performance (as discussed in more detail in later comments). ACP does want CMS to move to a performance period that is shorter and closer to the payment adjustment year in the future. However, we have concerns with moving to a shorter performance period before data are available on the impact such a change will have on clinicians' ability to report data that is reliable and valid, especially on small practices and specialists. Therefore, ACP recommends that CMS conduct and release a thorough analysis of performance data including analysis based on practice size and specialty using the 2015 quality and resource use data and consider shortening the performance period if data shows that a significant majority solo physicians and small practices (including specialist/subspecialist practices) would have data sufficient to be reliable and valid under a shorter performance period. It is important that an analysis of this kind be conducted to provide assurances that any decrease in the length of the performance period not have unintended negative consequences for any practice types including small practices and those with specialists/subspecialists.



## B. Complexity in MIPS Performance Scoring

### **Background:**

When Congress sunsetted the payment adjustments associated with PQRS, the value-based payment modifier, and the EHR meaningful use program through MACRA, the intent was that these programs would be rolled into one streamlined program – MIPS – that combines the piecemeal approach to assessing clinicians into a single program with a single payment adjustment attached to it. ACP has concerns with the fragmented structure of MIPS in the current proposed rule because it seems to allow each performance category to operate within its own silo, with little interaction between reporting categories in a more comprehensive fashion. There are different exclusions and carve outs, different scoring systems, and even different treatments of the definition of a small practice between the four performance categories. And while all of this may have been well-intentioned, the inconsistent construction adds significant complexity to the already complicated Quality Payment Program.

CMS proposes a different methodology for the weight of points in each performance category that does not align with the value of the category in contributing to the overall composite performance score (CPS). For quality, there are 80 or 90 points needed for a full performance score (dependent upon practice size) that add up to account for 50 percent of a physician's composite performance score. For resource use, there are 43 possible measures, and each applicable measure is worth a maximum of 10 points. The average score of all of the measures that can be attributed to a physician in the resource use category counts for 10 percent of the CPS. In the CPIA category, ECs select 3 to 6 activities, depending on the weighting of the activities selected, to reach a maximum score of 60 points, which then equates to 15 percent of the CPS. Advancing care information is even more complex, with a base score of 50 points that must be met in order to achieve any credit, an additional 80 points available for performance on other activities, and a bonus point for additional public health registry reporting. The maximum points for full credit is 100 points (even though 131 are possible), and this only equates to 25 percent of the composite score.

### **ACP Comments:**

The variation in point values and weighting in each performance category creates a system that is overly complex and confusing, and that makes it difficult for physicians to determine where to invest their resources to maximize their performance under MIPS. **ACP recommends that CMS simplify and clarify performance scoring in the final rule to allow physicians to better assess the scoring and weighting within each category.** The scoring system should be set up in a simpler format that allows physicians to easily determine the impact that reporting on a measure, objective, or CPIA could have on their overall composite performance score (i.e., 100 points).

**Therefore, the College strongly recommends that CMS consider modifying the point values within the overall MIPS performance scoring to reflect a more unified approach by making**

the points available for performance on each category and measure reflective of the value it has in the overall CPS (see Figure 1). This means that the all of the available points within the quality component would add up to a total of 50 points, not 80 – which then counts for 50 percent; the points within resource use would add up to a total of 10 or less (see the College’s recommendations on resource use later in this letter); the points within CPIA would add up to 15; and the points within ACI would add up to 25 (and not 131, with only 100 of those points actually “counting,” as currently proposed). By simplifying the scoring to allow the maximum points for each measure or activity to directly translate to its contribution to the overall CPS, the scoring will be streamlined to better account for MIPS as one comprehensive program rather than silos for each performance category. This will allow physicians to better focus their efforts on the activities and measures that are most meaningful to their patients and practice.

**Figure 1**

Comparison between CMS and ACP Proposed MIPS Composite Performance Score Methodology

CMS PROPOSED MIPS COMPOSITE PERFORMANCE SCORE METHODOLOGY				
QUALITY	RU/COST	CPIA	ACI	MIPS CPS
$\left( \frac{\#}{80^*} \times 50\% \right)$	$+ \left( \text{Average of Applicable Measures} \times 10\% \right)$	$+ \left( \frac{\#}{60} \times 15\% \right)$	$+ \left( \frac{\#}{100^{**}} \times 25\% \right)$	$\times 100 = ?$
ACP PROPOSED MIPS COMPOSITE PERFORMANCE SCORE METHODOLOGY				
QUALITY	RU/COST	CPIA	ACI	MIPS CPS
$\frac{\#}{60}$	$+ \text{Zeroed Out}^{***}$ N/A	$+ \frac{\#}{15}$	$+ \frac{\#}{25}$	$= \frac{\#}{100}$

\* could be #/90 depending on EC

\*\* 131 possible points

\*\*\* More details in Resource Use section of letter

Additionally, ACP recommends that CMS consider additional options in rulemaking to promote performance of quality improvement activities that crossover into multiple performance categories to strengthen MIPS and make the program more comprehensive rather than siloed. This could be done through the provision of bonus points or other performance incentives for participating in cross-performance category quality improvement initiatives. For example, immunizations are an important public health priority for both patients and physicians, and practices could be rewarded for selecting quality measures and CPIAs that have an immunization component in addition to performing on the public health registry objective in ACI.

Further, given the significant need for simplification, as well as other improvements in the rule (as outlined above and throughout all of ACP’s recommendations), the College calls on

**CMS to release an interim final rule with comment period as soon as possible to address a number of critical issues that would benefit from additional discussions with key stakeholders, including specialty societies, frontline clinicians, patients, other payers, vendors, and others.**

### **C. Performance Threshold**

#### **Background:**

CMS proposes to model 2014 and 2015 Part B allowed charges, 2014 and 2015 PQRS data submissions, 2014 and 2015 Quality and Resource Use Report (QRUR) and sQRUR feedback data, and 2014 and 2015 Medicare and Medicaid EHR Incentive Program data to inform where the performance threshold should be. The Agency plans to use this data to estimate the impact of the quality and resource use scoring proposals and use the EHR Incentive Program information to estimate which MIPS eligible clinicians are likely to receive points for the advancing care information performance category. Due to the lack of historical data for the CPIA performance category, CMS proposes to apply sensitivity analyses to help inform where the performance threshold should be for that performance category.

For the initial performance period, CMS proposes to set the performance threshold at a level where approximately half of ECs will fall below the threshold and half will be above. The Agency believes that this is consistent with Congress' treatment of the threshold in years three and subsequent years, which allows CMS to choose to set the performance threshold at the mean or median of the composite performance score in a prior period. The Agency also considered alternate options such as setting threshold to ensure that an EC earned a minimum number of points before becoming eligible to receive a positive adjustment or an exceptional performance bonus or setting the threshold so that the scaling factor for positive adjustments is 1.0.

#### **ACP Comments:**

**ACP recommends that CMS carefully consider the performance threshold for MIPS in the first performance period to take into account the impact that it will have on various types of clinicians, in particular weighing how small practices will be affected.** The College has concerns with arbitrarily setting the performance threshold at the halfway point without additional analysis of how the current reporting programs differ from the MIPS performance categories so that necessary adjustments could be made. CMS should carefully consider that the PQRS, VM, and EHR Meaningful Use programs do not directly translate to the requirements for the related performance categories in MIPS.

### **D. Group Reporting**

#### **Background:**

CMS proposes to define a group practice for reporting purposes as a Taxpayer Identification Number (TIN) with two or more MIPS eligible clinicians, as identified by their National Provider Identifier (NPI), who have reassigned their Medicare billing rights to the TIN. CMS will use

multiple identifiers for eligible clinicians that allow them to choose between being measured as an individual or collectively through a group's performance. The Agency proposes that the same identifier be used across all four performance categories, so if a group (identified through a TIN) chooses to submit information collectively for one performance category it must report collectively across all four performance categories. In order to have performance assessed as a group, individual MIPS eligible clinicians must aggregate their performance data across the TIN. Additionally, while the EHR Meaningful Use program only allowed for assessment at the individual clinician level, TINs that elect to report as a group will now be assessed on their EHR functionalities as a group through the Advancing Care Information performance category. CMS proposes to use a TIN/NPI identifier for applying the payment adjustments, regardless of how a MIPS EC is assessed.

**ACP Comments:**

The College has significant concerns with CMS' proposal to restrict group reporting to TIN-level identification. While some TINs may be representative of a group of clinicians that are solely primary care or focused on one specialty, many TINs represent many different specialties and subspecialists. Physicians may have elected to join together under a common TIN for billing purposes for a variety of reasons, but that does not necessarily equate to a TIN being representative of common patient conditions, treatments, etc. Internal medicine physicians and subspecialists may have assigned their billing privileges to a TIN that includes 20 or more different specialties within it. And while many of these TINs prefer to elect the group reporting option, current CMS proposals will mean that most of the physicians in multi-specialty TINs will be forced to report on a common set of general measures in order to find a measures set that can apply broadly across the different specialties within the group. Requiring groups with multiple specialties to report as a TIN also adds a layer of complexity and confusion to practices trying to find measures that are meaningful to each physician's scope of practice.

To address the concerns related to multi-specialty TINs, **ACP strongly urges CMS to allow group practices additional reporting options when they choose to report at the group-level by allowing TINs to choose to subdivide into smaller groups for the purposes of being assessed for performance in MIPS.** This option should be available to clinicians in addition to the proposed options of allowing individual reporting or TIN-level group reporting. CMS could implement this subgroup by allowing TINs to identify smaller groups of NPIs that should be grouped together for performance assessment. In allowing for specialty-focused subgroups within TINs to report collectively, these smaller groups would have the flexibility to choose the performance activities that are most relevant to their scope of practice and patient population. Rather than choosing a general set of activities or a set that is focused around the dominant specialty within a TIN, each subgroup within the TIN would have the ability to report on the quality measures (including a more specialty-specific outcome or high priority area measure) and CPIAs that are most relevant to the specialty/subspecialty members.

This option of allowing small group reporting within TINs will also be in the best interest of the patients and families/caregivers. Limiting group reporting to the TIN-level only for multi-

specialty practices will not create publicly reported data that is meaningful to consumers. For example, a patient or family/caregiver looking for information on Physician Compare might want to know how a cardiologist performed on quality measures related to managing heart diseases. Under the current TIN-level group reporting option, this patient or family/caregiver might be unable to find anything on measures related to heart disease management because the physician was in a multi-specialty group under TIN that had to report on measures with less of a specialty focus. By allowing smaller groups of clinicians within a TIN to be grouped together for assessment purposes, the cardiologists could form a group that reports on quality measures most relevant to their scope of practice and the patients that they treat.

## **E. Virtual Groups**

### **Background:**

Section 1848(q)(5)(I) of the Act establishes the use of voluntary virtual groups for certain assessment purposes. The statute requires the establishment and implementation of a process that allows an individual MIPS eligible clinician or a group consisting of not more than 10 MIPS eligible clinicians to elect to form a virtual group with at least one other such individual MIPS eligible clinician or group of not more than 10 MIPS eligible clinicians for a performance period of a year. While the rule recognizes this requirement, it proposes to delay the onset of this provision until the 2018 performance year based on identified significant barriers regarding the development of a technological infrastructure required for successful implementation and the operationalization of provisions that would make this a conducive option for MIPS eligible clinicians or groups.

### **ACP Comments:**

The College believes that the implementation of the virtual groups provision is an important step towards establishing a viable and effective quality payment program. It will allow small practice clinicians to aggregate their data to allow for more reliable and valid measurement as well as serve as a platform to facilitate shared accountability and collaborative efforts. While we recognize and appreciate the barriers mentioned towards implementation in time for the 2017 performance period, ACP is not supportive of the planned delay in implementation. It places small practices in a situation in which payment adjustments based-upon the 2017 performance year will likely be based upon suspect data.

**Therefore, ACP strongly urges CMS to include in the final rule for the 2017 performance period a policy that allows small practices to join together as virtual groups for the purposes of MIPS assessment in the initial performance period.** This is a critical option that small practices should be allowed in order to allow greater assessment opportunities under MIPS. To accomplish creating a virtual group option for the first performance period, the College notes that CMS can utilize Interim Final Rulemaking processes.

Along these lines, ACP has strongly championed the concept of encouraging connecting primary care medical homes with specialist medical homes that commit to coordinating care across

both settings, including entering into formal agreements on sharing information seamlessly. This concept—which we call the Patient-Centered Medical Home Neighborhood<sup>4</sup>—came out of the work of our own Council of Subspecialty Societies, and was the basis for the development of ACP’s High-Value Care Coordination Toolkit,<sup>5</sup> which provides resources to facilitate more effective and patient-centered communication between primary care and subspecialist doctors. This toolkit provides practical and actionable resources for primary care and specialist practices to more effectively coordinate care. Its use could be incentivized by CMS within the CPIA category of MIPS.

ACP’s Patient-Centered Medical Neighborhood policy paper was also the basis for the NCQA’s specialty medical home certification process. The College is aware that NCQA, in its comments on this proposed rule,<sup>6</sup> has proposed an approach whereby CMS would “include guidance on:

- Identifying virtual group partners, such as recognized PCMH and/or PCSP [patient-centered specialty practices] that MACRA actively promotes. Recognized PCMHs and PCSPs have demonstrated commitments to well-coordinated, high-quality, patient-centered care and thus greater potential to improve MIPS scores. These could be:
  - Other PCMH and PCSP practices in the same community or geographic region; or
  - Groups of similar PCSPs likely to report the same specialty measures.
- Drafting written agreements to establish virtual groups and share accountability and financial risk;
- Developing skills and tools for group reporting that will be new to virtual groups;
- Developing skills and expertise in analyzing data and addressing any quality gaps in order to improve MIPS scores and succeed as virtual groups; and
- Developing further skills and expertise to maximize use of CEHRT, base pay on performance and take two-sided risk in order to become APMs.”

While we are not endorsing the NCQA’s proposal per se, we join with NCQA in encouraging CMS to consider the concept of making the PCMH and PCMH-Neighbor the basis for proposing a virtual group reporting option.

The College is also aware that URAC, in their comment letter, stated that “CMS must protect against anti-trust issues that may arise regarding physician collaboration to recognize economies of scale. The Federal Trade Commission (FTC) has indicated that clinically integrated networks, formed to improve the quality and efficiency of care delivered to patients, is a network model compliant with federal laws.” As with above, ACP is not formally endorsing

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<sup>4</sup> American College of Physicians. The Patient-Centered Medical Home Neighbor: The Interface of the Patient-Centered Medical Home with Specialty/Subspecialty Practices. Philadelphia: American College of Physicians; 2010: Policy Paper. (Available from American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106.) Accessed at:

[https://www.acponline.org/system/files/documents/advocacy/current\\_policy\\_papers/assets/pcmh\\_neighbors.pdf](https://www.acponline.org/system/files/documents/advocacy/current_policy_papers/assets/pcmh_neighbors.pdf)

<sup>5</sup> <https://www.acponline.org/clinical-information/high-value-care/resources-for-clinicians/high-value-care-coordination-hvcc-toolkit>

<sup>6</sup> <http://www.ncqa.org/public-policy/comment-letters/ncqa-comments-on-macra>

URAC's specific proposal, however we do agree that the development of virtual groups should be done "in a manner that incentivizes sustainable growth as integrated networks capable of long-term success under value-based reimbursement."

**If the Agency is unable to provide a virtual group option through rulemaking for the first year, then as a backup, ACP recommends that CMS treat small practices in a manner similar to how they were treated in the phase-in of the Value-based Payment Modifier (VM) program.** This is similar to an approach offered by the American Academy of Family Physicians in its comment letter to the agency. Under this option, CMS would allow solo clinicians and groups of 2-9 ECs that report under MIPS to be held harmless from any potential downward adjustments until such time that a virtual groups option is made available. This would mean that these small practices would only be eligible to receive a neutral or positive adjustment (including a potential bonus for exceptional performance) for their performance in MIPS. Similar to the VM policy, solo and small practices that do not report for MIPS performance assessment would receive the maximum downward payment adjustment for failing to report. The College believes that a hold harmless policy is an important protection that CMS should add for small practices that do not have a virtual groups option.

#### **F. Low-volume Threshold**

##### **Background:**

MACRA requires CMS to set a low-volume threshold at which clinicians who fall below are not considered eligible clinicians for the purposes of MIPS. CMS has the discretion to use one or more of the following criteria in determining this exclusion: 1) the minimum number of Part B-enrolled beneficiaries who are treated by the clinician during the performance period; 2) the minimum number of items and services provided to Part-B enrolled beneficiaries during the performance period; and 3) the minimum amount of allowed charges billed by the MIPS eligible clinician during the performance period. CMS proposes to define MIPS eligible clinicians or groups who do not exceed the low-volume threshold as those who have Medicare billing charges of less than or equal to \$10,000 AND provide care for 100 or fewer Part B-enrolled beneficiaries during the performance period.

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

The College recommends that the low-volume threshold be revised significantly in the final rule. Since the release of the MACRA NPRM, many concerns have been expressed about the potential impact of MIPS on solo and small physician practices. To help mitigate adverse effects on small practices, CMS has proposed a low-volume threshold that would exempt physicians with less than \$10,000 in Medicare allowed charges AND fewer than 100 unique Medicare patients per year from MIPS. However, based on our analysis, the proposed threshold would help very few physicians and other clinicians. **Therefore, ACP recommends that CMS raise the threshold to \$30,000 in Medicare allowed charges OR require fewer than 100 unique Medicare patients be seen by the clinician, as this would help provide a better safety net for**

**small practices.** This would result in less than 30 percent of physicians being excluded, while still including more than 93 percent of allowed spending in the MIPS program.

**In addition to revising the low volume threshold, the College recommends that CMS develop a hardship exceptions process for MIPS through which ECs can apply to CMS on a case-by-case basis with special circumstances that warrant exclusion from MIPS for a performance period.** There may be some clinicians who would be unable to transition away from the current model of payment through no fault of their own; this might include ECs that are significantly impacted by a natural disaster such as a hurricane or earthquake, adoption of new technology that results in inability to report, hospital or practice closure, severe financial distress (bankruptcy), etc.

### **1. Medicare Participation Status**

The proposed rule states it “would establish the Merit-Based Incentive Payment System (MIPS), a new program for certain Medicare-participating practitioners.” The College urges the Agency to clarify whether the requirements of this new MACRA program apply to non-participating clinicians. Additionally, the College recommends that the Agency track the number and group size of participating clinicians that change their status to non-participating and make this data available, as this could cause access issues in the future.

### **G. Telemedicine in MIPS**

#### **Background:**

Under the section defining MIPS ECs, CMS proposes to include telehealth services within the definition of “patient-facing” or “face-to-face” encounters. In the past, telehealth services have not been included in the definition of patient-facing encounters when reporting quality measures through PQRS. CMS also proposes to include telehealth services within the clinical practice improvement activities subcategory.

#### **ACP Comments:**

A recent ACP position paper<sup>7</sup> recommends “telemedicine be held to the same standards of practice as if the physician were seeing the patient in person” and the College appreciates and supports the inclusion of telehealth services within the definition of patient-facing encounters. This inclusion is also beneficial for ECs providing certain telemedicine services who can now count these visits towards the minimum threshold for patient-facing encounters when reporting on quality measures.

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<sup>7</sup> Daniel H, Sulmasy LS, for the Health and Public Policy Committee of the American College of Physicians. Policy Recommendations to Guide the Use of Telemedicine in Primary Care Settings: An American College of Physicians Position Paper. *Ann Intern Med.* 2015;163:787-789. doi:10.7326/M15-0498



ACP also supports CMS' inclusion of telehealth services within the clinical practice improvement activities (CPIA) subcategory for Expanded Practice Access as a way to incentivize and expand the use of telehealth services. The proposed scoring weight for the telehealth services activity is "medium" instead of "high." **ACP recommends weighting the telehealth services activity as "high" (more specifics on ACP's weighting recommendations for CPIA are further described later in this letter).** Additionally, the College supports using administrative claims data, if feasible, for reporting on this specific telehealth activity within the CPIA category (e.g., an EC using the telehealth modifier GT code would receive automatic full credit for this activity without having to report it separately).

The College appreciates the addition of telehealth services to the provisions discussed above but recommends including additional language within the regulation that supports further expansion of telehealth services through lifting current telemedicine restrictions. ACP's recent letter of support<sup>8</sup> for the CONNECT for Health Act outlines some of the components necessary for continued meaningful expansion and incorporation of telehealth services within new health care models including the creation of demonstration projects that test lifting current telehealth restrictions for MIPS- and APM-ECs.

## **H. MIPS Performance Categories**

### **1. Quality Performance Category**

#### **a. Measure Requirements**

##### **Background:**

CMS is proposing that MIPS eligible clinicians or groups report at least six measures, including one cross-cutting measure (if the clinician sees patients) and at least one outcome measure, for a 12-month reporting period. If an applicable outcome measure is not available, then the clinician or group would be required to report on one high-priority measure (e.g., appropriate use, patient safety, efficiency, patient experience, and care coordination measures). Non-patient facing MIPS ECs will not be required to report on any cross-cutting measures—and CMS lays out further considerations related to non-patient facing MIPS eligible clinicians in the proposed rule. Additionally, there is no longer a requirement that the measures span multiple National Quality Strategy (NQS) domains.

The agency also states that if fewer than six measures apply to the individual MIPS eligible clinician or group, then they would only be required to report on each measure that is applicable. However, CMS notes that MIPS eligible clinicians who fail to report on an applicable measure or activity that is required to be reported shall be treated as receiving the lowest possible score for the measure or activity; therefore, for any MIPS eligible clinician who does not report a measure required to satisfy the quality performance category submission criteria

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<sup>8</sup> [https://www.acponline.org/acp\\_policy/letters/acp\\_support\\_letter\\_connect\\_for\\_health\\_2016.pdf](https://www.acponline.org/acp_policy/letters/acp_support_letter_connect_for_health_2016.pdf)

would receive zero points for that measure. In the case where a MIPS eligible clinician reports a measure that does not meet the required case minimum, he/she would not be scored on the measure but would also not receive a “zero” score. CMS further notes that they intend to develop a validation process to review and validate a MIPS eligible clinician's inability to report on the quality performance requirements that would function similar to the Measure Applicability Validity (MAV) process that occurred under PQRS, but with a few exceptions. Clinicians and groups can submit their quality data to CMS via the following mechanisms: claims, qualified registry, EHR or qualified-clinical data registry (QCDR).

CMS also has outlined several specialty-specific sets of measures to assist in measure selection—MIPS eligible clinicians and groups are proposed to be able to select their measures from either the overall list of MIPS measures or a set of specialty-specific measures. If a clinician or group selects a specialty-specific measure set that has fewer than six measures, then they are only required to report on those measures in the set, as well as at least one cross-cutting measure and one outcome or high priority measure (if no applicable outcome measure is available).

CMS also proposes to use acute and chronic composite measures of Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQIs) that meet a minimum sample size in the calculation of the quality measure domain for the MIPS total performance score. Eligible clinicians will be evaluated on their performance on these measures in addition to the six required quality measures discussed above. The agency proposes to incorporate a clinical risk adjustment as soon as feasible to the PQI composites and continue to research ways to develop and use other population-based measures for the MIPS program that could be applied to greater numbers of MIPS eligible clinicians going forward. Additionally, the agency proposes to include the all-cause hospital readmissions measure from the value-based modifier (VM) program as they believe this measure also encourages care coordination. Eligible clinicians in groups with 10 or more clinicians with sufficient cases will be evaluated on their performance on this measure in addition to the six required quality measures discussed previously. These proposed claims-based population measures would rely on the same two-step attribution methodology that is currently used in the VM.

With regard to reporting on patient experience, CMS has proposed to allow registered groups of two or more MIPS eligible clinicians to voluntarily elect to participate in the Consumer Assessment of Healthcare Providers & Systems (CAHPS) for MIPS survey. The use of CAHPS for MIPS survey would count as one cross-cutting and/or a patient experience measure for that group. CMS specifically states that a group may report any five measures within MIPS plus the CAHPS for MIPS survey to achieve the six measures threshold. However, the Agency is specifically asking for feedback as to whether the CAHPS for MIPS survey should be required for groups of 100 or more MIPS eligible clinicians or if it should be voluntary.

**ACP Comments:**

**In our comments on the quality component of MIPS, it seems imperative to reiterate our call for CMS to use the opportunity provided through the new MACRA law to actively build a learning health and healthcare system.** It is critically important that the new payment systems that are designed through the implementation of MACRA reflect the lessons from the current and past programs and also effectively allow for ongoing innovation and learning. **Overall, quality measurement must move toward becoming more relevant and accurate, and toward effective approaches of measuring patient outcomes.**

Additionally, as was noted in our comments to CMS on the draft Quality Measure Development Plan (MDP)<sup>9</sup>, it is critically important to constantly monitor the evolving measurement system to identify and mitigate any potential unintended consequences, such as increasing clinician burden and burn-out, adversely impacting underserved populations and the clinicians that care for them, and diverting attention disproportionately toward the things being measured to the neglect of other critically important areas that cannot be directly measured (e.g., empathy, humanity). **Therefore, the College strongly recommends that CMS collaborate with specialty societies, frontline clinicians, and EHR vendors in the development, testing, and implementation of measures with a focus on integrating the measurement of and reporting on performance with quality improvement and care delivery and on decreasing clinician burden.**

ACP is appreciative that CMS has proposed to reduce the overall number of measures required for reporting from nine measures to six, as well as removing the requirement that these measures fall across all of the National Quality Strategy domains. However, the College would like to reiterate our overall concerns with the performance measures that are currently in use within the PQRS program, as well as many of those proposed for use within MIPS. To begin to address this issue in the short term, in our comments on the draft MDP, ACP called on CMS to utilize the core set of quality measures identified by the Core Quality Measures Collaborative. Therefore, we are appreciative that the Agency has specifically identified those core measures within the proposed rule; however, the College believes that CMS could do more than simply include them in the overall list with identifying marks. At the very minimum, ACP recommends that the core measures be more clearly pulled out into their own table or set of tables so that clinicians do not need to wade through the entire list to find them. A more robust and meaningful short-term approach should go even further though. **Along these lines, the College recommends that ideally any measures CMS proposes to use outside of the core set identified by the Core Quality Measures Collaborative be endorsed by the Measure Application Partnership (MAP).** ACP remains concerned that a majority of new measures added to PQRS for the 2016 reporting year, and that remain on the proposed list of measures for the MIPS program, were given a MAP recommendation of “encourage continued development.” This

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

MAP designation is reserved for measures that often lack strong feasibility and/or validity data. Therefore, measures given the “encourage continued development” recommendation should be resubmitted to the MAP once the suggested development occurs.

Additionally, ACP continues to believe that it would be preferable for all measures, whenever possible and regardless of source, to go through a multi-stakeholder evaluation process—a role that is performed by the National Quality Forum (NQF). This process is important as it involves measures being evaluated against four important criteria—importance to measure, scientifically acceptable, usable and relevant, and feasible to collect.

**Further, the College recommends that CMS consider the recommendations made by ACP’s Performance Measurement Committee with regard to measure selection within MIPS.<sup>10</sup>**

These recommendations, as listed on the ACP website (with a thumbs up, down, or sideways), are based upon a scientific review process that involves four domains: purpose and importance to measure, clinical evidence base, measure specifications, and measure implementation and applicability. The ACP Performance Measurement Committee also specifically reviewed the MIPS measures in the proposed rule that they had not previously reviewed, with a focus on those relevant to internal medicine—these measures, with ratings, are included in the Appendix to this letter. Given the time constraints due to rulemaking, this additional review was undertaken with a somewhat different approach than described above. This revised approach did actively consider the four domains listed (however not in as detailed a manner as with the other measures), and it also took into account the potential consequences of using each measure in a payment incentive program. This latter consideration related to payment incentives is not one that is usually taken into account by the committee when making their measure recommendations; however, in this case, it was felt to be an important consideration given the urgency of finalizing a short term and practical starting point for quality measures within the MIPS program. As noted, the final recommendations of the ACP Performance Measurement Committee on the majority of the internal medicine-relevant measures in the proposed rule can be found either on the ACP website (each with a thumbs up, down, or sideways rating) or are listed in the Appendix.

Given that the approaches outlined above could result in a fewer number of measures available overall, particularly for a number of internal medicine subspecialties and other specialties, **ACP also recommends that CMS take concrete actions to provide clear options for those specialties and subspecialties that may be most impacted by too few appropriate measures.** Many of these specialties may already be impacted under the current proposal—particularly by a lack of outcomes and/or high priority measures—and certainly would be affected if number of the measures available were to be reduced through a more focused and needed approach of ensuring measure validity, clinical relevance, and ability to implement.

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<sup>10</sup> [https://www.acponline.org/clinical\\_information/performance\\_measurement/](https://www.acponline.org/clinical_information/performance_measurement/). Accessed: February 16, 2016.

These actions should include:

- **Developing a process to determine in advance of the reporting year which quality measures are likely applicable to each eligible clinician—and only holding them accountable for these relevant measures (i.e., weighting performance on the remaining measures higher, rather than penalizing them with a score of zero on unreported measures).** Perhaps this could be done through an analysis of the previous year’s claims data. The College strongly believes that ECs should not be vulnerable to situations where they are penalized after the fact for measures they were unaware that they could report on.
- **Putting a process in place, for the short term, to address the significant issues of validity and ability to implement associated with using measures that are not MAP-endorsed, NQF-endorsed, and/or ACP recommended (as outlined above).** This process could include clearly outlining the following:
  - Available evidence for a measure gap and that the proposed measure can potentially lead to improved care for patients—ideally the measure should be based on the most up-to-date clinical practice guidelines, if feasible;
  - Standards that clinicians and practices can use, in advance, to determine what threshold of performance constitutes high quality versus low quality—and this standard should be no higher than what has been achieved via randomized controlled trials (RCT), or the best available evidence if an RCT has not been conducted or completed;
  - Ability to reasonably collect appropriate and necessary data to calculate the measure;
  - Any potential unintended consequences of the measure, including a thorough assessment of the administrative burden of this measure on a clinician and his/her practice in terms of collecting and reporting the relevant data; and
  - Review and approval of the measure by at least one established medical organization that is not also the measure steward, such as a relevant professional society, if possible.
- **Establishing safe harbors for entities that are taking on innovative approaches to quality measurement and improvement as was recommended in a recent article by McGlynn and Kerr.**<sup>11</sup> This type of a coordinated program of safe harbors (that could involve CMS, other payers, as well as accrediting entities), where health care entities would be held harmless from penalties or other incentive systems if they take on the pursuit of measurement innovation, would be tremendously beneficial to all specialties. **Taking this recommendation a step further, the College also calls on CMS to provide clear protections for individual clinicians who participate in these types of activities—this could be done by having the entities register certain measures as “test measures.” Eligible clinicians then would not be required to report a specific performance score on these test measures, but their participation testing these measures (as some**

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<sup>11</sup> McGlynn, E.A. and E.A. Kerr. Creating Safe Harbors for Quality Innovation and Improvement. *JAMA*. 2016;315(2):129-130. <http://jama.jamanetwork.com/article.aspx?articleid=2481012>

established subset of the 6 required measures) would not count against them, and in fact could be given some level of points within the quality category and/or counted as a clinical practice improvement activity.

- Ensuring that the flexibility for QCDRs to develop and maintain measures outside of the CMS selection process is protected (this recommendation is discussed further below).

The College also reiterates our recommendation, as outlined in our response to the draft MDP—that it will be critically important for CMS over the longer term to continue to improve the measures and reporting systems to be used in MIPS to ensure that they measure items of clinical relevance, move toward clinical outcomes and patient- and family-centeredness measures, and do not create unintended adverse consequences. This recommendation is reflective of a recent article outlining the fact that there is no direct way to truly measure all of the important aspects of good patient care, but those aspects should still be supported, valued, and not undermined by the new measurement system.<sup>12</sup> These aspects include physicians’ confidence, empathy, humanity, personability, forthrightness, respect, and thoroughness. Additionally, a recent article by McGlynn, Schneider, and Kerr<sup>13</sup> sets out goals for how quality measurement could and should be reimaged in such a way that it would:

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

Others have called for these types of changes as well, for instance in a recent New York Times article, Robert M. Wachter<sup>14</sup> states that, “Measurement cannot go away, but it needs to be scaled back and allowed to mature. We need more targeted measures, ones that have been vetted to ensure that they really matter.” Most recently, Donald M. Berwick, MD, MPP, former CMS Administrator and one of the leading voices in health care quality, published a viewpoint article where he notes that we are in a current era of “excessive measurement, much of which is useless but nonetheless mandated. Intemperate measurement is as unwise and irresponsible as is intemperate health care.”<sup>15</sup> Dr. Berwick further states that “progress toward a much smaller set of outcome measures needs to be faster.”

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<sup>12</sup> Berenson, Robert A. and Deborah R. Kaye. “Grading a Physician’s Value—The Misapplication of Performance Measurement.” *NEJM*. 2013. Accessed at: <http://www.nejm.org/doi/full/10.1056/NEJMp1312287>.

<sup>13</sup> Elizabeth A. McGlynn, Ph.D., Eric C. Schneider, M.D., and Eve A. Kerr, M.D., M.P.H. “Reimagining Quality Measurement.” *N Engl J Med* 2014; 371:2150-2153. <http://www.nejm.org/doi/full/10.1056/NEJMp1407883>.

<sup>14</sup> Robert M. Wachter. January 16, 2016. “How Measurement Fails Doctors and Teachers.” *New York Times*. [http://www.nytimes.com/2016/01/17/opinion/sunday/how-measurement-fails-doctors-and-teachers.html?\\_r=4](http://www.nytimes.com/2016/01/17/opinion/sunday/how-measurement-fails-doctors-and-teachers.html?_r=4).

<sup>15</sup> Berwick, Donald M. “Era 3 for Medicine and Health Care” *JAMA*. 2016;315(13):1329-1330. Published Online: March 3, 2016. doi:10.1001/jama.2016.1509.

### *Outcome Measures*

The College reiterates our comments from the Quality Measure Development Plan regarding the use of outcome measures in the initial roll-out of MIPS. While ACP is strongly supportive of moving toward outcomes-based measures, as well as those focused on patient- and family-centeredness, care coordination, and population health and prevention, we do not recommend that CMS establish a minimum number of outcomes-based measures, at least initially. This is due to a number of factors, including but not limited to the need to more appropriately risk-adjust the outcome measures (discussed further below), attribution issues, and technology and infrastructure challenges that may prevent clinicians from being able to meaningfully impact these measures. CMS could (and should) instead incentivize clinicians to report on outcomes-based measures by assigning them more weight within the MIPS program. **Therefore, ACP calls on the Agency to remove the mandate for clinicians to report on at least one outcome measure, even though we recognize there is flexibility in that a “high priority” measure may be used when an outcome measure is not available. Clinicians that choose to use an outcome measure should be provided bonus points within the quality category of MIPS.**

### *Population-Based Measures*

The College reiterates our Measure Development Plan comments on the use of population- or community-based measures. ACP recognizes that individual clinicians do have a responsibility to work collaboratively with their patients to address and mitigate, to the extent possible, population- and community-level issues that impact patient health and well-being. However, attributing population health measure outcomes to specific clinicians is not appropriate and, in fact, defeats the purpose of population health measures. The core measure set recommended in the recent Institute of Medicine *Vital Signs* report<sup>16</sup> can serve as a framework to help with sharpening the focus of the measurement community on key priorities and ensuring the importance of population health, social determinants of health, and systems-based approaches are actively considered in the development, testing, and implementation of performance measures that are applicable at the individual clinician level. **However, in order to move toward developing measures that are appropriate for individual clinicians, CMS must collaborate with clinicians and specialty societies to ensure that individuals are not held accountable for measures that are designed to assess community-level outcomes.**

**Therefore, the College recommends that CMS remove the three population health measures from the quality category.** However, recognizing that there is evidence that community-level interventions improve individual health outcomes, **the College further recommends that CMS, and HHS more broadly, consider other approaches to support public health interventions and the work of the physicians involved in those efforts, including providing optional CPIA points for the proposed population health measures and/or for participation in public health efforts within the CPIA category of MIPS.**

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<sup>16</sup>Institute of Medicine. *Vital Signs: Core Metrics for Health and Health Care Progress*. 2015. <http://www.nationalacademies.org/hmd/Reports/2015/Vital-Signs-Core-Metrics.aspx>

### *Cross Cutting Measures*

The College is concerned about CMS' proposed removal of the following two measures: *PQRS #110 (Preventive Care and Screening: Influenza Immunization)* and *PQRS #111 (Pneumonia Vaccination Status for Older Adults)*. ACP believes it is critically important that elderly and disabled patients have access to ACIP-recommended vaccines. **Therefore, we recommend that CMS not remove PQRS #110 and PQRS #111 as cross-cutting measures, which will help ensure that eligible clinicians in a variety of care settings will be incentivized to offer immunization services in the course of providing care to patients.** Fewer clinicians offering these critical preventive services will result in more 'missed opportunities' for immunization and a greater likelihood of illness and complications from vaccine preventable conditions, such as influenza and pneumonia.

### *Patient Experience Measurement (i.e., CAHPS for MIPS)*

In line with the comments on the CMS Quality Measure Development Plan, **ACP strongly recommends that reporting CAHPS for MIPS remain voluntary at a minimum—and further recommends that this survey be removed from the quality component and instead be identified as one of the optional clinical practice improvement activities (CPIA), within the subcategory of beneficiary engagement.**

Additionally, in order to more cohesively address the issue of patient experience, **the College recommends that CMS consider an approach recently outlined by McGlynn, Schneider, and Kerr,<sup>17</sup> which calls on measure developers to actively consider how to integrate patient preferences and goals into measure design**—this would involve investments in new methods and systems with a focus on having quality measurement be part of care delivery “rather than existing as a parallel.”

### *Risk Adjustment of Quality Measures*

The College believes that valid risk adjustment is essential for the success of MACRA implementation, particularly for outcome and population-based measures. It is critical that clinicians and practices not be penalized for taking care of patients in underserved areas and/or with characteristics that are more likely to lead to worse outcomes. This is true both under the MIPS pathway, within the Quality and Resource Use components, and within the Alternative Payment Model (APM) pathways as it affects benchmarking, quality calculations, and the adequacy of various upfront (e.g. care management payment under CPC+) and backend (MSSP shared savings) payments. As a result, **the College recommends that CMS use its resources in an active effort to continually improve the risk adjustment methodology employed within MACRA implementation.** The College believes that the current Medicare HCC risk adjustment approach is a significant improvement from previously used methodologies. We look forward to the completion of studies being conducted by the HHS Office of the Assistant Secretary for

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<sup>17</sup> Elizabeth A. McGlynn, Ph.D., Eric C. Schneider, M.D., and Eve A. Kerr, M.D., M.P.H. “Reimagining Quality Measurement.” *N Engl J Med* 2014; 371:2150-2153. <http://www.nejm.org/doi/full/10.1056/NEJMp1407883>.



Planning and Evaluation (ASPE) on the issue of risk adjustment for socioeconomic status on quality measures and resource use, and the use of this information to improve further the risk adjustment methodology currently being applied.

**Along these lines, ACP recommends that the Agency actively work to incorporate socioeconomic status (SES) into its risk adjustment methodologies given that there is existing literature on the impact of SES on the rates of hospitalizations, readmissions, and other factors—and the ASPE report, once available, can be additionally informative on this issue.**

Ideally, and perhaps over time, this adjustment would be patient-specific (e.g., based on his/her specific income, education, etc.); however, in the short term an aggregate marker, such as zip code, could be used—particularly as recent data suggest that zip codes can be used to identify social determinants of health.

#### **b. QCDRs**

##### **Background:**

Quality measures that are used in QCDRs are excluded from many of the requirements that other measures utilized in MIPS must undergo. They do not need to go through notice and comment rulemaking; be published in the *Federal Register*; or be submitted for publication in specialty-appropriate, peer-reviewed journals. If a QCDR chooses to use non-MIPS measures (measures that are not part of the MIPS quality measures set), CMS proposes that these measures must go through a rigorous approval process by the Agency. This includes a review and analysis of measure specifications for scientific rigor, technical feasibility, duplication pertaining to current MIPS measures, clinical performance gaps evidenced by background and/or literature review, and relevance to specialty practice quality improvement. While non-MIPS measures used by QCDRs are not required to be NQF-endorsed, CMS encourages QCDRs to select NQF-endorsed measures and measures that have been in use prior to MIPS.

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

The QCDR reporting mechanism was introduced for the Physician Quality Reporting System (PQRS) beginning in 2014. These systems have been useful for performance reporting for value-based payment and professionalism. In addition to their reporting capabilities they are a rich source of data for better understanding clinical practice, including patient characteristics, treatments and performance measure testing and benchmarking. QCDRs provide the opportunity to conduct comparative effectiveness research, safety surveillance, gap analysis, performance measure development and validation of new quality measures that are meaningful and result in improved health outcomes.

While the College appreciates that MACRA requires the Secretary to encourage the use of QCDRs for quality reporting, ACP has concerns with the more stringent approach that CMS has taken in reviewing QCDR measures that are not NQF-endorsed or PQRS measures recently. While the requirements in the proposed rule pertaining to QCDR measures are consistent with what has been in place in the past, the College is concerned that it appears that CMS is trying to

push QCDRs to limit their quality measures selections to those that are currently used in PQRS (and soon in MIPS) and those with NQF-endorsement. The College emphasizes that QCDRs have been given special treatment under law that explicitly allows them to use measures that are that do not go through the vetting process that MIPS measures must undergo. **Therefore, the College recommends that CMS ensure that the flexibilities that were given to QCDRs in law to develop and maintain measures that are outside of the CMS selection process are protected.**

CMS also limits the number of non-MIPS measures that a QCDR can request to report on to 30 measures and limits each QCDR to only using its own non-MIPS measures. These limits place unnecessary restrictions on QCDRs that may result in the inability of a QCDR to include sufficient numbers of measures to allow them to be used by all subspecialty and sub-specialty clinicians who may wish to utilize them due to a dearth of specialty-specific measures within the MIPS measure set. **ACP encourages CMS to remove the arbitrary restriction on the number of non-MIPS measures that a QCDR can utilize. Further, the College recommends that CMS allow QCDRs to utilize measures from other QCDRs (with permission).** By allowing QCDRs to use more non-MIPS measures, including those from other QCDRs, multi-specialty practices will have more opportunities to select a QCDR with measures that are relevant to the different specialties and subspecialties in the practice.

Additionally, as CMS has been looking at the quality measures that are not in PQRS/MIPS and not NQF-endorsed more closely, **ACP recommends that the Agency publish the specific criteria that they plan to use in evaluating QCDR measures moving forward.** Many internal medicine subspecialist organizations have invested in QCDRs and their own specialty measures development processes to specifically give subspecialists a broader array of quality measures that are specific to their scope of practice. These measures are difficult and costly to develop and maintain, and the NQF endorsement process is not an option for many groups due to the resources and investments it requires. Placing arbitrary limitations on or denying the use of these specialty-specific measures will leave many physicians with few options that are relevant to their practice. ACP recommends that CMS publish specific guidance on the criteria it will use in allowing QCDRs to select measures outside of the CMS and NQF processes. **If CMS decides to deny the use of a measure in a QCDR, the College also recommends that the Agency provide the measure developer/steward with specific information on what criteria were not met that led to a measure not being accepted for use and provide a process for immediate reconsideration when the issues have been addressed.**

### c. Data Completeness

#### **Background:**

CMS proposes increasing the data completeness criteria for quality reporting, and physicians who do not meet the criteria would fail the quality reporting component. Rather than the current 50 percent data completeness criteria, CMS proposes:

- For clinicians reporting using QCDRs, EHRs, or qualified registries, physicians/groups must report on at least 90 percent of the patients that meet the measure's denominator criteria, regardless of the payer.
- For clinicians using claims reporting, at least 80 percent of the Medicare Part B patients for which the measure applies.
- Groups submitting quality measures using the CMS Web Interface or the CAHPS for MIPS survey would need to meet the data submission requirements on the sample of Part B patients that CMS provides.

CMS proposes to include all-payer data for QCDR, EHR, and qualified registry submission mechanisms because the Agency believes it will provide a more complete picture of the scope of practice of each clinician as well as provide access to data about specialties and subspecialties that is not currently captured in PQRS. Submissions using these mechanisms must also contain a minimum of one quality measure for at least one Medicare patient.

**ACP Comments:**

**The College recommends that CMS maintain the current 50 percent data completeness requirements for quality reporting during the first performance period under MIPS.** An increase in the data reporting requirements of this magnitude will place a significant additional administrative burden on clinicians and practices at a time when they are trying to learn and understand the new, complicated requirements of QPP and navigate the varying reporting requirements in each performance category. Currently, clinicians choosing to report via qualified registry are required to report on 50 percent of their Part B patients to meet PQRS requirements. CMS is now proposing for MIPS that this requirement not only increase from 50 to 90 percent but also that it now include all-payer data rather than be limited to Part B patients. An increase of this significance should be put on hold and current PQRS data completeness requirements should be maintained while clinicians adjust to all of the changes that are taking place under the implementation of QPP.

Additionally, during the 2014 performance period for PQRS, CMS experienced significant issues with QCDR and EHR data submissions that resulted in the Agency's inability to accurately analyze the data that was reported. Given these recent issues, requiring clinicians to submit significantly more quality data than was previously required at the same time as CMS is in the process of implementing MACRA and developing new mechanisms for collecting and analyzing the data that is reported does not seem feasible/rational. **Rather, ACP recommends that CMS utilize a slow, incremental phase-in of any new data completeness requirements for quality reporting in MIPS, and that higher data completeness requirements are phased in only after appropriate review has determined that doing so is both appropriate and feasible.** This will be particularly important to prevent a significant negative impact that the added administrative reporting burden will place on solo clinicians and small practices.

#### d. Topped-out Measures

##### **Background:**

CMS proposes that a measure may be considered topped out if performance is so high and unvarying that meaningful distinctions and improvement in performance can no longer be made. For the purposes of this rule, CMS defines topped out measure as “a measure where the Truncated Coefficient of Variation is less than 0.10 and the 75th and 90th percentiles are within 2 standard errors; or median value for a process measure that is 95 percent or greater.” The Agency proposes that the maximum number of points for a topped out measure is the midpoint of the highest and lowest scores within a cluster.

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

ACP is concerned that removing a measure from scrutiny, just because the measure is topped out, could actually lead to slippage in what had been consistently excellent performance. This approach could actually put patients at risk simply due to an exclusive focus on the data, rather than on the impact of the actions underlying the measure on patient care.

Further, the College is concerned with the negative impact that the lower maximum points value of topped out measures will have on quality performance scores, especially if physicians are not aware that a measure that they select for quality reporting has reached topped out status. Given that quality performance is proposed to count for 50 percent of composite performance score under MIPS in the first year, this impact could be significant. **For measures that reach the topped out threshold during the performance period, ACP urges CMS to hold harmless the physicians who report on these measures from any downside adjustment in the maximum points that the measure is worth by maintaining the 10-point maximum value of the measure for that performance period.**

**Additionally, ACP recommends that CMS publicly disclose any measures that are topped out prior to a performance period in advance.** This can be done as part of the publication of the final quality measures each year, which must be published by November 1 of the year prior to the performance period. Along with this information, CMS should also publish the statistics of any measures that are nearing the topped out status prior to the performance period. Because physicians often select the same measures to report year-after-year, it will be important for them to know in advance which measures are close to topping out in advance of the performance period so that they have the opportunity to select alternate measures. Since credit can be given for improving on performance from year-to-year, information on topped out measures as well as those nearing topped out status is important as physicians select which measures to report on.

## e. CEHRT Bonus for Quality Performance Category

### Background:

CMS proposes to allow one bonus point for each reported quality measure under the quality performance category score. ECs have the potential to earn a bonus point maximum of 5 percent of the total possible points if they meet three requirements:

- Use CEHRT to record the measure's demographic and clinical data elements in conformance to relevant standards;
- Export and transmit measure data electronically to a third party using relevant standards or directly to CMS; and
- The third party intermediary (e.g., QCDR) uses automated software to aggregate measure data, calculate measures, perform any filtering of measurement data, and submit the data electronically to CMS.

### ACP Comments:

The requirements for the CEHRT bonus under the quality performance category fail to take into account the large number of existing specialty registries that are not capable of fully supporting the required standards/protocols. While reporting to such registries requires extra manual labor, ECs are willing to perform that additional work due to the clinical value they see in the overall process. ECs who are willing and able to report to legacy registries should not be penalized due to the fact that the registries are not yet capable of supporting the required standards for all of the necessary data elements. **ACP recommends that ECs should be eligible for the extra point for reporting to otherwise qualified registries that are not yet capable of supporting the required standards for the submission of all data elements.**

## 2. Resource Use Category

### Background:

CMS proposes to use three types of measures for the resource use category: total per capita cost, Medicare spending per beneficiary (MSPB), and episode-specific measures. CMS will calculate the resource use measures using claims data, so no additional submission is required for this performance category. Each measure will be worth 10 points, and physicians will receive an average score of all resource use measures that can be attributed. This average score counts for the 10 percent weight given to resource use in the composite performance score. CMS proposes to use 41 episode-specific measures in place of the four condition-specific total cost per capita measures that were used in the VM. The case minimum for each measure is 20, and physicians will receive a score based on the number of applicable measures for which they meet the case minimum.

Under law the resource use performance category could account as no more than 10 percent of the composite performance score in the first year of MIPS and no more than 15 percent of the composite performance score in the second year of MIPS. Resource use is required to account for 30 percent of the composite performance score in year three and subsequent years. In

years one and two of MIPS, Congress gave CMS the authority to adjust resource use down from 10 and 15 percent respectively and increase the quality performance score commensurate with the amount of decrease in resource use.

**ACP Comments:**

**The College urges CMS to use its authority to adjust resource use down from 10 percent in the first performance period by setting resource use at zero and increasing the quality performance category by 10 percent to make up for the difference.** This would mean that quality performance would account for 60 percent of the composite performance score. ACP believes that it is necessary to weight the resource use performance category as zero in the first year because the measures have not proven to be reliable, validated measures in their application to physicians.

The total per capita cost measure and the MSPB measure are carried over from the VM program. These measures inappropriately attribute broad-based costs to physicians for services that are outside of their control and that they do not have the ability to impact such as costs associated with hospitalizations and other care settings that occur outside of the physician's practice.

ACP also has concerns with the 20 case minimum that is being applied to resource use measures. This minimum seems like an arbitrary number of cases that is not reflective of appropriate reliability and validity for factors such as practice size, specialty, etc. Additionally, ACP is concerned that CMS proposes to reduce the case minimum for the MSPB measure. CMS just increased the case minimum for the MSPB measure from 20 to 125 as a part of the FY 2016 Physician Fee Schedule, so it seems premature and arbitrary to drop this case minimum back down to 20 before there has been sufficient time for data collection and analysis to show that a reduction of this magnitude is warranted. At a minimum, additional transparency is needed from CMS as to how the Agency arrived at the 20-case minimum amounts for each resource use measure and a variety of factors such as practice size and physician specialty would be impacted through various options if other approaches or factors were used in this determination.

The proposed resource use measures also lack proper risk adjustment methodologies such as adjustments for socioeconomic status. Failing to properly risk adjust creates a system that inappropriately penalizes physicians with higher numbers of lower income or frailer patients, which could cause physicians to cherry-pick the patients that will be less costly at the detriment of those most in need of care. While we realize that CMS is in the process of studying how socioeconomic status could be incorporated into risk adjustment methodologies, it is imperative that appropriate risk adjustment be factored into resource use measures.

Additionally, the Congressional intent behind granting CMS the authority to adjust the resource use performance category weight downward in early years was, in part, related to the MACRA requirement that CMS create new sets of codes that will strengthen the attribution process to

better determine how to assign resources to clinicians who have been involved in the care of a specific patient. These new codes include sets for care episodes, patient conditions, and patient relationship categories. These three sets of codes are intended to be utilized as a group for attribution purposes to better tie each clinician's role in the treatment of a patient for an episode of care to the resource use related to that care. Since these new resource use code sets will not be available in the initial performance period of MIPS, ACP recommends that CMS zero out the resource use performance category and focus on the development and refinement of the new code sets to ensure that when resource use is accounted for in the composite performance score, it is done in a more appropriate manner that factors in components such as patient condition and the costs associated with clinicians in the role in which they treat each patient.

### **3. Clinical Practice Improvement Activities Category**

#### **Background:**

CMS proposes to allow eligible clinicians or groups to select from a list of more than 90 activities listed in Table H of the proposed rule. The activities are grouped in these 8 categories:

- Expanded Practice Access
- Population Management
- Care Coordination
- Beneficiary/Patient Engagement
- Patient Safety and Practice Assessment
- Achieving Health Equity
- Emergency Response and Preparedness
- Integrated Behavioral and Mental Health

CPIA activities would be performed for at least 90 days during the performance year rather than a full year for reporting. Year one will require a yes/no response from the eligible clinician or group on the CPIA Inventory.

**Scoring:** Activities have been weighted as high or medium based on alignment with CMS national priorities or requiring performance of multiple activities such as participation in the Transforming Clinical Practice Initiative. Activities weighed high are given 20 points each and those that are medium receive 10 points each. In order to receive the highest potential score of 100 percent (60 points), three high-weighted CPIAs (20 points each) or six medium-weighted CPIAs (10 points each), or some combination of high and medium-weighted CPIAs to achieve a total of 60 points. To achieve a 50 percent score, one high-weighted and one medium-weighted CPIA or three medium-weighted CPIAs are required for these MIPS eligible clinicians or groups.

**Exception:** MIPS small groups (consisting of 15 or fewer clinicians) located in rural areas or geographic HPSAs, or non-patient-facing MIPS eligible clinicians or groups, in order to achieve

the highest score of 100 percent, two CPIAs are required (either medium or high). Reporting of one CPIA (either medium or high) will achieve a 50 percent score.

**ACP Comments:**

We commend CMS for making accommodations for small, rural, and non-patient facing physicians to be able to meet the requirements for this Category. The requirement for the reporting period to be for 90 days is greatly appreciated. The number of activities available and the attempt to not be too prescriptive will allow clinicians and practices to be innovative as they strive to transform their practices to improve quality for their patients.

We applaud the requirement that only attestation is required for this Category. By requiring only attestation, this will relieve the issue of administrative burden that is having an increasing impact on physicians.

Section 1848(q)(5)(C)(ii) of the Act provides that MIPS eligible clinicians or groups who are participating in an APM (as defined in section 1833(z)(3)(C) of the Act) for a performance period must earn at least half of the highest potential score for the CPIA performance category for the performance period. CMS has proposed to apply this minimum. The College would recommend that those participating in an APM receive full credit in the CPIA Category. Successful APM participation warrants that a practice is already performing many of the activities identified in in this Category and attesting to additional activities is redundant.

The College strongly supports CMS' current inclusion of use of QCDRs in several of the CPIAs listed in Table H. This will incentivize physician participation in robust clinical data registries that provide feedback to participating clinicians and drives improvement in quality of care. Registries function as tools for quality and performance measurement, reporting and improvement.

Additionally, ACP is concerned that the number of activities that are required to be reported is too high and that some of the activities weighted "medium" require enough effort that they should be given "high" weighting. There is further concern that there is not a clear evidence base that might indicate why activities should be considered medium versus high weighting. CMS should collect data on CPIAs as reported by different practices and consider how it can be analyzed to determine an improved weighting system for CPIAs in the future. **Instead, ACP recommends that all activities be weighted the same at 5 points per activity to make the total be 15 points for this Category. Full scoring would be accomplished by attesting to 3 activities or attesting as being PCMH recognized or participating in an APM.**

**The College strongly recommends inclusion of completing ACP Practice Advisor® modules as an Activity in the subcategory of Patient Safety and Practice Assessment.** ACP Practice Advisor is an online tool designed to help clinician practices improve patient care, organization, and workflow through web-based interactive modules that focus on continuous quality improvement activities and care delivery transformation. ACP Practice Advisor includes 46



modules, six of which are available for Maintenance of Certification for the Self-Evaluation of Practice Performance. Three modules have been approved for Continuing Medical Education (CME)/Maintenance of Certification (MOC) credit. A practice assessment component is attached to each Practice Advisor Module and completion of the assessment can be verified.

**Further, ACP recommends that CMS specifically include ACP’s High Value Care resources<sup>18</sup> as clinical practice improvement activities.** These resources can be used by clinicians to implement optimal diagnostic and treatment strategies in their practice, including Clinical Guidelines & Recommendations, a Pediatric to Adult Care Transitions Toolkit, the High Value Care Coordination Toolkit, as well as High Value Care Cases, HVC Pediatric Cases, Managing Conflicts of Interest Cases, Video Learning Modules developed as part of the Choosing Wisely initiative, and Ethics Case Studies.

**The College urges CMS to recognize credit for certain defined CME activities:**

- **Accredited CME activities that involve assessment and improvement of patient outcomes or care quality, as demonstrated by clinical data or patient experience of care data.**
- **Accredited CME that teaches the principles of quality improvement and the basic tenets of MACRA implementation, including application of the “three aims,” the National Quality Strategy, and the CMS Quality Strategy, with these goals being incorporated into practice.**

Multidimensional interventions, including participation in professional development activities like CME, are necessary components of the change process that result in meaningful, sustained clinical performance improvement. Without this professional development, the measurement of adherence to quality metrics and use of health information technology are insufficient to produce clinical performance improvement. There are mechanisms already in place to ensure that accredited/certified CME activities are designed to address clinicians’ practice-relevant learning needs and practice gaps. The programs are also evaluated to measure the education and clinical impact of the activity.

**The College also recommends that CMS establish a clear and transparent process for adding new items to the list of CPIA that facilitates broad stakeholder input.** This process should be driven by evaluation of which activities are being reported in prior years. Efforts should be made for the activities to be applicable to a wide variety of clinicians and practice settings and, to the extent possible, be based upon evidence that they have an impact on improving patient outcomes. **Along these lines, ACP calls on CMS to permit practicing clinicians to submit alternative activities for credit and/or consideration for future credit, as this will help ensure that clinicians are able to identify and undertake quality improvement activities aimed at meeting their own specific goals, even if those activities are not yet included on the CPIA list.** It is critical that the CPIA category of MIPS facilitate ongoing improvement and innovation--and

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<sup>18</sup> <https://www.acponline.org/clinical-information/high-value-care>

not become a stagnant list that, over time, could make clinicians feel overly frustrated or limited.

**a. Patient-Centered Medical Homes within the MIPS CPIA Performance Category**

**Background:**

The MACRA law specifies that a MIPS eligible clinician or group that is certified as a patient-centered medical home (PCMH) or comparable specialty practice, as determined by the Secretary, with respect to a performance period must be given the highest potential score for the CPIA performance category for the performance period.

Within the proposed rule, CMS has defined a PCMH for the purposes of full credit within the CPIA category as one that “is a nationally recognized accredited patient-centered medical home, a Medicaid Medical Home Model, or a Medical Home Model.”

Nationally recognized accredited PCMHs are defined by the agency as being accredited by:

- (1) The Accreditation Association for Ambulatory Health Care;
- (2) The National Committee for Quality Assurance (NCQA) PCMH recognition;
- (3) The Joint Commission Designation; or
- (4) The Utilization Review Accreditation Commission (URAC).

The agency then goes on to define a Medical Home Model as follows:

- (1) The APM’s participants include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services. For the purposes of this provision, primary care focus means involving specific design elements related to eligible clinicians practicing under one or more of the following Physician Specialty Codes: 01 General Practice; 08 Family Medicine; 11 Internal Medicine; 37 Pediatric Medicine; 38 Geriatric Medicine; 50 Nurse Practitioner; 89 Clinical Nurse Specialist; and 97 Physician Assistant;
- (2) Empanelment of each patient to a primary clinician; and
- (3) At least four of the following:
  - (i) Planned coordination of chronic and preventive care.
  - (ii) Patient access and continuity of care.
  - (iii) Risk-stratified care management.
  - (iv) Coordination of care across the medical neighborhood.
  - (v) Patient and caregiver engagement.
  - (vi) Shared decision-making.
  - (vii) Payment arrangements in addition to, or substituting for, fee-for-service payments (for example, shared savings or population-based payments).

The Medicaid Medical Home Model is defined as being identical to Medical Home Model, except that it specifically describes a payment arrangement operated by a State under title XIX.

Finally, CMS defines a comparable specialty practice as one that is recognized by the NCQA Patient-Centered Specialty Recognition program.

**ACP Comments:**

The College sincerely appreciates CMS' active implementation of this component of the law—as it is critically important to facilitate movement by all clinicians toward care that is truly patient-centered, coordinated, and comprehensive. ACP has been a leader in supporting the medical home model, particularly in light of the plethora of currently available research<sup>19</sup> linking the model to higher quality and lower costs.

ACP recognizes that there will be a significant number of clinicians in patient-centered medical home practices that will be included in the MIPS pathway, even if CMS establishes a deeming process that would allow clinicians in medical home practices participating in programs run by states, other non-Medicare payers, and employers to become qualified advanced APM participants (as described later in this letter). These MIPS PCMH practices have taken significant steps to improve care for their patients through ongoing, meaningful, practice improvement approaches and therefore should be given the opportunity for full credit within the CPIA performance category. A number of these practices will, in fact, fall within the proposed definition from the agency (as outlined above); however, ACP believes that a number of clinicians in truly innovative PCMH practices could be left out of this opportunity and will therefore have the burden of documenting additional CPIA.

**Along these lines, ACP recommends that CMS broaden their definition of patient-centered medical home for the purposes of full CPIA credit to specifically be inclusive of programs that have a demonstrated track record of support by non-Medicare payers, state Medicaid programs, employers, and/or others in a region or state (but that do not yet meet all of the requirements to be deemed an advanced APM program per the recommendation later in this letter).** The programs to be included should be clearly articulated by CMS in advance, along with transparent criteria and methodology for the addition of new PCMH programs.

**With regard to “comparable specialty practice,” ACP also recommends that CMS broaden its definition to not only include those practices recognized by NCQA, but also those practices that may be certified in some manner by other nationally recognized accreditation bodies or programs implemented by non-Medicare payers, state Medicaid programs, employers, and others in a region that may become available. Additionally, the College recommends that specialty practices should be able to attest directly to CMS and document that they meet**

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<sup>19</sup> Patient Centered Primary Care Initiative. The Patient-Centered Medical Home's Impact on Cost and Quality. Annual Review of Evidence 2014-2015. Available at [http://www.milbank.org/uploads/documents/PCPCC\\_2016\\_Report.pdf](http://www.milbank.org/uploads/documents/PCPCC_2016_Report.pdf)

**standards comparable to those for primary care medical homes, as recognized through an accreditation body, other certification process, or direct application to CMS or one of its carriers.** Such comparable specialty practices must document that they provide at least four of the following:

- i. Planned coordination of chronic and preventive care.
- ii. Patient access and continuity of care.
- iii. Risk-stratified care management.
- iv. Coordination of care with primary care physicians and across the medical neighborhood.
- v. Patient and caregiver engagement.
- vi. Shared decision-making.
- vii. Payment arrangements in addition to, or substituting for, fee-for-service payments (for example, shared savings or population-based payments).

Further, the College recommends that CMS closely review the recommendations of the Patient-Centered Primary Care Collaborative (PCPCC) Accreditation Workgroup, released on June 27, 2016<sup>20</sup> to help inform the recommended effort to broaden the definition of patient-centered medical home for the purposes of full CPIA credit. The Accreditation Workgroup's recommendations include the following consensus statement:

PCMH recognition should ultimately be a “good housekeeping seal of approval” demonstrating achievement of the attributes (outcomes) ensuring consumer confidence in the practice and its clinicians. Recognized practices should be rewarded with increased payment or participation in other “preferred programs.”

In the immediate term, recognition should focus on a simplified set of evidence-based “change concepts”<sup>21</sup> (processes) that lead to achievement of the PCMH attributes (outcomes), and a less administratively burdensome way to recognize that practices have mastered the change concepts (and are therefore likely to reflect attributes of an ideal PCMH.)

This workgroup went on to outline a set of guiding principles to improve PCMH and specialty practice recognition overall, as well as more specific recommended improvements in those recognition approaches—whether conducted by a nationally recognized accreditation program or by a state or non-Medicare payer program. The agency should investigate how it can assist in moving all types of recognition and accreditation programs toward true improvement and patient-centeredness.

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<sup>20</sup> <https://www.pcpcc.org/2016/06/27/improving-patient-centered-medical-home-pcmh-recognition-board-endorsed-recommendations>

<sup>21</sup> "Change concepts" are general ideas/directions for transforming a practice to stimulate specific, actionable steps that lead to improvement. (Wagner EH, Coleman K, Reid R, Phillips K, Sugarman JR, 2012, *Guiding Transformation: How medical practices can become patient-centered medical homes*, published by The Commonwealth Fund, February)

#### 4. Advancing Care Information Category

##### **Background:**

CMS proposes that the Advancing Care Information (ACI) category (formerly the EHR Incentive Program or “Meaningful Use”) be composed of two scores, each valued at half of the total score. The “base score” is intended to measure participation and reporting, and a “performance score” is intended to measure performance at varying levels above the base score. The proposed measures within the ACI category, for both the base and performance scores, are revised from the Modified Stage 2 and Stage 3 of Meaningful Use (MU) program and focus on interoperability, information exchange, and security. In addition to the base and performance scores for the ACI category, CMS proposes supplementary attestation requirements including cooperation with surveillance and direct review of CEHRT and prevention of information blocking.

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

The ACP has been a consistent advocate of physicians and other clinicians leveraging EHRs and other health IT to make care better. As such, it was also a strong supporter of the goals of the HITECH Act and of Meaningful Use. The College subsequently determined that the uniform (or one-size-fits-all) and overly prescriptive approach taken by CMS, turned what should have been an incentive program towards specialty-specific optimization of the emerging health IT infrastructure – into a check-the-box compliance exercise. What could have engaged physicians and other clinicians instead enraged them.

That said, the ACP believed that the Meaningful Use program accomplished many of its objectives, and with the coming of Medicare’s Quality Payment Program via the MACRA, CMS had a golden opportunity to fix Meaningful Use into something truly meaningful for physicians, clinicians and patients. With clear targets for quality and resource use, it would no longer be necessary to create the artificial targets of EHR functional use measures that were at least to some extent, necessary prior to MACRA. Fixing Meaningful Use at this point could have taken a transformative program that was imploding due to its overly complex and prescriptive rules – and created a lasting legacy of value.

Instead, what is proposed for Meaningful Use inside of MIPS is even more complicated than what was proposed for Stage 3, and with even higher thresholds. This legacy – if not significantly changed in the MACRA/MIPS final rule, will not be one of using the enabling infrastructure of health IT to improve quality and value – but rather using it to satisfy regulatory compliance. What doctors, clinicians, and clinical informatics leaders should be doing now – analyzing and improving workflows and targeted use of health IT for specific quality and value purposes, will not happen. Instead, just as has occurred with each stage of Meaningful Use, they will be taking significant time to understand the rules and the FAQs that are certain to follow and continuing to develop workarounds and configuration “gimmicks,” particularly where the metric is not consistent with workflow.

In summary, the ACP believes that there is a place for Meaningful Use within MIPS, but it is one that plays a supportive role to improving care quality and value, and not one that promotes care information over patient care. Please see our specific recommendations and comments below, as well as an alternate proposal for Meaningful Use within MIPS, which we believe is responsive to the legislative requirements of MACRA.

In its descriptions of ACI throughout the proposed rule, CMS has stated repeatedly that, for ACI, thresholds have been removed from the measures and the all-or-nothing scoring has been eliminated. These are critical changes that ACP has advocated for repeatedly, and we firmly believe that this component of MACRA will not succeed unless CMS makes these changes. Unfortunately, the base measure set is still all-or-nothing, and all of the measures have a threshold of 1 or “yes.” This continuation of a one-size fits all approach only differs from the previously proposed rule for Stage 3 of MU, by a reduction in the threshold values. While this decrease in threshold values will make achieving the base score part of normal clinical workflow for some ECs, it is highly probable that achieving this mandatory all-or-nothing base score will be problematic for other ECs. And this is not the right legacy for Meaningful Use. At a time when ECs should be entirely focused on improving quality and value, many ECs will unfortunately have to devote significant attention to what will be “make work” for them.

Further, the amount of effort that will be required to perform, manage, and report all of the measures that make up ACI is more than what would have been required under the MU Stage 2 Modification rule for 2017. The number of required activities greatly exceeds the numbers for the other components of MIPS. It could be argued that the overall MIPS as proposed could be made manageable just by reducing the effort required to complete the ACI component. Also, the levels required to achieve the highest scores in the ACI component exceed the levels that would have been required under the Stage 3 MU program in 2018. **If CMS is committed to simplifying the reporting process for ECs participating in MIPS, then ACP recommends that CMS simplify the reporting requirements and scoring methodology within the proposed ACI category and not require the volume and complexity specified in the base and performance scores.** Each practice will be challenged to track and manage so many activities of so many people and systems if it is to successfully complete the ACI component. The likelihood of a costly error will be high.

The College’s comments on specific provisions within the ACI category as well as our proposal for the overall ACI scoring methodology are outlined below.

#### **a. Performance Period for ACI**

##### **Background:**

CMS proposes one full calendar year for the ACI performance period in order to align the performance period with that of the entire MIPS program.

**ACP Comments:**

It is extremely unlikely that all ECs will have a 2015 CEHRT on January 1, 2017. Therefore, many ECs will be required to report on CMS' alternate ACI proposal of modified objectives for the 2017 performance period. CMS should acknowledge this in the final rule. While this proposal appears to align closely to the previous scenario for the 2017 performance period under the MU Stage 2 Modification Final Rule, it does not attempt to improve upon the clear and much discussed deficiencies of the MU measures (see ACP's comments<sup>22</sup> on the Stage 2 Modification Proposed Rule). Assuming a best-case scenario, most practices will spend the 2017 MIPS performance period converting from a 2014 CEHRT system to a 2015 CEHRT system that will negatively impact their ability to perform all ACI measures for the full calendar year. **For the 2017 performance period, ACP recommends that the ACI measurement period should be 90 days instead of the full calendar year as done previously with the EHR Incentive Program performance period.**

**b. ACI Base Score and Performance Score Reporting Requirements & Scoring Methodology****Background:**

As stated previously, the ACI scoring is divided into two categories: base score and performance score. The base score measures are reported as a numerator and denominator, with the denominator value of 1 or more, or an answer of "yes" or "no" depending on the type of measure. A value of 1 or more or an answer of "yes" is required for successful completion of each measure. Successful completion of the submission criteria earns a base score of 50 percent for the ACI category. Failure to meet the submission criteria for any measure in any of the objectives within the base score would result in a score of zero for the base score, a score of zero for the performance score, and a total ACI category score of zero.

For the performance score portion, CMS proposes multiple paths to achieving higher scores with the total of available points exceeding the maximum possible score for ACI. ECs are able to select measures that best fit their practice from the following objectives: patient electronic access, coordination of care through patient engagement, and health information exchange (these three objectives are also incorporated in the base score).

**ACP Comments:**

ACP does not agree that the structure of CMS' proposed framework for the ACI performance category provides for flexibility and multiple paths to achievement nor does it incentivize continuous improvement through removal of a single threshold for a measure. ACP recognizes that health IT is potentially a very powerful tool – and in the hands of the untrained, can both fail to improve care, and in some cases even lead to unsafe conditions. The intent of ACP's Stage 3 of MU recommendations<sup>23</sup> for having no thresholds was to collect data on the use of

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<sup>22</sup> [https://www.acponline.org/acp\\_policy/letters/comment\\_letter\\_meaningful\\_use\\_stage\\_2\\_2015.pdf](https://www.acponline.org/acp_policy/letters/comment_letter_meaningful_use_stage_2_2015.pdf)

<sup>23</sup> [https://www.acponline.org/acp\\_policy/letters/acp\\_mu\\_stage\\_3\\_comments\\_2015.pdf](https://www.acponline.org/acp_policy/letters/acp_mu_stage_3_comments_2015.pdf)

EHRs and health IT – and compare that data to outcomes and patient satisfaction. That approach would define “continuous improvement” as improving the science of health IT in how it improves care – as well as engage clinicians in the use of health IT to improve care in a manner that is relevant to their specialty and scope of practice – but the proposed framework instead follows the same logic as the previously proposed Stage 3 of MU.

**The College urges CMS to modify the base score component of ACI and remove the threshold requirements of 1 or “yes” for all proposed base measures except for the protecting patient health information attestation which ACP believes is integral to the use of health IT.** This modification will support CMS’ public statements and those of its interim director, Mr. Slavitt, outlining goals that give ECs the ability to select measures that are relevant and that move them forward in using health IT to improve value of care. ECs are going to need health IT capabilities that they do not yet have, and the ACI program should be used as a vehicle to help them make the needed transitions. The proposed base measures, which are the same measures that physicians have already found to be cumbersome and inappropriate, do little to help ECs move forward.

**Within the proposed performance score component of ACI, ACP recommends that ECs be given the ability to select among a longer list of health IT-specific activities that are appropriate to the specialty of the EC.** Examples include adding data management and analysis capabilities, adding capabilities to share relevant clinical data among care team members, and adding new functions such as care plan management. Moreover, ECs are facing a steep learning curve when it comes to implementing new health IT in their practices and should also have the option to select health IT education opportunities in addition to the base score component EHR-functional measures. For example, participation in educational courses such as the online, 12-class Healthcare Data Analytics<sup>24</sup> course hosted by the Oregon Health & Science University and sponsored by ONC should count toward the total ACI score. More specifics on ACP’s proposed ACI scoring framework are outlined later in this letter.

Depending on how it was framed, the ACP could support ongoing attestations in support of protecting patient health information and enhancing meaningful interoperability. Additionally, the College could support the base score requirement to report EHR functional use – but only where the EHR functional-use requirements do not contribute to poor usability, where the numerator and denominator were auto-calculated, and where there were no base thresholds or performance requirements. The College supports reporting of designated activities, but does not support a requirement to perform each of those activities no matter their value to an EC or a practice. More specifics are outlined below.

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<sup>24</sup> <http://skynet.ohsu.edu/onc-course/>



**The following is an ACP recommended approach for the ACI Category:**

**BASE SCORE:**

For the ACI base score component, ACP proposes one required attestation in which the EC must attest “Yes.” (The College believes that this attestation is integral to furthering the safe use of health IT and therefore the one “all-or-nothing” piece that is acceptable for calculating the ACI score.)

- 1) Protect Patient Health Information: ECs must conduct or review a security risk analysis addressing the security of electronic protected health information created or maintained by their EHR.

The proposed base score component would also include 9 required submissions of EHR data that are automatically calculated by the EHR and do not require manual submission by the EC. The 9 measures included in ACP’s base score proposal are the same measures used in CMS’ proposal, ACP is simply proposing to remove the requirement for a specific numerator or denominator of at least one (i.e., no performance calculation).

- 1) ePrescribing
- 2) Patient Access
- 3) Patient Specific Education
- 4) View, Download, & Transmit (VDT)
- 5) Secure Messaging
- 6) Patient-Generated Health Data (PGHD)
- 7) Send patient record with referrals and transitions
- 8) Request/incorporate patient record for new patients and patients transitioned into the practice
- 9) Immunization Registry Reporting

**Note:** Clinical Information Reconciliation is not included in ACP’s base score proposal because the College recommends CMS eliminate the measure from the program. More specifics on the removal of this measure are described later in this section.

The College believes that this type of reporting and subsequent data collection and analysis of EHR-functional-use measures, will lead to a better understanding of what works well in health IT processes and under what circumstances. A key component of the learning health and health care system will be data that help us determine how best to use health IT in care delivery. Data from practices that do not achieve all of the objectives and measures are just as valuable to a learning system as data from those that are successful. EHR-functional-use data are most useful when they reflect actual workflow, not contrived attempts to achieve a performance threshold – even if the threshold value is only one. Learning is enhanced when reported data include naturally occurring variance and are not restricted to CMS’ prescriptive definition of threshold achievement. This approach to EHR-functional-use measurement will avoid the prior pitfall of narrow and/or overly prescriptive measurement – as that has been the cause of compliance-

driven and/or duplicative clinical workflows, poor EHR usability, and distraction from the development of more usable and useful software. CMS and ONC could then collaborate on using these process data to learn – rather than to grade.

ACP does not support the fact that a single mis-step by an EC or practice could still eliminate any opportunity to score well with ACI – unless the EC fails to attest to protecting patient information as referenced above.

### **HEALTH IT ACTIVITIES SCORE:**

ACP’s proposal for the performance score component – titled Health IT Activities Score – includes optional health IT-related activities that result in additional points towards the total ACI category. The proposed Health IT Activities score component would mirror the structure of the CPIA category in which ECs would attest to specific health IT-related activities that they select from a long list of activities including but not limited to:

**1. EHR/Health IT educational activity developed/endorsed by medical specialty or professional societies:**

- a. As previously stated, ECs are facing a steep learning curve when it comes to implementing new health IT in their practices. Providing an incentive to participate in educational courses (e.g., 12-class Healthcare Data Analytics<sup>25</sup> course hosted by the Oregon Health & Science University and sponsored by ONC) and continuing medical education in basic use of health IT (particularly when it comes to supporting patient engagement, safety, quality, and cost) would be beneficial to the EC, the health IT community, and most importantly, the patient. The ACP continues to support such programs where CMS and ONC partner with the medical specialty and professional societies – who could create or endorse such educational programs for its membership.

**2. Patient Engagement (e.g., develop a case report describing a patient engagement problem and the actions the practice took, including the use of health IT, to resolve the problem):**

- a. ACP recommends that measures of patient engagement shift from the existing one-size-fits-all prescriptive process measures to attestations of patient engagement activities that reflect the setting of care, context, and patient needs and preferences.

**3. Precision Medicine/Learning Health System (e.g., participation in practice-based research or other observational study efforts):**

- a. Precision medicine and the learning health system is the future of meaningful use of health IT and no matter what their specialty, ECs may find value in getting involved with an observational study or any other activity that might be

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<sup>25</sup> <http://skynet.ohsu.edu/onc-course/>

considered as evidence-generating medicine. ECs could run phenotyping algorithms on their data and contribute the results or use existing data collections to identify appropriate treatment patterns for specific patients based upon social determinants they have collected.

- 4. Clinical Informatics Improvement (e.g., support of iterative improvement in practical informatics via use of an “EHR feedback” application; or participation in an EHR user group):**
  - a. Certified EHR systems should have a “Feedback” mechanism available so that EHR users can quickly and easily collect context sensitive thoughts for submission to a vendor-managed improvement list or user group, or for later consideration and elaboration. Having this type of bottom-up approach to health IT design allows for ECs and other health care providers to have the opportunity to contribute to the software personalization that helps them consistently deliver better care.
  
- 5. Quality, Safety, Value Improvement Projects that Leverage Health IT:**
  - a. CMS should create a measure for reporting on an innovation involving health IT that ECs could report each year using a specified format. A simple example might be a data quality improvement project aimed at fixing variation in how a particular data element is collected at the point of care.
  
- 6. Patient Safety and Near-miss Reporting:**
  - a. ECs should have the ability to easily report patient safety, adverse events, and near miss reports directly from the EHR system. While the point value would be expected to be low for a single completed report, the value to health care is sufficient to make this an ACI activity. Safety reporting levels are unacceptably low, and ACI can help to resolve this problem.
  
- 7. Development of eQMs that support Quality Improvement (done within a QCDR):**
  - a. There is not a broad enough set of quality measures (QMs), and many existing measures are of such poor quality that they should not be used. Further, attempts to create eMeasures have resulted in an entirely new set of data quality problems. ECs should get credit for proposing measures that conform to the constraints of a defined template and that use existing EHR data. These eMeasures should measure implementation of evidence-based care. Registry technologies, such as QCDRs, offer a way for ECs and practices to collect encounter data and analyze them for opportunities to measure and improve quality. Such a platform will provide the opportunity to focus on what truly matters at the individual- and practice-level.

## TOTAL SCORE

The total score for ACP's proposed ACI scoring framework includes the base score of the required "yes" attestation for protection of patient health information and the required *reporting* of the 9 base score measures without a minimum threshold of 1 or "yes." Additionally, participation in one or multiple activities listed in the Health IT Activities Score would add to the base score and comprise the total score for ACI.

Under ACP's proposed framework for ACI – for future MIPS performance years – ACP supports CMS' proposal to define a "meaningful user" as an EC that obtains 75 percent of the overall ACI score. Thus, an EC who successfully attests to protecting patient health information; successfully reports on the 9 base measures and participates in any number of the health IT activities that adds up to 75 percent of the total possible points for ACI, would be defined as a "meaningful user."

ACP believes that this proposed structure for the base and performance (i.e., Health IT Activities) components of the ACI category falls in line with CMS' goals to provide ECs with the ability to select health IT measures that are relevant and that move them forward in using health IT to improve the quality and value of care. Table 1 below provides a side-by-side comparison between CMS' and ACP's proposed structure of the ACI category.

**Table 1: Comparison between CMS and ACP ACI Performance Category Proposal**

<b>CMS ACI Proposal</b>		<b>ACP ACI Proposal</b>	
<b>BASE SCORE</b>		<b>BASE SCORE: Auto-Calculated</b>	
<b>Protect Patient Health Information</b>			
<u>Measure</u>	<u>Requirement</u>	<u>Measure</u>	<u>Requirement</u>
Security Risk Analysis	Yes/No Attestation (YES required)	Security Risk Analysis	Yes/No Attestation (YES required)
<b>Electronic Prescribing</b>			
<u>Measure</u>	<u>Requirement</u>	<u>Measure</u>	<u>Requirement</u>
ePrescribing	## (at least 1)	ePrescribing	## (no minimum)
<b>Patient Electronic Access</b>			
<u>Measure</u>	<u>Requirement</u>	<u>Measure</u>	<u>Requirement</u>
Patient Access	## (at least 1)	Patient Access	## (no minimum)
Patient Specific Education	## (at least 1)	Patient Specific Education	## (no minimum)
<b>Coordination of Care Through Patient Engagement</b>			
<u>Measure</u>	<u>Requirement</u>	<u>Measure</u>	<u>Requirement</u>
View, Download or Transmit (VDT)	## (at least 1)	View, Download or Transmit (VDT)	## (no minimum)
Secure Messaging	## (at least 1)	Secure Messaging	## (no minimum)
Patient-Generated Health Data	## (at least 1)	Patient-Generated Health Data	## (no minimum)
<b>Health Information Exchange:</b>			
<u>Measure</u>	<u>Requirement</u>	<u>Measure</u>	<u>Requirement</u>
Patient Care Record Exchange	## (at least 1)	Patient Care Record Exchange	## (no minimum)
Request/Accept Patient Care Record	## (at least 1)	Request/Accept Patient Care Record	## (no minimum)
Clinical Information Reconciliation	## (at least 1)	N/A	N/A
<b>Public Health and Clinical Data Registry Reporting</b>			
<u>Measure</u>	<u>Requirement</u>	<u>Measure</u>	<u>Requirement</u>
Immunization Registry Reporting	Yes/No Attestation (YES Required)	Immunization Registry Reporting	Yes/No
<b>PERFORMANCE SCORE</b>		<b>HEALTH IT ACTIVITIES SCORE</b>	
<b><u>Patient Electronic Access:</u></b>		<b><u>Proposed Activities:</u></b>	
Patient Access	10 pts.	EHR/HIT Educational Activity	Points TBD
Patient Specific Education	10 pts.	Patient Engagement Activity	Points TBD
<b><u>Coordination of Care Through Patient Engagement:</u></b>		Precision Medicine/Learning Health System Participation	Points TBD
View, Download or Transmit (VDT)	10 pts.	Clinical Informatics Improvement	Points TBD
Secure Messaging	10 pts.	Quality, Safety, Value Improvement in HIT	Points TBD
Patient-Generated Health Data	10 pts.	Patient Safety and Near-miss Reporting	Points TBD
<b><u>Health Information Exchange:</u></b>		Development of eQMs	Points TBD
Patient Care Record Exchange	10 pts.		
Request/Accept Patient Care Record	10 pts.		
Clinical Information Reconciliation	10 pts.		

### c. ACI Proposed Objectives and Measures

#### **Background:**

The proposed objectives and measures within the ACI Category are a revised set of the same objectives and measures used in the Modified Stage 2 and Stage 3 of MU program.

#### **ACP Comments:**

The most difficult measures for practices are those that require actions on the part of patients. There are many contributing factors, such as the lack of perceived value by patients in the activities, measure designs that failed to account for the real ways that patients and physicians interact, and low-quality, unusable technology. The history of patient measures in the MU program is a history of what seemed like good ideas, but with no actual evidence of value, becoming impossible to achieve measures that do nothing but increase physician and patient frustration. There must be clear field-based evidence of clinical value, valid measure design, and usable technology before ECs can be held accountable for patient actions.

Furthermore, the alternate measurement proposals for ACI simply add back measures that CMS has determined to be unnecessary. It seems unlikely that any EC would choose to report on additional measures that are not required for this exceedingly complex reporting program. The rule could be simplified by removing the alternate measure proposals.

In addition to the College's proposed alternate approach to the structure of the ACI category outlined above, the following are specific comments on CMS' current proposal for ACI measures. **While ACP calls for use of the proposed measures without thresholds, we also have specific concerns about the structure of many of the proposed measures (see Table 2).** To the extent that CMS revises these proposed measures, they will be more useful and more valuable in reflecting the real world of clinical practice.

**Table 2: ACP Comments on Proposed ACI Category Objectives and Measures**

<b>Objective: Protect Patient Health</b>
<b>Measure: Security Risk Analysis</b>
<b>ACP Comment:</b> The ACP supports this measure attestation as long as ONC and CMS continue to make sure that satisfaction of this requirement is simple enough for ECs in small practices to do, and not costly or time consuming. <b>The College urges CMS to provide more specific guidance regarding what is and is not acceptable in the risk analysis.</b>
<b>Objective: Electronic Prescribing</b>
<b>Measure: ePrescribing</b>
<b>ACP Comment:</b> Continued improvement of ePrescribing is necessary to make the process more efficient and effective. <b>ACP supports this measure as long as there is no minimum threshold and no performance measurement.</b>
<b>Objective: Patient Electronic Access</b>
<b>Measure: Patient Access</b>
<b>ACP Comment:</b> The ACP believes that all patients should be offered on-demand access to their own health information but the College has concerns in how CMS defines on-demand access. For some EHRs and patient portals, the vehicle for moving information from the EHR to the portal requires a clinician-signed document and the College is concerned that the requirement of less than four business days is unreasonable. Overly prescriptive requirements for viewable on-demand patient information have resulted in an information format that is not necessarily useful to patients – because the useful information is buried in lengthy clinical summaries. The requirement that this measure be met each and every time this type of information is made available to the EC is very problematic and unnecessary. <b>As previously stated, ACP supports this measure as long as there is no minimum threshold and no performance measurement.</b>
<b>Objective: Patient Electronic Access</b>
<b>Measure: Patient-Specific Education</b>
<b>ACP Comment:</b> The ACP believes in providing to patients educational resources that are requested or needed – and that for education to be meaningful, appropriate, and within a format that is appropriate. The College is concerned that the existing denominator assumes that all patients require educational materials annually. Not only do we believe this to be wrong – but we further believe that having such an approach all but requires an automated response that may not be clinically relevant. <b>As previously stated, ACP supports this measure as long as there is no minimum threshold and no performance measurement.</b>
<b>Objective: Coordination of Care through Patient Engagement</b>
<b>Measure: View, Download or Transmit (VDT)</b>
<b>ACP Comment:</b> While measuring VDT is doable within a patient portal, it is difficult if not impossible to measure in a patient owned/managed application. While the ACP recognizes the value of this measure – the College strongly believes that, in some circumstances, the achievement of this measure is not consistent with normal workflow and patient expectations and may be only possible with gimmicks and workarounds. <b>As previously stated, ACP supports this measure as long as there is no minimum threshold and no performance measurement.</b>
<b>Objective: Coordination of Care through Patient Engagement</b>
<b>Measure: Secure Messaging</b>
<b>ACP Comments:</b> While secure messaging might be sufficient as an ACI base measure (as proposed), it becomes problematic as a performance measure (as proposed). ECs are supposed to ask patients for their preferred method of communication (at least in the PCMH care delivery model), but this measure would require an EC to disregard the patient’s preferred method of communication if it is not electronic. While the ACP recognizes the value of this measure – the College strongly believes that, in some circumstances, the achievement of this measure is not consistent with normal workflow and patient expectations and may be only possible with gimmicks and workarounds. <b>As previously stated, ACP supports this measure as long as there is no minimum threshold and no performance measurement.</b>

<b>Objective: Coordination of Care through Patient Engagement</b>
<b>Measure: Patient-Generated Health Data</b>
<b>ACP Comments:</b> The College believes that the definition of this measure is inappropriately focused on the device generating the data and not focused on the patient. Patients can and do generate data in many other ways, such as filling out forms and surveys, and by self-report. <b>ACP recommends expanding the definition of patient-generated health data to include other more relevant data sources described above and, as previously stated, ACP supports this measure as long as there is no minimum threshold and no performance measurement.</b>
<b>Objective: Health Information Exchange</b>
<b>Measure: Patient Care Record Exchange</b>
<b>ACP Comment:</b> The patient care record exchange is another measure where the denominator has been a problematic from the day this measure was proposed. As the objective of this measure is to provide useful information at transitions of care – the definition of transition of care needs to be clearly defined. <b>The College recommends simply counting care record exchanges regardless of the clinical situation and, as previously stated, supports this measure as long as there is no minimum threshold or performance measurement.</b>
<b>Objective: Health Information Exchange</b>
<b>Measure: Request/Accept Patient Care Record</b>
<b>ACP Comment:</b> In order to provide complete and up-to-date information when a patient is seen by another clinician, the denominator for this measure should be every referral and not just for new patients. <b>As stated previously, ACP supports this measure as long as there is no minimum threshold or performance measurement.</b>
<b>Objective: Health Information Exchange</b>
<b>Measure: Clinical Information Reconciliation</b>
<b>ACP Comment:</b> It is not clear that clinical reconciliation is an activity that adds value from care transfers from any clinician to any other clinician. Mandatory clinical list reconciliation without a shared convention of how the lists are used, which is the current state of practice, is likely to cause more problems that it resolves. <b>ACP recommends eliminating this measure from the program.</b>
<b>Objective: Public Health and Clinical Data Registry Reporting</b>
<b>Measure: Immunization Registry Reporting</b>
<b>ACP Comment:</b> ACP supports this measure for requiring active engagement with a public health agency to submit immunization data. <b>As previously stated, ACP supports this measure as long as there is no minimum threshold and no performance measurement – and this specific case – the ability to report a null value for those ECs that do not administer immunizations.</b>



#### d. Cooperation with Surveillance and Direct Review of Certified EHR Technology

##### **Background:**

In order to cooperate with the surveillance process, CMS proposes that ECs and hospitals attest that they have cooperated in good faith with the surveillance and ONC direct review of their health IT through requiring timely response to phone calls, emails, and surveys. The second part of the surveillance attestation involves ECs and hospitals providing access to their production EHR for surveillance and review.

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

Considering the volume of junk mail and junk email received by practices, **ACP recommends ONC clearly label on the envelope, subject line, or phone message with the official nature of the Surveillance and Direct Review request so as to differentiate itself from the abundance of other types of communications.**

The College is concerned with the requirement for ECs to provide access to their live EHR system which has the potential to be very burdensome and could even interfere with server production – except if there was a preconfigured remote connection functionality that did not involve clinician configuration, or if this review was to take place on-site which assumes that ECs have space for a non-staff member to perform such work. Further, the presumption is that the outside reviewer would not be running anything more than simple reports or reviewing specific records as complex searches on a production server can interfere with server performance. Conducting surveillance tests will require significant effort on the part of several staff in the practice, and it could require the participation of consultants and third-party support personnel in smaller practices.

ACP supports this attestation as long as providing this access would not compromise patient care or be unduly burdensome to the EC or hospital as described above. The proposed plan to require the use of the live EHR system and live patient data for these tests would impose unnecessary risks to patient care and require the involvement of too many different staff and/or outside consultants. **ACP recommends that the Surveillance tests conducted by ONC should be performed on EHR test systems using test data, and involve the same test scripts that ONC uses during the EHR certification process. Further, the College recommends that ECs who participate should receive ACI bonus points for successful participation.**

#### e. Support for Health Information Exchange and the Prevention of Information Blocking

##### **Background:**

CMS proposes ECs demonstrate support of health information exchange and prevention of information blocking through three attestation statements that the EC acted in good faith to implement and use the CEHRT to support and not interfere with the electronic exchange of

health information among health care providers and with patients to improve quality and promote care.

**ACP comments:**

ACP supports the first attestation statement that an EC would be required to attest that they did not knowingly and willfully take action to limit or restrict the compatibility or interoperability of certified EHR technology. ACP does not support the second and third attestation statements for health information exchange and information blocking because the explanations and definitions within the statements are too vague and they appear to require knowledge likely to be unavailable to the ECs. ECs would not have the IT competence or the awareness of the work of other staff to make such attestations. ECs must be protected from the obligation to develop and support links requested by health care institutions, information exchanges, application developers, and others where the value to the practice is not clear. **The College recommends that the second and third statements for the Health Information Exchange and Prevention of Information Blocking Attestation be struck or revised so that ECs are not held accountable for factors beyond their control.**

**f. Clinical Quality Measurement under ACI**

**Background:**

CMS proposes to remove the separate requirements for clinical quality measure reporting within the ACI category and instead requires submission of quality data within the quality performance category under MIPS.

**ACP Comments:**

ACP appreciates and supports the proposal to remove separate requirements for clinical quality measure reporting with the ACI performance category. These types of measures are reported through the quality performance category and having to report these measures through the ACI category would be duplicative and burdensome.

**g. Method for Data Submission for ACI**

**Background:**

CMS proposes to allow for ECs to submit ACI category data through a qualified registry, EHR, QCDR, attestation and CMS Web Interface submission methods.

**ACP Comments:**

ACP supports CMS' proposal to allow for MIPS ECs to submit ACI category data through a qualified registry, EHR, QCDR, attestation and CMS Web Interface submission methods. **The College recommends that CMS provide ECs with cost estimates for electronic data submissions through registries and EHRs as well as time estimates for submission of attestations through CMS Web Interface to provide as much upfront information on which submission method would be the least burdensome and most cost effective.**

## **h. Future Considerations under ACI – Review of Measures**

### **Background:**

Unlike its approach to MU, CMS is proposing a continual commitment to review and improve measures and seeks comments on further methods to increase the stringency of the ACI performance measures.

### **ACP Comments:**

ACP urges CMS to treat all ACI measures just as it does quality measures. All measures should be evidence-based, and all measures should be continually monitored and improved or removed from use. **ACP recommends that CMS focus the review and improvement of ACI process measures on the value of the measures and whether they assist practices in applying health IT to improve the quality and value of care and not focus on the performance levels of the ACI process measures.** Further, use of the term “stringent” is reminiscent of how CMS described their approach to the Stages of Meaningful Use – namely that what was elective in one Stage will be mandatory in the next; and that low thresholds in a stage will be replaced by higher thresholds in a subsequent stage. This commitment to increasing stringency is unnecessary, and not supportive of the principles of a learning healthcare system.

## **i. ACI Exclusions**

### **Background:**

CMS proposes providing exclusions for ECs who write less than 100 permissible prescriptions during the EHR reporting period to report a null value and for ECs who do not administer immunizations to report a null value for that measure in the base score.

### **ACP Comments:**

The College supports CMS’ proposal to allow ECs who write less than 100 permissible prescriptions during the EHR reporting period to report a null value for the Electronic Prescription measure under the base score. ACP also supports the proposal to allow those ECs who do not administer immunizations to report a null value for the base score since it is not applicable to their practice.

## **5. MIPS APMs**

### **Background:**

The rule proposes to establish a scoring standard for MIPS eligible clinicians participating in certain types of APMs in order to reduce participant reporting burden by eliminating the need for eligible clinicians in such APMs to submit data for both MIPS and their respective APMs. These APMs are labeled as MIPS APMs, and are defined as APMs that meet the following criteria: (1) the APM Entity participates in the APM under an agreement with CMS; (2) the APM Entity includes one or more MIPS eligible clinicians on a Participation List; and (3) the APM

bases payment incentives on performance (either at the APM Entity or eligible clinician level) on cost/utilization and quality measures.

#### **ACP Comments:**

The College applauds CMS for including within the proposed rule provisions --- under the category of MIPS APM --- for eligible clinicians participating within certain recognized APMs, but who do not qualify as QPs or partial QPs, that reduces participant reporting burden by eliminating the need for such APM eligible clinicians to submit data for both MIPS and their respective APM. This approach also ensures that eligible clinicians in these APMs are not assessed in multiple ways on the same performance activities. Finally, we support the decision to assess the performance of MIPS eligible clinicians within these APMs based on their collective performance as an APM Entity group, which not only further reduces reporting burden, but also recognizes the common goal to improve quality and lower cost for all participants within the APM.

#### **ACP makes the following recommendations to improve MIPS APM participation:**

- **Expand the number of reporting categories potentially reportable through the MIPS APM entity to all four performance components within the program.** It is not clear if this is currently allowed under the proposed rule. Thus, participants in MIPS APMs that are capable of reporting all four components will not have to individually report their data, which would further CMS' stated goal of reducing unnecessary reporting burden.
- **Provide participants within a MIPS APM Entity with credit for 100 percent of the potential points under the Clinical Practice Improvement Activity (CPIA) component for their participation in a recognized MIPS APM.** This would further CMS' goal to reward efforts to transition away from traditional fee-for service models.
- **Develop expedited "glide paths" to facilitate, where appropriate, the transitioning of MIPS APMs to Advanced APMs.** This also would further CMS' goal to reward efforts to transition away from traditional fee-for service models.

## **V. Alternative Payment Models**

### **A. Medical Home Model**

#### **Background:**

In the proposed rule, the Agency outlines a definition for the Medical Home Model as an APM that is determined by CMS to have the following characteristics:

- (1) The APM's participants include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services. For the purposes of this provision, primary care focus means involving specific design elements related to eligible clinicians practicing under one or more of the following Physician Specialty Codes: 01 General Practice; 08 Family Medicine; 11 Internal

Medicine; 37 Pediatric Medicine; 38 Geriatric Medicine; 50 Nurse Practitioner; 89 Clinical Nurse Specialist; and 97 Physician Assistant;

(2) Empanelment of each patient to a primary clinician; and

(3) At least four of the following:

- (viii) Planned coordination of chronic and preventive care.
- (ix) Patient access and continuity of care.
- (x) Risk-stratified care management.
- (xi) Coordination of care across the medical neighborhood.
- (xii) Patient and caregiver engagement.
- (xiii) Shared decision-making.
- (xiv) Payment arrangements in addition to, or substituting for, fee-for-service payments (for example, shared savings or population-based payments).

The proposed rule then outlines the requirements for a Medical Home Model to be determined an advanced APM, which means that the qualifying participants in that medical home would not be included in the MIPS program and would receive the 5 percent bonus payments on their Medicare Part B reimbursements for several years. These requirements are generally aligned with those of all advanced APMs; however, CMS has outlined a different, reduced bar for Medical Home Models in terms of the financial risk standard and nominal amount standard that they need to take on. The Medical Home Model financial risk standard is proposed as follows:

For an APM Entity owned and operated by an organization with fewer than 50 Clinicians whose Medicare billing rights have been reassigned to the TIN of the organization or any of the organization's subsidiary entities, the following standard applies instead of the standard set forth in paragraph (c)(1)(i) of this section. An APM Entity participates in a Medical Home Model that, based on the APM Entity's failure to meet or exceed one or more specified performance standards, does one or more of the following:

- (i) Withholds payment for services to the APM Entity or the APM Entity's eligible clinicians.
- (ii) Reduces payment rates to the APM Entity or the APM Entity's eligible clinicians.
- (iii) Requires the APM Entity to owe payment(s) to CMS.
- (iv) Causes the APM Entity to lose the right to all or part of an otherwise guaranteed payment or payments.

Further, the proposed rule outlines the following definition of nominal amount standard for the Medical Home Model as:

For an APM Entity owned and operated by an organization with fewer than 50 eligible clinicians whose Medicare billing rights have been reassigned to the TIN of the organization or any of the organization's subsidiary entities, the following

standard applies instead of the standard set forth in this paragraph (c)(3)(ii). For a Medical Home Model to be an Advanced APM, the minimum total annual amount that an APM Entity must potentially owe or forego under the APM must be:

- (A) In 2017, 2.5 percent of the APM Entity's total Medicare Parts A and B revenue;
- (B) In 2018, 3 percent of the APM Entity's total Medicare Parts A and B revenue.
- (C) In 2019, 4 percent of the APM Entity's total Medicare Parts A and B revenue.
- (D) In 2020 and later, 5 percent of the APM Entity's total Medicare Parts A and B revenue.

#### **ACP Comments:**

The College commends CMS for its recognition within the proposed rule regarding the unique status of the medical home within the APM portfolio. The College has been a leader in supporting the medical home model, particularly in light of the plethora of currently available research<sup>26</sup> linking the model to higher quality and lower costs. *However, we are greatly concerned the CMS did not meet Congress' intent that medical homes be able to qualify as [advanced] APMs without being required to bear more than nominal risk (even via the less stringent Medical Home Model Standard for financial risk and nominal amount).* The following explains our interpretation of the Congressional intent of the law and proposes specific steps that should be taken to modify the proposed rule to meet this intent.

**A reasonable reading and interpretation of the statute can lend one to understand what we believe to be the clear congressional intent—that CMS should allow a medical home to qualify as an [advanced] APMs, without bearing more than nominal financial risk; if it is a medical home that meets criteria comparable to medical homes expanded under section 1115A(c).** While this language is included in the discussion of the all-payer option that begins in 2021 (which is when other payer payments can be counted toward the threshold to determine if one is a qualifying APM participant), it makes clear that the intent of the law is to incentivize medical homes that are aligned with Medicare initiatives—and therefore ACP sees no reason to unnecessarily limit the initial opportunities for practices to become advanced APMs that are clearly meeting comparable criteria.

Criteria “comparable to medical homes expanded under section 1115A(c)” means:

- (1) the Secretary determines that such expansion is expected to—
  - (A) reduce spending under applicable title without reducing the quality of care;or

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<sup>26</sup> Patient Centered Primary Care Initiative. The Patient-Centered Medical Home's Impact on Cost and Quality. Annual Review of Evidence 2014-2015. Available at [http://www.milbank.org/uploads/documents/PCPCC\\_2016\\_Report.pdf](http://www.milbank.org/uploads/documents/PCPCC_2016_Report.pdf)

- (B) improve the quality of patient care without increasing spending;
- (2) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce (or would not result in any increase in) net program spending under applicable titles; and
- (3) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under the applicable title for applicable individuals. In determining which models or demonstration projects to expand under the preceding sentence, the Secretary shall focus on models and demonstration projects that improve the quality of patient care and reduce spending.

In sum, the Congressional intent and even the statutory language and criteria clearly do not require medical homes to bear more than nominal financial risk in order to qualify for payments as [advanced] APMs.

Nor does it require that the Secretary and the Chief Actuary determine/certify that medical homes would reduce net program spending—rather, the applicable standard is that the Secretary determines they would “reduce spending . . . without reducing the quality of care *or* “improve the quality of patient care without increasing spending’ and the Chief Actuary certifies they “would reduce (or would not result in any increase in) net program spending.” [Emphasis added]. The College believes that there is abundant evidence that medical homes at the very least can improve the quality of care without increasing spending (although there is growing evidence from the many PCMH programs around the country that can also bring about reductions in costs).

**Therefore, ACP recommends that CMS take the following steps to provide multiple pathways for medical homes to be included in the advanced APM pathway, to be implemented in a timely enough basis for eligible medical homes to qualify as advanced APMs within the first year of program implementation (2019). See Table 3 for a summary of the following proposals.**

- 1. Immediately initiate plans to undertake an expedited analysis of the results of the Comprehensive Primary Care initiative (CPCi) to determine whether the statutory requirements for expansion by the Secretary are met (i.e., Section 1115A(c), cited above). This analysis should be completed no later than six months from promulgation of the final rule to allow for a determination to expand CPCi in time for medical home practices to qualify as advanced APMs in 2019.** The five comprehensive primary care functions that are required for practices participating in CPCi are clearly aligned with the definition of Medical Home Model that the Agency has described in the proposed rule. Additionally, ACP is very optimistic regarding the likelihood of this model to fulfill the requirements for expansion based on the first 2 years of CPCi results—that is, they “**improve the quality of patient care without increasing spending.**” This clearly is a model that aligns well with the type of care our members desire to deliver, and their patients want to receive.

- **In parallel with this analysis, CMS should initiate advanced planning to develop their expansion approach for the CPCi program.** This expansion should take place nationally with regard to Medicare payments to those practices that apply, attest to the five comprehensive primary care functions, and are able to meet the milestones over the course of a given timeframe that is clearly articulated in advance. Other payers should be actively invited to apply to collaborate with Medicare; however, the expansion of this program should NOT be dependent upon additional payer participation. Practices should be fully informed in advance of finalizing their agreements with CMS to participate as to whether or not their other regional payers are participating.
- 2. Establish a deeming program or process to enable practices enrolled in medical home programs run by states (including state Medicaid programs), other non-Medicare payers, and employers as being deemed to have met criteria “comparable to medical homes expanded under section 1115A(c)”**
- A deemed PCMH program is one that:
    - a. has a demonstrated multi-year track record of support by non-Medicare payers, state Medicaid programs, employers, and/or others in a region or state;
    - b. shares data with participating practices to assist them in improving quality and lowering costs;
    - c. provides financial support such as risk-adjusted prospective per enrollee payments for care coordination to the practices and/or other types of support to such practices; and
    - d. submits sufficient data to the Secretary that the deemed program, based on the experience of the patient populations served by the program, can be expected to:
      - i. reduce Medicare spending without reducing the quality of care; or
      - ii. improve the quality of patient care without increasing Medicare spending.
  - The PCMH practice in a deemed program would need to provide patient-centered care to Medicare beneficiaries, as well as the other patient populations served by the deemed program, consistent with the requirements that are outlined for the Medical Home Model in the proposed rule.
    - a. The PCMH practice in a deemed program would qualify as a Medical Home Model that is an advanced APM, without having to bear more than nominal financial risk (per both the intent of the law)—and therefore the participating practices in that program would be eligible to be qualifying participants (QPs) and not be part of the MIPS program, but rather would receive the 5 percent bonus payment on their Medicare fee-for-service payments, should their Medicare Part B payments meet the required threshold.
    - b. Along those lines, ACP recognizes that, per the statute in 2019 and 2020, at least 25 percent of the payments to the APM participant must come from Medicare



Part B in order for that clinician to be determined to be a qualifying participant and receive the 5 percent advanced APM bonus on their Medicare Part B reimbursements. As per the law, this threshold to be a qualifying APM participant would then broaden to include payments from the other payers, starting in 2021.

- This deeming process can use the five comprehensive primary care functions as its criteria, along the lines of how the Agency is expected to be able to expand the CPCi program. Newly deemed programs would not be eligible for the additional financial support that CPCi provides (i.e., care management fees and shared savings) provided by Medicare; however, they would still be able to receive any additional payment incentives being provided by the other payers and also the 5 percent bonus payment on Medicare fee-for-service reimbursements over the course of time that those bonuses are available.

**3. Allow inclusion of medical home programs as advanced APMs that meet the Medical Home Model Standard for financial risk and nominal amount as outlined in the proposed rule.** While, as outlined above, the law specifically calls for medical home programs to be advanced APMs without taking on financial risk, ACP is supportive of the latitude that CMS has taken to establish separate financial risk and nominal amount standards for the Medical Home Model to be used as needed until such time as CMS completes an expedited review and expansion of CMMI, and creates a “deemed” PCMH program pathway for advanced APMs, as described above. This is particularly important given the very limited ability of most medical home practices to take on any substantial financial risk above their significant investment in practice redesign and ongoing improvement.

Along these lines, ACP is appreciative of the Agency recently launching the new Comprehensive Primary Care Plus (CPC+) program—and allowing participating clinicians in the CPC+ to also participate in the Medicare Shared Savings Program (MSSP). However, the College is concerned that in the recently released FAQs on CPC+,<sup>27</sup> it appears that CPC practices that are in Track One MSSP ACOs could not be considered Advanced APMs and therefore could not qualify for the 5 percent bonus. This is problematic because it will likely cause CPC practices that are currently in Track One ACOs to leave the ACO program rather than allowing practices to participate in both CPC+ and MSSP Track One, which the College believes was the intent behind allowing practices to participate in both programs. Thus, ACP recommends that CMS consider any CPC+ practice that meets the threshold requirements to be a qualified participant in an Advanced APM be eligible to receive the 5 percent bonus, regardless of whether the practice is also in MSSP Track One.

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<sup>27</sup> CMMI CPC+ Frequently Asked Questions. May 27, 2016. Accessed at: <https://innovation.cms.gov/Files/x/cpcplus-faqs.pdf>.

Additionally, even though CPC+ does have a broader reach than CPCi, it is still limited to a maximum of 5000 practices in 20 regions of the country—and then the opportunity to be an advanced APM (and receive the 5 percent bonus on Medicare fee-for-service reimbursements) for those in CPC+ is proposed to be further limited to those practices with 50 or fewer eligible clinicians. ACP strongly believes that while the CPC+ model is tremendously important, the interpretation by CMS of CPC+ being the only Medical Home Model available as an advanced APM, even with financial risk, is too narrow and restrictive. **Therefore, the College strongly recommends that CMS use the Medical Home Model Standard for financial risk and nominal amount to allow additional PCMH practices to qualify as advanced APMs.**

- Under this option, practices would be required to meet at least the track 1 requirements for those in the new CPC+ program and would be required to take on risk for their Medicare Part B payments that is aligned with the Medical Home Model Standard. They may also already be taking on some level of risk for their payments from other payers within a regional or state-based program, but this would not be required.
- These practices would not be eligible for the additional financial support that CPC+ provides (i.e., care management fees) provided by Medicare; however, they would still be able to receive any additional payment incentives being provided by the other payers and also the 5 percent bonus payment on Medicare fee-for-service reimbursements over the course of time that those bonuses are available.
- As noted above, in this case as well, it is understood that this approach would only be applicable to clinicians that meet the Medicare fee-for-service payment threshold for the initial years—with additional payer reimbursements and/or attributed patients counting toward that threshold beginning in year 2021.
- We also recommend consideration of the Independence at Home demonstration project as meeting the requirements of an Advanced APM within the Medical Home Model specifications.

**Table 3: PCMH Pathways to Qualify as Advanced APMs**

Model	Practice Eligibility	Require “More than Nominal” Financial Risk*	Medicare Payment Model	Medicare Advanced APM 5% FFS bonus
<u>CPC+</u>	CPC+ participating practices, 20 regions, up to 5000 practices	Yes	Risk-adjusted PBPM, FFS	Yes
<u>CPCI “as expanded”</u> <u>(as specified in Section 1115 A [c] of MACRA)</u>	Any PCMH practice that meets CPC+ participation requirements	No	Risk-adjusted PBPM, FFS, shared savings	Yes
<p><b><u>A deemed PCMH program that:</u></b></p> <ul style="list-style-type: none"> <li><b>a.</b> has a demonstrated multi-year track record of support by non-Medicare payers, state Medicaid programs, employers, and/or others in a region or state;</li> <li><b>b.</b> shares data with participating practices to assist them in improving quality and lowering costs;</li> <li><b>c.</b> provides financial support such as risk-adjusted prospective per enrollee; and</li> <li><b>d.</b> submits sufficient data to the Secretary that the deemed program, based on the experience of the patient populations served by the program, can be expected to: <ul style="list-style-type: none"> <li><b>i.</b> reduce Medicare spending without reducing the quality of care; and</li> <li><b>ii.</b> improve the quality of patient care without increasing Medicare spending.</li> </ul> </li> </ul>	The PCMH practice in a deemed program would need to provide patient-centered care to Medicare beneficiaries, as well as the other patient populations served by the deemed program, consistent with the requirements that are outlined for the Medical Home Model in the proposed rule	No	Usual FFS payments for Medicare population seen by the practices (each deemed program will have its own payment model for non-Medicare populations served)	Yes
<b><u>Medical Home Model – inclusive of other medical home programs</u></b>	PCMH practices that meet the Medical Home Model Standard for financial risk and nominal amount as outlined in the proposed rule.	Yes	Usual FFS payment	Yes

\* as defined in the NPRM

## **1. Recommended Modifications to the Proposed Medical Home Model Risk Requirement**

The proposed rule defines the nominal risk standard for the Medical Home Model as beginning at 2.5 percent of the APM Entity's total Medicare Parts A and B revenue in 2017 and ramping up to 5 percent by 2020. **The College, in recognition of the up-front costs of establishing the infrastructure required to deliver services within this model and the limited ability of most primary care practices to accept even minimal downside risk, recommends that the 2.5 percent risk requirement remain at that level until it is determined that a sufficient number of model participants have demonstrated the ability to succeed under even this minimal downside risk requirement.**

The proposed rule states that the special Medical Home Model nominal risk standard be limited, after the first performance year, to organizations with fewer than 50 clinicians. This limitation was created in recognition that larger entities would be more capable of accepting the standard nominal risk requirement. The College believes the 50-clinician limit is arbitrary and does not provide a meaningful distinction in the type or quality of care that patients would receive. Thus, we recommend that the clinician-based limitation be removed, and be replaced with a limitation based upon the amount of Part A and B revenue received by the entity.

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

#### **Background:**

The proposed rule defines the specific requirements for entities to be considered either as MIPS APMs for scoring purposes and Advanced APMs for the purposes of qualifying for the 5% Part B bonus and being exempt from MIPS reporting. The requirements reflect multiple components including the entity's contractual relationship with CMS, the nature of the model implementation (e.g. was it a CMMI initiative?), and whether it meets specified performance measurement and nominal risk requirements. Table 32 of the proposed rule provides a list of current CMS programs based on proposed criteria that would qualify as recognized APMs (MIPS APMs) or advanced APMs. A review of this list indicates that only two of these programs, the Comprehensive ESRD Care (CEC) (LDO arrangement) and the Oncology Care Model (OCM) (two-sided risk arrangement) are directly linked to services provided by specialist/subspecialists. Factors specifically contributing to the limited number of Specialty/Subspecialty related Advanced APMs include that few CMMI models related to these physicians are currently being tested through CMMI, and that, as opposed to the special status provided to Medical Home models both in the statute and rule that provides both no nominal risk and reduced nominal risk pathways for Advanced APM recognition, all other APMs must meet a very high risk standard. Nominal risk refers to the downside financial liability (risk) the entity has if it doesn't meet the specified benchmark of the payment model.

### ACP Comments:

The College expresses significant concern regarding the limited number of opportunities currently available for non-primary care specialists /subspecialists to participate in recognized Alternative Payment Models (APMs) and Advanced APMs. ACP makes the following specific recommendations to address this problem.

### CMS should:

- **Provide priority for consideration through the Physician Focused Payment Models Technical Advisory Committee (PTAC) and for CMMI testing for models involving physician specialty/subspecialty categories for which there are no current recognized APMs and Advanced APM options available. We further recommend that CMS provide a clear pathway for models recommended by PTAC to be implemented as APMs under MACRA.**
- **Reduce the nominal risk requirement for potential advanced alternative payment models other than the Medical Home model.** The current nominal risk requirement for these models is onerous -- essentially requiring a maximum risk of 4% of total health expenditures for the attributed population. This degree of risk taking would place the financial viability of most physician-led entities in question, and realistically is only suitable for larger, facility-based, integrated entities. The College recommends that the nominal risk requirement for these entities be modeled along the lines of the Medical Home nominal risk standard. Thus,
  - The risk requirement be linked to a percent of Part A and B revenue (Part B drug costs excluded) received by the entity. In order to ensure that this reduced nominal risk requirement is focused on the relatively smaller, typically physician-led entities that are incapable of accepting the current, proposed requirement. CMS can consider limiting this reduced risk requirement to entities whose total revenue (Part A and B) is at or below a certain limit.
  - Include requiring the APM Entity to lose the right to all or part of an otherwise guaranteed payment or payments, as one of the options if the APM Entity's actual aggregate expenditures exceed expected aggregate expenditures.
- **Create a platform to expedite the testing for APM recognition of bundled payment and similar episodes of care payment models.** In discussion with many of our related subspecialty societies, it is clear that bundled and episode of care payment models are best aligned with the type of services provided. This platform could possibly be accomplished by immediately extending the Bundled Payment for Care Initiative (BPCI) and expanding it beyond the current inpatient-based tracks, or instituting a new ambulatory-based bundled payment initiative.

In addition, the College further recommends that CMS specifically address within the final rule how currently available (e.g. BPCI) or potential bundled payment (episode) approaches could qualify as Advanced APMs, and participating professionals can qualify as QPs. A major problem faced by most bundled payment APMs being considered by members of our Council of Subspecialty Societies (CSS) is how participants in these

developing payment models, which will likely meet the general requirements of an Advanced APM, will be able to meet the necessary payment amount or patient count thresholds. The bundled services within the developing models only cover a relatively small number of the overall patients within their panels. While it appears that the actual threshold amounts are included in the ACT and cannot be modified under current CMS authority, we believe that there may be alternative means of addressing this issue. These include:

- Providing increased flexibility for eligible participants to participate in multiple Advanced APMs and combining payment/patient count amounts when determining whether the threshold has been obtained. CMS' recent decision to allow CPC+ practices to participate within the Medicare Shared Saving Program is an example of the type of flexibility that may assist physicians and other eligible health professionals to become QPs while engaged in a recognized bundled payment advanced payment model.
- Developing pathways using the "virtual group" language in the ACT to allow practices to combine their advanced APM activities and related payment/patient count amounts when determining whether the QP threshold has been obtained.

### **C. Medicare Shared Saving Program**

#### **Background:**

The rule indicates that Tracks 2 and 3 of the Medicare Shared Savings Program (MSSP), and the Next Generation ACO model all would qualify under proposed criteria as MIPS APMs and Advanced APMs. Track 1 under the MSSP, while qualifying as a MIPS APM, would not qualify as an Advanced APM under the proposed criteria. As of April 2016, 95 % of MSSP participants are in Track 1 of the program, and only 18 ACOs are participating within the Next Generation program.

#### **ACP Comments:**

Comments from our members and the results of a recent survey study released by the National Association of Accountable Care Organizations (NAACOS)<sup>28</sup> continue to reflect the intensive capital outlay (which is "at risk" capital under most business definitions) to establish and maintain a viable ACO within the Medicare Shared Savings Program (MSSP). Furthermore, the ability to accept downside risk remains problematic for many MSSP entities, as reflected by the preponderance of MSSP involvement under Track One. This is particularly true for physician-led ACOs. The College commends CMS for the policy change that allows Track One practices to remain under one-sided risk for an additional 3-year contractual term. We also support the inclusion under the recent MSSP final rule of a fourth year option under Track 1 without benchmark rebasing for Track One entities that have selected and have been approved for two-

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<sup>28</sup> National Association of Accountable Care Organizations. ACOs at a Crossroads: Cost, Risk and MACRA. 2016 Available at <https://www.naacos.com/news/ACOsataCrossroads-NAACOSWhitePaper060116.htm>

sided risk. We make the following additional recommendations to improve the MSSP --- a program that we believe is a very important part of CMS APM portfolio and a crucial component in its overall efforts to transition Medicare payment towards value.

- **The College reaffirms its belief that Track One MSSP ACOs should qualify as meeting the nominal risk requirement for determining an advanced APM.** This is based on the significant “at risk” capital requirements necessary to start and maintain these programs. This position was more fully articulated in a joint comment letter signed-on by the College dated March 25, 2016, which is available at [https://www.acponline.org/acp\\_policy/letters/joint\\_comment\\_mssp\\_aco\\_benchmarking\\_2016.pdf](https://www.acponline.org/acp_policy/letters/joint_comment_mssp_aco_benchmarking_2016.pdf).
- **The College recommends the addition of a new Track within the MSSP that helps bridge the transition for one-sided to two-sided risk.** It is clear from the comments received from many of our members who are currently involved within the MSSP that the jump from one-sided risk under Track 1 to two-sided risk under Tracks 2 and 3 is onerous, and financially unfeasible. The required potential loss of 5 % of the total cost-of-care benchmark (ramping up to 10 % over the three year contract) under Track 2 and 15 % of the benchmark under Track 3 would place the participating practices at financial jeopardy --- these risk amounts consume most or all of the capital base of the practices. Thus, despite the ability presently to stay within Track One for a second 3-year contractual term, few of the participating physician-led entities currently feel they would be able --- even after that 6-year period --- to assume the currently required downside risk of Tracks 2 and 3. The College recommends, as a means of addressing this issue, that CMS add a Track to the MSSP program that includes two-sided risk, but at a level that would not place the participating practices at unreasonable financial jeopardy. For example, a Track that would limit potential loss to up to 10 % of the Part A and B revenue received through the entity would reflect significant nominal risk to the practices within the entity, but not place them in unreasonable financial jeopardy. Entities within this new Track would gain valuable experience delivering services under down-side risk contracting, while also qualifying as an advanced APM under the current CMS definition of nominal risk.

#### **D. Other APM Issues**

##### **1. Delay the Start Date for APM Participation**

The rule proposes a start date for APM participation of January 1, 2017. Thus, physicians would need to already be participating in an APM before the final regulations are published defining whether the APM would qualify as an APM under MACRA, either as a MIPS or Advanced APM, during the first performance year. The College views this start date as unreasonable, particularly given that the first Advanced APM incentive payment to QPs will not be made until mid-2019, two and half years after physicians will have been required to be participating in an APM. Currently, very few APMs qualify as Advanced or MIPS APMs under the proposed rule,

and those participants considering entering into a recognized APM have little time to finalize necessary contractual arrangements prior to the proposed start date. **Thus, the College recommends that CMS delay the start day for the first performance period for MIPS APMs and Advanced APMs until January 1, 2018, with the payment adjustment year remaining 2019.** The College also encourages CMS to work closely with the PTAC and move quickly to implement additional APMs during 2017 that meet the requirements of the law and rule so that as many physicians as possible have the option to participate in APMs as soon as possible, which is what Congress intended in MACRA.

## **2. Treatment of Non-Fee-For-Service Payments**

**ACP recommends that CMS withdraw its proposal to decide on a case-by-case basis whether to exclude many payments made to physicians that are not traditional Medicare Physician Fee Schedule payments from calculations of the five percent lump sum payments to participants in Advanced APMs.** It is completely inappropriate to declare that “financial risk payments” should not count as physician payments for services, since under CMS shared savings models, this is the only way that physicians can be compensated for services delivered that are not directly paid under the fee schedule. These payments are not “incentives,” they are compensation contingent on performance. It is also inappropriate to indicate that monthly payments for patient care are merely “cash flow mechanisms,” when in most cases, they are flexible payments designed to enable physicians to deliver a range of services, including services that are not directly paid for under the fee schedule. This proposal adds unnecessary complexity and uncertainty to the calculations and could provide a disincentive for physicians who want to transition away from a fee-for-service approach.

## **VI. Conclusion**

ACP sincerely appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services’ (CMS) notice of proposed rulemaking (NPRM) regarding the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) – Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule and Criteria for Physician-Focused Payment Models. The enactment of the MACRA law represented a rare situation where physicians, nurses, patient and consumer advocacy groups, and so many others, were able to come together with members of both political parties, in both chambers of Congress, to help craft legislation to create a better physician payment system. Therefore, we believe that CMS has an obligation to take into account the feedback from all of these stakeholders as it works toward implementation. Along these lines, we truly appreciate that the agency has initiated some promising approaches and ideas in this proposed rule, including but not limited to reducing the overall number of quality measures required for reporting, stating an intent to ensure that meaningful use (now advancing care information) is no longer a pass/fail enterprise, initiating the clinical practice improvement activities category of MIPS with a clear interest in flexibility, and making an effort to ensure that patient-centered medical homes are given special status within both MIPS and



APMs. However, the College strongly believes that much more can and should be done to ensure that this new payment system is rolled out successfully.

Therefore, we urge CMS to actively consider all of our recommendations in this letter--and ACP has made every effort to provide the agency with detailed rationales and a number of specific alternative approaches. Additionally, we have articulated our top priority recommendations in several categories:

- Patient-Centered Medical Homes
- Advanced Alternative Payment Model (APM) Options for Internal Medicine Subspecialists and other Medical Specialties
- Simplify the Implementation of the Quality Payment Program (QPP)
- Provide Better Opportunities for Small Practices to Succeed
- Improve Quality Measurement
- Improve the Advancing Care Information Category
- Change the Start Date for the First Performance Year

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

Sincerely,

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

Robert McLean, MD, FACP, FACR  
Chair, Medical Practice and Quality Committee  
American College of Physicians

Appendix: ACP Performance Measurement Committee (PMC) Quality Measure Recommendations in Response to the MACRA Proposed Rule<sup>11</sup>

MIPS ID Number	NQF/PQRS	CMS E-Measure ID	National Quality Strategy Domain	Data Submission Method	Measure Type	Measure Title and Description <sup>¥</sup>	Measure Steward <b>ACP Recommendation</b>
!	0326/047	N/A	Communication and Care Coordination	Claims, Registry	Process	<b>Care Plan:</b> Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance / American Medical Association- Physician Consortium for Performance Improvement  <b>Support with Modifications</b> ACP supports the concept behind this measure; however, it is burdensome for clinicians to annually document an advance care plan for all patients aged 65 years and older. Evidence does not support annually documenting care plans for patients beginning at age 65. A more appropriate measure would incentivize one-time documentation for patients older than 65 years.
	N/A/048	N/A	Effective Clinical Care	Claims, Registry	Process	<b>Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older:</b> Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months.	National Committee for Quality Assurance / American Medical Association- Physician Consortium for Performance Improvement  <b>Support</b> ACP supports this measure because it is evidence-based and there is an existing performance gap.
!	N/A/050	N/A	Person and Caregiver-	Claims, Registry	Process	<b>Urinary Incontinence: Plan of Care for Urinary</b>	National Committee for Quality Assurance / American Medical

<sup>11</sup> Additional measures from the MACRA proposed rule are also listed with ACP PMC ratings on the website ([https://www.acponline.org/clinical\\_information/performance\\_measurement/](https://www.acponline.org/clinical_information/performance_measurement/)).

MIPS ID Number	NQF/PQRS	CMS E-Measure ID	National Quality Strategy Domain	Data Submission Method	Measure Type	Measure Title and Description <sup>‡</sup>	Measure Steward <b>ACP Recommendation</b>
			Centered Experience and Outcomes	y		<b>Incontinence in Women Aged 65 Years and Older:</b> Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence with a documented plan of care for urinary incontinence at least once within 12 months.	Association- Physician Consortium for Performance Improvement  <b>Do not Support</b> ACP does not support this measure because the specifications discourage the development and evaluation of patient-specific care plans. Modifying the description to include “evaluate”, rather than “document” would disincentivize “checking the box” and focus efforts on outcomes-based care. Additionally, the measure does not specify that diagnosis and patient encounter should occur in the same calendar year. Lastly, the denominator specifications do not include additional forms of incontinence training methods that may be appropriate.
!	N/A/109	N/A	Person and Caregiver-Centered Experience and Outcomes	Claims, Registry	Process	<b>Osteoarthritis (OA): Function and Pain Assessment:</b> Percentage of patient visits for patients aged 21 years and older with a diagnosis of osteoarthritis (OA) with assessment for function and pain.	American Academy of Orthopedic Surgeons  <b>Do not support</b> It is clinically inappropriate for physicians to assess pain and function in all patients aged 21 years and older at each visit. A more appropriate measure would focus on adults aged 65 years and older with a diagnosis of OA. This measure is appropriate for evaluating orthopedic surgeons, but general internists should not be held accountable to this measure.
!	0420/131	N/A	Communication	Claims,	Process	<b>Pain Assessment and Follow-</b>	Centers for Medicare & Medicaid

MIPS ID Number	NQF/PQRS	CMS E-Measure ID	National Quality Strategy Domain	Data Submission Method	Measure Type	Measure Title and Description <sup>‡</sup>	Measure Steward <b>ACP Recommendation</b>
			and Care Coordination	Registry		<b>Up:</b> Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present.	Services/ Quality Insights of Pennsylvania  <b>Do not support</b> ACP does not support this measure for several reasons: 1) the specifications do not address the importance of including a functional assessment during the patient visit, 2) the specifications do not exclude patients who have known diversions to opioid therapy (e.g., substance abuse and alcohol abuse disorders) and this could fuel the opioid epidemic, and 3) referral to a pain management specialist is not practical in every area of the country.
!	0101/154	N/A	Patient Safety	Claims, Registry	Process	<b>Falls: Risk Assessment:</b> Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months.	National Committee for Quality Assurance/ American Medical Association- Physician Consortium for Performance Improvement  <b>Support</b> ACP supports this measure because the interventions are based on current evidence, the measure is risk-adjusted, there is a performance gap, and it is clinically relevant to perform risk assessments on patients with fall histories.
!	N/A/181	N/A	Patient Safety	Claims, Registry	Process	<b>Elder Maltreatment Screen and Follow-Up Plan:</b> Percentage of patients aged 65 years and older with a documented elder	Centers for Medicare & Medicaid Services/ Quality Insights of Pennsylvania  <b>Do not support</b>

MIPS ID Number	NQF/PQRS	CMS E-Measure ID	National Quality Strategy Domain	Data Submission Method	Measure Type	Measure Title and Description <sup>‡</sup>	Measure Steward <b>ACP Recommendation</b>
						maltreatment screen using an Elder Maltreatment Screening Tool on the date of encounter AND a documented follow- up plan on the date of the positive screen.	It is clinically inappropriate for physicians to document maltreatment screening for all patients aged 65 years and older at every visit. The measure should define “high risk” as some way other than age (e.g., cognitive impairment, functional impairment). Additionally, clinicians must specifically document which screening tool they used to receive credit for this measure even when abuse is self-evident.
!	0022/238	156v4	Patient Safety	Registry, EHR	Process	<b>Use of High-Risk Medications in the Elderly:</b> Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported. Percentage of patients who were ordered at least one high-risk medication. Percentage of patients who were ordered at least two different high-risk medications.	National Committee for Quality Assurance  <b>Do not support</b> This measure does not stratify patients into well- defined risk groups. It’s conceivable for some patients 66 years and older to tolerate high risk medications as appropriate treatment. Additionally, the measure specifies medications that are not presumed to be high risk in all elderly adults (e.g., Acetaminophen). A stronger measure would focus on a more specific medication list. Furthermore, the specifications do not include exclusion criteria for patient preference.
!	N/A/260	N/A	Patient Safety	Registry	Outcome	<b>Rate of Carotid Endarterectomy (CEA) for Asymptomatic Patients, without Major Complications (Discharged to Home by Post- Operative</b>	Society for Vascular Surgeons  <b>Do not support</b> This measure has significant potential to cause patient harm by incentivizing clinicians to discharge patients early.

MIPS ID Number	NQF/PQRS	CMS E-Measure ID	National Quality Strategy Domain	Data Submission Method	Measure Type	Measure Title and Description <sup>¥</sup>	Measure Steward <b>ACP Recommendation</b>
						<b>Day #2):</b> Percent of asymptomatic patients undergoing CEA who are discharged to home no later than post-operative day #2.	Balancing this measure with a readmission measure may discourage inappropriate early discharges and would focus on achieving quality outcomes.
*	1814/268	N/A	Effective Clinical Care	Claims, Registry	Process	<b>Epilepsy: Counseling for Women of Childbearing Potential with Epilepsy:</b> All female patients of childbearing potential (12 - 44 years old) diagnosed with epilepsy who were counseled or referred for counseling for how epilepsy and its treatment may affect contraception OR pregnancy at least once a year.	American Academy of Neurology  <b>Do not support</b> It is clinically inappropriate for clinicians to spend clinic time counseling patients on the effects of epilepsy treatments on pregnancy or contraception annually. Additionally, women aged 45 years and older who are of childbearing potential should be included in the measure denominator.
!	N/A/316	61v 5 & 64v 5	Effective Clinical Care	EHR	Intermediate Outcome	<b>Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL-C) Test Performed AND Risk-Stratified Fasting LDL-C:</b> Percentage of patients aged 20 through 79 years whose risk factors* have been assessed and a fasting LDL test has been performed AND percentage of patients aged 20 through 79 years who had a fasting LDL-C test performed and whose risk-stratified fasting LDL-C is at or below the recommended LDL-C goal.	Centers for Medicare & Medicaid Services/ Quality Insights of Pennsylvania  <b>Do not support</b> This measure does not align with the AHA/ACC recommendations on the diagnosis and management of Coronary Heart Disease.

MIPS ID Number	NQF/PQRS	CMS E-Measure ID	National Quality Strategy Domain	Data Submission Method	Measure Type	Measure Title and Description <sup>‡</sup>	Measure Steward <b>ACP Recommendation</b>
						<p>*There are three criteria for this measure based on the patient's risk category.</p> <p>Highest Level of Risk: Coronary Heart Disease (CHD) or CHD Risk Equivalent OR 10-Year Framingham Risk &gt;20%</p> <p>Moderate Level of Risk: Multiple (2+) Risk Factors OR 10-Year Framingham Risk 10-20%</p> <p>Lowest Level of Risk: 0 or 1 Risk Factor OR 10-Year Framingham Risk &lt;10%.</p>	
*	N/A/317	22v 4	Community/ Population Health	Claims, Registry, EHR	Process	<p><b>Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:</b></p> <p>Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.</p>	<p>Centers for Medicare &amp; Medicaid Services/ Mathematica / Quality Insights of Pennsylvania</p> <p><b>Do not support</b> ACP supports the precept of this measure; however, the measure does not align with the USPSTF recommendation to monitor blood pressure at home. Additionally, variations in blood pressure assessment (e.g., clinical skill level of the clinician assessing the BP, office setting) may contribute to inadequate readings and result in inappropriate BP management.</p>
!!	N/A/322	N/A	Efficiency and Cost Reduction	Registry	Efficiency	<p><b>Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low-Risk</b></p>	<p>American College of Cardiology</p> <p><b>Support with modifications</b> ACP agrees with the principle of the</p>

MIPS ID Number	NQF/PQRS	CMS E-Measure ID	National Quality Strategy Domain	Data Submission Method	Measure Type	Measure Title and Description <sup>¥</sup>	Measure Steward <b>ACP Recommendation</b>
						<b>Surgery Patients:</b> Percentage of stress single- photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), or cardiac magnetic resonance (CMR) performed in low risk surgery patients 18 years or older for preoperative evaluation during the 12-month reporting period.	measure; however, the measure semantics may be misinterpreted as written. ACP suggests the numerator include cardiac stress images performed within 30 days preceding low-risk, non-cardiac surgery and the denominator include asymptomatic patients undergoing low-risk surgery.
!!	N/A/324	N/A	Efficiency and Cost Reduction	Registry	Efficiency	<b>Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients:</b> Percentage of all stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), and cardiovascular magnetic resonance (CMR) performed in asymptomatic, low coronary heart disease (CHD) risk patients 18 years and older for initial detection and risk assessment.	American College of Cardiology <b>Support</b> ACP supports this measure because it may discourage clinicians from prescribing unnecessary stress imaging in asymptomatic patients and it will reward clinicians that offer efficiency and expertise.
!!	N/A/330	N/A	Patient Safety	Registry	Outcome	<b>Adult Kidney Disease: Catheter Use for Greater Than or Equal to 90 Days:</b>	Renal Physicians Association <b>Support</b>



MIPS ID Number	NQF/PQRS	CMS E-Measure ID	National Quality Strategy Domain	Data Submission Method	Measure Type	Measure Title and Description <sup>¥</sup>	Measure Steward <b>ACP Recommendation</b>
						Percentage of patients aged 18 years and older with a diagnosis of End Stage Renal Disease (ESRD) receiving maintenance hemodialysis for greater than or equal to 90 days whose mode of vascular access is a catheter.	ACP supports this measure because the specifications include appropriate exclusions and it addresses patient safety criteria.
!!	N/A/331	N/A	Efficiency and Cost Reduction	Registry	Process	<b>Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Overuse):</b> Percentage of patients, aged 18 years and older, with a diagnosis of acute sinusitis who were prescribed an antibiotic within 10 days after onset of symptoms.	American Academy of Otolaryngology-Head and Neck Surgery  <b>Support with modifications</b> ACP supports the principle of this measure; however, the measure does not align with the IDSA guideline for treating acute bacterial rhinosinusitis in adults.  We suggest the developers modify the measure to exclude patients who experience severe or worsening symptoms within 10 days after onset of symptoms who would benefit from earlier antibiotic management.
!!	N/A/332	N/A	Efficiency and Cost Reduction	Registry	Process	<b>Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use):</b> Percentage of patients aged 18 years and older with a diagnosis of acute bacterial sinusitis that were prescribed amoxicillin, with or without clavulanate, as a first line	American Academy of Otolaryngology-Head and Neck Surgery  <b>Support with modifications</b> ACP supports this measure; however, the developers should update the measure to align with IDSA recommendations to treat bacterial sinusitis with Amoxicillin-Clavulanate. Amoxicillin therapy is no longer the standard of care.

MIPS ID Number	NQF/PQRS	CMS E-Measure ID	National Quality Strategy Domain	Data Submission Method	Measure Type	Measure Title and Description <sup>¥</sup>	Measure Steward <b>ACP Recommendation</b>
						antibiotic at the time of diagnosis.	
!!	N/A/333	N/A	Efficiency and Cost Reduction	Registry	Efficiency	<b>Adult Sinusitis: Computerized Tomography (CT) for Acute Sinusitis (Overuse):</b> Percentage of patients aged 18 years and older with a diagnosis of acute sinusitis who had a computerized tomography (CT) scan of the paranasal sinuses ordered at the time of diagnosis or received within 28 days after date of diagnosis.	American Academy of Otolaryngology-Head and Neck Surgery  <b>Support</b> This measure may discourage inappropriate use of CT scans to diagnose acute sinusitis. Additionally, the specifications include appropriate exclusions to justify appropriate use of CT scan as an essential diagnosis tool when other diagnostic tests are not self-sufficient.
!!	N/A/334	N/A	Efficiency and Cost Reduction	Registry	Efficiency	<b>Adult Sinusitis: More than One Computerized Tomography (CT) Scan Within 90 Days for Chronic Sinusitis (Overuse):</b> Percentage of patients aged 18 years and older with a diagnosis of chronic sinusitis who had more than one CT scan of the paranasal sinuses ordered or received within 90 days after the date of diagnosis.	American Academy of Otolaryngology-Head and Neck Surgery  <b>Support</b> This measure may discourage inappropriate use of CT scans to diagnose acute sinusitis. Additionally, the specifications include appropriate exclusions to justify appropriate use of CT scan as an essential diagnosis tool when other diagnostic tests are not self-sufficient.
	N/A/337	N/A	Effective Clinical Care	Registry	Efficiency	<b>Tuberculosis Prevention for Psoriasis, Psoriatic Arthritis and Rheumatoid Arthritis Patients on a Biological Immune Response Modifier:</b> Percentage of patients	American Academy of Dermatology  <b>Support with modifications</b> ACP supports the principle of this measure; however, we suggest developers modify the denominator to include all patients who are at risk for

MIPS ID Number	NQF/PQRS	CMS E-Measure ID	National Quality Strategy Domain	Data Submission Method	Measure Type	Measure Title and Description <sup>¥</sup>	Measure Steward <b>ACP Recommendation</b>
						whose providers are ensuring active tuberculosis prevention either through yearly negative standard tuberculosis screening tests or are reviewing the patient's history to determine if they have had appropriate management for a recent or prior positive test.	TB and are prescribed a Biologic. Additional indications for prescribing Biologics place patients at risk for TB and these indications should be captured in the denominator. Including all indications in the denominator will support CMS' aims to simplify and harmonize measures.
!	N/A/342	N/A	Person and Caregiver-Centered Experience and Outcomes	Registry	Outcome	<b>Pain Brought Under Control Within 48 Hours:</b> Patients aged 18 and older who report being uncomfortable because of pain at the initial assessment (after admission to palliative care services) who report pain was brought to a comfortable level within 48 hours.	National Hospice and Palliative Care Organization  <b>Support with modifications</b> ACP supports this measure for specified inpatient palliative care services; however, the measure specifications do not identify a validated pain assessment construct. We suggest the measure developers consider modifying the measure to include a more appropriate assessment tool, like the Numeric Pain Rating Scale.
§ !	N/A/343	N/A	Effective Clinical Care	Registry	Outcome	<b>Screening Colonoscopy Adenoma Detection Rate Measure:</b> The percentage of patients age 50 years or older with at least one conventional adenoma or colorectal cancer detected during screening colonoscopy.	American College of Gastroenterology/ American Gastroenterological Association/ American Society for Gastrointestinal Endoscopy  <b>Support</b> ACP supports this measure because it aligns with USPSTF clinical

MIPS ID Number	NQF/PQRS	CMS E-Measure ID	National Quality Strategy Domain	Data Submission Method	Measure Type	Measure Title and Description <sup>¥</sup>	Measure Steward
							<b>ACP Recommendation</b> recommendations on screening colonoscopy, there is wide variation in adenoma detection rates, and the measure focuses on achieving quality outcomes.
	N/A/367	169v4	Effective Clinical Care	EHR	Process	<b>Bipolar Disorder and Major Depression: Appraisal for Alcohol or Chemical Substance Use:</b> Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use.	Center for Quality Assessment and Improvement in Mental Health  <b>Support</b> ACP supports this measure because it aligns with clinical recommendations of the American Psychiatric Association and focuses on achieving quality outcomes.
	N/A/369	158v4	Effective Clinical Care	EHR	Process	<b>Pregnant Women that had HBsAg Testing:</b> This measure identifies pregnant women who had a HBsAg (hepatitis B) test during their pregnancy.	OptumInsight  <b>Support</b> ACP supports this measure because it aligns with the clinical recommendations of the American College of Obstetrics and Gynecology
!	N/A/373	65v 5	Effective Clinical Care	EHR	Intermediate Outcome	<b>Hypertension: Improvement in Blood Pressure:</b> Percentage of patients aged 18-85 years of age with a diagnosis of hypertension whose blood pressure improved during the measurement period.	Centers for Medicare & Medicaid Services/National Committee for Quality Assurance  <b>Do not support</b> ACP does not support this measure because the specifications do not include appropriate exclusion criteria (e.g., patients diagnosed with terminal diseases, patients currently managed

MIPS ID Number	NQF/PQRS	CMS E-Measure ID	National Quality Strategy Domain	Data Submission Method	Measure Type	Measure Title and Description <sup>¥</sup>	Measure Steward
							<b>ACP Recommendation</b> on multiple blood pressure medications). Additionally, the threshold of improving the blood pressure by 10 mmHg is arbitrary and doesn't account for individual starting points for each patient.
!	N/A/374	50v 4	Communication and Care Coordination	EHR	Process	<b>Closing the Referral Loop: Receipt of Specialist Report:</b> Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services/ Mathematica  <b>Support with modifications</b> ACP supports this measure because it encourages care coordination, but we also recognize the potential for implementation challenges considering perplexities of the health information infrastructure. CMS should consider these measurement challenges and create a system to capture all forms of documentation, including referrals excluded from the EMR (e.g., fax, ground mail).
* !	N/A/377	90v 4	Person and Caregiver-Centered Experience and Outcomes	EHR	Process	<b>Functional Status Assessment for Patients with Congestive Heart Failure:</b> Percentage of patients aged 65 years of age and older with congestive heart failure who completed initial and follow-up patient-reported functional status assessments.	Centers for Medicare & Medicaid Services/ Mathematica  <b>Do not support</b> ACP does not support this measure because the background information does not identify a performance gap, the recommendation to classify functional status is based on outdated evidence, and it is burdensome for clinicians to document functional status based on administration of an assigned assessment instrument.

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!	N/A/386	N/A	Person and Caregiver-Centered Experience and Outcomes	Registry	Process	<b>Amyotrophic Lateral Sclerosis (ALS) Patient Care Preferences:</b> Percentage of patients diagnosed with Amyotrophic Lateral Sclerosis (ALS) who were offered assistance in planning for end of life issues (e.g. advance directives, invasive ventilation, hospice) at least once annually.	American Academy of Neurology  <b>Support</b> ACP supports this measure because it is patient-centered and clinically relevant; however, there are no data to support this as an annual effort and this measure should target neurologists who participate in the neurology registry.
	N/A/387	N/A	Effective Clinical Care	Registry	Process	<b>Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users:</b> Percentage of patients regardless of age who are active injection drug users who received screening for HCV infection within the 12 month reporting period.	American Medical Association-Physician Consortium for Performance Improvement  <b>Support</b> ACP supports this measure because it is clinically relevant to test injection drug users for HCV, the measure includes appropriate exclusion criteria, and it aligns with AASLD and the IDSA recommendations for Testing, Managing, and Treating Hepatitis C.
!	N/A/390	N/A	Person and Caregiver-Centered Experience and Outcomes	Registry	Process	<b>Hepatitis C: Discussion and Shared Decision Making Surrounding Treatment Options:</b> Percentage of patients aged 18 years and older with a diagnosis of hepatitis C with whom a physician or other qualified healthcare professional reviewed the range of treatment options appropriate to their	American Medical Association-Physician Consortium for Performance Improvement/ American Gastroenterological Association  <b>Support</b> ACP supports this measure because it encourages shared decision making and it's important to discuss potential or adverse side effects, even when minimal. It is also important to discuss affordability as part of the shared-

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						genotype and demonstrated a shared decision making approach with the patient. To meet the measure, there must be documentation in the patient record of a discussion between the physician or other qualified healthcare professional and the patient that includes all of the following: treatment choices appropriate to genotype, risks and benefits, evidence of effectiveness, and patient preferences toward treatment.	decision making process because payers play a significant role in the therapy selection process.
!	N/A/398	N/A	Effective Clinical Care	Registry	Outcome	<b>Optimal Asthma Control:</b> Patients ages 5-50 (pediatrics ages 5-17) whose asthma is well- controlled as demonstrated by one of three age appropriate patient reported outcome tools.	Minnesota Community Measurement  <b>Do not support</b> This measure is not appropriately risk adjusted for socioeconomic status and it's unnecessarily burdensome for clinicians to report on seven performance rates. It is especially important to adjust for SES in asthma patients because high co- pays for controller inhaled medications are an adherence barrier for lower socioeconomic class patients. Additionally, this measure is not risk adjusted for asthma severity levels. Therefore, clinicians treating severely affected populations may incur financial penalties which would worsen health disparities by penalizing safety-net hospitals and institutions

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							with lower socioeconomic patients.
!	N/A/403‡	N/A	Person and Caregiver-Centered Experience and Outcomes	Registry	Process	<b>Adult Kidney Disease: Referral to Hospice:</b> Percentage of patients aged 18 years and older with a diagnosis of end-stage renal disease (ESRD) who withdraw from hemodialysis or peritoneal dialysis who are referred to hospice care.	Renal Physicians Association/ American Medical Association- Physician Consortium for Performance Improvement  <b>Support</b> ACP supports this measure because it encourages a shared-decision making approach. The measure includes appropriate exclusion criteria; however, the denominator specifications should exclude patients who withdraw from hemodialysis to receive a kidney transplant.
!!	N/A/407‡	N/A	Effective Clinical Care	Claims, Registry	Process	<b>Appropriate Treatment of MSSA Bacteremia:</b> Percentage of patients with sepsis due to MSSA bacteremia who received beta-lactam antibiotic (e.g. nafcillin, oxacillin or cefazolin) as definitive therapy.	Infectious Disease Society of America  <b>Support</b> ACP supports this measure because it prevents vancomycin overuse, encourages effective care, and the specifications include appropriate exclusion criteria.
	N/A/408‡	N/A	Effective Clinical Care	Registry	Process	<b>Opioid Therapy Follow-up Evaluation:</b> All patients 18 and older prescribed opiates for longer than six weeks duration who had a follow-up evaluation conducted at least every three months during Opioid Therapy	American Academy of Neurology  <b>Support</b> ACP supports this measure because it aligns with Centers for Disease Control and Prevention recommendations on Prescribing Opioids for Chronic Pain.



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						documented in the medical record.	
	N/A/412‡	N/A	Effective Clinical Care	Registry	Process	<b>Documentation of Signed Opioid Treatment Agreement:</b> All patients 18 and older prescribed opiates for longer than six weeks duration who signed an opioid treatment agreement at least once during Opioid Therapy documented in the medical record.	American Academy of Neurology <b>Support with modifications</b> ACP supports this measure because it aligns with the Centers for Disease Control and Prevention recommendations for Prescribing Opioids for Chronic pain; however, the denominator specifications should exclude patients receiving active cancer treatment, palliative care, and end-of-life care.
	N/A/414‡	N/A	Effective Clinical Care	Registry	Process	<b>Evaluation or Interview for Risk of Opioid Misuse:</b> All patients 18 and older prescribed opiates for longer than six weeks duration evaluated for risk of opioid misuse using a brief validated instrument (e.g. Opioid Risk Tool, SOAAP-R) or patient interview documented at least once during Opioid Therapy in the medical record.	American Academy of Neurology <b>Support with modifications</b> ACP supports this measure because it aligns with the Centers for Disease Control and Prevention recommendations for Prescribing Opioids for Chronic pain; however, the denominator specifications should exclude patients receiving active cancer treatment, palliative care, and end-of-life care.
	0053/418‡	N/A	Effective Clinical Care	Claims, Registry	Process	<b>Osteoporosis Management in Women Who Had a Fracture:</b> The percentage of women age	National Committee for Quality Assurance/ American Medical Association- Physician Consortium for Performance Improvement

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						50-85 who suffered a fracture and who either had a bone mineral density test or received a prescription for a drug to treat osteoporosis.	<b>Support with modifications</b> ACP supports this measure; however, it may promote overuse of bone mineral density testing. The developers should consider tapering the fracture definition to only include women with vertebral and hip fractures.
!!	N/A/419‡	N/A	Efficiency and Cost Reduction	Claims, Registry	Efficiency	<b>Overuse Of Neuroimaging For Patients With Primary Headache And A Normal Neurological Examination:</b> Percentage of patients with a diagnosis of primary headache disorder whom advanced brain imaging was not ordered.	American Academy of Neurology  <b>Support</b> ACP supports this measure because it will prevent overuse of neuroimaging and the data source attributes the prescribed imaging to the ordering clinician.
!	N/A/435‡	N/A	Effective Clinical Care	Claims, Registry	Outcome	<b>Quality Of Life Assessment For Patients With Primary Headache Disorders:</b> Percentage of patients with a diagnosis of primary headache disorder whose health related quality of life (HRQoL) was assessed with a tool(s) during at least two visits during the 12 month measurement period AND whose health related quality of life score stayed the same or improved.	American Academy of Neurology  <b>Do not support</b> ACP supports the precept of this measure; however, the only validated tool to assess quality of life for patients with primary headache disorders is specific to migraines. Therefore, clinicians would have to rely on general quality of life assessment tools for all other headache disorders and the results of these assessments may have other influences.
	N/A/438‡	N/A	Effective	Web	Process	<b>Statin Therapy for the</b>	Centers for Medicare & Medicaid

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			Clinical Care	Interface, Registry		<p><b>Prevention and Treatment of Cardiovascular Disease:</b>            Percentage of the following patients—all considered at high risk of cardiovascular events—who were prescribed or were on statin therapy during the measurement period:            Adults aged ≥ 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR            Adults aged ≥21 years with a fasting or direct low-density lipoprotein cholesterol (LDL-C) level ≥ 190 mg/dL; OR            Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70- 189 mg/dL</p>	<p>Services/ Mathematica /Quality Insights of Pennsylvania</p> <p><b>Support with modifications</b>            ACP supports this measure because the balance of evidence provides a strong foundation for the treatment of blood cholesterol for the primary and secondary prevention of atherosclerotic cardiovascular disease in adult men and women. We note the measure would be improved by revising the specifications to align with the ACC/AHA recommendations on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults. The specifications should clearly favor high- and moderate-intensity statin therapy and address high risk primary prevention in the absence of diabetes or very high LDL.</p>
§ !!	N/A/439‡	N/A	Efficiency and Cost Reduction	Registry	Efficiency	<p><b>Age Appropriate Screening Colonoscopy:</b> The percentage of patients greater than 85 years of age who received a screening colonoscopy from January 1 to December 31.</p>	<p>American Gastroenterological Association/ American Society for Gastrointestinal Endoscopy/ American College of Gastroenterology</p> <p><b>Support</b>            ACP supports this measure because the denominator specifications include appropriate exclusions and it discourages overuse of screening colonoscopy.</p>

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+ !	N/A/New		Effective Clinical Care	Registry	Intermediate Outcome	<p><b>Ischemic Vascular Disease All or None Outcome Measure (Optimal Control):</b> The IVD All-or-None Measure is one outcome measure (optimal control). The measure contains four goals. All four goals within a measure must be reached in order to meet that measure. The numerator for the all- or-none measure should be collected from the organization's total IVD denominator. All-or-None Outcome Measure (Optimal Control) - Using the IVD denominator optimal results include: Most recent blood pressure measurement is less than 140/90 mm Hg -- And Most recent tobacco status is Tobacco Free -- And Daily Aspirin or Other Antiplatelet Unless Contraindicated -- And Statin Use.</p>	<p>Wisconsin Collaborative for Healthcare Quality (WCHQ)</p> <p><b>Support</b> This measure disregards patient preferences, the specifications do not consider factors beyond the clinicians control (e.g., patient compliance, patient access), and it does not align with the JNC 8 recommendations for hypertension management.</p>
+ § !!	N/A/New		Patient Safety	Registry	Process	<p><b>Non-recommended Cervical Cancer Screening in Adolescent Females:</b> The percentage of adolescent females 16–20 years of age unnecessarily screened for cervical cancer.</p>	<p>National Committee for Quality Assurance</p> <p><b>Support</b> ACP supports this measure because it aligns with recommendations from the USPSTF and the Centers for Disease Control and Prevention (CDC) and evidence supports screening in primary care as feasible and effective.</p>

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+ § !!	0216/New		Effective Clinical Care	Registry	Outcome	<b>Proportion admitted to hospice for less than 3 days:</b> Percentage of patients who died from cancer, and admitted to hospice and spent less than 3 days there.	American Society of Clinical Oncology  <b>Do not support</b> Although we recognize the benefit of admitting patients to hospice at the appropriate time, it is often difficult to estimate patient longevity. This measure disincentivizes admitting patients appropriately to hospice even if they are in their last few days of life.