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Via Electronic Submission (www.regulations.gov)

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Mr. Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
ATTN: CMS-5517-P
7500 Security Blvd.
Baltimore, MD 21244-8013

Dear Mr. Slavitt:

Re: Medicare Program; Merit-Based Incentive Payment Systems (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed Rule, File Code CMS-5517-P

The Association of American Medical Colleges (AAMC or Association) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's or the Agency's) *Medicare Program; Merit-Based Incentive Payment Systems (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed Rule*, 81 Fed. Reg. 28162 (May 9, 2016). The AAMC is a not-for-profit association representing all 145 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems; and, 93 academic and professional societies. Through these institutions and organizations, the AAMC represents 160,000 faculty members, 83,000 medical students, and 115,000 resident physicians.

The AAMC appreciates that CMS has given stakeholders an opportunity to provide feedback on the extremely complex and challenging task of implementing the new physician payment system required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The program needs to encourage collaboration among providers to improve patient care and should allow as many physicians as possible to be successful. Furthermore, CMS should provide as much flexibility as possible at least during the initial years to allow sufficient time for physicians and other clinicians to adapt to the new payment system. This is essential for the health of the Medicare program and for ensuring that beneficiaries have the access to care that they need.

There must be a recognition that the purpose of alternative payment models (APMs) is to innovate and provide team-based, quality care. Therefore, APMs should not be measured against standards that were designed for a fee-for-service care delivery system that was not designed to deliver coordinated care. Further, when appropriate, risk adjustments must be incorporated so as not to disadvantage those physicians who are caring for the most complex and vulnerable patients. To achieve these ends, the program needs to allow maximum flexibility for meeting requirements, particularly in the early years as physicians adjust to a radically different payment system.

Additionally, the AAMC is pleased that CMS has expressed that it is open to identifying proposals that need to be changed to encourage successful participation. While the regulation includes provisions aimed at reducing burden and complexity, the AAMC still has significant concerns with a number of provisions in the proposed rule, including the complexity of the rules for physicians, and suggests a number of revisions.

We are committed to working with CMS to ensure that MACRA promotes improvements in delivery of care and is not overly burdensome to clinicians and the organizations for which they work. The following highlights the AAMC's top recommendations to CMS:

- Simplify the proposed MIPS program to decrease administrative burden and enable successful participation.
- Increase the opportunities for physicians to transition to new delivery payment models.
- Accommodate the needs of physicians in large multi-specialty practices, whether they participate under the general MIPS program, MIPS APMs, or as qualified participants in Advanced APMs.

What Does A Large, Multi-Specialty Group Practice Look Like?

With good reason, CMS has devoted a lot of energy to the needs of solo and small physician practices as they move into the new payment system. However, there is a need for more consideration of the challenges posed by the Quality Payment Program for large, multi-specialty group practices, such as those typically found in academic medical centers. These large multi-specialty practices face difficult and confusing decisions about how to approach the MACRA Quality Payment Programs. For myriad of reasons, these groups of faculty physicians frequently are organized under a single tax identification number (TIN). They also are the clinicians who treat the most vulnerable patients, those individuals who are poor, sick, and have complex medical needs.

It is difficult to paint a picture of a faculty practice plan as there is wide variation, but data from the Faculty Practice Solutions Center (FPSC), a joint product of Vizient and the AAMC, is helpful for an understanding of the breadth, depth and complexity of these groups. FPSC data on 87 practice plans shows that they range from a low of 128 individual National Provider Identifier Standards (NPIs) to a high of 4,319, with a mean of 989 and a median of 816. FPSC also has data on over 70 adult and pediatric specialties which does not count the numerous subspecialties, such as burn surgery, cardiac surgery, and general surgery, to name a few. In some cases faculty

practice plans are highly integrated and make decisions about quality improvement and care coordination as a single entity. In other instances such decision making occurs at the specialty level. As much as these large groups differ from one another, they have a common characteristic that they are all very different from small and solo physician practices. While they have learned how to report under the current quality programs, the choices under MIPS and APMs present a level of uncertainty, complexity and risk for these large organizations that are the cornerstone of the American health care system, providing not only patient care but also conducting research and teaching the next generation of physicians.

Overarching Comments on the Merit-based Incentive Payment System (MIPS) Program

The MIPS program consolidates the payment adjustments from the Medicare Electronic Health Record (EHR) Incentive Program ("meaningful use"), the Value-based Modifier (VM), and Physician Quality Reporting System (PQRS) into a large pay-for-performance-program. Providers will be measured on quality, resource use, clinical practice improvement activities (CPIA), and advancing care information (ACI), resulting in an overall composite performance score (CPS) that will determine their Medicare payment starting two years after the performance period. The AAMC is pleased to see that the Agency has proposed to continue group reporting options for the quality and resource use categories and has added a group option under ACI which replaces meaningful use; many academic practices have adopted this reporting option as it allows the organization to focus on a shared set of goals and build the infrastructure necessary to improve care. Additionally, the AAMC appreciates that CMS has made efforts to ensure that the transition is smooth and efficient as possible by proposing to select measures used in the PQRS and VM programs and to maintain the same data submission mechanisms. The following highlight the AAMC's top recommended revisions regarding the MIPS program:

- ***Overall***: Given the short ramp up time, reduce the number of measures to make participation in the program less burdensome.
- ***Risk Adjustment***: As appropriate, risk adjust outcome, population based measures, and resource use measures for clinical complexity and sociodemographic factors.
- ***MIPS Identifiers:*** In addition to using the TINs, NPIs, and APM Identifiers, create an option for a MIPS identifier that would allow large multi-specialty groups to have sub-groups under the same TIN that could be assessed in the quality payment programs in a way that is meaningful.
- ***Group Reporting Quality Measures***: Modify or remove specific Group Practice Reporting Option (GPRO) Web Interface measures to more appropriately capture relevant and meaningful data regarding the quality of care.
- ***Quality Category***: Reduce the proposed reporting threshold of 80 or 90 percent for reporting on quality measures to 50 percent in the data completeness criteria. This will reduce burden and make it easier for eligible clinicians to be successful under the MIPS program.
- ***Resource Use Category***: Allow eligible clinicians to be measured on either Total Per Capita Costs or episode costs; the Total Per Capita Cost and the Medicare Spending Per Beneficiary (MSPB) measures are inclusive of the episode-based measures. Prior to applying episode-based measures under MIPS, CMS must improve the validity of the episode groups, and

update the groups to reflect the transition from ICD-9 to ICD-10. Instead of using hospital-based measures, such as MSPB, CMS should develop and test resource measures that are appropriate for physician practices.

- ***Clinical Practice Improvement Category***: Give full credit for CPIA to eligible clinicians participating in APMs reporting under MIPS, similar to those participating in Patient Centered Medical Home (PCMH) models.
- ***Advancing Care Information Category***: Provide hardship exemptions for both 2017 and 2018 for practices that are experiencing transitional, infrastructural changes along with practices that are reporting portions of the year using previous year's Certified Electronic Health Record Technology (CEHRT) requirements.
- ***MIPS APM Scoring*:** Modify the APM Scoring Standard to reduce burden and encourage participation in these models by allowing reporting at the APM level for all categories rather than the aggregate of TINs or individual clinicians**.** Allow the APM participants to receive the MIPS score that is the highest if they are an APM participant and also provide services through their group practice TIN.
- ***MIPS APM Participants*:** Consider other approaches to identifying APM participants, including changing the APM model requirements to enable more frequent updates to the participant list and using claims data to identify who the APM participants are instead of relying solely on a participant list.

Overarching Comments for the Alternative Payment Models (APMs) Program

The qualified APM (QAPM) track provides qualifying APM participants with a 5% incentive payment for participating in Advanced APMs. Beginning in 2026, the qualifying APM participants will also receive a higher annual fee schedule update. By providing incentives for participation in Advanced APMs, CMS hopes to expand the opportunities for participation in APMs, maximize participation in current and future Advanced APMs, create clear and attainable standards for incentives, promote the continued flexibility in the design of APMs, and support multi-payer initiatives across the healthcare market. While the AAMC strongly supports these initiatives, CMS's definition of Advanced APMs is too narrow and ultimately discourages Advanced APM participation. To create a more flexible program and encourage participation, the AAMC recommends that CMS:

- ***Overall:*** Implement flexible requirements around the classification of qualified APM participants to allow for maximum participation including not limiting a cut-off period for the list of eligible clinicians listed as of December 31st of the performance period.
- ***Qualifying List of Advanced APMs:*** Expand the list of Advanced APMs to include the Bundling Payment for Care Improvement (BPCI) initiative and Comprehensive Care for Joint Replacement (CJR) model, and other models, by making minimal operational revisions to those programs. Physicians are central to the success of these models.
- ***Threshold Requirements:*** Inform the Advanced APM about whether the thresholds are met earlier so that Advanced APM participants are not burdened with reporting on MIPS if they would meet the criteria as QAPM participants.

- ***Participation in MIPS APMs:*** Avoid redundant or conflicting reporting requirements under MIPS when APM participants do not meet the threshold requirements to be qualifying APM participants.
- ***Nominal Financial Risk Definition:*** Revise the definition of nominal financial risk to take into account the financial risk of redesigning practices, reduced volume, and impacts on payments when investing in Advanced APMs. Remove the requirement for a minimum loss rate regarding financial risk. Modify the requirement that total potential risk be at least 4% of the APM target and instead require that it be 3% of the physician's Medicare Part B revenue.
- ***CEHRT:*** Keep the threshold for clinicians in the APM who use CEHRT at 50% instead of increasing it to 75% in subsequent years. Exclude from the calculation of the threshold services provided by clinicians in post-acute settings (e.g. SNFs, IRFS) and clinicians who have had the ACI category reweighted to 0.
- ***Physician-Focused Payment Models (PFPM):*** Reduce the timeframe for making a decision about whether a model will become a PFPM to allow adequate time for physicians to implement the models and qualify for the 5% bonus payment which is only available for 5 years. Develop different criteria for PFPM's to be recognized as Advanced APMs.

MERIT-BASED INCENTIVE PAYMENT SYSTEM

MIPS ELIGIBLE CLINICIAN IDENTIFIER

CMS Should Allow Multiple Options for Assessing Eligibility, Participation, and Performance to Account for the Many Different Practice Models

CMS proposes to use multiple identifiers that allow MIPS eligible clinicians to be measured as an individual or through a group's performance, and that the same identifier would be used for all four performance categories. To assess performance for individual MIPS eligible clinicians, CMS would use a combination of billing TIN/NPI, and for a group CMS would use the group's billing TIN. In addition, CMS proposes that each eligible clinician who is a participant of an APM entity would be identified by a unique APM participant identifier that would be a combination of four identifiers: 1) APM identifier; 2) APM entity identifier; 3) TIN(s); and 4) the MIPS eligible clinicians NPI.

The AAMC supports CMS's proposal to allow providers to select whether they want to be assessed as an individual (TIN/NPI), group (TIN), or APM participant identifier. The Association encourages CMS to establish a group MIPS identifier in addition to these other identifiers that would allow groups with many different physicians under one TIN to identify sub-groups that could be assessed under MIPS. As a strong proponent of group reporting, the AAMC supports the need for a flexible definition of what constitutes a group. The current PQRS and VM policies recognize groups only by TIN. While a TIN is a reasonable option to use, the AAMC encourages CMS to make available a range of options, such as a distinct group MIPS Identifier. This would allow related TINs to report as a group or allow a subset of physicians within a large TIN to form their own group for reporting. CMS could request that the group provide a list of participants in the subset identified by the group MIPS identifier.

With evolving delivery and practice models, it is important for CMS to allow multiple options for identifying providers to assess eligibility, participation and performance under the MIPS program. Some faculty practices have multiple TINs for business or legal reasons but for all other purposes the physicians in the practice are part of the same group and want to be identified for reporting purposes under the same identifier. Use of a group MIPS identifier could enable these TINs to be measured as one group practice under the MIPS program. Some groups may be under a larger TIN but may want to break into sub-specialty components to allow for more accurate and meaningful measurement under the program. This is particularly important in instances when only a subset of providers within a TIN participate in an APM. A group MIPS identifier could be a mechanism for allowing smaller components under these large TINs to be measured separately from the TIN. The single TIN could attest to CMS that it would like to be measured at a smaller unit level and provide a list of participants in each separate group formed with each group having a distinct MIPS identifier.

Depending on the practice, there are advantages and disadvantages to reporting under a group MIPS identifier, an NPI, a TIN, or a combination. Under the MIPS program, the practices should be given the opportunity to assess the advantages and disadvantages and select whichever option works best. Among the numerous benefits to a group MIPS identifier option are that it: 1) focuses an organization's attention on common goals and encourages investment in infrastructure; 2) encourages team-based care; and, 3) reduces administrative burden for practices with large numbers of physicians. For academic medical centers that typically have large physician practices, tracking individual performance can be very difficult.

For smaller practices, individual reporting through use of a combination of NPIs and TINs can be appealing because the performance assessment is applied separately to each provider within a group. Each physician's success or failure does not affect the success or failure of any of the other physicians within the group. Therefore, this option should also remain available.

QUALITY PERFORMANCE CATEGORY

For the 2019 MIPS payment adjustment year, the quality performance category will account for 50 percent of the CPS, with some exceptions. CMS proposes that individual MIPS eligible clinicians submitting data via claims and individual eligible clinicians and groups submitting via all mechanisms (except CMS Web Interface) would be required to report at least 6 measures, including 1 cross-cutting measure and one outcome measure, if applicable. In addition, CMS would apply 3 population based measures derived through administrative claims. CMS also proposes to remove the requirement that measures have to span a set number of National Quality Strategy (NQS) domains.

Submission Criteria for Quality Measures (Excluding Web Interface)

Reduce Measures Required for Reporting and Allow for More Flexibility

We support the CMS proposal to reduce the number of measures required from reporting from the 9 measures and the elimination of the requirement that measures span NQS domains. CMS should further reduce the number of measures required for reporting to fewer than six. It is important for CMS to reduce administrative burden and allow flexibility in the selection of quality measures for reporting. This will enable eligible clinicians to report measures that are more relevant to their practices. AAMC also encourages CMS to align measures across payers and consider use of core measure sets in the future.

Data Completeness Criteria

Reduce Threshold and Number of Required Quality Measures

CMS proposes that individual MIPS eligible clinicians or groups submitting data on quality measures using QCDRs, qualified registries, or via EHR report on at least 90 percent of the MIPS eligible clinician or group's patients that meet the denominator criteria for the measure, regardless of payer. For claims based reporting CMS is requiring reporting on 80 percent of the MIPS eligible clinician's patients. If these thresholds are not met, the eligible clinician would receive a 0 score for that particular measure.

The 90 percent threshold is a dramatic increase from the existing requirement under PQRS that eligible clinicians report on at least 50 percent of Medicare Part B patients. This is a significant administrative burden and will make it much more difficult to achieve higher quality scores. In addition, eligible clinicians may be discouraged from reporting through registries, QCDRs and EHRs due to the requirement that they report on all of their patients regardless of payer. **Therefore, the AAMC recommends that CMS maintain the existing 50 percent reporting threshold and reduce the number of required quality measures**.

Submission Criteria for Quality Measures Reporting Using GPRO Web Interface

CMS proposes that groups reporting through GPRO Web Interface would be required to report on all measures included in the Web Interface by populating data fields for the first 248 consecutively ranked and assigned Medicare beneficiaries. CMS requires that groups report all measures in the set. CMS proposes to eliminate the requirement that groups of 100 or more eligible clinicians participate in the CAHPS survey.

CMS Should Either Remove or Modify Some Quality Measures in the Web Interface

Several of the quality measures include criteria that are very difficult to achieve, making it extremely difficult to score well under MIPS. CMS needs to evaluate all the quality measures to ensure they are appropriate for large group practices and reflect current recommendations. Additionally, CMS needs to take steps to ensure that EHR vendors create crosswalks between

the Hierarchical Condition Categories (HCC) model and diagnosis functions in EHRs to avoid inaccurate risk adjustments for ICD-10 codes. While providers may spend a significant time properly documenting patients' diagnoses, it is unclear whether the HCC adjustment accurately aligns with the ICD-10 code that the EHR produces. For example, the depression remission measure (MH-1) measures the number of patients with major depression as defined as an initial PHQ-9 score > 9 who demonstrate remission at twelve months as defined as a PHQ-9 score <5. The requirement for PHQ-9 use for evaluating patients combined with a follow-up evaluation is problematic for many large group practices. The measure must be recorded for 248 patients, a very difficult bar for large multi-specialty group practices which refer patients for treatment and follow-up to psychiatrists if they have a PHQ of 9. The measure seems to be designed for group practices that do not have this type of referral pattern to psychiatrists. This is just one example of practice pattern differences between large academic medical groups and small and or/ rural practices. The AAMC asks that the measure be removed and that CMS determine if there may be other measures related to depression that would be more appropriate to use in the MIPS program.

Another problematic example is the medication safety measure (CARE 3). The score includes all medications the patient is taking, including over-the-counter and herbal medications, and therefore relies on the patient recalling and accurately reporting this information. For each medication on the list providers must include the dose, route (e.g., by mouth or by injection), and frequency. This measure is difficult to meet, even if medication lists are substantially complete. According to the specifications, if a multi-vitamin is listed but "by mouth" isn't recorded then the encounter(s) is scored as non-performance.

From a safety standpoint, the most critical information in a medication list is the names of the medications. This allows drug-drug interaction checking and drug allergy checking to be accomplished. By requiring the all the additional details in this measure, a potential unintended consequence may be a reluctance to list any medication for which the patient does not provide the complete information (a frequent occurrence). The measure has to be recorded for 248 patients and must be done for each encounter. For a patient with a large number of encounters this is burdensome. With up to 12 encounters per patient possible, this could require the manual review of over 2900 medication lists to submit for just one measure. One alternative to consider would be that the measure is met if the organization has a medication reconciliation policy that has been accepted by a national accrediting body such as the Joint Commission.

In addition, the blood pressure measure must be updated to reflect recent national consensus about appropriate blood pressure measurements. A national consensus has developed that blood pressure should vary by age and diagnosis. However, the measure requires a strict policy of controlling to less than 140/90 for hypertensive patients, regardless of age, and 120/80 for screening purposes. These levels are not consistent with current medical evidence or opinion such as those noted in the Eighth Joint National Committee. There should be a mechanism for expeditiously changing measures that are no longer consistent with published best practices.

Global and Population Based Measures

CMS proposes to use Prevention Quality Indicators (PQIs), the acute and chronic composite measures developed by the Agency for Healthcare Research and Quality (AHRQ), which meet a minimum sample size in the calculation of the quality measures domain for the MIPS performance score. In addition, CMS proposes to include the all-cause hospital readmission measure for groups with 10 or more eligible clinicians with 200 cases.

The PQI Measures Should Not Be Used in MIPS Until Appropriately Risk Adjusted for Patient Complexity and Sociodemographic Status

The AAMC has significant concerns with the use of these measures in the MIPS program and therefore recommends that they be removed until issues related to risk adjustment, sociodemographic factors, and attribution are addressed.

The PQIs were originally designed to measure ambulatory sensitive conditions at a community level presented as a rate calculated per 100,000 population. Such a large sample size allows communities to evaluate their primary care system at a macro level. These measures were not tested or endorsed by NQF for use at the clinician level, where the population is much smaller. If implemented in the MIPS program, it is possible that physician practices with only 20 attributed patients could be held accountable for performance under this measure. The AAMC does not believe it is appropriate to apply measures that are intended to address overall rates at a population level to individual physicians in the MIPS program that have populations significantly smaller than 100,000 patients.

The characteristics of the attributed Medicare beneficiaries can vary widely by physician group practice. Not accounting for the clinical variation in the underlying population leads to misleading results that disproportionately affect the physicians who care for the most complex patients. CMS acknowledges there is not adequate risk adjustment and states that the Agency intends to "incorporate a clinical risk adjustment as soon as feasible to the PQI composites." Prior to implementation in any program, these measures should have appropriate clinical risk adjustment. In addition, as admissions and readmissions are often connected to the broader community, CMS should consider adding an adjustment or stratification to account for socio-demographic factors.

Despite these challenges with these measures, CMS is currently using PQI measures under the physician value-based modifier program. In the 2015 Value Modifier Experience Report, groups in the low-quality and/or high-cost categories had worse performance on these measures. This report showed that of the 106 groups that went through quality tiering, none with patients in the highest quartile of risk received an upward adjustment, and a little over 30 percent had a downward adjustment.

The 30- day hospital readmission measure will also potentially penalize physicians who care for the most complex patients or those with low socioeconomic status. The impact of inadequate risk adjustment has been raised as a significant concern in the context of the hospital readmission

quality program. This measure also is not appropriate as a physician quality measure as physicians may have limited control over some of the factors that result in readmission to the hospital.

Topped out Measures and Scoring

CMS Should Provide Information in Advance on Which Measures are "Topped Out" and the Benchmarks for Those Measures

CMS proposes to assign 1-10 points for each measure in the quality performance category based on how a MIPS eligible clinician's performance compares to benchmarks. CMS states that they will not remove "topped out" measures at this time, but proposes to modify the benchmark methodology for topped out measures. Rather than assigning 10 points per measure, CMS proposes to limit the maximum number of points a topped out measure can achieve based on how the scores are clustered. In an example in the proposed rule, CMS indicted that a topped out measure could receive a maximum of 8.5 points instead of 10**.** Informing group practices about the benchmark will enable eligible clinicians to make informed choices about which measures to select for use in the quality performance category. Due to limited time to prepare, we also request that CMS not apply any point adjustment for "topped out" measure for at least the first year of the program.

RESOURCE USE CATEGORY

CMS proposes to assess performance in the resource use category by utilizing: 1) the Total Per Capita Measure; 2) the MSPB measure; and, 3) 41 episode based measures. Performance would be assessed by identifying Medicare patients attributed to eligible clinicians and using administrative claims data. In this category, all measures would be weighted equally and there would be no minimum number of measures required to receive a score. This category will be weighted at 10 percent of the CPS for the first payment MIPS year. The AAMC recognizes the need for resource use measures in the program; however, as discussed in further detail below, we recommend that CMS:

- Adjust all resource use measures to account for both clinical conditions and sociodemographic (SDS) factors.
- Hold accountable for resource use the physician who is responsible for managing the patient's care and ensure that the resources used are within that physician's control.
- Ensure that the resource use measures, including the new episode condition measures, are appropriate and reliable both at the individual and group level prior to implementation.
- Avoid assessing performance on measures that are duplicative, such as episode condition measures and per capita cost measures.
- Improve attribution methods for the resource use category.
- Develop resource use measures specifically for physician offices.

All Resource Use Measures Must be Appropriately Adjusted for Clinical Severity and Sociodemographic (SDS) Factors; Improvements are Needed in the Attribution Methodology.

Physicians at AMCs care for a vulnerable population of patients who are sicker, poorer, and more complex than many patients treated elsewhere. Due to these factors, these patients typically require higher resource utilization. In order to reasonably compare physicians who treat a range of patients with different case mixes, all resource use measures must be adjusted for both clinical and SDS factors, and should incorporate a beneficiary risk score. Only by adjusting for both types of variables is it possible to ensure a fair comparison among physicians. Differences in patient severity, rates of patient compliance with treatment, SDS, patient engagement, patient preferences for treatment approaches, and sites of care, can all drive differences in average costs. Appropriate risk adjustment is essential so that differences in patient characteristics that are beyond a health care provider's control do not have an unfair impact on a provider's resource use performance score.

The issue of addressing SDS factors is critical, particularly when measuring resource use among certain populations. Recent studies have clearly demonstrated that SDS variables (such as low income and education) may explain adverse outcomes, particularly readmissions. Hospitals and physician groups practices that care for vulnerable patient populations are disproportionately disadvantaged when SDS factors are not accounted for in resource use measurement. The AAMC believes that there are ways to appropriately adjust for SDS by incorporating SDS factors in the risk adjustment methodology. Recently, CMS officials recognized the impact of SDS and have adjusted the Medicare Advantage star rating system to account for the SDS of a plan's enrollees.

While the AAMC appreciates that the NQF and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) currently are studying the inclusion of such an adjustment, a resolution on this critical issue could be far into the future. We urge CMS to adjust for these factors in the interim as evidence continues to mount that when such factors are not accounted for the providers caring for the most challenging patients are the most likely to be penalized.[1] Patient access to care may be hindered if clinicians who care for medically complex or poor patients are penalized due to lack of appropriate risk adjustment.

Develop Resource Use Measures for Use in Physician Offices Instead of Using Hospital Measures

Measures such as the MSPB were developed for use in hospitals. Many of the costs incurred in the hospital may be beyond the control of the physician. Instead of using this measure, CMS should develop and test resource use measures for physician practices.

[1] Michael Barnett, MD, et al. "Patient Characteristics and Differences in Hospital Readmission Rates." JAMA intern Med. 2015;175(11):1803-1812.

Episode Based Measures

If CMS Uses the Total Per Capita Cost Measure and MSPB Measure to Assess an Eligible Clinician or Group Practice Then It Should Not Also Apply Episode Based Measures to the Eligible Clinician or Group

CMS states in the proposed rule that several stakeholders expressed a desire to transition to episode-based measures and away from the general total per capita measures used in the VM. Therefore, CMS proposes that in lieu of using the total per capita cost measures for populations with specific conditions that are used for VM, it would use 41 clinical condition and treatment episode based measures for a variety of conditions and procedures. CMS proposes a minimum of 20 cases for episode-based measures. The Agency proposes that procedural episodes would be attributed to all MIPS eligible clinicians that bill Part B claims with a trigger code during the trigger event of the episode. Acute condition episodes would be attributed to all MIPS eligible clinicians that bill at least 30 percent of inpatient evaluation and management visits during the initial treatment or a "trigger event that opens the episode." In addition, CMS would use the Total Per Capita Cost Measure and MSPB to assess resource use performance.

The Total Per Capita Cost is a global measure of all Part A and Part B resources used during the performance period. The measure itself would be inclusive of the 41 episode measures. It is duplicative to assess performance in this category on both the per capita cost measures and episode condition measures. Therefore, if CMS assesses an eligible clinician or group practice utilizing the total per capita cost measure and MSPB measure, CMS should not also apply these episode based measures to the eligible clinician or group. In addition, as discussed below, we do not think that episode groups are ready to be used for performance measurement.

CMS Should Improve the Validity of the Episode Groups, Update Them to ICD-10, and Appropriately Risk Adjust

To construct the 41 episode types, CMS groups clinically related services to the episode based on service and/or diagnosis codes on claims. We are concerned that using ICD-9-CM diagnosis and procedure codes from the claims data as a building block for the episodes has significant reliability issues. Some diagnosis and procedure codes are general which could be difficult to group. The codes do not contain adequate information for risk adjustment. In addition, there is lack of consistency among providers in their selection of diagnosis codes used to report a given clinical condition. To help with validity, claims-based groupers should be cross-validated against clinical data (e.g. from electronic health records).

Also of concern with the 41 episode groups is that they are based on ICD-9-CM diagnosis and/or procedure codes, which are no longer reported. While ICD-9-CM reached its capacity at 14,000 codes, there are approximately 69,000 ICD-10-CM Codes that are tailored to be more specific in identifying the patient's condition. Similarly, there are substantially more specific ICD-10-PCS codes with an increase from approximately 3,800 ICD-9-PCS codes to approximately 72,000 ICD-10-PCS codes. **The AAMC recommends that to address the ICD-9 to ICD-10 transition, CMS should develop a process to identify the appropriate ICD 10-CM codes for**

the 41 episode groups. The Association further recommends that CMS seek the input of clinicians, representatives from specialty societies, and others with expertise in diagnosis coding to determine which ICD 10-CM codes to use in the episode groups. In addition, the episodes and the appropriate ICD-10 codes should be posted for public review and comment. Identifying the ICD 10-CM codes for the episode groups is a massive undertaking and it is important that CMS provide sufficient time to allow meaningful input from experts on the appropriate ICD 10-CM codes.

Finally, CMS would set a bar of 20 cases in order for a particular episode condition group to be applied to an eligible clinician. We believe that this is not a sufficient volume of cases to achieve reliable results.

CLINICAL PRACTICE IMPROVEMENT ACTIVITIES (CPIA)

CPIA is defined as an activity that relevant eligible clinician organizations and other relevant stakeholders identify as improving clinical practice or care delivery, and when effectively executed, will likely to result in improved outcomes. In the proposed rule, CMS identifies a list of 94 clinical improvement activities that eligible clinicians can select from which are weighted as high (20 points) or medium (10 points). The maximum score in this category is 60 points and weighted at 15% of the overall CPS.

CMS Should Allow Maximum Flexibility for Scoring to Reduce Burden

CMS Should Expand the List of High Weighted Activities and Reduce the Number of Required Activities

The quality, resource use, and advancing care information categories are relatively similar to the previous years' quality programs, providing physicians with some familiarity with the requirements. However, this is the first year eligible clinicians are required to report on clinical practice improvement activities. Hence, the AAMC encourages CMS to allow maximum flexibility in reporting CPIA during the transition to MACRA. The complexity of scoring and the burden of reporting, especially for physicians in large multi-specialty group practices such as those found at academic medical centers, will require significant time as it will be necessary to prepare and implement operational and infrastructure changes, including the ability to track these activities.

Additionally, CMS proposes that to achieve the highest score MIPS eligible clinicians and groups must select the appropriate number of activities under the CPIA performance category and must perform each activity for at least 90 days during the performance period. The AAMC appreciates that CMS did not require a determined number of activities within a specific subcategory. However, the Association believes that CMS's proposed number of required activities to score the maximum number of points is too high. Instead, CMS should be flexible in the scoring of activities.

There are certain resource-intensive and high-quality activities listed as only medium-weighted. For example, in the proposed rule, CMS has given the population management activity of improving health status of communities a medium weight (*Fed Reg 81 pg. 28572)*. This CPIA addresses population management in several ways including: giving access to vulnerable populations, addressing chronic conditions, and telehealth. The costs and time needed for these activities are relatively high. As with the outcomes and resource investment, the activity should be deemed high, at least for the first two years. Expanding the list of high-weighted activities will allow for an increased participation in high-weighted activities with a reduced amount of burden. Additionally, while CMS acknowledges that certain activities are more time and resource intensive than others by proposing to weight them differently, having groups and individuals fulfill 6 activities of variable weights is burdensome. The AAMC recommends that CMS reduce the number of required activities for full CPIA credit.

CMS Should Make Clinical Practice Improvement Activity Reporting Requirements Broad and Flexible

In the rule, CMS also proposes three additional clinical practice improvement activity categories, which are achieving health equity for underserved populations, integrated behavioral and mental health, and emergency preparedness and response. While the AAMC appreciates that the Agency has proposed additional relevant categories, it is necessary that requirements in each category remain broad and flexible. When assessing which additional activities can count as CPIA credit, the Agency also needs to consider the different contractual arrangements that exist to support practice improvement. Population management, data analytics, and care coordination activities are very expensive, and the cost is typically shared among many participants. The Agency's policy needs to reward practices that are actively involved with care improvement, rather than the organization that is paying for that improvement activity. For example, a hospital or health system, not the physician practice, might own the PCMH, but the physicians care for the patients who are enrolled. Similarly, a teaching hospital might be the awardee in a BPCI contract, but the faculty practice physicians are leading the effort to redesign care.

CMS Should Count Physician Engagement in Federally Funded Clinical Research as a CPIA

Teaching physicians regularly engage in research that benefits all by improving patient care, for example, enhancing therapies or determining which treatments are most effective. The involvement of medical students and residents in these efforts further increases their value, as the new generation of physicians learn about the value of this work. CMS could add research done by faculty physicians to the category of Patient Safety and Practice Assessment. The research must be reviewed by an Institutional Review Board (IRB) and could be limited to research that is funded by the National Institutes of Health, the Department of Veterans' Affairs, or any other Federal agency. Research should be a high weighted activity.

Additional Activities Should Be Recognized Under the Emergency Preparedness CPIA

Academic medical centers frequently are leaders in emergency preparedness activities so the AAMC is pleased that CMS added this as a CPIA category. As proposed, this category includes participation in disaster medical assistance teams or community emergency responder teams. CMS also recognizes participation in domestic or international humanitarian volunteer work under the emergency response and preparedness subcategory. This recognition is likely to encourage this work and better enable the medical community to meet the needs of individuals needing care in the context of natural disasters and severe economic hardship.

We ask CMS to expand the proposed emergency response and preparedness CPIA to include the following activities:

- Participation by trauma clinicians in the multi-disciplinary planning for triage and medical management of mass casualties following all disasters and
- Participation in a multi-disciplinary peer review program and demonstration of a continuous process of monitoring assessment and management directed at improving care.

Submission Mechanisms for CPIA Category

The AAMC appreciates that CMS has proposed a broad range of submission mechanisms that provide physicians with the ability to choose a reporting option that will be the most streamlined and efficient in their day to day workflow. However, CMS should provide guidance as to the types of infrastructure changes that third party vendors could make in EHRs to incorporate the yes/no response for activities on the CPIA inventory. Finally, the AAMC appreciates CMS's intention to provide further sub-regulatory guidance on these activities when the final rule is released. Additional clarification needs to be provided on how eligible clinicians will be scored on these activities as both individuals and groups.

Physicians Participating in APMs Must Receive Full Credit under the CPIA Category

Section 1848(q)(5)(c)(i) of the Act specifies a MIPS eligible clinician or group that is certified as a PCMH or comparable specialty practice must be given the highest potential score for the CPIA performance category for the performance period. Additionally, section 1848(q)(5)(C)(ii) of the Act provides that MIPS eligible clinicians or groups who are participating in an APM for a performance period "shall earn such eligible professional a **minimum score of one-half** of the highest potential score for the performance category."

CMS proposes that MIPS eligible clinicians who participate in an APM (including but not limited to MIPS APM) and submit either individual or group level data to MIPS may earn a minimum score of 50 percent of the highest potential CPIA performance category score as long as such MIPS eligible clinicians are on the list of participants for an APM and are identifiable by the APM participant identifier. The statutory requirements states that an APM participant must receive ***at least*** one half of the highest potential score for the CPIA category. To achieve savings required in APM models, APM entities must engage in numerous clinical improvement activities

that redesign care, coordinate care, improve population health, and increase access. In recognition of these extensive activities on performance improvement and the desire to increase participation in APMs, APM participation should be rewarded the full points under CPIA, similar to scores for the primary care medical home (PCMH).

In the proposed rule CMS discusses that practices may receive a PCMH designation at a practice level. Thus, individual TINs may be composed of both undesignated practices and practices that have received designation as a PCMH. To simplify, we recommend that the full TIN be given credit for the PCMH status.

ADVANCING CARE INFORMATION (ACI) CATEGORY

The ACI category, which replaces the meaningful use program, is weighted at 25% of the composite score. ACI makes several changes from the Meaningful Use program including: allowing a group reporting option, comprising of a base and a performance score and removal of Clinical Provider Order Entry (CPOE) and Clinical Decision Support (CDS).

Group Reporting Option

The AAMC Applauds CMS for Proposing a Group Reporting Option for the ACI Category

In the past under Meaningful Use, it was only possible to report as individuals. The AAMC is pleased with CMS's proposal to now allow for group reporting in addition to individual reporting. The group reporting option proposal not only streamlines the reporting options for the other categories but also allows for flexibility and maximum participation.

Base and Performance Score

The ACI Scoring Methodology and Requirements Should Be More Flexible

CMS proposes a rigorous scoring methodology and requirements to receive full credit in the ACI category. Eligible clinicians will be scored on 2 categories: a base and performance score. Eligible clinicians must meet all the objectives and measures for protecting patient health information or they will receive a score of 0 for the entire ACI performance category. The base score in the ACI category requires that the eligible clinician report on all the numerator and denominator or yes/no for the objectives and measures related to protecting patient health information, patient electronic access, coordination of care through patient engagement, electronic prescribing, health information exchange, and public health and clinical data registry reporting. The requirement for the public health and clinical data registry category can be met by reporting to an immunization registry. The Agency will not require reporting to a public health or clinical data registry at this time. An eligible clinician can receive one bonus point for reporting to a qualified clinical data registry (QCDR). The eligible clinician can receive a total base score of 50 points.

While CMS proposes to partially remove the "all or nothing" approach, a pass-fail element is retained in the base ACI score. CMS has indicated that all measures must be reported in order to receive a base sore. Instead, the AAMC urges CMS to revise its proposal to provide credit for each measure that is reported.

The Proposed Performance Score Measures Are Not Adjusted to Reflect the Patient Population

In addition to the base score, CMS adds some more flexibility to the program in the performance score section. An eligible clinician will receive a performance score for this ACI category which is based on performance on 8 measures in 3 objectives (patient electronic access, coordination of care through patient engagement, and health information exchange). According to CMS this category allows some flexibility for selecting measures that are the most meaningful for a particular practice or eligible clinician.

The AAMC appreciates that CMS proposed to keep a portion of the score flexible; however, we are concerned that 5 of the 8 measures require patient action over which an eligible clinician has no control: patient access, patient-specific education, secure messaging, patient care record exchange, and request/accept patient care record. In the first year these measures are required for at least one unique patient seen by the MIPS eligible clinician. Despite the low number of patients, the Agency should not hold eligible clinicians accountable for actions they cannot control. Some physicians may treat many patients who are poor, elderly, or have limited English proficiency, and this strongly disadvantages them in these measures when compared to physicians whose patient populations are better educated and well-off financially. The AAMC recommends that CMS continue to engage stakeholders and receive feedback on which measures are meaningful and will improve care delivery.

Other Changes within the ACI Category

Another key change proposed by CMS to reduce burden is removing the reporting requirement for clinical provider order entry (CPOE) and clinical decision support (CDS). We support this change. It should be noted that even if the reporting requirement is removed, these measures continue to be part of the EHR system in order to meet EHR certification requirements. Finally, CMS proposes that for nurse practitioners, physician assistants, clinical nurse specialists, and certified registered nurse anesthetists, the ACI category would be optional in 2017. The AAMC supports the CMS proposal as these non-physician groups have not been part of the Meaningful Use program to date. CMS should also make the ACI category optional for clinicians who primarily provide services in post-acute care settings, which have not been part of the meaningful use program in the past.

Potential Exceptions under the ACI Category

Practices with Scheduled CEHRT Upgrades for 2018 Should Not Be Penalized

The proposed rule addresses the situation of a practice that upgrades from 2014 to 2015 EHR technology in 2017. However, The AAMC is concerned that the proposed rule does not address the circumstance when the practice has scheduled to upgrade from 2014 to 2015 technology during the 2018 performance year. As with those practices that convert during 2017, CMS should allow eligible clinicians practices that have a signed agreement with a vendor as of 6 months after the effective date of the rule to make the conversion during 2018 without a penalty.

Certain Eligible Clinicians Should be Assigned a Zero ACI Weight and the Remaining Performance Categories Should be Reweighted

CMS proposes to assign a weight of 0 to the ACI category for the following MIPS eligible clinicians: hospital-based clinicians, MIPS clinicians facing a significant hardship, and nurse practitioners, physician assistants, certified registered nurse anesthetists, and clinical nurse specialists. CMS proposes to use the same significant hardship categories defined in the Stage 2 final rule (insufficient internet connectivity, extreme and uncontrollable circumstances, lack of control of availability of certified EHR technology; and lack of face to face patient interaction) for the ACI program. An application must be submitted to reweight the category.

The Association supports CMS's proposal to reweight the categories for the hospital-based clinicians, non-patient facing clinicians and those facing a significant hardship. CMS should maintain all existing Meaningful Use program exclusions and hardships, and should ensure that the application process for reweighting the category is not burdensome.

ELIGIBLE CLINCIANS PARITICIPATING IN MIPS APM REPORTING

APM Scoring Standard for MIPS Eligible Clinicians Participating in MIPS APMs

CMS proposes to establish a scoring standard for MIPS eligible clinicians participating in certain APMs that would reduce participant reporting burden by eliminating the need for such APM eligible clinicians to submit data for both MIPS and their respective APMs. CMS proposes to reweight performance categories for different types of APMs. For the APM scoring standard, CMS proposes to generate a MIPS CPS by aggregating all scores for eligible clinicians in the APM Entity who are participating in the MIPS APM to the level of the APM entity. CMS would calculate one MIPS CPS for each APM Entity group and that MIPS score would apply to all MIPS eligible clinicians in the group.

AAMC Commends CMS on its Proposal to Simplify Reporting for MIPS Eligible Clinicians Participating in APMs but Modifications Are Needed

It is important to reduce MIPS data submission requirements to enable MIPS eligible clinicians participating in APMs to focus on care delivery redesign. The AAMC commends CMS on

attempting to mitigate the burden on providers, but the Agency's proposals could go further to alleviate the burden. As discussed in further detail below, the AAMC has concerns with the definition of MIPS APMs, determination of APM participants, and the reweighting of the MIPS performance categories.

Criteria for MIPS APMs

CMS proposes that the APM Scoring standard under MIPS would only apply if the following criteria are met: 1) APM entities participate in the APM are under an agreement with CMS; 2) the APM entities include one or more MIPS eligible clinicians on the APM participation list; and 3) the APM bases payment incentives on performance in cost/utilization measures. We recommend that CMS modify this definition to enable more clinicians participating in APMs to report under MIPS as an APM Entity.

CMS Should Allow Facility-Led APM Entities to Qualify as MIPS APMs.

It is important to encourage eligible clinicians to participate in the facility led-models such as BPCI and CJR, which have been effective in reducing costs and improving quality. These models rely on robust physician participation to guide their clinical success, and reimbursement for physician services is included in the price of the bundle. Physicians cannot be considered ancillary to these models – they are central. Their participation should be evaluated and rewarded as such.

If the APM scoring standards do not apply, clinicians may be discouraged from participating in these models in the future. Most facilities maintain lists of clinicians who are participating in their models, or they could be required to do so if they want their models to quality as APMs. This is a minor operational issue and CMS should work with these facilities to identify a method to obtain these lists so that the clinicians can be uniquely identified for MIPS scoring purposes.

CMS Should Not Limit MIPS APMs to Eligible Clinicians on a Participant List

CMS should recognize clinicians who participate in APMs as affiliated practitioners, i.e., those who are in a contractual relationship with the APM entity based in part on supporting the APM's quality or cost goals. This would be consistent with CMS's recognition in the proposed rule that these affiliated practitioners could be "qualified APM participants." According to CMS, the APM scoring standard would not apply to MIPS eligible clinicians involved in APMs that include only facilities as participants (such as the Comprehensive Care for Joint Replacement Model). Participants in these models would need to be assessed under the generally applicable MIPS data submission requirement.

APM Entity Group Scoring

CMS Should Allow Reporting at the APM Entity Level for All Performance Categories

CMS proposes to calculate one CPS for each MIPS APM entity. The score would be calculated by aggregating all scores for MIPS eligible clinicians in the APM at the level of the APM entity. This score would be applied to each eligible clinician who is a participant in the APM entity on December 31 of the performance period. Depending on the type of MIPS APM, the weights associated with performance categories may be different than the generally applicable weights for MIPS eligible clinicians. CMS includes three different approaches for scoring depending on whether it is a shared savings APM, Next Generation, or other type of APM.

For shared savings APMs, CMS would determine the CPS score as follows:

- Use quality measure data submitted through the Web Interface to evaluate the quality performance category.
- Not assess the resource use category since APMs usually assess resource use as total cost of care.
- Aggregate the CPIA scores at the TIN levels. An ACO would receive a minimum of one half the CPIA points.
- Aggregate the ACI scores at the TIN levels.

For Next Generation ACO, CMS would determine the CPS score as follows:

- Use quality measure data submitted through the Web Interface to evaluate the quality performance category.
- Not assess the resource use category since APMs usually assess resource use as total cost of care.
- Aggregate the CPIA score at the individual level. An ACO participant would receive a minimum of one half the CPIA points.
- Aggregate the ACI scores submitted at the individual level.

For all other APMs, the quality performance category and resource use categories initially will be weighted at 0%, the CPIA category at 25% and the Advancing Care Information category at 75%. For the CPIA and ACI performance categories, eligible clinicians would submit individual level data. **AAMC recommends that CMS modify the APM Scoring Standard to reduce burden and encourage participation in these models by allowing reporting at the APM level for all categories rather than the aggregate of TINs or individual clinicians**.

As proposed in the rule, eligible clinicians participating in Advanced APMs that are also MIPS APMs would have to proactively submit data for CPIA and ACI before knowing if they will meet thresholds to be considered qualified participants or partial qualified participants. In particular, requiring eligible clinicians to submit individual level data on CPIA and ACI in the case of Next Generation and other APM models is overly burdensome. In addition, as discussed previously, **CMS should give full credit for the CPIA category for participation in an APM**.

The AAMC supports CMS's decision not to assess APMs on resource use since eligible clinicians participating in these programs are already subject to cost and utilization performance assessments under the APM.

APM Participant Identifier and Participant Database

CMS will establish and maintain an APM participant database that will include all of the MIPS eligible clinicians who are part of the APM entity. Each APM entity would be identified in the MIPS program by a unique APM entity identifier. The unique APM identifier for a MIPS eligible clinician would be a combination of four identifiers: 1) APM identifier; 2) APM Entity identifier; 3) eligible clinician's billing TIN; and, 4) NPI.

CMS recognizes that there may be scenarios in which MIPS eligible clinicians change TINs, use more than one TIN to bill Medicare, or change their APM participation status during a performance period. We have found that these scenarios are common for many clinicians. While the AAMC appreciates that CMS has acknowledged these confounding factors, we encourage the Agency to think of them more as the rule than the exception.

CMS proposes that only those clinicians listed as participants in the APM entity in a MIPS APM on December 31 (the last day of the performance period) would be considered part of the APM Entity group for purposes of the scoring standards. Clinicians who leave the participant list mid-year would need to submit data to MIPS using one of the other MIPS data submission mechanisms. These proposals do not sufficiently respond to the often complex billing relationships clinicians maintain across TINs.

CMS Should Consider Other Approaches to Identifying APM Participants

If a clinician participates in the APM for 6 months of the year and then leaves mid-year (e.g. June), that clinician's quality score could be negatively impacted if the physician is assessed as an individual under MIPS for the performance year. To prevent potential negative impacts on the quality performance category, clinicians would need to proactively submit other quality measures not required by the APM, just in case they changed participation status during the year.

This would be overly burdensome and would discourage APM participation. To alleviate this burden, the Association suggests that CMS consider assigning such clinicians a 0 score for quality and reweighting the categories of CPIA and ACI. Another option would be to give credit to the eligible clinician for APM participation if that clinician participated in the APM for the majority of the year.

An additional challenge with the December 31 date proposed by CMS is that some APM models have set time frames for submission of participant lists that vary each year depending on when CMS issues the requirements. The AAMC strongly suggests that for those APMs, such as Next Generation ACO, CMS should revise the operational requirements that currently stand as barriers to becoming qualified APMs. The Agency should allow for more frequent updates to the

participant lists so that providers can be both added and removed as needed so that the lists accurately reflect participants as of December 31.

Alternatively, CMS could consider looking at claims data to identify the APM participants rather than relying solely on a participant list. Such an analysis would allow the Agency to create lists of clinicians who are presumptively designated as APM participants based on their billing relationships with APM entities. Using such a list as a default designation would decrease pressure on submission of lists by APM entities, which CMS has acknowledged are often riddled with errors and which are currently submitted on timelines misaligned with MIPS reporting requirements.

Eligible Clinician Participation in Group Practice and APMs: Overlap of Measures

According to the proposed rule, it is possible that eligible clinicians who are part of the same TIN may be scored differently under MIPS. For example, a large multi-specialty group practice may decide to have only its primary care physicians participate in the Next Generation ACO Model. The primary care physicians in Next Generation would potentially receive the 5% bonus payment if they meet the threshold to be qualifying APM participants. If they do not meet the threshold, these primary care physicians would receive the Next Generation MIPS APM score. The specialists who are part of the same TIN would receive the score of the group practice under MIPS. In these situations, the overlap in quality measurement is complex and it is unclear whether the quality activities of the primary care physicians would be attributed to the APM alone or to the entire group practice.

Further Clarification Is Needed When Only Some Physicians in a TIN Are Participants in APMs

CMS needs to provide further clarification on how patient attribution and quality and resource use measurements will apply to large multi-specialty group practices when some eligible clinicians participate in an APM and others do not. Currently, some APMs require the entire TIN to participate while others allow for participation by specific NPIs. More guidance will enable group practices to make more informed decisions regarding APM participation. Given the complex patchwork of APM program requirements, the AAMC urges CMS to issue this additional guidance with an emphasis on flexibility.

In the proposed rule, CMS states that the APM participants would be assessed based on the MIPS APM score instead of the score of their group practice TIN. **The Association strongly urges CMS to allow the APM participants to receive the MIPS score that is highest if they are an APM participant and also provide services through their group practice TIN.** Without this revision, bizarre measurement situations will arise. This policy change would be consistent with CMS's proposal in the rule that clinicians who participate in multiple APMs would receive the score of the APM that did best under the MIPS program. Assigning these clinicians the highest score is an important way to encourage participation and high performance in APMs.

PERFORMANCE FEEDBACK

CMS proposes that beginning on July 1, 2017 it will include information on the quality and resource use performance categories to eligible clinicians annually through reports similar to the quality and resources use reports (QRURs).

Feedback reports must provide timely, accurate, and actionable information to help providers understand and improve the quality and efficiency of care. CMS should guide the stakeholder community on how to more effectively use the data from QRURs. Although the July 2017 reports referenced by CMS in the proposed rule will offer useful information for providers to gauge how they are currently performing, the reports will use historical data which are not indicative of a provider's current performance. The AAMC understands that due to time constraints CMS is unable to use the relevant performance year's data and solely relies on claims data to present the information in the Mid-Year QRURs. However, it is unclear how providers can use this information to implement changes. At a minimum, the AAMC urges CMS to provide QRURs on a quarterly basis, just as CMS does for ACOs. The AAMC encourages CMS to develop material to educate providers on how to utilize the presented data in the feedback reports. Additionally, CMS should provide the feedback reports early enough to allow an adequate amount of time to prepare and implement changes to improve performance for the following year.

MIPS PUBLIC REPORTING

CMS proposes to publicly report both the composite score for each MIPS eligible clinician and the score in each performance category. The AAMC supports public reporting that has a clear purpose, is transparent, and is valid,[2] and supports CMS's continued efforts to improve public reporting. However, it is unclear how reporting by category will be useful to the intended audience of beneficiaries and their families. CMS has already acknowledged that initial interactions with beneficiaries in focus groups and other forums have revealed that these future patients currently are generally mystified by the MIPS categories as well as by the concept of an APM. Before CMS finalizes this proposal it should be certain that the information to be provided publicly will be actionable by beneficiaries as an aid to selecting high value healthcare.

In the effort to ensure that publicly reported information is meaningful, CMS should risk adjust and appropriately weight measures to ensure that providers caring for the sickest, most complex, and most vulnerable patients are not portrayed as providing poorer care than their peers with more straightforward patient populations. As has been demonstrated in Medicare Advantage star ratings and proposed Hospital Compare star ratings, condensing complex performance data into consumer friendly ratings can systematically disadvantage academic medical centers. As CMS develops a methodology to publicly report MIPS performance, it should work closely with the stakeholder community to ensure that public ratings reflect provider performance and not case mix.

[2] https://www.aamc.org/download/370236/data/guidingprinciplesforpublicreporting.pdf

Finally, if a group of physicians report under one TIN then data should be presented in a way that highlights that the score represents the score of the group; a similar reporting methodology should be applied if a MIPS identifier is created.

ALTERNATIVE PAYMENT MODELS

Eligible Clinicians either have the option to participant in the MIPS program and receive adjustments to payment or be part of an Advanced Alternative Payment model that may potentially qualify to receive a 5% payment bonus. In order to receive the 5% bonus payment, clinicians must participate in the most advanced APMs and must meet certain thresholds of Medicare patients or payments provided through those APMs. If the clinicians are determined to be qualifying participants, they will not be subject to MIPS.

The MACRA creates strong incentives for the rapid adoption of APMs. In order to opt out of MIPS and be recognized as a "qualifying APM participant," CMS proposes that an eligible clinician must meet certain thresholds, with 25% of Medicare patients or payments being covered by an APM in 2019 and 2020. This amount is set to increase to 75% in APMs in 2023 and beyond. The desire to shift Medicare reimbursement from volume to value must be balanced with the need to provide eligible clinicians with the time required to understand how to participate in APMs as a way to improve patient care.

The AAMC strongly supports the work of our members in increasing the efficiency and quality of healthcare delivery through APMs, as is evident from our role as a facilitator convener for 27 AMCs in the Bundled Payments for Care Improvement (BPCI) initiative. AMCs are leaders in delivery reform, with many participating in CMMI programs and commercial APMs. Our own and our members' experiences with such alternative delivery models largely inform the content of this portion of our comment letter. AAMC also urges CMS to implement flexible requirements around the classification of qualified APM participants and to create a tenable on-ramp to managing increasing levels of financial risk.

With regard to Advanced APMs, CMS should:

- Continue to build a portfolio of more Advanced APMs that would allow participation for a broad range of physicians and other practitioners.
- Design the program to maximize participation in advanced APMs for physicians and other practitioners by designating more APMs as advanced APMs. In particular, payment programs such as BPCI and Comprehensive Care for Joint Replacement should be designated as advanced APMs.
- Implement flexible requirements around the classification of advanced APM participants.
- Recognize that risk in excess of a nominal amount can be demonstrated in a variety of ways.
- Allow a tenable on ramp for increased amount of risk.
- Give credit for APM participation to physicians working with their partner teaching and other hospitals in APM risk-based models.

- Enable providers to know whether or not they are qualifying APM participants with sufficient time to allow those physicians to determine whether MIPS participation is required.

Criteria for Advanced APMs

To be considered an advanced APM, an APM must meet the following three criteria: 1) require participants to use certified EHR technology; 2) provide for payment for covered professional services based on quality measures comparable to those in MIPS; and, 3) bear risk for monetary losses of a more than nominal amount under the APM. CMS discusses each of these three requirements in the proposed rule and we offer the comments below.

CMS Should Retain the 50% CEHRT Use Threshold Beyond 2017 and Should Exclude from the Calculation Certain Clinicians and Types of Providers

CMS proposes that an Advanced APM must require at least 50 percent of eligible clinicians who are enrolled in Medicare to use the certified health IT functions outlined in the proposed definition of CEHRT to document and communicate clinical care with patients and other health care professionals. CMS proposes to increase this threshold to 75% for the second performance period.

The AAMC recommends that CMS keep the threshold at 50% beyond the first performance year. An increase to 75% will likely set a bar that is unattainable for most APMs. In addition, CMS should exclude from the calculation of the CEHRT threshold those services provided by any clinicians who have had their MIPS ACI component weight reduced to 0 (e.g. hospitalists or non-face- to -face clinicians). CMS should also exclude from the calculation any services provided by clinicians in post-acute settings (e.g. SNFs, IRFs). Post-acute care settings were not included in the Meaningful Use program and therefore are less likely to have CEHRT available at this time. Including these settings in the calculation would make it difficult for APM models that include post-acute care providers to be considered Advanced APMs. This would have a chilling effect on ACOs' inclusion of post-acute care providers and would dampen efforts to improve post-acute care coordination and outcomes. Further, it would all but exclude APMs that focus directly on post-acute care, such as BPCI and CJR, from ever qualifying as Advanced APMs.

The Definition of "More than Nominal Risk" Should be Significantly Revised

According to the statute, an Advanced APM must be either a Medical Home model expanded under section 1115A(c) or bear financial risk in excess of a nominal amount. CMS proposes that the medical home model must have 50 or fewer eligible clinicians in the organization to meet this criteria. CMS would use the count of eligible clinicians in the parent organization of the APM entity as the metric or organizational size for Medical Home models. This limit is entirely arbitrary and excludes the very groups that may be best resourced and equipped to deliver PCMH home services. Such a limit would particularly hinder access to PCMH services in underserved communities, where large faculty practice plans are some of the only providers

offering coordinated, culturally appropriate care. Excluding these medical homes simply for their size will discourage large groups from seeking this designation. **CMS should eliminate the 50-clinician cap on medical homes eligible for this standard.**

CMS sets forth 3 financial risk requirements that must be met for "more than nominal risk." These include: 1) total potential risk (maximum amount of losses possible) must be at least 4% of APM spending target; 2) Marginal risk (% spending about the APM benchmark) for which the APM is responsible must be at least 30% of losses in excess of expenditures; and, 3) minimum loss rate (amount by which spending can exceed the APM benchmark) without triggering financial risk) must be no greater than 4% of expenditures.

The Association recommends that CMS simplify the definition and remove the requirement for a minimum loss rate. Also, CMS should modify the requirement that total potential risk be at least 4% of the APM target and instead require that it be 3% of the physician's Medicare Part B revenue. Physician fee schedule costs are only 19% of total Medicare Part A and B expenditures and therefore should not be subject to such a large amount of risk. In addition, many of the Part A expenditures are outside the physician's control.

Many of the costs incurred by providers to participate in APMs are not reimbursable by Medicare. The Agency should establish criteria that recognize the significant financial investments associated with the implementation and infrastructure support of APMs, as there is substantial financial risk that such costs will never be recouped. For example CMS estimates the first year costs to be $1.8 million.

The AAMC urges CMS to acknowledge that even in an upside-only risk model, a portion of physician compensation is at risk and modify its proposed risk standard accordingly. For instance, under BPCI gainsharing arrangements a physician's total potential compensation is equal to a contractual amount plus a gainsharing cap, or 50% of Part B payments attributable to BPCI beneficiaries. If a physician fails to contribute to savings and meet certain quality metrics, the physician cannot receive his or her total potential compensation. As such, a portion of compensation is at more than nominal risk based on a combination of care delivery and financial metrics. This level of risk should qualify under MACRA.

<u>CMS Should Expand Its List of Advanced APMs to Include Facility-Led APMs, such as BPCI and the Comprehensive Care for Joint Replacement Model</u>

Using the Advanced APM criteria proposed in the rule, CMS identifies current APMs that they anticipate would be Advanced APMs (Table 32, 81 *Fed.Reg. 28312*). CMS does not include the Comprehensive Care for Joint Replacement (CJR) Model or the Bundled Payments for Care

Improvement (BPCI) in the list and seeks comment specifically on how CJR could be amended to be an advanced APM. We are encouraged by this request for comment and we urge CMS to make changes to the program to include these APMs.

It is important to encourage eligible clinicians to participate in these facility led models, which have been effective in reducing costs and improving quality. Inclusion of these as APMs will facilitate participation by the procedure-oriented segment of the physician community. If these models do not qualify as advanced APMs, clinicians may be discouraged from participating in these models in the future. Furthermore, the program needs to encourage collaboration among providers and should allow as many physicians as possible to be successful.

CMS states that one of the reasons these APMs are not considered advanced APMs is that the Agency is unable to identify the unique clinicians who participate in them. This is a problem of CMS's own creation as it is CMS that sets the requirements for participation in BPCI and CJR. Though participants in these programs are not currently required to submit lists of participating physicians, definitions of participation could be developed and incorporated into program rules that would allow for identification of participating clinicians. Most facilities already maintain lists of clinicians who are participating in their models. It would not be overly burdensome for the hospitals and other facility-based settings to provide such a list.

Another barrier to recognition of CJR and the BPCI model is that there is no explicit requirement that clinicians in these models use CEHRT. As referenced previously in this comment letter, the AAMC believes that these models could meet the requirement that 50% of clinicians use CEHRT as long as CMS excludes post-acute care providers and clinicians who have had the ACI category reweighted to 0 from determination of the threshold amount. If hospitals and physicians participating in these bundled models confirm that they are using CEHRT, as is likely because of meaningful use, then that should be sufficient for these models to qualify as Advanced APMs.

CMS Should Allow More Flexibility for MSSP ACOs to Shift Tracks Within a Contract Term

Under existing rules, MSSP ACOs are required to commit to a specific track for a three year contract period. Many practices committed to particular MSSP tracks prior to the release of this proposed rule, a time when they were unaware of the criteria for Advanced APMs. The AAMC encourages CMS to make changes to the shared savings programs to allow ACOs to shift to a different track prior to the end of their 3 year agreement. This will enable health systems to begin taking on additional risk and enable eligible clinicians to participate in the Advanced APM program under MACRA.

CMS Should Take Steps to make it More Feasible to Achieve the Qualifying or Partial Qualifying APM Threshold

In the proposed rule, CMS sets forth the threshold requirements for qualifying and partial qualifying APMs using payment or patients. In the first year, CMS sets a threshold of 25% for payments and 20% for patients. Each eligible clinician's qualifying threshold will be determined based on 2017 data but CMS will not know until 2018 who meets the thresholds. The threshold for payments will increase to 75% in 2023.

As proposed in the rule, eligible clinicians participating in Advanced APMs will have to proactively submit data for the four MIPS categories to CMS since they will not know until after the 2017 performance year whether they meet the thresholds. This places an unreasonable burden on eligible clinicians. As discussed previously, and to address this issue, it is incumbent on CMS to make the MIPS APM requirements as streamlined as possible. This is an important step in encouraging clinicians to participate in APMs, regardless of whether they meet the QAPM thresholds.

CMS could also consider calculating presumptive threshold determinations based on an APM entity's historic patient population and billing characteristics. If an APM's presumptive calculation indicated that it would meet the threshold CMS could give the APM a modest amount of leeway if end of year calculations indicated that it was slightly below the threshold. This would protect eligible clinicians from year to year minor variations in APM size and scope.

The AAMC also recommends that CMS limit the threshold calculations to those beneficiaries that live within the APM entity's primary service area. Even the most motivated academic medical center seeking to draw all of its community's Medicare beneficiaries into APM alignment will continue to see many patients who travel great distances to access specialty care. These cases are often complex and expensive, and may balloon an APM entity's threshold denominator, leaving no possibility of ever being able to attribute such patients to the numerator. Already, CMS has excluded such patients from the financial reconciliation calculations of some APMs. They should be similarly excluded from the threshold calculation.

While it may be feasible to meet the 25% threshold of Medicare payments, the 75% threshold in the future will be very challenging and few eligible clinicians may be able to meet it. We recognize that this threshold is set in statute and encourage CMS to work with stakeholders to monitor this potential problem so that real data can be provided to Congress for the purpose of considering legislative relief in the future. We commend CMS for being flexible in allowing a lower threshold to qualify for the bonus for payments of 20 percent of patients receiving care through the APM for 2019 and support finalization of this approach.

APM Participants

CMS Should Broaden Its Approach for Identifying APM Participants

As discussed previously in these comments, CMS will establish and maintain an APM participant database that will include all of the MIPS eligible clinicians who are part of the APM entity. CMS recognizes that there may be scenarios in which MIPS eligible clinicians change TINs, use more than one TIN to bill Medicare, or change their APM participation status during a performance period. We note that academic medical center clinicians relocate with some frequency for a variety of personal and professional reasons and these moves are often in mid-year to coincide with the July 1 start of most academic years. While the AAMC appreciates that

CMS has acknowledged these confounding factors, we encourage the Agency to think of them more as the rule than the exception.

CMS proposes that only those clinicians listed as participants in the APM entity in a MIPS APM on December 31 (the last day of the performance period) would be considered part of the APM entity group for purposes of the scoring standards. Clinicians who are no longer on the participant list mid-year would need to submit data to MIPS using one of the other MIPS data submission mechanisms.

An additional challenge with the December 31 date proposed by CMS is that some APM models have set time frames for submission of participant lists that vary each year depending on when CMS issues the requirements. The AAMC strongly suggests that for those APMs, such as Next Generation ACO, CMS should revise the operational requirements that currently stand as barriers to becoming qualified APMs. The Agency should allow for more frequent updates to the participant lists so that providers can be both added and removed as needed so that the lists accurately reflect participants as of December 31.

Alternatively, CMS could consider looking at claims data to identify the APM participants rather than relying solely on a participant list. Such an analysis would allow the Agency to create lists of clinicians who are presumptively designated as APM participants based on their billing relationships with APM entities. Using such a list as a default designation would decrease pressure on submission of lists by APM entities, which CMS has acknowledged are often riddled with errors and which are currently submitted on timelines misaligned with MIPS reporting requirements.

PHYSICIAN FOCUSED PAYMENT MODELS

CMS Should Commit to Implementing PFPMs and Develop a Fast-Track Process for Their Approval

The statute established a Physician-Focused Payment Model Technical Advisory Committee (PTAC) to review proposed PFPMs, which provided an opportunity for stakeholders to propose additional qualifying Advanced APMs. CMS proposes to establish PFPM criteria organized into three categories including: providing payment incentives for higher-value care, addressing care delivery improvements that promote better care, and addressing information enhancements that improve the availability of information to guide decision-making. CMS proposes additional criterion to give a deeper insight into specifics they seek in PFPMs to qualify as APMs or Advanced APMs. While it is critical that the MACRA regulations establish a clear pathway for models to be proposed to the PTAC, the pathway also needs to be less stringent than proposed and encourage more submissions of PFPMs.

CMS should recognize the upfront investment of time and energy to first develop these models, and the subsequent time for the committee to review, followed by the additional time for practices to implement operational and infrastructure changes required for the approved model. It also should be noted that the financial incentive of the 5% bonus is only available for 5 years. With the current proposed requirements, it is difficult to see how it will be possible for the PTAC to review the models and CMS to make them available during the limited time that the bonus is available. While the increased payment update will be available for eligible clinicians in QAPMs

starting in 2026, it is unfair to establish a system that may result in large numbers of physician specialties being unable to take advantage of the early 5% bonus, or with participation in a MIPS APM.

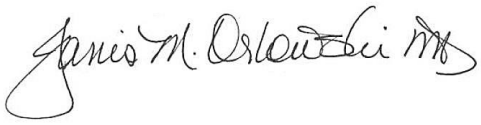
Additionally, CMS notes that it normally takes the Agency 18 months to develop an APM, and additional time is needed for a number of actions, including for the entities to complete applications, CMS to review applications and prepare participation agreements, and many other steps. This is not only a time consuming process but disadvantages those who need to have adequate time to operationalize and implement PFPMs. Instead, CMS should establish a "fast-track" approval mechanism that will create more of an efficient process. Otherwise the opportunity for the physician community to participate in PFPMs will be merely theoretical and will undermine the intent of the statutory provision.

In the proposed rule, CMS has stated that it has no obligation to test models that are recommended by the PTAC. We disagree with this is extremely narrow perspective. For MACRA to succeed in reforming the delivery of care and improving value for patients, CMS must be willing to give serious yet swift consideration to proposed PFPMs recommended by the PTAC and work quickly towards their implementation.

CONCLUSION

The AAMC appreciates your consideration of the above comments. Should you have any questions, please contact Gayle Lee at galee@aamc.org, Ivy Baer at ibaer@aamc.org, or Tanvi Mehta at tmehta@aamc.org.

Sincerely,



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