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December 19, 2016

Mr. Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Submitted at: www.regulations.gov

Re: (CMS-5517-FC) 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

Dear Acting Administrator Slavitt:

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; Final Rule*, 81 Fed. Reg. 77008. The AAMC is a not-for-profit association representing all 145 accredited U.S. and 17 accredited Canadian medical schools; over 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 listened to the concerns of physicians and other stakeholders and made significant changes in the final rule to the framework of the new physician payment system required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). We commend CMS for providing more flexibility during the initial year through the "Pick Your Pace" approach to allow time for physicians and other clinicians to adapt to the new payment system. In the rule, CMS was responsive to many of the concerns raised by AAMC and others regarding requirements that needed modification to encourage successful participation. While the final rule reduces burden and complexity, the AAMC still has concerns with some of the provisions, which we discuss in this comment letter.

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 for both the Merit-Based Incentive Program (MIPS) and Alternative Payment Models (APMs).

- ***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 to be assessed in the quality payment programs in a way that is meaningful.
- ***Cost Category***: Prior to implementation address risk adjustment and attribution concerns.
- ***Group Reporting Quality Measures***: Modify or remove specific Group Practice Reporting Option (GPRO) Web Interface measures.
- ***Improvement Activities***: Continue to expand the list of high weighted activities.
- ***Advancing Care Information***: Allow the use of 2014 edition certified electronic health records technology (CEHRT) past 2017 and clarify the scoring methodology.
- ***Nominal Financial Risk Definition:*** Do not increase the financial threshold in future years and eliminate the 50 clinician cap on medical homes.
- ***Qualifying Participant Threshold***: Make it more feasible to achieve the qualifying APM thresholds by limiting the threshold calculations to those beneficiaries that live within the APM entity's primary service area.

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

MIPS Eligible Identifier

In the rule, CMS finalizes its proposal to use multiple identifiers that allow MIPS eligible clinicians to be measured as an individual or through a group's performance. CMS notes that the MIPS payment adjustment of individual MIPS eligible clinicians is applied to the Medicare Part B payments for items and services furnished by each MIPS eligible clinician. For groups reporting at the group level, scoring and the application of the MIPS payment adjustment applies at the TIN level for Medicare Part B payments for items and services furnished by the eligible clinicians of the group. Additionally, CMS notes that it could establish new identifiers to more accurately identify eligible clinicians who are excluded from the MIPS requirements both at the individual and group level.

The Association encourages CMS to establish a group MIPS identifier in addition to these other identifiers that would allow large multi-specialty groups under one TIN to identify sub-groups that could be assessed under MIPS.

While the AAMC appreciates that CMS chose to allow providers to select whether they want to be assessed as an individual (TIN/NPI), group (TIN), or APM participant identifier, additional group identifiers should also be established. 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.

Additionally, 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, and that often are leaders in transforming health care, tracking individual performance can be very difficult.

CMS Should Exclude Performance of Eligible Clinicians Who Are Unable to Report Certain Measures from the Group Score

CMS states that a group deciding to submit data at the group level will have its performance assessed and scored across the TIN, which could include items and services furnished by individual NPIs within the TIN who are not required to participate in MIPS. Excluded eligible clinicians (new Medicare enrolled, QPs or Partial QPs who do not report on applicable MIPS measures and activities and do not exceed the low-volume threshold) are part of the group and are considered in the group's score. The MIPS payment adjustment will only apply to the Medicare Part B allowed charges pertaining to the group's MIPS eligible clinicians and not apply to clinicians excluded from MIPS.

CMS seeks additional comments on how it should apply the group-related policies pertaining to group-level performance assessment and scoring, and the MIPS payment adjustment, to groups with eligible clinicians that are excluded from MIPS based on the three exclusions, or that have clinicians who are not MIPS eligible. CMS requests comments on the advantages and disadvantages of its policies and alternative approaches.

AAMC supports group reporting for all the categories. CMS states that excluded eligible clinicians activities are considered in the group score. It is unclear whether CMS will exclude members of the group that would receive a hardship exception or have their ACI performance re-weighted to zero as a part of the overall group score. We recommend that CMS give the group

the option to exclude performance for those particular eligible clinicians from the group score for categories that do not apply to these eligible clinicians so that the score is not inappropriately weighted down by clinicians who are unable to report on certain measures. As an example, practices with hospitalists or non-patient facing physicians should not have performance in the ACI category count toward the group score unless they voluntarily choose to do so**.**

Cost Performance Category

CMS finalizes a weight of 0 percent for the 2019 MIPS payment year and 10 percent for the 2020 MIPS payment year for the cost performance category in the MIPS final score. Starting with 2021 MIPS payment year, the cost performance category will be weighted at 30 percent. CMS plans to assess performance in the cost category by utilizing: 1) the Total Per Capita Measure 2) the MSPB measure; and 3) 10 episode based measures. Performance would be assessed by identifying Medicare patients attributed to eligible clinicians and using administrative claims data. We commend CMS for delaying the cost performance category.

All Cost Measures Must be Appropriately Adjusted for Clinical Severity and Sociodemographic (SDS) Factors

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 such patients typically require higher resource utilization. In order to reasonably compare physicians who treat a range of patients with different case mixes, all outcome and cost 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, sociodemographic (SDS) factors, 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 cost performance score and quality 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 cost 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. In addition, the most recent report from the National Academies of Science, Engineering, and Medicine suggested that data is now available that could be used to adjust for SDS.[1]

[1] Accounting for ***socioeconomic status*** in medicare payment payment (http://www.nationalacademies.org/hmd/Reports/2016/accounting-for-social-risk-factors-in-medicare-payment-4.aspx)

If CMS is unable to address these issues soon, we recommend delaying the cost performance category for an additional year.

Quality Performance Category

CMS finalizes its proposals with modification including allowing MIPS eligible clinician or groups to report at least six measures including at least one outcome measure. There are significant issues related to risk adjustment, SDS factors, and attributions that need to be addressed prior to implementation.

Maintain the Removal of the Acute and Chronic Composite Measures

The AAMC supports the elimination of the Acute and Chronic Composite Prevention Quality Indicators (PQI) measures from the calculation of MIPS score. However, we are concerned with CMS's statement that the Agency plans to modify the existing PQI measures for use in the program in future years.

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

The AAMC had previously commented encouraging CMS to 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. While CMS has stated that some of these measures will not be scored on for the first year due to the lack of ACO benchmark, we highly encourage CMS to continue to re-evaluate the measures given the complex nature and reporting burden of these measures. **CMS needs to evaluate all the quality measures to ensure they are appropriate for large group practices and reflect current standards of care.**

Improvement Activities (IA) Performance Category

CMS reduced the number of activities required to achieve full credit from six medium-weighted or three high-weighted activities to four medium-weighted or two high-weighted activities to receive full credit in the IA performance category in CY 2017. The AAMC applauds CMS for reducing the number of activities required to report for the IAs performance category. Given that 2017 is the first year eligible clinicians are required to report on IAs, this flexibility will provide a smoother transition.

However, there are certain resource-intensive and high-quality activities listed as only medium-weighted. For example, in the final rule, CMS has given the population management activity of improving health status of communities a medium weight (*Fed Reg 81 pg. 77819)*. This IA 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.

Physicians Participating in APMs Must Receive Full Credit under the CPIA Category
CMS finalizes that all clinicians identified on the Participation List of an APM will receive at least one-half of the highest score for the IA performance category. CMS also states that the Agency will compare the requirements for the specific APM with the list of activities in the improvement activities inventory and score those activities in the same manner that they are otherwise scored for MIPS eligible clinicians. If the MIPS APM does not receive the maximum improvement activities performance category score, then the APM entity will be able to submit additional improvement activities.

The AAMC appreciates that CMS has deemed several APMs eligible to receive full credit for the IA performance category under MIPS APM reporting. AAMC encourages CMS to continue assessing other APMs to be eligible to receive full credit as well. APMs engage in numerous improvement activities to 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, all APM participation should be rewarded the full points under CPIA, similar to scores for the primary care medical home (PCMH).

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.

Advancing Care Information (ACI) Performance Category

CMS makes several revisions to the ACI category including allowing group reporting option and reducing the number of measures required to report under the base score. Additionally, CMS notes its desire to have a holistic approach to health IT in which there is a direct link between health IT and patient outcomes. CMS intends to move MIPS beyond the measurement of EHR adoption and process measures and into a more patient-focused health IT program. Hence, AAMC encourages CMS to continue be more flexible within the ACI category.

The AAMC Encourages CMS to Further Simplify the ACI Score Methodology

The Association appreciates that CMS has reduced the number of required measures that must be reported. However, the AAMC believes the ACI scoring system, which is comprised of both performance and base scores, remains extremely complex and creates significant barriers to achieving CMS' goals of a simplified program. We feel that the scoring methodology will be confusing for clinicians during the first years of the program and they may inadvertently fail the entire ACI category because of the retained pass-fail approach of the base score. Furthermore, the opportunity for clinicians to receive bonus percentage points is helpful but remains confusing. The AAMC recommends that CMS provide clinicians with additional guidance to avoid clinicians facing unintentional harm in their ACI performance score.

Allow the use of 2014 edition certified electronic health records technology (CEHRT) past 2017

We appreciate CMS' recognition that physicians will need time to transition their technology from 2014 edition to 2015 edition CEHRT. However, we are concerned that 2015 edition technology will not be ready and available to all physicians and specialties by 2018. Therefore, we recommend CMS allow physicians to continue to use the 2014 edition until more versions of the 2015 edition are available and include features that assist clinicians with MIPS reporting.

ADVANCED ALTERNATIVE PAYMENT MODELS

The AAMC commends CMS for changing some provisions in the rule to allow more opportunities for physicians to be qualified APM participants and receive the 5% incentive payments. The AAMC supports alternative payment model (APM) programs, such as accountable care organizations (ACOs) and bundled payment initiatives, that seek to promote high-quality, efficient care while retaining at their core the essential patient-physician relationship. Many academic medical centers (AMCs) are participating in new payment models, including Pioneer ACOs and Medicare Shared Savings Program (MSSP) ACOs, and BPCI. The AAMC strongly supports the work of our members, as is evident from our role as a facilitator-convener for the Bundled Payments for Care Improvement (BPCI) initiative for 30 hospitals and 19 health systems. Our own and our members' experiences with such alternative delivery models largely inform our comments below.

Criteria for Advanced APMs

Retain the 50% CEHRT Use Threshold Beyond 2017

We support CMS' decision in the final rule to keep the threshold for use of certified health IT by eligible clinicians at 50% instead of increasing it to 75%. An increase to 75% would have set a bar that is unattainable for most APMs.

Definition of "More than Nominal Risk"

Eliminate the 50 Clinician Cap on Medical Homes

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. In the final rule, CMS sets forth a nominal amount standard for medical home models that is different from the Generally Applicable Nominal Amount Standard. CMS states that beginning in 2018 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 for 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 coordinately, culturally appropriate care. Excluding these medical homes simply for their size will discourage large groups from seeking this designation. Therefore, CMS should eliminate the 50-clinician cap on medical homes eligible for this standard from going into effect in 2018.

Do Not Increase Nominal Risk Amount

The final rule makes significant modifications to the generally applicable nominal amount standards from what was proposed. We were pleased that CMS removed the marginal risk and minimum loss ratio from the standard and agreed that the proposed financial risk standard was excessive. CMS states that for 2017 and 2018, an APM may meet the nominal risk standard in two ways: "revenue-based" (the total annual amount potentially owed to CMS or forgone is greater than or equal to 8% of the average estimated total Parts A and B revenues of participating APM Entities) or "benchmark-based" (the owed or forgone amounts is greater than or equal to 3 percent of the expected expenditures). CMS invites comment on its intention to set the revenue-based standard for 2019 and beyond at up to 15 percent of revenue, or equal to 10 percent of revenue if risk is also greater than or equal to 1.5% percent of expenditures.

AAMC commends CMS for establishing a revenue based standard of 8% as an alternative to the benchmark-based standard. This will result in increased opportunities for physicians to be meet the requirements to be qualified APM participants. **The AAMC urges CMS not to raise the level of risk for 2019 and beyond.** If the levels of risk are set too high, physicians will be discouraged from participating in alternative payment models. The levels for 2017 and 2018 are more than sufficient to promote accountability. In addition, eligible clinicians will already be taking on additional risk in advanced APMs as the thresholds to be a qualified participant in an

Advanced APM increase from 25% of Medicare payments to 75% of Medicare payments or 20% of patients to 50% of patients over the next several years. As a result, a much higher amount of the revenues of the entity are at risk in future years.

The AAMC Appreciates CMS Increasing the Opportunities for Advanced APMs to Encourage Maximum Participation

Using the Advanced APM criteria, CMS identifies current APMs that the Agency anticipates will be Advanced APM**s** for 2017**.** While Comprehensive Care for Joint Replacement (CJR) Model and the Bundled Payments Medicare model are not included on the list for 2017, we are encouraged by the fact that CMS has indicated that with some modification these models will be included as Advanced APMs in 2018**.**

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 CJR, EPM, and BPCI models as Advanced APMs will facilitate participation by the procedure-oriented segment of the physician community. This program needs to encourage collaboration among providers and should allow as many physicians as possible to be successful**.**

Finalize ACO Track 1 Plus As and Advanced APM in the Future

In the rule CMS states that it plans to develop a Track 1 plus ACO track that would have sufficient financial risk to qualify as an Advanced APM. We strongly support CMS establishment of Track 1 plus ACOs that would be considered as advanced APMs. The 5% incentive payments and the increased fee schedule updates in the future will incentivize ACOs to take on the risk in ACO Track 1 plus. We strongly support CMS finalizing the ACO Track 1 plus to meet the criteria for Advanced APMs. We support the use of the criteria proposed that the total annual amount potentially owed to CMS or forgone is greater than or equal to 8% of the average estimated total Parts A and B revenues of participating APM Entities or "benchmark-based" meaning the owed or forgone amounts is greater than or equal to 3 percent of the expected expenditures.

CMS states that Track 1 plus would be voluntary and available to new ACOs and those in Track 1. We urge CMS to allow those ACOs currently in MSSP Track 2 and 3 and Next Generation models to participate in a Track 1 plus ACO. The ACOs in these models have shown a commitment to improving care delivery and assuming financial accountability. However, it is possible that some of these ACOs may not be successful and may suffer financial losses. CMS should make Track 1 plus an option for these ACOs if they determine that they are unable to continue to participate in their current track. Allowing them to move to Track 1 plus would be a much better option than having them drop out of the ACO program. We also recommend that CMS allow the ACOs to move into Track 1 plus at the start of new performance year rather than waiting until the end of a 3 year agreement term.

Another change in policy that may encourage ACOs to take on greater risk in the future would be to allow ACOs to split TINs so that a subset of their providers could take on greater risk. Organizations that use a single TIN to cover a vast array of providers may be reluctant to take on

additional risk of the full patient population that would be attributed to their TIN. Therefore, the AAMC encourages CMS to allow the ACO Track 1 plus to form on the basis of partial TINs. Doing so would allow large organizations, such as academic medical centers and their faculty practice plans, to enter the program with a subset of their providers rather than staying away from two-sided risk until they feel more confident of success.

In addition to these comments, the AAMC submitted a joint comment letter with 10 other leading organizations representing physicians, hospitals, shared savings organizations, and medical group practices that provides detailed recommendations regarding specific elements of the new ACO model's design.

Qualifying and Partial Qualifying APM Participant

Broaden Approach for APM Participants

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 had proposed that only those clinicians listed as participants in the APM entity in a MIPS APM on December 31 would be considered part of the APM entity group. CMS modifies its proposal and finalizes a plan to take three snapshots annually for the purpose of making QP determinations: March 31, June 30 and August 31. We support the decision to consider 3 dates in making determinations regarding APM participation.

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. This will enable more physicians to be included as APM participants. The 3 snapshots will also help to address the challenge of time frames for submission of participant lists that may vary depending on the APM model.

CMS Should Take Steps so that it is More Feasible to Achieve the Qualifying APM Threshold

CMS sets forth the threshold requirements for qualifying and partial qualifying APMs using payment or patients. Initially, the threshold will be 25% for payments and 20% for patients, and will increase to 75% in 2023. CMS sets forth the method for threshold calculations in the final rule. CMS states that the numerator would be the aggregate of all covered Part B professional services furnished by an Advanced APM Entity's eligible clinicians to attributed beneficiaries during the QP Performance period. The denominator would be the aggregate of all payments for Medicare Part B covered professional services furnished by an Advanced APM entities eligible clinicians to attribution-eligible beneficiaries during the QP performance period.

The AAMC continues to have concerns with the threshold calculations. We recommend 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

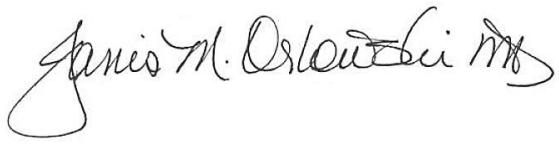
may balloon an APM entity's threshold denominator, leaving no possibility of ever being able to attribute such patients to the numerator. Already, CMS has excluded such patients from the financial reconciliation calculations of some APMs. They should be similarly excluded from the threshold calculation.

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.

CONCLUSION

Thank you for your consideration of these comments. If you have any questions concerning these comments, please feel welcome to contact Gayle Lee, Director of Physician Payment Policy and Quality at 202-741-6429 or galee@aamc.org or Tanvi Mehta, Payment and Quality Specialist at 202-909-2020 or tmehta@aamc.org.

Sincerely.



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