



April 26, 2017

Seema Verma, MPH, CMS Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Verma:

Consistent with the [Executive Order](#) on Reducing Regulation and Controlling Regulatory Costs issued on January 30, 2017, which the American Academy of Family Physicians (AAFP) strongly supports, the AAFP is pleased to provide the enclosed recommendations on how to meaningfully improve and simplify implementation of the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA). As discussed below, we intend these recommendations to fulfill the original intent of MACRA, support the Executive Order in question, and better enable independent primary care practices to serve their patients and communities.

The AAFP represents 124,900 physicians and medical students nationwide and is the only medical society devoted solely to primary care. Family physicians conduct approximately one in five office visits. This represents more than 192 million visits annually, which is 48 percent greater than the next most visited medical specialty. Today, family physicians provide more care for America's underserved and rural populations than any other medical specialty. Our members are at the frontline of care delivery and are the trusted partners that millions of people rely upon for health and wellbeing.

Unfortunately, family physicians are facing a regulatory environment that is distracting them from their core purpose to care for their patients. A recent [study](#) found that physicians reported spending nearly 50 percent of their in-office time on administrative and EHR-related work – and only 27 percent on direct patient care and turning them into data clerks. While many industries face heavy regulatory burdens, it is difficult to imagine any industry that is more regulated than the practice of medicine. And to this point, there is not a single discipline of medicine that faces greater administrative and regulatory burden than family medicine and other primary care physicians. In fact, family physicians face a regulatory burden that is unmatched among the various medical disciplines. This burden ranges from onerous documentation guidelines to cumbersome prior-authorization criteria and the ongoing frustrations associated with electronic medical records.

The AAFP believes that Congress designed MACRA with the intention to simplify Medicare payment, quality improvement, and performance measurement programs. We also believe that if the Executive Order referenced above had been in place when CMS released the initial MACRA

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proposed rule, the rule would have better met Congressional intent instead of introducing new constructs and increasing the complexity of the law, without it resulting in improved care for beneficiaries. In particular, we fully agree with the recent MedPAC [discussion](#) that MIPS is an overbuilt system and unlikely to be successful in identifying high-value clinicians.

In a [letter](#) sent June 24, 2016, and in [comments](#) sent December 15, 2016, the AAFP provided a number of suggestions to administratively simplify quality and other reporting requirements for Medicare physicians, and we appreciate many of the changes CMS made. However we believe there are still a number of areas where CMS can administratively simplify the design of the Quality Payment Program (QPP) and its requirements. Thus, much more work remains to keep reporting and regulatory burdens to a minimum, which we understand is a shared goal of the Administration. We offer the enclosed recommendations to eliminate or modify existing policies, many of which were not included or envisioned in the original statute, with that goal in mind.

In summary, the AAFP strongly encourages CMS to:

1. Remove the financial risk standards from regulatory definitions of Medical Home Model.
2. Remove arbitrary size restrictions limiting AAPM participation on Medical Home Models.
3. Eliminate all documentation guidelines for evaluation and management codes for primary care physicians in both the MIPS and AAPM pathways.
4. Jettison the complicated and entirely uncalled-for MIPS APM category.
5. Eliminate administrative claims population health measures.
6. Use consistent terms from proposed to final rulemaking to avoid confusion in the physician community.

In addition to *eliminating* the above provisions, the AAFP urges CMS to *modify* the following requirements in order to improve and simplify MACRA for CMS and physicians:

1. Primary Care Payment Recommendations:
 - Immediately adjust upward the Medicare relative value units (RVUs) for common primary care services in order to pay appropriately for those services which as a family of CPT codes and services are greatly undervalued compared to other groups of CPT codes and services..
 - Increase spending on services provided by primary care physicians in the Medicare Part B program to, at minimum, 15 percent of Medicare Part B physician spending. This increase should be achieved over time through increases in the primary care workforce, the percentage of office-based visits that are conducted by primary care physicians, the aforementioned increase in the RVUs for primary care services, and through further investment in and payment for primary care AAPMs.
 - Consistently define the size of a “small” practice as 10 or fewer eligible clinicians.
2. Advanced Alternative Payment Model Recommendations:
 - Support patient-centered primary care models that both strengthen primary care and allow small practice participation as new AAPMs are developed.
 - Do not replace fragmented fee-for-service (FFS) with fragmented condition or specialty-specific APMs.
 - Consider and release new AAPMs in a timely fashion, so practices can participate.
 - Make primary care-oriented AAPMs available nationally to all primary care physicians.

- Review and approve the AAFP's "[Advanced Primary Care: A Foundational Alternative Payment Model \(APM\)](#)" proposal made to PTAC.
3. Establish a more gradual MIPS transition period, promote successful participation, and provide prompt (i.e. at least quarterly) and clinically actionable feedback to help physicians progress into AAPMs.
 4. Virtual Groups Recommendations:
 - Offer an interim pathway in 2018 to virtual groups such that physician practices with 10 or fewer physicians, billing under a single TIN, who participate in the MIPS program through the submission of quality data, use of certified electronic health record technology (CEHRT), and involvement in improvement activities should be exempt from any negative payment adjustments until virtual groups—as outlined and mandated by MACRA—are readily available.
 - Redirect such funds as necessary from the \$500 million intended for positive payment adjustments to “exceptional performers” to finance this proposed safe harbor for solo and small group practices.
 - Prioritize establishing virtual groups as envisioned in the law.
 5. ACI Recommendations:
 - Move away from health IT utilization measures and simplify QPP and ACI.
 - Evaluate ACI's impact on physician experience and implement changes that reduce unnecessary burden.
 - Allow ECs to use 2014, 2015, or combination CEHRT, if the ACI scoring and methodology is not fundamentally changed and continue the 2017 transition year base ACI criteria in 2018 while moving forward with the planned 2018 performance measuring and scoring.
 - Maintain a 90-day reporting period.
 6. Quality Measure Recommendations:
 - When available, use only the core measure sets developed by the multi-stakeholder Core Quality Measures Collaborative to ensure alignment, harmonization, and the avoidance of competing quality measures among payers.
 - Require all physicians participating in the MIPS program to meet the same program expectations and report on the same number of measures.
 - Release MACRA measure development funding.
 7. Continuing Medical Education (CME) as Improvement Activities.
 - Approve for fulfillment of improvement activities any CME activities that are designed to measurably improve performance and/or patient outcomes.
 - Utilize AAFP's reporting capabilities to reduce the administrative burden on ECs and the burden on CMS of verifying completion of improvement activities.
 - Include PerformanceNavigator® live course and PerformanceNavigator® On Demand (online) be included among CMS's approved improvement activities.
 8. Coding Recommendations:
 - Provide additional information on how patient-relationship categories and codes will be used to attribute cost and patient outcomes to physicians.
 - Thoroughly pilot test these patient-relationship categories and codes before their use impacts payments.
 - Minimize the reporting burden for physicians through pilot testing to address logistical issues, especially for small practices.

9. Simplify and stabilize the Improvement Activities scoring process by only requiring practices to do three activities, each carrying a weight of 5 percentage points, to obtain the 15 percent needed in the category.
10. Reduce the acceleration of data completeness criteria standards.
11. Make AAPM incentive payments to QPs (i.e. "to such professional") as identified by either the QP's National Provider Identifier (NPI) or TIN/NPI combination.

The implementation of MACRA will impact our health care system for years to come, and it must be done thoughtfully, carefully, and as simply as possible. The AAFP sees a strong and definite need for CMS to step back and reconsider the current approaches to MACRA, which we view as overly complex and burdensome to physicians. Given the significant complexity of these programs, we strongly encourage CMS to follow the AAFP's recommendations by which CMS can better align the requirements with the goals and intent of the legislation. The AAFP and our members stand ready to assist CMS in ensuring that the MACRA regulations achieve the goals established by the law, and advance high-quality and efficient health care for Medicare beneficiaries. We welcome the opportunity to further discuss our ideas and policy proposals.

We appreciate the opportunity to provide these recommendations and make ourselves available for your questions. Please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org.

Sincerely,



Wanda D. Filer, MD, MBA, FFAFP
Board Chair

Enclosed:

- AAFP's Recommendations to meaningfully improve and simplify implementation of MACRA

Recommendations to meaningfully improve and simplify implementation of MACRA

Consistent with the [Executive Order](#) on Reducing Regulation and Controlling Regulatory Costs issued on January 30, 2017, and to strengthen MACRA and reduce the administrative burden to physicians, the AAFP developed and proposes the following set of regulatory reforms.

I. Provisions to ELIMINATE Based on Complicated and Needless Regulatory Interpretation

1. Remove the financial risk standards from regulatory definitions of Medical Home Model.

Background: The term “Medical Home Model” is not mentioned in the MACRA legislative text. CMS created this term in the proposed rule, and it has led to enormous confusion. The definition of Medical Home Model is very similar to that of a medical home, which is in the statute, but includes a financial component and is an abstract term applied to an APM rather than a practice. Physicians as well as policy makers have a hard time distinguishing between the two.

CMS finalized its proposed financial risk standard for Medical Home Models in the final rule. To be an AAPM, Medical Home Models must include provisions that would allow CMS to do the following:

- Withhold payment for services to the APM entity and/or the APM entity’s ECs;
- Reduce payment rates to the APM entity and/or APM entity’s ECs;
- Require the APM entity to owe payment(s) to CMS; or
- Cause the APM entity to lose the right to all or part of an otherwise guaranteed payment if either:
 - Actual expenditures, for which the APM entity is responsible under the APM, exceeded expected expenditures during a specified performance period; or
 - APM entity performance on specified performance measures does not meet or exceed expected performance on such measures for a specified performance period.

The statute does not include these financial risk standards. CMS established them via regulation. This construct has created unnecessary confusion and increased complexity for family physicians – many of whom have already undertaken practice transformation efforts to provide care under medical homes. Furthermore, the CMS definitions on risk do not adequately address transformational risk, which is the human capital, time, and dollars expended for transformation from traditional care to patient-centered, team-based care.

The AAFP continues to adamantly oppose the financial risk and nominal risk standard for all Medical Home Models and urges CMS to remove these needless regulatory requirements, which are administratively burdensome and complex for both participating Medicare physicians and CMS. These risk requirements limit the number of Medical Home Models available to ECs

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and will deter participation in the models. These risk models also are overly complex and assume an actuarial understanding from physicians that is unrealistic. .

2. Remove arbitrary size restrictions limiting AAPM participation in Medical Home Models.

Background: Despite the AAFP's early concerns, CMS finalized its proposed limitation on the applicability of the Medical Home Model financial risk and nominal amount standard to AAPM entities with fewer than 50 ECs in their parent organizations. This limitation will begin in the second QP performance period (2018). For entities owned and operated by an organization with more than 50 ECs, participation in a Medical Home Model AAPM would not offer an opportunity to attain QP status unless the Medical Home Model met the generally applicable AAPM financial risk criterion.

How CMS determined 50 ECs was the appropriate number for this threshold remains a mystery. CMS should not use an arbitrary threshold when determining the amount of financial risk an entity can assume. Further, the assumption of risk should not be determined by a general threshold number of ECs within the organization; it should be based on each entity's demonstrated capabilities.

In addition, the 50 EC threshold policy contradicts CMS's stated desire to encourage and expand participation in AAPMs. The size limit discourages participation in CPC+, which is currently the only Medical Home Model available to participants.

CMS needs to remove this arbitrary threshold, which it implemented via regulation without regard to the original MACRA statute. This provision adds more administrative burden and complexity for participating physicians and practices as well as CMS, which already has enough burden implementing the statute as it is.

3. Eliminate all documentation guidelines for evaluation and management codes for primary care physicians in both the MIPS and AAPM pathways.

Background: Physicians are frustrated with the onerous levels of documentation required to justify the level of service for each evaluation and management (E/M) encounter with a patient. CMS wrote the current, archaic CMS Documentation Guidelines for Evaluation and Management Services 20 years ago. They do not reflect the current use and further potential of electronic health records (EHRs) and team-based care to support clinical decision-making and patient-centeredness. These outdated requirements contribute to poor usability and interoperability of health information technology (IT). Further, under both MIPS and APMs, physician payment is increasingly tied to quality and cost, not the bulleted minutiae included in the E/M documentation guidelines. Those guidelines have outlived their utility. CMS needs to recognize that fact and stop requiring primary care physicians to adhere to them for purposes of MIPS and AAPMs and for Medicare payment in general.

4. Jettison the complicated and entirely uncalled-for MIPS APM category.

Background: While CMS was unable to implement the virtual group policy for the first MIPS performance year as called for in MACRA, the agency was able to create an entirely new payment pathway that does not exist within the MACRA legislative language.

In 2017, some APMs will not meet requirements for AAPMs. Physicians in these APMs (referred to as "MIPS APMs"), will be subject to a modified set of MIPS reporting requirements and the standard MIPS payment adjustments. MIPS-eligible clinicians who participate in MIPS APMs

will be scored using a different scoring standard than otherwise used in MIPS, and the scoring standard can differ between various MIPS APMs.

The AAFP objected to the implementation of the entire section of the proposed and final rules related to MIPS APMs. This policy is incredibly confusing, and it may inadvertently incentivize physicians to remain in the fee-for-service program rather than continue their progress towards AAPMs. CMS and the Center for Medicare and Medicaid Innovation (CMMI) have implemented policies in the Medicare Shared Savings Program that allow accountable care organizations (ACOs) to maintain a neutral financial position for a defined period of time. We believe a similar approach may be appropriate here—that is, to allow APMs to sit between the two programs, not eligible for the 5 percent AAPM bonus and not subject to the MIPS methodology for a period of time, such as two years. At the completion of this time period, the APM would either have to move into the full Advanced APM program or be subject to the standard MIPS criteria as applicable, with no special consideration under any of the four categories. We believe there is policy precedent for this approach, and it would send a clear signal to ECs that they are expected to move to AAPMs.

5. Eliminate administrative claims population health measures.

Background: MACRA allows, but does not require, CMS to use global outcomes measures and population-based measures for the quality performance category. In rulemaking, CMS chose to fully and immediately utilize this authority. CMS finalized the hospital developed All-Cause Hospital Readmission measure that was part of the value-based modifier (VBM) and incorporates this measure into the MIPS quality category. The measure was developed and tested for use at the hospital-level and has low statistical reliability when applied at the individual physician level, and even at the group level. We strongly urge CMS to eliminate such measures, which it should not have implemented in the first place.

6. Use consistent terms from proposed to final rulemaking to avoid confusion in the physician community.

Background: MACRA calls for the MIPS performance categories to be based on quality, resource use, clinical practice improvement activities, and meaningful use of certified EHR technology, which would then make up a composite performance score. CMS subsequently published proposed regulations with these terms, and physician organizations like the AAFP began MACRA educational campaigns based on these terms to prepare our members. Between the proposed and final MACRA rules, CMS unfortunately changed the name of “clinical practice improvement activities” to “improvement activities,” “resource use” to “cost,” and “composite performance score” to “final score.” CMS also renamed the “meaningful use” program as the “advancing care information” category. In doing so, the agency caused needless confusion to practicing physicians and their staff that had already begun familiarizing themselves with what became outdated terms. Whenever possible and as a way to minimize unnecessary confusion, CMS needs to maintain consistent and legislatively-based terms when making policy proposals and when issuing final rules.

II. Provisions to *MODIFY* in order to Improve and Simplify MACRA for CMS and Physicians:

1. Primary Care Payment Recommendations:

- **Immediately adjust upward the Medicare relative value units (RVUs) for common primary care services in order to pay appropriately for those services which as a**

family of CPT codes and services are greatly undervalued compared to other groups of CPT codes and services.

- **Increase spending on services provided by primary care physicians in the Medicare Part B program to, at minimum, 15 percent of Medicare Part B physician spending. Currently, services provided by primary care physicians represent between four to six percent of Medicare Part B physician spending. This increase should be achieved over time through increases in the primary care workforce, the percentage of office-based visits that are conducted by primary care physicians, the aforementioned increase in the RVUs for primary care services, and through further investment in and payment for primary care AAPMs.**
- **Consistently define the size of a “small” practice as 10 or fewer eligible clinicians.**

Background: The MIPS pathway modifies payment under the existing fee-for-service payment system, and payment under AAPMs is often based on the same payment system. As such, addressing flaws in current payment rates and methodologies is a critical element in a successful transition to and implementation of MACRA. CMS must correct longstanding inequities in physician payment if primary care is to be the foundation of new payment and delivery models under MACRA.

Payment experts offer similar assessments of the problems with testing and building value-based payment models on a flawed physician fee schedule. Drastic payment discrepancies continue to raise serious concerns about fee schedule mispricing and its resulting negative impact on primary care. To help ensure the success of MIPS and AAPMs, the AAFP sent a [letter](#) on April 11, 2016, that details steps CMS can take to address these discrepancies. We strongly encourage CMS to consider these recommendations and meet with the AAFP to further discuss how these goals can be accomplished.

Despite our support for MACRA and optimism regarding the AAPM pathway, the AAFP and other [health policy experts](#) are apprehensive that the MIPS and AAPM programs will fail if they are built upon the biased and inaccurate relative value data currently used in fee-for-service payments. CMS undervalues payment for evaluation and management (E/M) codes and other primary care services. Without remedying this flaw, payments under MIPS and future actuarial calculations for AAPMs will not adequately compensate primary care for the complexity of care provided –undermining broader goals to improve care, improve health, and reduce costs.

Finally, the AAFP urges CMS to be consistent across all agency programs in their definitions of “small” practice as 10 or fewer eligible clinicians.

2. Advanced Alternative Payment Model Recommendations:

- **Support patient-centered primary care models that both strengthen primary care and allow small practice participation as new AAPMs are developed.**
- **Do not replace fragmented fee-for-service (FFS) with fragmented condition or specialty-specific APMs.**
- **Consider and release new AAPMs in a timely fashion, so practices can participate.**
- **Make primary care-oriented AAPMs available nationally to all primary care physicians.**
- **Review and approve the AAFP’s [“Advanced Primary Care: A Foundational Alternative Payment Model \(APM\)”](#) proposal made to PTAC.**

Background:

The AAFP strongly supports moving a larger percentage of payments from traditional FFS towards alternative payment models (APMs) and AAPMs. The AAFP believes APMs and AAPMs should support the delivery of comprehensive, longitudinal care for patients and promote quality of care over volume. Family medicine's commitment to models of care that are built for patients is clear. Among the AAFP's clinically active members, 45 percent already work in an officially recognized patient-centered medical home.

Moving to a value-based health care system in a sustainable way requires transitioning away from a model of symptom- and illness-based episodic care to a system of comprehensive, coordinated primary care for children, youth, and adults. With implementation of MACRA, the development of new AAPMs—including physician-focused payment models—is accelerating. However, the proliferation of numerous models that may be overlapping could add to administrative complexity for physicians, as well as lead to confusion for beneficiaries and the delivery of fragmented care.

Primary-care oriented Advanced Alternative Payment Models (AAPMs) must be made available nationally to all primary care physicians. Though primary care oriented AAPMs will continue to clinically coordinate with other payment models, primary care AAPMs must be distinct from bundled payment models to maximize support for the delivery of continuous, longitudinal, and comprehensive care across settings and providers. Including primary care in bundled payments will not provide the support our health system needs to increase value and strengthen primary care.

CMS needs to consider primary care and small practices in model design as new AAPMs are developed. CMS also needs to release models in a timely fashion, so practices can participate. While some models may deliver comprehensive, longitudinal care, many run the risk of perpetuating (or even exacerbating) the fragmented care many patients receive under the current FFS system. Evidence shows that health systems built with primary care as their foundation have positive impacts on quality, access, and costs.

The AAFP only supports patient-centered advanced primary care models that promote comprehensive, longitudinal care across settings and hold clinicians appropriately accountable for outcomes and costs. To support the development and implementation of AAPMs that accomplish these objectives, the AAFP developed a position paper on an advanced alternative payment model (AAPM) for primary care. The paper, "[Advanced Primary Care: A Foundational Alternative Payment Model \(APM\) for Delivering Patient-Centered, Longitudinal and Coordinated Care](#)," covers in substantial detail all the pieces this model must include. The AAFP also created and released [AAFP Principles to Support Patient-Centered Alternative Payment Models](#). We strongly urge CMS, CMMI, the Assistant Secretary for Planning and Evaluation, the Physician-focused Payment Model Technical Advisory Committee, and others to follow these documents to ensure that payment models place patients—and not clinicians—at the center. Finally, the AAFP encourages CMS to review and comment on the AAFP's "[Advanced Primary Care: A Foundational Alternative Payment Model \(APM\)](#)" proposal that we submitted to the Physician-Focused Payment Model Technical Advisory Committee on April 14, 2017.

3. Establish a more gradual MIPS transition period, promote successful participation, and provide prompt and clinically actionable feedback to help physicians progress into AAPMs.

Background: CMS has the authority to structure the MIPS program for 2017 and 2018, and the AAFP strongly urges CMS to fully exercise this authority. CMS should adopt a similar transition

year for 2018 to allow physicians to become more familiar with the program and keep program requirements stable as physicians and CMS learn from 2017 results. CMS should set the MIPS performance score threshold to promote successful participation by ensuring a majority of physicians are held harmless from penalties. To avoid confusion, we urge CMS to simplify the scoring by:

- Defining what must be reported to avoid a penalty, earn a bonus, and earn a maximum incentive payment (similar to the approach taken in pick-your-pace)
- Harmonizing the scoring requirements across MIPS categories.
- Maintaining the reporting thresholds at 50 percent of Medicare Part B patients.
- Keeping the cost category's weight in the composite score at zero in 2018
- Continuing a minimum 90-day reporting period to receive full credit for reporting a measure under the quality performance category.
- Maintaining a minimum point floor for reporting on measures regardless of performance on the measure or the measure type.

CMS should also develop tools that physicians could use to help predict their score with examples tailored to type of practice and specialty. For MIPS to be successful, CMS must provide physicians with timely, and ideally clinically actionable, feedback so that they can assess their performance. The AAFP calls on CMS to generate feedback reports at least quarterly or more frequently since clinicians need timely and actionable claims data to make value-based care decisions, both for their practice, as well as for those to whom they refer.

4. Virtual Groups Recommendations:

- **Offer an interim pathway in 2018 to virtual groups such that physician practices with 10 or fewer physicians, billing under a single TIN, who participate in the MIPS program through the submission of quality data, use of certified electronic health record technology (CEHRT), and involvement in improvement activities should be exempt from any negative payment adjustments until virtual groups—as outlined and mandated by MACRA—are readily available.**
- **Redirect such funds as necessary from the \$500 million intended for positive payment adjustments to “exceptional performers” to finance this proposed safe harbor for solo and small group practices**
- **Prioritize establishing virtual groups as envisioned in the law.**

Background:

The AAFP still has significant concerns regarding CMS's inability and reluctance to implement “virtual groups” under MIPS. Congress expressly established the option for solo and small groups to aggregate their data—in an effort to remove any methodology biases due to their potential small number of Medicare beneficiaries—through the deliberate inclusion of virtual groups. Congress included language establishing Virtual Groups to provide a plausible mechanism for solo and small group practices to participate and compete in the MIPS pathway against larger groups that would inherently benefit from larger numbers of beneficiaries, upon which CMS would calculate their evaluation.

However, CMS stated that it was unable to establish or implement the virtual group option for the initial performance year as mandated by MACRA even though it managed to find the time and resources to create the MIPS APM category, which MACRA did not require. CMS' inaction delays an opportunity for these physicians to participate in an equitable manner in the MIPS program. CMS has experience with the creation of new delivery models (i.e., ACOs), so why CMS determined this model too complex and worthy of omission for the initial performance year of MIPS is unfathomable. Virtual groups should be designed to incorporate physicians from a

single or similar discipline. The geographic factor is not necessary and should be left to physicians to determine. The AAFP supports maximum flexibility with no arbitrary restrictions based on population, size, location, geographic boundaries, or specialty.

The lack of virtual groups will result in a “methodology bias” between solo and small practices on the one hand and larger practices on the other. Yet, they all will compete against each other in the MIPS program. The gap will widen between solo and small group practices with limited financial resources and larger practices or those affiliated with health systems. These disparities among practices based on size and location could also introduce—or exacerbate—disparities in outcomes for beneficiaries. Only CMS is to blame if that is the case.

The virtual group option established a reasonable approach for solo and small group physicians to begin building networks that would encourage them to progress towards more sophisticated delivery models such as ACOs, APMs, and AAPMs. Again, we are shocked and disappointed that this option is not available and implore CMS to get its act together and implement virtual groups for the 2018 performance period.

Given the fact that a provision, mandated by law to ensure the viability of solo and small physician practices in the MIPS program is not available in the initial performance period, we continue to strongly urge CMS to offer an interim pathway to virtual groups, as outlined below.

Physician practices with 10 or fewer physicians, billing under a single TIN, who participate in the MIPS program through the submission of quality data, use of certified electronic health record technology (CEHRT), and involvement in improvement activities should be exempt from any negative payment adjustments until virtual groups—as outlined and mandated by MACRA—are readily available. These practices however, should be eligible for any positive payment adjustments based upon their performance in any given performance period. Any physician or small group that fails to participate in MIPS-required activities would still be subject to the full negative payment adjustment. This will encourage Medicare-participating physicians to continue to pursue quality and performance improvement.

We recommend that CMS redirect funds from the \$500 million intended for positive payment adjustments to “exceptional performers” to finance this proposed safe harbor for solo and small group practices. We find it difficult to comprehend why CMS would reward an extremely small subset of Medicare-participating physicians, while knowingly placing smaller practices at a distinct disadvantage.

Furthermore, we urge CMS to prioritize establishing virtual groups for the reasons outlined above. The AAFP stands ready to partner with the agency and to be included in any stakeholder group or workgroups that will help CMS structure and implement virtual groups. The AAFP has extensive experience supporting the implementation of new payment models through our engagement with the Transforming Clinical Practice Initiative (TCPI), and the Comprehensive Primary Care (CPC) and CPC+ initiatives. Our standing as a professional association, as well as the experiences of our individual members who are operationally involved with nearly every payment model currently being tested, would be a valuable asset in the stakeholder group. Thirty percent of our members are partial owners or sole owners of their practice, indicating a strong representation of small practices. Their feedback and participation will be critical to the success of the virtual group program, as well as enhancing the ability of solo and small group practices to successfully participate in MIPS.

5. ACI Recommendations:

- **Move away from health IT utilization measures and simplify QPP and ACI.**
- **Evaluate ACI's impact on physician experience and implement changes that reduce unnecessary burden.**
- **Allow ECs to use 2014, 2015, or combination CEHRT, if the ACI scoring and methodology is not fundamentally changed and continue the 2017 transition year base ACI criteria in 2018 while moving forward with the planned 2018 performance measuring and scoring.**
- **Maintain a 90-day reporting period.**

Background: Compared to earlier proposals, the AAFP appreciates the steps CMS took to restructure the ACI component in the MACRA final rule. Those steps will reduce burden and increase participation. The AAFP hopes CMS continues this work, since the final ACI structure is still too complex and administratively burdensome.

We still have concerns about the complexity of the scoring methodology and the need for EC awareness and education. First, CMS failed to eliminate the “all-or-nothing” requirement from ACI. If an EC fails to report even one measure in the base score category, they will get a 0 percent for the base score and a 0 percent for the entire ACI category. Also, ECs in the ACI category can earn 155 percentage points, but only get credit for 100 percentage points, which then accounts for 25 percentage points of the MIPS final score. This methodology is complex and confusing. CMS must simplify ACI.

Even if scoring is simplified, we disagree with the use of health IT utilization measures in light of the additional policy levers available within MACRA (cost and quality), as well as movement toward value-based payment with performance and risk-based reimbursement models that are driving change. We recommend CMS continue to move away from using health IT utilization measures due to the negative unintended consequences of clinical workflow disruptions experienced in the meaningful use (MU) program without commensurate increases in quality and/or decreases in cost. Health IT utilization measures only add burden to ECs. They siphon vendor attention toward delivery of solely CEHRT-specified functionality at the expense of improving functionality required to support clinician workflows. Finally, such measures distract both ECs and vendors from utilization of health IT.

CMS is naïve to think that all that is needed is for clinicians to work with their vendors, CMS's stated solution for workflow disruptions in the MACRA final rule. We ask CMS to continue to implement changes that reduce unneeded and unproductive burdens associated with the use of health IT, as outlined in the AAFP's separate [letter](#) on February 16, 2017. CMS and the Office of the National Coordinator for Health Information Technology (ONC) should devote significant resources and effort to improve how CEHRT supports and enhances clinical workflow, including more accountability of vendors, and remove overly prescriptive health IT utilization measures. We strongly encourage CMS to simplify QPP by eliminating health IT utilization measures from ACI.

We have strong concerns regarding the requirement of ECs to upgrade to 2015 Edition CEHRT by 2018. Many EHR vendors do not have 2015 Edition certification yet. Once available, there will be a delay between market availability and ability to implement as there are significant time and cost investments that must be made in order to upgrade. Additionally, many ECs dissatisfied with their current CEHRT are evaluating whether they should switch EHRs since both an upgrade or switch would be costly and disruptive. However, due diligence in selecting and implementing new CEHRT involves significant time and disruption. Because of this delay, if

the ACI scoring and methodology is not fundamentally changed, we recommend that the 2017 transition year base ACI criteria be continued in 2018 while moving forward with the planned 2018 performance measuring and scoring – and allow ECs to use 2014, 2015, or combination CEHRT. This will thread the needle by giving ECs, who will struggle in adopting 2015 Edition CEHRT in 2018, the option to use 2014 Edition CEHRT. At the same time, it will incentivize use of 2015 Edition CEHRT, as the total possible points for using a 2015 Edition CEHRT or combination would be 155, whereas a 2014 Edition CEHRT would only allow for a total score of 135.

6. Quality Measure Recommendations:

- **When available, use only the core measure sets developed by the multi-stakeholder Core Quality Measures Collaborative to ensure alignment, harmonization, and the avoidance of competing quality measures among payers.**
- **Require all physicians participating in the MIPS program to meet the same program expectations and report on the same number of measures.**
- **Release MACRA measure development funding.**

Background: All measures used in MIPS and APMs must be clinically relevant, harmonized and aligned among all public and private payers, and minimally burdensome to report. To accomplish this, the AAFP recommends that CMS use the core measure sets developed by the multi-stakeholder Core Quality Measures Collaborative, in which the AAFP participates, to ensure alignment, harmonization, and the avoidance of competing quality measures among payers.

CMS must ensure the reporting burden under MIPS is equivalent for all participating physicians. To accomplish equivalency in the reporting burden, all physicians participating in the MIPS program should be required to meet the same program expectations and report on six measures. If six measures are not available in the sub-specialty list, MIPS-eligible clinicians should report at the higher specialty level. If six measures are still not available that are specialty specific, these MIPS-eligible clinicians should choose measures from the list of cross-cutting measures until they reach a total of six measures. If CMS requires a lower number of quality measures for a particular specialty group in MIPS, then the minimum number should be lowered for all physician specialties. Parity in reporting across all physician groups is critically important.

The key to achieving the goals of MACRA is an adequate portfolio of appropriate quality measures. MACRA specifically authorizes \$15 million per year for each of fiscal years 2015 through 2019, for a total of \$75 million, to fund the development of physician quality measures for use in MIPS. We recommend any funds go to physician-led organizations, such as medical societies and the PCPI and not be provided to contractors that lack sufficient physician input.

7. Continuing Medical Education (CME) as Improvement Activities:

- **Approve for fulfillment of improvement activities any CME activities that are designed to measurably improve performance and/or patient outcomes.**
- **Utilize AAFP's reporting capabilities to reduce the administrative burden on ECs and the burden on CMS of verifying completion of improvement activities.**
- **Include PerformanceNavigator® live course and PerformanceNavigator® On Demand (online) in CMS's approved improvement activities.**

Background: Since 1947, the AAFP has been committed to setting standards for CME that facilitate improvement in clinicians' knowledge, professional competence, practice performance, and patient

outcomes. The types of CME activities that improve performance are essentially the same as the types of quality improvement activities that CMS is now requiring of ECs.

If CMS chooses to continue with separately weighted categories, we urge CMS to include in the list of approved improvement activities those CME activities that involve assessment and improvement of care quality or patient outcomes as demonstrated by clinical data or patient experience of care.

U.S. accreditors/credit systems including the AAFP, ACCME and AMA, have a long history of designating different types of CME activities for various purposes/stakeholders. For example,

- AAFP and ACCME have a process in place to designate activities as being compliant with the FDA ER/LA Opioid REMS requirements.
- AAFP, ACCME and AMA are each able to designate improvement activities distinct from other learning programs.
- AAFP, ACCME and AMA have all partnered with specialty certification boards (ABFM, ABIM, ABP, etc.) to designate activities as being compliant with their requirements.

In all these scenarios, the accreditors manage the data to allow physicians to report completion to external entities. The AAFP, ACCME and AMA are willing to collaborate to help engage ECs in CME activities that meet CMS' Improvement Activity requirements and then report ECs' completion to CMS. This can increase participation in CMS' program, and reduce reporting complexities for ECs and for CMS. ECs can choose how they report completion of their requirements, whether directly, through one of several national accreditors, or another vendor offering these services.

The AAFP recommends that the PerformanceNavigator® live course and On Demand (online activity) be included among CMS's approved improvement activities in the Patient Safety and Practice Assessment subcategory. PerformanceNavigator® enables ECs to objectively assess their practice to identify areas for improvement via baseline chart information and patient survey data, practice assessment, and case study questions. PerformanceNavigator® uses MIPS quality measures to identify practice deficits and direct practice transformation efforts. Clinicians then complete activities to guide improvement; track progress; reassess; and identify areas for added improvement and better patient outcomes.

We propose that CMS include PerformanceNavigator® in the inventory of approved improvement activities with the following brief description:

- Completion of the American Academy of Family Physicians' PerformanceNavigator® performance improvement continuing medical education activity.

8. Coding Recommendations:

- **Provide additional information on how patient-relationship categories and codes will be used to attribute cost and patient outcomes to physicians.**
- **Thoroughly pilot test these patient-relationship categories and codes before their use impacts payments.**
- **Minimize the reporting burden for physicians through pilot testing to address logistical issues, especially for small practices.**

Background: MACRA requires the establishment and use of patient-relationship categories and codes. In a [letter](#) sent December 21, 2016, we articulated concern that this reporting requirement will cause severe administrative burden for Medicare-participating physicians. Well before these codes are required, CMS must provide additional information on how it will use these patient-relationship categories and codes to attribute cost and patient outcomes to physicians and also how it will use this information with episode groups. CMS also must

thoroughly pilot test these patient-relationship categories and codes before their use impacts payments. Finally, CMS must minimize the reporting burden for physicians and the agency through pilot testing to address logistical issues and possible unintended consequences, especially for small practices.

9. Simplify and stabilize the improvement activities scoring process by only requiring practices to do three activities, each carrying a weight of 5 percentage points, to obtain the 15 percent needed in the category.

Background: The improvement activities performance category, as required by MACRA, included subcategories on expanded practice access, population management, care coordination, beneficiary engagement, patient safety, and participation in an APM. As designed by Congress, these improvement activities were not subject to an artificial weight classification, which the agency created and finalized with “high” and “medium” weights. By doing so, CMS significantly complicated calculations physicians and practice administrators must make to reach a sufficient number of improvement activities. CMS should simplify this process by only requiring practices to do three activities, each carrying a weight of 5 percentage points, to obtain the 15 percent needed in the category.

10. Reduce the acceleration of data completeness criteria standards.

Background: Currently, the quality category of MIPS requires ECs, not reporting through claims, to report on 50 percent of their patients that qualify for a measure regardless of payer. This number is scheduled to increase to 60 percent in 2018. The AAFP encourages CMS to hold this data completeness criteria percentage to 50 percent in 2018 as they learn the outcomes of quality measurement and as they assess the ability of practices to report, and CMS to receive, this volume of information.

11. Make AAPM incentive payments to QPs (i.e. “to such professional”) as identified by either the QP’s National Provider Identifier (NPI) or TIN/NPI combination.

Background: MACRA explicitly states, “...there also shall be paid *to such professional* an amount equal to 5 percent of the estimated aggregate payment amounts for such covered professional services under this part of the preceding year.” (Emphasis added) The law clearly requires the AAPM incentive payment to be made to the qualifying AAPM participant (QP), not the TIN that is affiliated with the AAPM entity through which the EC met the threshold during the QP performance period. However, the change in payment to TIN was made via regulation – introducing additional complexity.

We agree with CMS that the intent of section 1833(z) of the Act is to incentivize participation in AAPMs. However, as the law clearly states, the law incentivize QPs, not their affiliated TINs. There is no reward to a QP for participating in an AAPM if the QP does not receive the AAPM incentive payment. If a TIN wants to avail itself of a QP’s AAPM incentive payment, that is a contractual matter between the TIN and the QP. It is not something for CMS to decide. Accordingly, we strongly urge CMS to make AAPM incentive payments to individual QPs (i.e. “to such professional”) as identified by either the QP’s National Provider Identifier (NPI) or TIN/NPI combination. That will incentivize eligible clinicians (ECs) to participate in AAPMs and fairly reward performance in the MIPS.