December 15, 2016

Andrew M. Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS–5517–FC
200 Independence Avenue, SW
Washington, DC 20201

Dear Acting Administrator Slavitt:

On behalf of the American Academy of Family Physicians (AAFP), which represents 124,900 family physicians and medical students across the country, I write with the Academy's reaction to the Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models final rule with comment period, as published by the Centers for Medicare & Medicaid Services (CMS) in the November 4, 2016, *Federal Register*.

To improve the implementation of the MIPS and APM pathways, in summary the AAFP:

- Encourages CMS to consider primary care and small practices in their model design as new APMs are developed. We encourage CMS to release these models in a timely fashion so that practices can participate.
- Appreciates CMS's decision to modify the low-volume threshold.
- Remains uncomfortable with CMS setting the registration deadline, where applicable, at June 30 of the applicable performance period. We continue to believe that September 30 is a more reasonable deadline, especially in 2017, when MIPS participants have until October 2 to begin reporting.
- Continue to question the necessity for groups to register to elect to report the CAHPS for MIPS survey.
- Believes virtual groups are critical to the ability of small practices, especially those in rural areas, to participate successfully in MIPS.
- Requests to be included in the stakeholder group engaged with CMS to structure and implement virtual groups.
- Supports maximum flexibility with no arbitrary restrictions based on population, size, location, geographic boundaries, or specialty for virtual groups.
- Strongly believes the quality reporting burden under MIPS should be equivalent for all participating physicians by performance period 2018. If CMS requires a lower number of quality measures for a particular specialty group in MIPS, then the minimal number should be lowered for all physician specialties.
- Appreciates CMS' close alignment of final measures with the core measures and encourage continued effort at further alignment in the future.

- Is supportive of CMS' decision to lower the weight of the cost category for the transition year. We hope CMS is able to use this time to adjust the cost measures to include only measures that more accurately assess a physician's individual utilization.
- Does not believe family physicians can or should be held accountable for total cost of care.
- Believes patients must be prospectively attributed, based on who can control those specific costs. Attribution should include a reconciliation process for clinicians to review, add, or remove patients from the list.
- Believes patients should be attributed to the physician billing the largest portion of Part B allowable charges. Attributing patients, based on the number of visits, does not attribute patients to the physician that can make the biggest impact on reducing costs, and would disproportionately hold primary care physicians responsible for the costs of specialists.
- Anticipating that private payers will follow the lead of CMS and adopt improvement activities in their payment structure, the AAFP strongly believes that CMS should create a parsimonious and harmonized list of improvement activities, which can be utilized by all payers and would prevent an overwhelming list in the future.
- Recommends that CMS approve for fulfillment of improvement activities any continuing medical education (CME) activities that measurably improve performance and patient outcomes.
- Recommends that PerformanceNavigator® be an approved improvement activity.
- Recommends that CMS utilize AAFP's reporting capabilities to reduce the administrative burden on ECs and the burden on CMS of verifying completion of improvement activities.
- Still has concerns that in the context of the entire QPP, the final structure is still too complex and contains too much administrative burden on family physicians and other clinicians.
- Is concerned about the clinical workflow disruptions caused by CEHRT stemming from requirements from meaningful use (MU), and now ACI. We believe it is naïve to think that all that is needed is for clinicians to work with their vendor.
- Recommends that CMS and ONC should devote significant resources and effort to improve how CEHRT supports and enhances clinical workflow, including more accountability of vendors.
- Appreciates the flexibility to use both 2014 and 2015 edition products in 2017, and the 90-day reporting of ACI in 2018 to support clinicians' transition to 2015 edition products for 2018.
- Recommends CMS continue to move away from using health IT utilization measures, due to the negative unintended consequences experienced in the MU program.
- Wishes to be included in the stakeholder group that is contacted for feedback on these and any other reports.
- Strongly encourages CMS to work with third party vendors (registries, QCDRs and qualified registries) to provide more timely and actionable feedback in the quality category.
- Recommends that CMS exercise great caution in determining whether implementation decisions result in willful information blocking. Decisions might support care delivery and work toward achieving the Triple AIM™, but still result in non-standard implementation of CEHRT.
- Fails to see how any clinical provider, much less a small physician practice, could meet the requirements of attestation statement 2 by holding their health IT vendors accountable for these requirements, which appears to be the intent of this attestation.

- Is concerned that ECs will not be able to meet the requirements of attestation statement 2 because they do not have sufficient awareness of the standards that must be communicated to their health IT vendors and others involved with implementation and configuration of their CEHRT. The AAFP believes certification should confirm that standards have been implemented. If attestation is needed, it should be required of the health IT vendor, not the EC.
- Appreciates and supports CMS's decision to set the performance threshold at three points for the 2019 MIPS payment year.
- Supports CMS' decision to set the additional performance threshold for the 2019 MIPS payment year at 70 points. From our perspective, 70 points is a reasonable additional performance threshold because it is high enough to necessitate what could be construed as "exceptional performance" in the first year and low enough to be reasonably attainable.
- Strongly supports moving a larger percentage of payments from traditional FFS payments towards alternative payment models (APMs). The AAFP believes APMs should support the delivery of comprehensive, longitudinal care for patients and promote quality of care over volume.
- Only supports patient-centered advanced primary care models that promote comprehensive, longitudinal care across settings and hold clinicians appropriately accountable for outcomes and costs. One example is the Comprehensive Primary Care Plus (CPC+) initiative.
- Regrets and is disappointed that CMS chose to add obstetrics and gynecology (specialty code 16) to the list of designated primary care providers on the basis that these physicians "often coordinate primary care services for women." Obstetricians and gynecologists are not primary care physicians. Their training and the care that they provide is, by definition, limited to the organ systems of female patients.
- Regrets and is disappointed that CMS decided to finalize its proposal to include ECs under one or more of the following specialty codes: 50 Nurse Practitioner; 89 Clinical Nurse Specialist; and 97 Physician Assistant.
- Recognizes and appreciates the inclusion of measures from the core measure set within the MIPS quality performance category.
- Continues to adamantly oppose the financial risk and nominal risk standard for all Medical Home Models and urges CMS to remove these requirements.
- Appreciates the inclusion of a revenue-based standard, but believes CMS should continue to monitor it before deciding to increase required levels of risk. 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.
- Believes the 50 EC threshold policy seems contradictory to CMS' stated desire to encourage and expand participation in Advanced APMs. The size limit discourages participation in CPC+, which is currently the only Medical Home Model available to participants.
- Recommends a patient-based, prospective, four-step process that includes a 24-month lookback period for attribution.
- Believes that granting states deference in designing payment arrangements without a floor that is at least equal to Medicare payment is ill-advised and will undermine the chance for success in all payer models.
- Adamantly opposes that CMS require APM entities and/or ECs to submit information for CMS to assess whether other payer arrangements meet the Other Payer Advanced APM criteria. The onus of submitting relevant information on payer arrangements should be the burden of the payer.

- Continues to adamantly oppose and urge CMS to remove the financial risk and nominal risk standard from all medical home models.
- Continues to adamantly oppose and urge CMS to remove the financial risk and nominal risk standard from all medical home models. These requirements limit the number of medical home models available to ECs, and will deter participation in the models due to the risk requirements. Medicaid APM participants should not be subject to the same risk as those that take Medicare or private insurance.
- Remains disappointed that CMS does not feel confident enough in its abilities and the abilities of its contractors to commit to actually paying the APM incentive payments before the end of the payment year.
- Agrees with CMS that the intent of section 1833(z) of the Act is to incentivize participation in APMs. However, the way to do that, as the law clearly states, is to directly pay QPs, not their affiliated TINs.
- Strongly urges CMS to make APM incentive payments directly to QPs (i.e. "to such professional") as identified by either the QP's NPI or TIN/NPI combination.
- Still disagrees with CMS that it should not set a deadline for the Secretary's review of PTAC comments and recommendations and publication of a response to them.
- Still believes that individuals and entities who submit PFPMs to the PTAC using criteria set by CMS should have a reasonable idea when CMS will respond to PTAC comments and recommendations on those PFPMs.
- Notes that, with respect to the revised definition finalized by CMS, that a "physician-focused payment model" may not include any physicians at all. CMS will not require physician group practices or individual physicians to be included as APM entities, and they have expanded the list of ECs to include a host of non-physician providers.
- Urges CMS to return to its originally proposed definition so that the APMs in question are indeed "physician-focused," as the law requires.

1. MIPS-Eligible Clinician Identifier

Summary

CMS is finalizing the use of multiple identifiers that allow MIPS-eligible clinicians (ECs) to be measured as an individual or collectively through a group's performance. Additionally, CMS is finalizing its proposal that the same identifier be used for all four performance categories. CMS is finalizing the use of a single identifier, Tax Identification Number/National Provider Identifier (TIN/NPI), for applying the MIPS payment adjustment, regardless of how the MIPS-EC is assessed.

CMS recognizes that it is not able to identify groups with ECs who are excluded from the MIPS requirements, both at the individual and group levels, such as new Medicare-enrolled clinicians. CMS notes that it could establish new identifiers to more accurately identify such ECs. For future consideration, CMS seeks additional comment on the following issues regarding the identifiers:

- What are the advantages and disadvantages of identifying new Medicare-enrolled ECs and ECs not included in the definition of a MIPS-EC until year three, such as therapists?
- What are the possible identifiers that could be established for identifying such ECs?

AAFP Response

We appreciate CMS's proposal not to establish a new identifier for the MIPS-EC, so we support their decision to finalize that proposal. We also appreciate the proposal that the same identifier be used for all four performance categories, and we support CMS's decision to finalize that proposal, too.

Regarding the idea of establishing new identifiers to more accurately identify ECs who are excluded from the MIPS requirements in a group context, we note that it is not immediately apparent what the advantage may be to identify these clinicians, given that CMS will use TIN/NPI for applying the MIPS payment adjustment. CMS should be able to identify excluded individuals at the point of application, if not before. Absent a clear need, we oppose its establishment because it would only add to the daily administrative complexity that physicians face. Another disadvantage of creating a new distinct identifier for these clinicians would be the requirement to use a crosswalk to link them to other data sets.

1.a. Low-Volume Threshold

Summary

CMS is finalizing a modification to its proposal to define MIPS-ECs or groups who do not exceed the low-volume threshold. The low-volume threshold is defined as clinicians with Medicare Part B billing charges less than or equal to $30,000, or clinicians who provide care for 100 or fewer Medicare Part B beneficiaries.

The low-volume threshold also applies to MIPS-ECs who practice in APMs under the APM scoring standard at the APM Entity level. APM Entities that do not exceed the low-volume threshold would be excluded from the MIPS requirements and not be subject to a MIPS payment adjustment. Such an exclusion will not affect an APM Entity's Qualifying APM Participant (QP) determination if the APM Entity is an Advanced APM.

CMS also finalized a modification to its proposal that allows it to make eligibility determinations regarding low-volume status using two twelve-month segments of data. The first 12-month segment begins September 1, two years prior to the performance period. The second 12-month segment begins September 1, one year prior to the performance period. Both segments include a 60-day claims run out. CMS will conduct the second eligibility determination analysis only to identify additional clinicians and groups eligible for the low-volume exclusion. CMS will not remove eligibility from any clinician identified during the first analysis.

CMS also notes that ECs who are excluded from the definition of a MIPS-EC under the low-volume threshold, or another applicable exclusion can still participate voluntarily in MIPS, but are not subject to positive or negative MIPS adjustments. For future consideration, CMS is seeking additional comment on possible ways that excluded ECs might be able to opt-in to the MIPS program (and the MIPS payment adjustment) in future years in a manner consistent with the statute.

AAFP Response

> **We appreciate CMS's decision to modify the low-volume threshold.** Raising the threshold to $30,000 in Medicare Part B allowed charges, or 100 Medicare Part B beneficiaries will appropriately exclude more individual physicians who might otherwise be subject to MIPS. We also appreciate CMS's plan to make this status determination using historical data during the "low-volume threshold determination period." Finally, we appreciate that CMS will not change the low-volume status of any individual EC or group identified as not exceeding the low-volume threshold during the first eligibility determination analysis based on the second eligibility determination analysis.

We believe CMS should examine ways to permit excluded ECs to report under MIPS and subject themselves to the MIPS payment adjustment. We note that partial QPs in the APM track

have this option. This facet of the Quality Payment Program (QPP) may provide a model for doing something similar with excluded ECs.

b.2. Registration

Summary

CMS is finalizing the following policy that a group must adhere to an election process established and required by CMS which includes:

- Groups will not be required to register to have their performance assessed as a group, except for groups submitting data on performance measures via participation in the CMS Web Interface or groups electing to report the Consumer Assessment of Healthcare Providers & Systems (CAHPS) for MIPS survey for the quality performance category. For all other data submission methods, groups must work with appropriate third party entities, as necessary, to ensure the data submitted clearly indicates that the data represents a group submission rather than an individual submission.
- In order for groups to elect to participate via the CMS Web Interface, or administer the CAHPS for MIPS survey, such groups must register by June 30 of the applicable performance period (i.e., June 30, 2017, for performance periods occurring in 2017).

If technically feasible, CMS is considering the establishment of a voluntary registration process for groups that intend to submit data on performance measures via a qualified registry, such as a qualified clinical data registry (QCDR) or electronic health record (EHR). This will enable such groups to specify whether or not they intend to participate as a group and which submission mechanism (qualified registry, QCDR, or EHR) they plan to use for reporting data. The voluntary registration process will provide other applicable information pertaining to the TIN/NPIs. The assessment of a group's performance would not be impacted by whether or not a group elects to participate in voluntary registration. CMS intends to issue further information regarding the voluntary registration process for groups in sub-regulatory guidance.

AAFP Response

We appreciate that CMS plans to make the registration process for groups voluntary, except for groups submitting data on performance measures via participation in the CMS Web Interface or groups electing to report the CAHPS for MIPS survey for the quality performance category. We view this plan as consistent with CMS's proposals in this area and as a step in the direction of administrative simplification for many physician groups.

That said, **we remain uncomfortable with CMS setting the registration deadline, where applicable, at June 30 of the applicable performance period. We continue to believe that September 30 is a more reasonable deadline, especially in 2017, when MIPS participants have until October 2 to begin reporting.** The AAFP is specifically concerned that this could limit group registration for those that will engage in MIPS reporting in the last quarter of the year.

We also continue to question the necessity for groups to register to elect to report the CAHPS for MIPS survey. As we understand it, groups who choose this option will also use a third-party entity (i.e., a CMS-approved survey vendor). We fail to see why such groups must be treated differently from groups who choose to use other CMS-approved third-party vendors, such as qualified registries, health IT vendors, and QCDRs. Further, we think the deadline for signing up with CAHPS survey vendors should be between the group and the vendor, not CMS. The group will need to use another submission mechanism (like qualified registries, QCDRs, EHR, etc.) to complete the quality data submission, which further suggests that these groups are no different from those whom CMS will otherwise exempt from the registration process. Absent a clear and compelling rationale for requiring CAHPS for MIPS survey users to register,

we continue to strongly recommend that CMS exempt them from the registration process like other groups using third-party entities.

e. Virtual Groups

Background

Section 1848(q)(5)(I) of the Act establishes the use of voluntary virtual groups for certain assessment purposes. The statute requires the establishment and implementation of a process that allows an individual MIPS-EC, or a group consisting of not more than 10 MIPS-ECs to elect to form a virtual group with at least one other such individual MIPS-EC or group of not more than 10 MIPS-ECs for a performance period of a year. Virtual groups are required to make the selection to form a virtual group prior to the start of the applicable performance period under MIPS, and cannot change their election during the performance period. CMS was unable to finalize rules for implementation of virtual groups for performance year 2017 due to operational and programmatic challenges. CMS states it would be impossible for them to develop the infrastructure for electronic transactions pertaining to an election process, reporting of data, and performance measurement before the start of the performance period beginning on January 1, 2017.

Recognizing that failure to implement this section of the law places small practices at risk, CMS made additional allowances to protect small practices during the 2017 transition year, such as increasing the low-volume threshold, lowering the number of activities that must be conducted for the improvement activities category, introducing the "pick your pace" option, and lowering the performance threshold to three points to avoid a negative payment adjustment in 2019.

In the final rule, CMS states they want to make sure the virtual group technology is meaningful and simple to use for clinicians. CMS is seeking stakeholder engagement on how to structure and implement virtual groups in future years of the program. They intend to implement virtual groups for the calendar year 2018 performance period, and will address all of the requirements pertaining to virtual groups in future rulemaking.

CMS requested comments on factors that should be considered regarding the establishment and implementation of virtual groups.

AAFP Response

As we noted in our comments to the MACRA request for information (RFI) and the proposed rule, the AAFP believes **virtual groups are critical to the ability of small practices, especially those in rural areas, to participate successfully in MIPS.** We are disappointed that the virtual group option will not be implemented for the 2017 performance year, but would like to offer the following comments for consideration as CMS prepares for future rulemaking to implement the statutory requirements related to virtual groups. Further, we urge CMS to release a proposed rule as soon as possible to ensure that virtual groups are available to small practices starting in 2018.

MACRA established virtual groups with a few principles and goals in mind: 1) to gain efficiencies for small practices through group reporting; 2) to reduce data and methodology biases for quality measures, which could potentially penalize those physicians in small groups or reporting independently; 3) to allow for the pooling of data infrastructure among solo or independent physicians; and ultimately, 4) to increase the number of patients who are receiving their care through–-and would presumably benefit from—the QPP. In the final MACRA rule, CMS solicits input on a number of provisions and elements to consider as

requirements applicable to virtual groups are developed. However, the AAFP believes requirements should be minimal and as straightforward as possible, so long as they align with and promote the principles noted above. This will allow for maximum flexibility and innovation among eligible physicians.

As the virtual group construct aims to help independent and solo practitioners participate in MIPS (and not create a separate performance and reporting pathway), we strongly urge CMS to keep requirements and standards aligned with those for MIPS-ECs. We support efforts to maintain the integrity of the QPP, including virtual groups. We ask that CMS monitor the program in the early years, and then determine what, if any, additional requirements or parameters are needed if the program is not achieving the goals outlined above.

We believe this approach allows for the innovation necessary for a successful transition to value-based payment programs. It will limit undue restrictions, while still protecting patients and ECs through ongoing evaluation and improvement in the QPP. Furthermore, recognizing CMS has already experienced problems implementing virtual groups in a timely manner, keeping additional requirements to a minimum will help avoid further implementation delays.

The AAFP requests to be included in the stakeholder group engaged with CMS to 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 Comprehensive Primary Care (CPC) initiative. 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 small and solo practices to successfully participate in MIPS.

Virtual Group Minimum Standards
CMS is seeking additional comment on: 1) the advantages and disadvantages of establishing minimum standards; 2) the types of standards that could be established for members of a virtual group; 3) the factors that would need to be considered in establishing a set of standards; and 4) the advantages and disadvantages of requiring members of a virtual group to adhere to minimum standards.

AAFP Response
There are advantages to keeping additional standards to a minimum, especially given the standards already required generally under QPP. Minimum standards will allow virtual groups to lay the groundwork for potential participation in innovative payment models that work best for patients and communities served by small practices. The ingenuity of small groups and solo practices and their patients should be allowed to define these models. Outside of MIPS and APMs, there will be very little opportunity for income to keep pace with expenses under the Medicare physician fee schedule (PFS). To remain viable, clinicians may find it necessary to participate in MIPS, even if allowed an exemption. Virtual groups are a viable option for participation. Participation will allow more patients to be covered by QPP and reap the benefits of incentives to provide high-quality, low-cost care.

Many small practices have avoided payment models being tested because they fear they will lose their autonomy and ability to care for their patients in a personal, patient-centered manner. They may lack understanding of the models and potential risk involved, and fear they will be unable to control risks, or they may not identify with the providers or structure required by these formal arrangements.

Allowing virtual groups to form with minimal standards will encourage the clinicians excluded from MIPS (due to low volume or those uncomfortable with more formal APM arrangements) to participate in MIPS. Virtual groups provide an environment that is less threatening than formal models, and will allow practices to develop the capabilities needed to transition to performance-based payment.

Standards should be limited to those required by law with additional standards added only as necessary to implement the law. Virtual groups should be measured and evaluated as any other MIPS group reporting to reduce overall complexity of implementation.

Virtual Groups Composition Standards
The AAFP believes voluntary virtual groups should be able to collaborate as a team in order to transform health care delivery. Virtual groups can demonstrate commitment to transformation by signing an agreement. The AAFP believes the groups themselves will be in the best position to determine the parameters of the agreement, including but not limited to outlining performance expectations and risk and reward parameters; transparency of data and patient satisfaction; reporting; use of technology; clinical outcomes and cost results; and rules for adding and removing members and dissolving the group. The AAFP encourages CMS to withhold mandating the contents of such agreements.

Providers in small practices tend toward autonomy and independence. They find ways to interact with colleagues with whom they identify to stay current; address common challenges; share strategies and lessons learned; and adopt patient-centered approaches to care for their patients. By allowing small providers to establish their own virtual group based on their own needs, provider relationships will be enhanced in a learn-all, teach-all environment. In turn, this will build networks that encourage progress toward more sophisticated delivery models, such as medical homes and accountable care organizations (ACOs).

While the AAFP originally proposed that virtual groups should be aligned by specialty, we withdraw this position for a less prescriptive approach with no arbitrary limitations based on population, size, location, geographic boundaries, or specialty. Needs will vary among providers, and the virtual group should be left to determine the composition of their own group to best address their unique needs. Group members may be connected geographically, by specialty, by referral patterns, by comradery, by shared vision and goals, by practice style, or by other factors, but should be allowed to determine their own rationale for forming the group. This flexibility is not prohibited by MACRA. Virtual groups can lead to better patient care and lower costs, and groups will guard their own success by including only physicians and other clinicians who commit to value-based care.

For TINs with two to 10 ECs that join a virtual group, the AAFP supports requiring all ECs that have reassigned their billing rights to the TIN to be part of the virtual group. We oppose allowing TINs to split, at least in the early years for the sake of administrative simplicity.

The AAFP supports prohibiting APM participants from joining virtual groups in order to maintain the integrity of existing APM payment models.

Virtual groups are limited by statute to individual MIPS-EC or a group consisting of not more than 10 MIPS-ECs. CMS should not further dictate and restrict the number of providers participating in a virtual group. The AAFP believes virtual groups will limit themselves to a manageable size and membership that allows them to work effectively and succeed. In addition, CMS should not establish thresholds for virtual groups based on the eligible number of patient-lives attributed to the virtual group.

As virtual group programs have already been established and have demonstrated favorable quality and cost performance before the implementation of MACRA, the AAFP believes there should not be a limit on the number of virtual groups allowed in the first year (2018). Limiting the availability of this pathway would restrict opportunities for small and independent practices.

Virtual Group Registration
Virtual groups are required by statute to self-nominate prior to the reporting year and cannot change their nomination election during the performance year. The AAFP encourages CMS to set a registration deadline date of September 30 before the applicable performance period. The AAFP agrees with CMS that a web-based registration is desirable, and urges CMS to implement this system early in 2017 to make certain it is tested and operational prior to September 30, 2017.

A web-based process that combines some of the features of the Group Practice Reporting Option (GPRO) self-nomination process and the APM participant list could be used for virtual groups. Specifically, the virtual group would designate at least one representative that has access to CMS systems and who would perform self-nomination and other functions on behalf of the virtual group (e.g., updates of participant lists, submission of data, informal review requests, access to feedback reports). We believe it is critical that each solo provider or TIN that participates in the virtual group also be able to access feedback reports and CMS should not limit the number of persons from the virtual group that can access reports.

We suggest that virtual groups maintain a participant list in a manner similar to which CMS has finalized for APMs. Specifically, all TIN/NPI combinations and solo providers would be identified in a virtual group participant list. The virtual group would be responsible for maintaining a current list of participants. CMS should apply similar participant rules to virtual groups as are applied to APMs, (i.e., if a TIN/NPI combination is listed as a participant in a virtual group on 3/31, 6/30, or 8/31 then they will be considered as part of the virtual group for that performance year, even if they drop out of the group during the year).

CMS should maintain a database of virtual groups and their participant lists, similar to the database they will be maintaining for APM participants, to allow easy verification and updating of participants in the virtual groups.

Virtual Groups Assessment and Scoring
Scoring for the quality, cost, and advancing care information (ACI) categories should be the same for virtual groups as it is for other groups reporting under MIPS. For the improvement activities category, the virtual group participant agreement should be analyzed to determine if enough activities are required by participants to receive the maximum score. If so, reporting for this category would not be required. If a maximum score is not achieved, then the designated representative could report additional activities on behalf of the group. This scoring approach is similar to that used by MIPS APMs. Along the same line, if any member

of the virtual group is a certified or recognized patient medical home, as defined in the final rule, the entire group should be awarded maximum credit in the improvement activities category.

Except for the initial pilot year (2018) all categories of performance should be assessed at the virtual group level. During the pilot year, analysis should be done at both the individual and virtual group level with the highest score used for payment adjustments. Attribution methods should follow those of other groups. Group reporting would motivate providers to work together to maintain focus on improvement, address common gaps, and encourage strategic thinking and problem solving. Virtual groups should report through existing MIPS reporting mechanisms for administrative simplicity.

Virtual groups will need to be protected against antitrust issues that might arise regarding physician collaboration to recognize economies of scale. We recommend that CMS work with other relevant federal agencies, such as the Department of Justice (DOJ) and Federal Trade Commission (FTC), to ensure that all federal laws and regulations are appropriately aligned in this regard.

Virtual Groups and Meaningful Analytics
At this time, a major barrier to using data for improvement in small groups is the lack of expertise, trained personnel, and time to dedicate toward quality improvement activities. Improvement efforts in small practices may become secondary to daily demands of patient care and running a business. Formation of virtual groups would allow small providers to share the administrative expense of hiring a manager to organize, oversee, and carry out quality reporting and analytic and improvement activities on behalf of the group, similar to what larger organizations do now. A trained quality professional shared among a virtual group would help small groups overcome some of the frustrations of data collection, reporting, accessing feedback reports, analyzing data, implementing change, and implementing an organized, efficient, and effective quality improvement process, while still maintaining the independence of each practice.

While assessment and payment adjustments should be made at the group level, feedback reports should also include individual-level performance analysis to allow providers to identify gaps, weak performance, and cost-reduction opportunities so that members of groups can mentor each other to improve performance. The AAFP encourages this individual analysis of performance for all groups, not just virtual groups. The importance is more critical in virtual groups that are less strictly regulated than more formal groups. Each member of the virtual group must be able to access feedback reports, dashboards, and technical assistance, as desired.

Obtaining timely feedback, particularly on cost data, would be critical in allowing virtual groups to effectively use their data for meaningful analytics. CMS should provide, at minimum, quarterly feedback on costs to virtual groups and feedback for all other categories as frequently as feasible in accordance with the final rules under MIPS.

Aggregation of data from small groups would support more meaningful analysis by removing methodological bias due to small numbers.

Virtual groups should be given the option to participate in technical assistance opportunities, such as TCPi, CPC+, Quality Innovation Network-Quality Improvement Organization (QIN-QIO) efforts, and the MACRA technical assistance (TA) program as a group. Barriers to

current participation in these programs include administrative burden, time, and resource commitment needed to meet program requirements. Efficiencies may also be realized with technical support in developing, implementing, and advancing information technology (IT) solutions to support analytics and improvement needed for success in a value-based environment. This would decrease the current dependency small practices have on IT vendors to develop costly analytic support.

Virtual Groups and Advantages and Disadvantages of Forming a Virtual Group Pilot
We support pilot testing the concept of virtual groups, with 2018 serving both as the pilot and a transitional year for virtual groups. The pilot should test all proposed standards and systems and allow participants to determine if composition of the virtual group is suitable and supportive of improved care, better outcomes, and reduced cost, and if agreements and infrastructure are sufficient. Performance during the pilot should be analyzed at both the individual level and at the virtual group level to allow participants to determine the benefits and drawbacks of participation as a virtual group. CMS should apply the highest of the scores (i.e., individual or the virtual group score) to each TIN/NPI participant to determine MIPS payment adjustments for the pilot year, thereby reducing risk while systems are tested.

CMS should allow an unlimited number of virtual groups to participate in the pilot in 2018 so as to not further delay this option for any provider.

Virtual Groups and Unique Characteristic Compositions and Technical and Operational Elements
We continue to strongly recommend that the entire QPP should be further simplified. We believe that virtual group metrics should be kept simple and CMS should apply the same analytics and metrics used for other groups in the QPP. It does not make sense to create a completely new set of analytics and metrics. We recommend using the proposed analytics and metrics for other groups within the QPP, and then evaluate to see if changes from the standard analytics and metrics are needed for future performance years. By statute, virtual groups were intended to facilitate MIPS participation (not as an alternative to MIPS participation), so the same set of rules should apply.

Virtual Groups and Requirements that Promote and Enhance the Coordination of Care
The AAFP believes that MIPS payment adjustments are enough to promote and enhance coordination of care, quality, and health outcomes. Similar to any other group, this would also promote simplification across the QPP. Instead of creating requirements solely for virtual groups, CMS could create a pilot year to capture the needed evidence for establishing any different requirements for virtual groups.

Virtual Groups and Parameters to Ensure Flexibility
The AAFP supports maximum flexibility with no arbitrary restrictions based on population, size, location, geographic boundaries, or specialty. Group members may be connected geographically, by specialty, by referral patterns, by comradery, by shared vision and goals, by practice style, by patient population, or by other factors, but should be allowed to determine their own rationale for forming the group. CMS should continue to evaluate the virtual group option under QPP and adjust the requirements if small practices are being unfairly burdened or scored.

Virtual Groups Factors that Could Lead to an Unsuccessful Implementation
We agree with the commenters' concerns that the lack of interoperability of certified electronic health record technology (CEHRT), as it relates to sharing and aggregating

measures will be a contributor to unsuccessful implementation. While we agree with CMS and the Office of the National Coordinator for Health Information Technology (ONC) that limiting changes to the certification process for CEHRT gives vendors consistency and ample time to deploy 2015 edition versions, we are concerned that interoperability, especially around aggregation of measures for virtual groups, is not being advanced. CMS and ONC should consider additional interoperability requirements of CEHRT.

While we believe, as commenters suggested, that virtual groups whose members use different CEHRT products would be challenged by the lack of interoperability, CMS should not place restrictions on virtual groups to use specific CEHRT products. We also would add that these interoperability challenges are not negated when all members of a virtual group use the same CEHRT product.

We also have concern about the timeline for virtual groups to erect the needed infrastructure to form the virtual group and to be successful. There are companies working to provide products and services in this space. We would encourage CMS to be cautious not to hamper innovation and cause disruption.

We believe one way to mitigate factors leading to potential unsuccessful implementation of virtual groups is to allow ECs to report both as individuals and as a virtual group. CMS can take the best score for at least the first year of joining a virtual group. CMS should also consider hardship exclusions for all or part of the QPP should these challenges for virtual groups be insurmountable in time for small practices to be successful in a virtual group.

Virtual Groups and Identifiers
Each virtual group should be assigned a virtual group identifier, similar to the APM identifier, that will identify the virtual group, the TIN, and NPIs within each [i.e., (1) virtual group identifier established by CMS (for example, VG); (2) virtual group entity identifier established by CMS (for example, A1234); (3) EC's billing TIN (for example, 123456789); and (4) NPI (for example, 1111111111)].

The advantage of creating an identifier for virtual groups similar to that finalized for APMs is that CMS is already familiar with this type of identifier. It has the infrastructure in place (or will need to develop it for APMs) and can apply this same infrastructure to virtual groups. In addition, providers are already familiar with the TIN and NPI identifiers and use them routinely during practice and for existing quality programs. The identifier is lengthy, which is a disadvantage, but one that CMS believes is necessary, as evidenced by its inclusion in the final rule.

Quality Data Submission Criteria
i. Submission Criteria for Quality Measures Excluding CMS Web Interface and CAHPS for MIPS
Summary
CMS finalized, during the transition year, that ECs will report six measures, one of which must be an outcome measure, or if an outcome measure is not available, then a high priority measure must be reported. CMS did not finalize the need to report a cross-cutting measure. If fewer than six measures are available that are applicable to a specialty, then all that are applicable must be reported.

If more than the six required measures are submitted, CMS would score all the measures, then use those with the highest performance when calculating the category score.

CMS is seeking comment on whether or not to add a cross-cutting measure requirement, in addition to the high priority requirement for year two and beyond.

AAFP Response
The AAFP strongly believes the quality reporting burden under MIPS should be equivalent for all participating physicians by performance period 2018. To accomplish equivalency in the reporting burden, we believe that all physicians participating in the MIPS program should be required to meet the same program expectations as other MIPS participants and report on six measures. If six measures are not available in the sub-specialty list, the MIPS-ECs need to report at the higher specialty level. **If CMS requires a lower number of quality measures for a particular specialty group in MIPS, then the minimal number should be lowered for all physician specialties.** We believe that parity in reporting across all physician groups is critically important to achieve scoring equity.

In regards to the addition of cross-cutting measures to the requirements for the quality category, the AAFP is supportive of this proposal. We believe this promotes shared accountability and will improve the health of the population. We recognize that any single cross-cutting measure may not be meaningful across all specialties; may lead to unnecessary duplication of services; may result in "checkbox-style measurement;" and may become annoying and frustrating to a patient that is asked the same questions and provided the same service by many providers over a short time period (e.g., Hemoglobin A1c testing, or smoking and weight counseling by several providers in a short time frame). Cross-cutting measures need to be more patient-oriented. Cross-cutting measures, such as communicating services and results of care with the primary care provider, or medication reconciliation are meaningful across all or nearly all providers. These could become part of most specialty measure sets in support of care coordination. Other cross-cutting measures may be appropriate only under certain circumstances. We believe there is opportunity for development of meaningful, patient-centered, cross-cutting measures for use under specified circumstances, and encourage the re-introduction of cross-cutting measures as such patient-centric measures are developed.

b. Data Completeness Criteria
Summary
In the proposed rule, CMS proposed that if data is submitted via a qualified registry, QCDR, or EHR, one must report on 90% of all patients regardless of payer. If one submits via claims, 80% of Medicare Part B patients seen during the performance year should be reported upon. Submission via CMS Web Interface or CAHPS for MIPS requires one meet the specific criteria outlined for those programs. CMS proposed ECs who do not meet data completeness criteria would fail the quality category of MIPS.

This proposal was not finalized based on feedback. CMS finalized for performance year 2017 submission via qualified registry, QCDR, and EHR, and will require reporting on 50% of all patients, regardless of payer. For 2018, the threshold increases to 60%. For 2019 and beyond, the threshold will increase.

During the transition year, ECs who submit measures that do not fulfill the data completeness standard will receive three points for submitting the measure and will avoid a negative adjustment.

CMS finalized those submitting via claims need to report at least 50% of Medicare Part B patients seen during the performance year. CMS finalized the criteria as proposed for submission via CMS Web Interface or CAHPS for MIPS.

CMS did not finalize the proposal to have ECs fail the quality category for falling below the data completeness criteria for the transition year. Instead, during this year, three points are awarded for submitting any data.

AAFP Response
The AAFP is supportive of the changes, but encourages CMS to watch for "cherry-picking" of patients now that thresholds have decreased.

5.C and 5.D. Selection of Quality Measures for Individual MIPS-Eligible Clinicians and Groups
Summary
CMS provides specific deadline dates when the final list of measures, measure specifications, and benchmarks must be published. CMS also discusses the process that will be used to propose, receive feedback, and finalize measures for use in quality payment programs, which is the same as what has been used historically. CMS states they will continue to research methods for risk-adjusting measures for socioeconomic factors, and states risk adjustment is done for quality measures, if the measure specifications include it. CMS states 90% of measures are submitted and stewarded by the medical community, but retains the option of building their own measures to fill gaps. CMS finalized nearly all core measures from the Core Quality Measure Collaborative with the exception of two measures.

AAFP Response
We appreciate CMS' close alignment of final measures with the core measures and encourage continued effort at further alignment in the future.

The AAFP urges CMS to move forward with expanding its risk-adjustment methodology in quality measures to incorporate social and economic factors such as race, income, education, and region. Risk adjustment will reduce disparities and minimize unintended consequences due to factors beyond the control of providers that serve disadvantaged patients. We agree that measure developers should incorporate risk adjustment factors into their measure specifications, but unavailability of patient-specific data prevents this from being incorporated into measure specifications. Until such patient-specific data is available, we believe socioeconomic status should be factored in at the community, facility, and/or provider-level to improve comparability of performance. We appreciate CMS acknowledging the need for future socioeconomic adjustment and supporting research on these factors.

e(1)(a) General Overview and Strategy
Summary
CMS proposed the existing condition and episode-based measures, and the total per capita costs measures for use in the cost (previously called resource use) category. Measures used under this category would be derived from administrative claims data. However, CMS is finalizing a weight performance of zero for the transition period.

AAFP Response
The AAFP is supportive of CMS' decision to lower the weight of the cost category for the transition year. We hope CMS is able to use this time to adjust the cost measures to include only measures that more accurately assess a physician's individual utilization.

e(2) Weighting in the Final Score

Summary

CMS is not finalizing its proposal to weight cost at 10% in the first performance period. Instead, CMS is finalizing a weighting of 0% for the 2019 MIPS payment year and 10% for the 2020 MIPS payment year. Beginning with the 2021 payment year, cost will be weighted at 30%. CMS will still provide performance feedback to clinicians to help them transition into cost measurement.

AAFP Response

The AAFP is supportive of CMS' decision to lower the weight to 0% for the transition year. While CMS still plans to provide physicians with feedback on their cost performance, the AAFP adamantly urges CMS to make this data timely and actionable. The AAFP also recommends that CMS analyze the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services (ASPE) study results to determine how best to apply socioeconomics and social determinants of health into risk adjustment for quality and cost measures.

e(3)(a) Value Modifier Cost Measures Proposed for the MIPS Cost Performance Category

Summary

CMS is finalizing its proposal to include the total cost per capita and the Medicare spending per beneficiary (MSPB) measure within the cost category in the transition period.

AAFP Response

The AAFP does not believe family physicians can or should be held accountable for total cost of care. The AAFP believes both of these measures should be removed from the cost category. We believe CMS should use care episode group measures as the only measures to calculate cost at this time. However, additional measures need to be developed that are relevant to primary care. Once developed, CMS needs to ensure the new measures are harmonized across programs and payers. The existing episode measures are geared towards specialists, giving them a larger pool of measures to be reported. This disadvantages family physicians, and primary care in general, by then basing their cost performance on two poorly developed measures. After the completion of the transition year, the AAFP does not believe it is appropriate to base a clinician's score on only one or two measures. We believe any category should be reweighted if there are not sufficient measures available to the clinician. A score from one or two measures is not a reliable indication of a clinician's true performance. As a comparison, within the quality performance category, physicians are exempt from reporting an outcome measure if there are no applicable measures. That same logic should apply to the cost category.

While primary care often serves as the centralized location for coordination of care, there are numerous factors outside of the primary care physician's control that contribute to a patient's total cost of care, especially in a continuing, traditional fee-for-service (FFS) environment. Complex patients are often the highest utilizers of the health care system and require specialist care. It is not the role, nor is it appropriate, for a primary care physician to control how specialists provide their services. It is difficult for primary care providers to obtain cost and quality information from their specialist colleagues. Additionally, a physician can make every effort to provide open access to a patient, but individual patient behavior is beyond physician control.

Any assessment of impact on cost of care metrics should be made over the long term and across the care continuum. In the short term, measurement of utilization can help assess the impact of primary care on costs. Such utilization measures include reduced admissions and readmissions; reductions in duplicative or clinically unnecessary testing; and reduced medication-related complications.

As new cost measures are developed, they need to be accurate and attributable to the clinician(s) who can have the greatest impact on cost. The AAFP urges CMS to maintain a transparent process and engage stakeholders in a similar manner as they do in the development and selection of quality measures.

With respect to total cost of care, we note that recommendation 19 of the draft white paper on primary care payment models (PCPMs), which the Health Care Payment Learning and Action Network's (HCP-LAN) PCPM Work Group released in October states:

> Although incremental progress will need to be made much more quickly, PCPMs can only be expected to deliver a return on investment over the long term. Therefore, payers should develop business models that do not require investments in PCPMs to be recouped from reduction in total cost of care in the short term.

The AAFP believes that this is an important point and strongly agrees with the following related statement in the work group's proposal:

> Because primary care emphasizes a preventive approach and longitudinal care for the whole patient, improved patient outcomes often do not materialize immediately, and may take years (and in the case of some preventive measures, decades) to realize. Accordingly, and because primary care has traditionally been such a minor part of the total cost of care, it is unreasonable to expect PCPMs to significantly impact total cost of care in the short term. Nevertheless, taking into account the heterogeneity of practices within PCPMs, it is reasonable to expect to see other, incremental, returns on investment in the short to medium term. For example, it is reasonable to expect practices to demonstrably reduce hospitalizations and readmissions, and duplicative or unnecessary imaging; implement better medication management; and better integrate care in the first five years of a PCPM.

This statement represents both the need for a greater investment in primary care while recognizing the return on investment in total cost of care will occur over a longer period of time, but that primary care can in the interim achieve other measureable outcomes, as mentioned.

e(3)(a)(i) Attribution

Summary

CMS is finalizing its proposal to use modified attribution methods from the value modifier (VM) for the total per capita costs and MSPB measures. CMS is modifying the two-step methodology in two ways: (1) update the definition of primary care services to include chronic care management (CCM) and transitional care management (TCM) codes; and (2) remove services billed under codes 99304 through 99318 when the claim includes the Place of Service (POS) 31 modifier.

AAFP Response

The AAFP believes patients must be prospectively attributed, based on who can control those specific costs. Attribution should include a reconciliation process for clinicians to review, add, or remove patients from the list.

e(3)(a)(ii) Reliability

Summary

CMS is finalizing a minimum case volume of 35 for the MSPB measure. They are also finalizing two technical changes to the calculation of the MSPB. This increases the reliability to 0.4. The first technical change removes the specialty adjustment. The second adjustment modifies the cost ratio used within the MSPB equation. CMS will now take the observed to expected cost ratio for each MSPB episode and then average the assigned ratios. This average ratio would be multiplied by the average of observed episode costs nationally in order to convert it to a dollar amount.

AAFP Response

The AAFP believes CMS should use a reliability threshold of 0.7. The AAFP is supportive of the removal of the specialty adjustment for the MSPB measure. However, we recommend that CMS only use episode-based cost measures primarily due to the lack of appropriate measures and attribution to costs.

e(3)(b) Episode-Based Measures Proposed for the MIPS Cost Performance Category

Summary

CMS is finalizing 10 episode-based measures from the proposed rule. This is a modification from the proposed 41 measures. All of the finalized episode-based measures were previously included in the supplemental Quality and Resource Use Report (sQRUR) and meet CMS' 0.4 reliability threshold. The case minimum is 20. CMS intends to provide performance feedback on these measures, as well as additional episode-based measures that were not approved. They may wish to propose changes to performance feedback on these measures in the future.

AAFP Response

The AAFP believes CMS should include all measures to monitor and reduce cost, thereby capturing a wide array of specialists and the largest number of MIPS-ECs.

e(3)(b)(i) Attribution

Summary

CMS is finalizing its attribution methods as proposed. Specifically, CMS is finalizing that condition episode-based measures will be attributed to the EC who bills at least 30% of inpatient (IP) evaluation and management (E/M) visits during the initial treatment (triggering event) that opened the episode. An episode may be attributed to more than one EC. Procedural episodes will be attributed to all MIPS-ECs that bill a Part B claim with a trigger code during the triggering event of the episode. The triggering events are defined as follows:

- Inpatient procedural episodes—the IP stay that triggered the episode, plus the day before the admission to the IP hospital
- Outpatient procedural episodes (method A)—the day of the triggering claim, plus one day before and two days after
- Outpatient procedural episodes (method B)—the day of the triggering claim

A procedural episode can be attributed to more than one EC. Any Part B claim or line during the trigger event with the episode's triggering codes is used for attribution.

AAFP Response

The AAFP believes patients should be attributed to the physician billing the largest portion of Part B allowable charges. Attributing patients, based on the number of visits, does not attribute patients to the physician that can make the biggest impact on reducing costs, and would disproportionately hold primary care physicians responsible for the costs of specialists.

e(3)(b)(ii) Reliability

Summary

CMS is finalizing its proposal of 20 cases for episode-based measures. This maintains the 0.4 reliability threshold established for the cost measures.

AAFP Response

The AAFP believes the minimum reliability threshold should be 0.7 for all cost measures in MIPS. A case minimum should be developed for each measure so that it meets the 0.7 threshold.

e(4) Future Modifications to Cost Performance Category

Summary

CMS will investigate ways to account for cost of drugs under Medicare Part D.

AAFP Response

To make informed, value-based decisions on prescribing drugs, the AAFP believes physicians need clear, real-time, patient-specific information to make the best care decisions for their patients. Clinical and cost information on drugs should include:

- Drug efficacy
- Drug interaction and allergy alerts, along with clinical support guidelines
- Patient's demographic information
- Patient's prescription drug-benefit coverage
- Out-of-pocket costs the patient will incur at any given pharmacy for prescribed medications (along with alternative pharmacy options)
- Alternative drug therapies for a physician's consideration

5.F. Improvement Activities Performance Category

Summary

This section discusses determination of activities to include under the improvement activities category; scoring of this category; requirements to receive the maximum score for medical homes; special considerations given to small, rural, health professional shortage area (HPSA) and non-patient facing providers; and easing reporting requirements for MIPS APMs. CMS lowered the number of activities that must be reported and expanded the programs that can recognize practices as medical homes. The final rule eliminated the need for MIPS APMs to report activities in this category as long as their agreements included sufficient activities from the approved list to reach the maximum score. The rule also described a proposed "call for measures" process that is similar to the existing call for measures under the quality category.

AAFP Response

The final rule incorporated much of what the AAFP requested and we support the changes in the final rule with the following exceptions.

The final rule described a proposed "call for activities" process to add new activities to this category that is similar to the existing call for measures under the quality category. The AAFP

encourages CMS to shorten the process for adoption of measures into the improvement activities category to allow innovative activities to be quickly included in the approved list. The AAFP previously encouraged CMS to learn from quality measure development. Quality measures now take approximately two years to be included in payer programs. CMS needs to prevent improvement activities from becoming a similarly burdensome process. **Anticipating that private payers will follow the lead of CMS and adopt improvement activities in their payment structure, the AAFP strongly believes that CMS should create a parsimonious and harmonized list of improvement activities, which can be utilized by all payers and would prevent an overwhelming list in the future**. The current process keeps new knowledge sequestered from measurement and patient benefit until the lengthy "call for measures" and measure update process can be completed.

As stated in our response to the proposed rule regarding CMS' request for comment on an approach to encourage continued innovation in health IT to support improvement activities, the AAFP is generally opposed to the proposed bonus point structure. We believe it is too complex for clinicians in practices who lack dedicated analytic support. We recommended elimination of the bonus structure until further experience is gained to reduce complexity. However, in light of the fact that the bonus structure was finalized, we support the awarding of bonus points in the ACI category. We continue to believe that the bonus point incentive is too weak to have much impact on technological innovation and adoption. Further, it requires considerable investment in resources and energy, and may simply be adding complexity to the program.

The AAFP recommends that CMS approve for fulfillment of improvement activities any continuing medical education (CME) activities that measurably improve performance and patient outcomes. Since 1947, the AAFP has been committed to setting standards for CME that facilitate improvement in patients' health by helping clinicians continuously improve their 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 that CMS is now requiring of ECs.

We urge CMS to include in the list of approved high-weighted 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.

The AAFP recommends that PerformanceNavigator® be an approved improvement activity. We recommend that PerformanceNavigator® On Demand be included among CMS' improvement activities. Specifically, we propose that it be listed as a high-weighted activity in the Patient Safety and Practice Assessment subcategory of the improvement activities.

PerformanceNavigator® is consistent with the improvement activities performance category, and relevant for Patient Safety and Practice Assessment subcategory. It enables ECs to efficiently and objectively assess their practice to identify areas for improvement by entering baseline chart information and patient survey data, completing a practice assessment, and answering case study questions. Users can complete self-directed learning and improvement activities, including video clips with evidence-based information from expert faculty about how to transform office processes and improve patient outcomes. Learning is consistent with principles of patient-centered medical homes. Activities including creating an action plan to guide improvement; tracking progress through a digital dashboard; reassessing the practice to recognize improvements; and identifying areas that need additional improvement for better patient outcomes.

PerformanceNavigator® is accessible online, so it can easily be completed with minimal burden for all ECs in primary care practices, including those in small practices, rural areas, and geographic health professional shortage areas.

PerformanceNavigator® requires participation over an extended period of time, which is consistent with the CMS 90-day performance period requirement. It is designed to ensure that the activities being performed are robust enough to result in actual practice improvements.

ECs can submit data from the improvement activity via the CMS Web Interface or via attestation data submission mechanisms.

CMS can validate the activity, or CMS can choose to have the AAFP's credit system function as a reporting agent for PerformanceNavigator®, thus simplifying the data verification burden for CMS by using the well-established validation and audit process that is already in use by a state medical board and a certifying board.

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.

The AAFP recommends that CMS utilize AAFP's reporting capabilities to reduce the administrative burden on ECs and the burden on CMS of verifying completion of improvement activities. The AAFP can offer CMS a means of reducing the reporting complexities for ECs by sharing their improvement activity completion data with CMS. We understand that it is important for ECs to have the opportunity to choose which way they report completion of their requirements, whether it be direct, through one of several national accreditors, or another vendor offering these services.

The AAFP has substantial experience in this area and has a successful track record of collaborating with organizations to share this information on behalf of our members. Depending on the needs and interest of CMS, a data-sharing arrangement could be as simple as reporting the number of activities each physician reported during the designated time frame. It could also be a more comprehensive reporting of the dates each performance improvement activity was completed. The AAFP has experience with multiple types of automated intra-organizational sharing of CME-related data. While there would be some incremental cost to establishing a data feed with CMS (or a vendor of its choosing), we believe it would be minimal because it would build upon the infrastructure that the AAFP has been using for over a decade.

g. Advancing Care Information (ACI) Performance Category

Summary

CMS describes the restructuring of the program requirements in the "final rule with comment" as being geared toward increasing participation and EHR adoption. CMS states plans to continue to review and evaluate performance with ACI. CMS will take this, and evaluations in health IT, into consideration for future ACI scoring. In the commentary CMS states, "Our first step toward that goal of reducing reporting burden, and toward a more holistic approach to EHR measurement is to award a bonus score in the advancing care information performance category if a MIPS-EC attests to completing certain improvement activities using CEHRT functionality."

AAFP Response

We greatly appreciate CMS restructuring the ACI component in the "final rule with comment," demonstrating a desire to reduce burden and increase participation. **Compared to the proposed rule structure, the structure in the "final rule with comment" does reduce burden and complexity. However, the AAFP still has concerns that in the context of the entire QPP, the final structure is still too complex and contains too much administrative burden on family physicians and other clinicians.**

As CMS continues to evaluate the ACI participation and performance, we ask that CMS evaluate the impact on quality, cost, patient experience, and physician experience. We ask CMS to continue to implement changes that reduce unneeded and unproductive burden, and not add requirements and give bonus points, which are ineffective methods to reduce burden.

For those MIPS-ECs, if they use their CEHRT to achieve one or more of the designated improvement activities, they will receive 10 bonus points toward their ACI score. CMS is seeking comment on this integration of the improvement activities within the ACI performance category, and other ways to further the advancement of health IT measurement. The AAFP is supportive of credit for ECs that use CEHRT to improve their practice. We have some concern that small practices may not be able to navigate the bonus and ACI scoring structure as well as larger practices, which could put them at a disadvantage. As CMS continues to evaluate ACI performance, attention should be placed on identifying ACI structures that do not provide a level playing field.

As for CMS' request for comment on other ways to advance health IT measurement, we believe that health IT utilization measurement is not a good predictor of achieving the Triple Aim™. Given the other levers available to CMS with MACRA, we again ask that CMS move away from the use of health IT utilization measures in the QPP.

(4) Performance Period Definition for Advancing Care

Summary

CMS did not finalize their proposed full-year reporting period for ACI. CMS has established a 90-day EHR reporting period for 2017 and 2018. Additionally, CMS mentioned their proposed Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) (81 FR 45753) rule, which finalized a change to the 2016 EHR reporting period to also be 90 days. CMS did finalize their proposal to align the performance period for ACI with the MIPS performance period of one full calendar year after 2018.

AAFP Response

The AAFP applauds CMS in making the needed changes to support participation by family physicians and other ECs.

(a) Definition of Meaningful EHR User and Certification Requirements

Summary

Commenters recommended that CMS consider ways to measure workflow disruptions caused by CEHRT and provide some potential measures. CMS responded, "We appreciate the feedback and will take this suggestion into consideration in the future. We encourage MIPS-ECs to work with their EHR vendor to improve the clinical workflow in a way that best suits their individual practice needs."

AAFP Response

The AAFP also is concerned about the clinical workflow disruptions caused by CEHRT stemming from requirements from meaningful use (MU), and now ACI. We believe it is naïve to think that all that is needed is for clinicians to work with their vendor. Since the start of the MU program, we have seen a steady decline in physician satisfaction around EHRs and increases in the cost of CEHRT. Issues that need to be addressed regarding CEHRT requirements include productivity loss, physician burnout, and disruption of workflow, all of which can lead to patient safety concerns. **CMS and ONC should devote significant resources and effort to improve how CEHRT supports and enhances clinical workflow, including more accountability of vendors.**

(b) Base Score

Summary

CMS made significant revisions to the ACI scoring methodology. This section discusses the appropriate CEHRT required, which did not change significantly. In addition to performing the required measures (four in 2017, and five after), to receive the 50% represented by the base score, the EC must adopt and use a CEHRT.

- For 2017, ECs can use 2014 edition and/or 2015 edition certified product(s)
- For 2018 and beyond, ECs must use a 2015 edition certified product(s).

Also, if an EC switches from a 2014 edition to a 2015 edition CEHRT during the performance period, the usage data must be combined from both.

AAFP Response

The AAFP appreciates the flexibility to use both 2014 and 2015 edition products in 2017, and the 90-day reporting of ACI in 2018 to support clinicians' transition to 2015 edition products for 2018. As clinicians are dependent on their CEHRT to capture numerators and denominators for the ACI measures, we have concerns that combining outputs from multiple CEHRTs may have a significant burden. While such a burden is mitigated with the 90-day reporting option, we ask that CMS consider alternative reporting for ECs switching CEHRT after 2018.

(d) Overall Advancing Care Information Performance Category Score

Summary

The performance score is the total of the scores of each of the nine measures in the performance category. The immunization registry measure is an all or nothing measure. If the EC exchanges data with a registry, at all, they will receive the maximum 10 points. Otherwise, they receive zero points. For the other eight measures, the EC will receive a point for every 10 percentage points they meet on the measure, rounded up to the next full point. For example, if their measure score is 81%, then they would receive 9 points for that measure. There are also five bonus points available for reporting to public health or clinical data registries. An additional 10 bonus points are also available for using CEHRT to achieve the improvement activities score (1 or more). With this scoring, including the 50 points from the base score, an EC can potentially achieve 155 points. The maximum possible score is 100. Anything over 100 will be scored 100.

Two separate sets of ACI objectives and measures are outlined, based upon whether the 2014 edition or 2015 edition CEHRT is used. The "ACI objectives and measures" are associated with 2015 edition CEHRT use, and the "2017 transition ACI objectives and measures" are associated with 2014 edition CEHRT use. To ensure no advantage or disadvantage tied to the CEHRT edition used, points for those measures that would require a 2015 edition CEHRT have been re-distributed to other measures within the 2017 transition

ACI objectives and measures. The 10 points from the measures "patient-generated health data" and "request/accept summary of care" are re-distributed to the measures "provide patient access and health information exchange" and "send a summary of care," respectively.

CMS is seeking comment on their final scoring methodology policies and future enhancements to the methodology.

AAFP Response
The scoring and measures in the final rule are significantly improved from the proposed rule. We believe that the proposed rule did not provide a reasonable opportunity for an EC to reach 100 points in the ACI scoring. While we believe scoring 100 on ACI will still be a challenge, we believe it is reasonable for an EC to score 100 if they are able to capture the bonus points.

We still have concerns about the complexity of the scoring methodology, and therefore the need of EC awareness and education. We disagree with the use of health IT utilization measures in light of the additional levers available within MACRA and the movement toward value-based payment. **We recommend CMS continue to move away from using health IT utilization measures, due to the negative unintended consequences experienced in the MU program.**

5.H. APM Scoring Standard for MIPS-Eligible Clinicians Participating in MIPS APMs
Summary
CMS is easing reporting requirements for ECs that are part of a MIPS APM. CMS has eliminated the need to report improvement activities if the APM agreement requires sufficient activities that meet the maximum score in this category. CMS is also making it easier to report ACI activities by allowing (if desired) a TIN group score to be used by MIPS APM participants, rather than requiring MIPS APM participants to report ACI as individuals. The final rule will re-weight the quality score to zero for the first year for APMs (other than Shared Savings Program and Next Generation ACO models) and reallocate weights to the improvement activity category (25%) and ACI (75%) for these participants during the first year, due to operational and programmatic reasons.

AAFP Response
The AAFP appreciates the final changes that ease the reporting burden for MIPS APM participants. The AAFP believes re-weighting the quality category to zero for non-Shared Savings Program and non-Next Generation ACO models due to operational and programmatic reasons is undesirable and should not be allowed past the first performance year. Re-weighting leads to an unbalanced view of quality and overall performance rates that are not comparable across providers who report various numbers and types of measures.

a. Feedback and Information to Improve Performance
Summary
CMS solicited comment on various questions related to performance feedback, such as what type of information should be contained in the performance feedback data; how often the feedback should be made available; and who should be able to access the data.

AAFP Response
The AAFP appreciates the effort by CMS to engage providers and other stakeholders in the design of feedback reports and CMS systems to enhance user experience. **We wish to be**

included in the stakeholder group that is contacted for feedback on these and any other reports.

The AAFP recognizes that feedback reports in the quality category can only be provided as CMS receives data. As of now, data is submitted annually. **We strongly encourage CMS to work with third party vendors (registries, QCDRs and qualified registries) to provide more timely and actionable feedback in the quality category.**

Since CMS and the Medicare Administrative Contractors (MACs) are the sole collector of data in the cost category, we believe it is feasible that feedback reports could be generated at least quarterly or more frequently for the cost category. 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. Additionally, if CMS is successful at creating a dashboard for more timely feedback which allows providers to enter their own quality data, timely cost data would be critical to gain a better picture of the entire MIPS score.

The AAFP encourages CMS to make the 2016 QRUR available to individuals, in addition to making the reports available to administrative security officials at the group level. While we realize it may be impossible to provide quality data at the individual level for groups that reported as a GPRO, we encourage individual-level data to be made available in the cost category for all providers to support the MIPS transition.

We also suggest CMS provide both individual- and group-level analysis so clinicians can determine if one would be more beneficial than the other.

The AAFP suggests CMS provide aggregate information by specialty to medical societies. Medical societies currently have no data available regarding their members, but are often called upon to assist with analysis.

Finally, the AAFP requests feedback reports to include confidence intervals and other indices of validity and reliability; transparency as to the method of risk stratification; and disclaimers about the limitations of the data.

c. Targeted Review

Summary

CMS changed the period during which an informal review may be requested to 60 days after the day on which CMS makes available the MIPS payment adjustment (ending on September 30 of the year prior to the payment year). In addition, CMS lengthened the amount of time given to clinicians to respond to CMS requests for additional information to 30 days (as opposed to 10 days in the proposed rule) and is allowing authorized representatives of groups to file targeted reviews on behalf of their group members.

CMS will consider requests for reimbursing time and effort required to meet data submission requirements. In the first year, ECs will be randomly selected for audit, and while CMS will recoup any overpayment, no penalties will be assessed. CMS will use validation and audit as an educational opportunity for all MIPS clinicians.

AAFP Response

These changes are consistent with those requested by the AAFP and we appreciate CMS' responsiveness to the needs and efforts of providers.

2. Supporting Health Care Providers with the Performance of Certified EHR Technology, and Supporting Health Information Exchange and the Prevention of Health Information Blocking

a. Supporting Health Care Providers with the Performance of Certified EHR Technology

Summary

CMS is finalizing a requirement for ECs to cooperate in good faith with any request relating to ONC direct review of certified health IT. Two attestation statements are required concerning awareness of, and participation in good faith with, direct review of CEHRT. Since direct review is initiated to mitigate potentially serious risk to public health and safety, CMS holds that upon request, EC participation with direct review is necessary, and in fact "is important to demonstrating that a health care provider used certified EHR technology in a meaningful manner as required by sections 1848(o)(2)(A)(i) and 1886(n)(3)(A)(i) of the Act…." However, CMS is finalizing a modification to the requirement for ECs to participate, upon request, with ONC-Authorized Certification Body (ACB) surveillance of CEHRT. This modification will allow ECs to choose whether to participate in ONC-ACB surveillance of CEHRT or not. Likewise, the two attestation statements associated with EC awareness of, and participation in good faith with, surveillance are now optional attestations.

AAFP Response

Any request for EC participation with direct review or surveillance of CEHRT should very clearly state whether participation is required and obligatory, or optional. Although required attestation statements include attestation regarding awareness that participation with direct review of CEHRT is required, and attestation statements tied to participation with surveillance of CEHRT were optional attestations, ECs are not likely to recall, at later dates, which was required versus optional.

b. Support for Health Information Exchange and the Prevention of Information Blocking

Summary

This section focuses on the requirement for health care providers to demonstrate (via attestation) that they have acted in good faith to implement and use CEHRT in a manner that supports, and does not interfere with, electronic exchange of health information among care providers and with patients, to enable quality improvement and promote care coordination.

Three information blocking attestation statements are required. These apply to and impact ACI reporting (the EHR Incentive Payment Program) only, and to determinations as to whether the EC is technically a meaningful user or not, rather than being attestations applicable to the entirety of the QPP. These attestation requirements apply to attestations on or after 1/1/2017 and apply to both the Medicare and Medicaid EHR Incentive Payment Program, and also apply to ECs who report on the ACI performance category as part of an APM entity group under the APM scoring standard.

CMS notes compatibility or interoperability of CEHRT may be restricted in various ways which are too numerous to catalog. It does provide examples of what could be considered information blocking, including "implementing certified EHR technology in non-standard ways that are likely to substantially increase the costs, complexity, or burden of sharing electronic health information (especially when relevant interoperability standards have been adopted by the Secretary)." CMS notes such actions would be contrary to section 106(b)(2) only when engaged in "knowingly and willfully."

CMS notes that the forms and methods of exchanges engaged in by ECs may be relevant to determining whether they acted in good faith to implement CEHRT in a manner that supports,

and does not limit, compatibility and interoperability. For example, CMS states that an EC may find that CEHRT comes bundled with a health information service provider (HISP) that limits the ability to send and receive Direct messages to only health care providers with an EHR vendor that participates in a particular trust network. The EC may overcome this or other technical limitations by participating "in a variety of other health information sharing arrangements."

CMS states that commenters requested clarification regarding what documentation would be required (in the event of an audit) to demonstrate compliance with the terms of the above attestations. Such clarification would help providers better understand the requirements and prepare for an audit. CMS acknowledges these concerns, but notes that it will provide guidance to auditors regarding the final policy and the attestation process, and require auditors to work closely with ECs to gather the necessary supporting documentation, as applicable to each EC's individual case. CMS emphasizes that case-by-case audit determinations allow it to adequately account for a variety of circumstances that are potentially relevant to assessing compliance.

AAFP Response
Of the three information blocking attestation statements, the AAFP has serious concerns regarding statement 2, and subparts 2 and 4, which note:

> Statement 2: A health care provider must attest that it implemented technologies, standards, policies, practices, and agreements reasonably calculated to ensure, to the greatest extent practicable and permitted by law, that the certified EHR technology was, at all relevant times:
> (1) Connected in accordance with applicable law;
> (2) Compliant with all standards applicable to the exchange of information, including the standards, implementation specifications, and certification criteria adopted at 45 CFR part 170;
> (3) Implemented in a manner that allowed for timely access by patients to their electronic health information (including the ability to view, download, and transmit this information); and
> (4) Implemented in a manner that allowed for the timely, secure, and trusted bi-directional exchange of structured electronic health information with other health care providers (as defined by 42 USC 300jj(3)), including unaffiliated health care providers, and with disparate certified EHR technology and vendors.

Due to current poor usability and incomplete functionality profiles of CEHRT, **CMS must exercise great caution in determining whether implementation decisions result in willful information blocking. Decisions might support care delivery and work toward achieving the Triple AIM™, but still result in non-standard implementation of CEHRT.**

We have serious concerns about information blocking attestation statement 2 because it requires ECs to have awareness of what the identified standards are. Though CMS notes that providers are not expected to have any technical expertise or personally tend to technical details of their health IT implementation, CMS explicitly states providers are required to attest that they took reasonable steps to verify that their CEHRT is connected (i.e., implemented and configured) in accordance with applicable standards and law. Providers are obligated to communicate the requirements to health IT developers, implementers, and others responsible for implementing and configuring CEHRT. **We fail to see how any clinical provider, much less a small physician practice, could meet the requirements of attestation statement 2 by holding their health IT vendors accountable for these requirements, which appears to be the intent of this attestation.** Meeting this requirement would only be possible if CMS

provided a handout that an EC could email as an attachment to relevant health IT vendors, requesting electronic documentation of each health IT vendor's confirmation that they have implemented and configured the provider's CEHRT technology in accordance with applicable standards and law. **ECs will not be able to meet the requirements of attestation statement 2 because they do not have sufficient awareness of the standards that must be communicated to their health IT vendors and others involved with implementation and configuration of their CEHRT. The AAFP believes certification should confirm that standards have been implemented. If attestation is needed, it should be required of the health IT vendor, not the EC.**

We have also heard from an EP that they failed a MU audit because, due to a Consolidated-Clinical Document Architecture (C-CDA) issue, recipients of Summary of Care (SoC) documents were unable to open and read attachments sent with the SoC. Reportedly, after two years of corrective efforts tied to this issue were undertaken by the affected EC and the chief information officer (CIO), challenges remain with opening SoC attachments. Bidirectional exchange of electronic health information is still challenging. Therefore, we also note CMS must exercise caution in determining whether ECs have implemented CEHRT in a manner that allows for bidirectional exchange.

We note that CMS must be cautious in evaluations of whether ECs demonstrated good faith participation in support of information exchange. While we agree that health information exchange is important to enable sound medical decision making and in the provision of quality care, it is important to understand that good faith does not mean that the provider should be expected to spend thousands of additional dollars and/or significant effort to support varying information sharing arrangements. We cannot overstate what a significant burden supporting various information sharing arrangements would be to small and solo practices. We find it deeply troubling that details regarding documentation required to demonstrate compliance are not available so that ECs can be confident of correct attestation at the time of the attestation, rather than years later during an audit.

E. MIPS Program Details

Summary

CMS is finalizing a performance threshold that will be specified for each MIPS payment year and published in advance of each performance period. Specifically, CMS is finalizing a performance threshold of three points for the 2019 MIPS payment year in accordance with the special rule set forth in section 1848(q)(6)(D)(iii) of the Act. CMS intends to increase the performance threshold in year two. Beginning in year three, CMS will use the mean or median final score from a prior period, as required by the law.

AAFP Response

The AAFP appreciates and supports CMS's decision to set the performance threshold at three points for the 2019 MIPS payment year. Along with the "Pick Your Pace" approach and the decision to raise the low-volume threshold, we believe this performance threshold will facilitate participation in MIPS by family physicians in almost every practice setting, especially those in solo practice or small groups and those in rural settings. In addition, it guarantees that ECs who attempt to participate will avoid a negative payment adjustment in 2019. We appreciate CMS' multipronged effort to implement MIPS in a way that holds participants harmless in the initial stage of implementation.

(1) Additional Performance Threshold for Exceptional Performance

Summary

CMS is codifying the definition of additional performance threshold as the numerical threshold for a MIPS payment year against which the final scores of MIPS-ECs are compared to determine the additional MIPS payment adjustment factors for exceptional performance. CMS is also finalizing that an additional performance threshold will be specified for each of the MIPS payment years 2019 through 2024. The additional performance threshold for the 2019 MIPS payment year is 70 points.

AAFP Response
The AAFP views the proposed definitions as consistent with the statute, so we support CMS' decision to codify them in the regulations. The AAFP also agrees with CMS' proposal to establish the additional performance threshold for 2019 at the 25th percentile of the range of possible composite performance scores above the performance threshold, given that CMS will not have any actual final scores for MIPS-ECs to use. Since CMS has set the base performance threshold at three points, **we support CMS' decision to set the additional performance threshold for the 2019 MIPS payment year at 70 points.** As CMS notes, at this level, ECs will need to submit data for and perform well on more than one performance category (except in the event that the ACI measures are not applicable or available to a MIPS-EC). **From our perspective, 70 points is a reasonable additional performance threshold because it is high enough to necessitate what could be construed as "exceptional performance" in the first year and low enough to be reasonably attainable.**

9. Third Party Data Submission
a. (4) QCDR Criteria for Data Submission
c. (4) Qualified Registry Criteria for Data Submission
Summary
CMS finalized criteria for data submission for QCDRs and qualified registries largely as proposed. The following criterion is included: "Mandatory participation in ongoing support conference calls hosted by [CMS] (approximately one call per month), including an in-person QCDR kick-off meeting (if held) at [CMS] headquarters in Baltimore, MD." More than one unexcused absence could result in the QCDR [or qualified registry] being precluded from participation in the program for that year. If a QCDR is precluded from participation in MIPS, the individual MIPS-EC or group would need to find another QCDR or utilize another data submission mechanism to submit their MIPS data.

CMS acknowledges that several commenters opposed each element of this criterion because they believe that proposed requirements for data submission, validation, and ongoing auditing criteria are sufficient motivators to encourage QCDRs and qualified registries to utilize support services. However, CMS believes that mandatory participation in support calls and attendance at the QCDR kick-off meeting are important to help improve the reliability of data CMS receives for scoring in MIPS.

CMS also finalized the requirement for QCDRs and qualified registries to obtain email addresses of participating ECs (and authorization to release the email addresses) for the purpose of distributing performance feedback.

AAFP Response
We appreciate CMS' desire to increase reliability of data received and used for scoring in MIPS. However, as noted in our initial comments on the proposed rule, we reiterate that implementation of this criterion can be detrimental to EC and group participants of any QCDR or qualified registry that is precluded from participation in the program simply due to lack of attendance at two meetings. Absences from mandatory conference calls or meetings

may have no bearing on the quality of the services a QCDR or qualified registry provides. However, participating ECs and their patients could be significantly harmed by receiving notice that they are no longer able to use their QCDR or qualified registry.

Since CMS has chosen to finalize this criterion, we urge it to do the following: for the applicable reporting period, hold harmless any EC or group participants of a QCDR or qualified registry that loses eligibility to participate as a qualified third-party data submission entity due to absences from meetings. All applicable ECs of such a QCDR or qualified registry should be held harmless through an automated process that does not require ECs to complete a hardship exception application. Qualified third-party data submission entities have all the information required to enable CMS to hold harmless all participating clinicians in an automated fashion, including participant NPI numbers and TINs. The process should be automated because participating ECs will already experience significant administrative burdens when they have to review other available options for third-party data submission entities that offer existing interfaces with their CEHRT. In addition, investigating alternative reporting options is not as simple as identifying other qualified reporting entities that exist and enable reporting of data. The third-party data submission entity must also offer reporting on the specific measures on which the EC has chosen to report and for which the EC has invested significant effort to improve quality of care. Quite often, ECs also invest time and/or financial resources to actively engage or participate in collaboratives and initiatives that focus on improvement activities for the EC's selected measures for a performance period. We cannot overemphasize the negative impact on solo and small practices if their QCDR or qualified registry is precluded from participation in the program.

Regarding the requirement for QCDRs to obtain email addresses of ECs for the purpose of providing (i.e., pushing) performance feedback from CMS to ECs, we reiterate our initial recommendation that Direct addresses be utilized for trusted exchange of performance feedback information.

9.e. Probation and Disqualification of a Third Party Intermediary

Summary

If, at any time, CMS determines that a third party intermediary (i.e., a QCDR, health IT vendor, qualified registry, or CMS-approved survey vendor) has not met all of the applicable criteria for qualification, CMS may place the third party intermediary on probation for the current performance period and/or the following performance period.

AAFP Response

Regardless of the reason why a third-party data submission intermediary becomes disqualified to serve, all participating ECs of such a third-party intermediary should be held harmless through an automated process. As noted previously, qualified third-party data submission intermediaries have all the information required to enable CMS to hold harmless all participating clinicians in an automated fashion, including participant NPI numbers and TIN numbers, if applicable.

10. Public Reporting on Physician Compare

Summary

On Physician Compare, CMS is required to publicly report each MIPS-EC's final score and performance categories, subject to statistical and consumer testing that ensures the data are accurate, represent quality of care, are statistically comparable, and are well understood and correctly interpreted by consumers.

AAFP Response
The AAFP agrees with the above requirements outlined by CMS for publicly reported data. The AAFP also believes physician measurement programs should support the physician/patient relationship; lead to better informed patients; report on quality standards and cost assessment separately; and appropriately and easily designate physicians who have insufficient data to assess their performance. In support of this policy, we agree that scores for each performance category should be displayed separately. To ensure results are comparable, CMS should only publicly report a final score for individuals and groups that were scored on all four categories. Reweighting can skew results and lead to a high or low final score for individuals/groups based on a minimal number of quality measures. This could potentially lead a consumer to draw inaccurate conclusions about quality. We refer CMS to a recent analysis of the hospital star rating system that describes problems caused by reweighting categories when one or more of them contain an insufficient number of measures.

F. Overview of Incentives for Participation in Advanced Alternative Payment Models
1. Policy Principles
The AAFP strongly supports moving a larger percentage of payments from traditional FFS payments towards alternative payment models (APMs). The AAFP believes APMs 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% already work in an officially recognized patient-centered medical home (PCMH). 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 APMs—including physician-focused payment models—is accelerating. While some of these 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. One example is the Comprehensive Primary Care Plus (CPC+) initiative.

To support the development and implementation of APMs that accomplish these objectives, the AAFP has developed the following set of principles to guide our evaluation of proposed models to ensure that they place patients—and not clinicians—at the center:

- APMs must provide longitudinal, comprehensive care.
- APMs must improve quality, access, and health outcomes.
- APMs should coordinate with the primary care team.
- APMs should promote evidence-based care.
- APMs should be multipayer in design.

We ask that CMS consider the AAFP Principles to Support Patient-Centered

Alternative Payment Models when approving Advanced APMs to ensure that patient-centered, longitudinal, comprehensive primary care is being promoted across providers and care settings.

b. Definitions of Medical Home Model and Medicaid Medical Home Model

Summary

CMS is finalizing the definitions the terms "Medical Home Model" and "Medicaid Medical Home Model," with modifications to emphasize the requirement that the APM must have a primary care focus; clarify the required versus additional elements; and add obstetrics and gynecology (specialty code 16) as a primary care specialty. CMS is finalizing the definitions as follows:

"A Medical Home Model or Medicaid Medical Home Model is an APM or payment arrangement under title XIX, respectively that [CMS determines] to have the following required elements:

- Primary care focus with participants that include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services. For the purposes of this provision, primary care focus means involving specific design elements related to eligible clinicians practicing under one or more of the following Physician Specialty Codes: 01 General Practice; 08 Family Medicine; 11 Internal Medicine; 16 Obstetrics and Gynecology; 37 Pediatric Medicine; 38 Geriatric Medicine; 50 Nurse Practitioner; 89 Clinical Nurse Specialist; and 97 Physician Assistant.
- Empanelment of each patient to a primary clinician.

In addition to these required elements, a Medical Home Model or Medicaid Medical Home Model must have at least four of the following additional elements:

- Planned coordination of chronic and preventive care.
- Patient access and continuity of care.
- Risk-stratified care management.
- Coordination of care across the medical neighborhood.
- Patient and caregiver engagement.
- Shared decision-making.
- Payment arrangements in addition to, or substituting for, FFS payments (for example, shared savings, population-based payments)."

AAFP Response

The AAFP appreciates and supports CMS's decision to make the first two elements under the definition of a Medical Home Model or Medicaid Medical Home Model mandatory while requiring such a model to have only four of the additional seven elements finalized by CMS. The AAFP also appreciates and supports the modification of the first required element to emphasize that the APM must have a primary care focus, as exemplified by the following language: "Primary care focus with participants that include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services." This modification and emphasis is very consistent with the comments made by the AAFP in response to the proposed rule.

We regret and are disappointed that CMS chose to add obstetrics and gynecology (specialty code 16) to the list of designated primary care providers on the basis that these physicians "often coordinate primary care services for women." Primary care is that care provided by physicians specifically trained for and skilled in comprehensive first contact

and continuing care for persons with any undiagnosed sign, symptom, or health concern (the "undifferentiated" patient) not limited by problem origin (biological, behavioral, or social), organ system, or diagnosis. A primary care physician is a specialist in family medicine, internal medicine, or pediatrics who provides definitive care to the undifferentiated patient at the point of first contact, and takes continuing responsibility for providing the patient's comprehensive care.

Obstetricians and gynecologists are not primary care physicians. Their training and the care that they provide is, by definition, limited to the organ systems of female patients.

Obstetricians and gynecologists—like other physicians who are not trained in the primary care specialties of family medicine, general internal medicine, or general pediatrics—may sometimes provide patient care services that are usually delivered by primary care physicians. These physicians may focus on specific patient care needs related to prevention, health maintenance, acute care, chronic care, or rehabilitation. However, obstetricians and gynecologists do not offer these services within the context of comprehensive first contact and continuing care. Occasionally providing or coordinating primary care services does not make a clinician a primary care physician, and CMS is wrong to think so.

We also regret and are disappointed that CMS decided to finalize its proposal to include ECs under one or more of the following specialty codes: 50 Nurse Practitioner; 89 Clinical Nurse Specialist; and 97 Physician Assistant. As we noted in response to the proposed rule, these health care professionals are not always primary care providers. Under CMS' policy, it seems possible that a gynecological surgeon who employed one or more of these clinician types could claim to have a primary care focus under a Medical Home Model. Such an arrangement remains a distortion of the term "primary care," in our opinion. Furthermore, the Joint Principles of the Patient-Centered Medical Home—developed by the AAFP, the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA)—include "physician-directed medical practice." Potentially relying on eligible health care professionals such as nurse practitioners and physician assistants without the involvement of a primary care physician is contrary to these joint principles.

F.4.a. Advanced APM Determination

Summary

CMS is finalizing its proposal to release the initial set of Advanced APMs as soon as possible and no later than January 1, 2017. After the initial determination, APMs will be announced in conjunction with the first public notice of the APM, such as the request for application (RFA) or final rule. Determinations will be posted on the CMS website and updated on an ad hoc basis, but no less than annually. These announcements will include which track or option within the APM is or is not an Advanced APM.

Response

The AAFP continues to urge CMS to update its website in real time to allow physicians to make informed decisions on a more predictable basis. The AAFP sees no reason CMS would not be able to update the website at the time of the release of an APM's RFA.

F.4.b.(2) Comparable Quality Measures

Summary

CMS is finalizing its proposal for Advanced APMs that would require APMs to base payment on quality measures that are evidence-based, reliable, and valid. In addition, at least one measure must be an outcome measure, unless there is not an applicable measure available on the MIPS

quality list at the time of the APM's development. The outcome measure does not have to be a measure on the MIPS quality list. CMS is finalizing its proposal to establish an internal Innovation Center quality measure review process for measures that are not endorsed by the National Quality Forum (NQF) or included on the final MIPS measure list. This process will not change CMS' processes for adopting measures to be used in CMS programs. It will only be assessing whether a measure meets the criteria to be comparable to MIPS for the purpose of identifying Advanced APMs. CMS recognizes the advantages of identifying a core set of measures, but also recognizes the need to include measures that are appropriate to assess performance for the specific patient populations for which Advanced APM participants are providing care.

AAFP Response
We appreciate CMS' close alignment of final measures with the core measures and encourage continued alignment in the future. **The AAFP recognizes and appreciates the inclusion of measures from the core measure set within the MIPS quality performance category.** The AAFP continues to ask CMS to urge private payers to adopt the core measure sets in order to create a sense of stability between public and private payers. APMs will be able to prioritize measures more easily if a standard set of measures is used by CMS and private payers.

F.4.b.(3)(b)(ii) Medical Home Model Financial Risk Standard (for bearing financial risk for monetary losses)
Summary
CMS is finalizing its proposed financial risk standard for Medical Home Models. In order to be an Advanced APM, Medical Home Models must include provisions that CMS could 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.

CMS addresses comments stating that participants in Medical Home Models should not bear any financial risk. CMS does not agree with that sentiment and believes the statute is clear in stating that Medical Home Models must actually be expanded under section 1115A(c) of the Act to meet the financial risk criterion without requiring APM entities to bear more than nominal risk. CMS states it does not have the authority to dispense with the statutory requirement and the finalized Medical Home Model financial risk policy is already an exception to the generally applicable rule.

AAFP Response
The AAFP continues to adamantly oppose the financial risk and nominal risk standard for all Medical Home Models and urges CMS to remove these requirements. These risk requirements limit the number of Medical Home Models available to ECs and will deter participation in the models.

F.4.b.(4)(a) Advanced APM Nominal Amount Standard

Summary

CMS is modifying its proposal and finalizing two ways an APM can meet the Advanced APM nominal amount standard. If the total amount the APM entity potentially owes CMS or foregoes is equal to at least: 1) for 2017 and 2018 QP performance period only, 8% of the average estimated total Medicare Parts A and B revenues of the participating APM entities (revenue-based); or 2) for all QP performance periods, at least 3% of the expected expenditures for which an APM entity is responsible under the APM (bench-mark based). The expected amount for an episode payment model is the target price for an episode. CMS is only finalizing these modified amounts for the first two QP performance periods.

CMS seeks comment on a standard that tailors the level of risk particular to APM entities' circumstances, while also ensuring that APMs include strong incentives to improve performance and coordinate care across clinician types. CMS seeks comment on the amount and structure of the revenue-based nominal amount standard for the QP performance periods in 2019 and later. Specifically, they seek comment on: 1) setting the revenue-based standard for 2019 and later at up to 15% of revenue; or 2) setting the revenue-based standard at 10%, so long as risk is at least equal to 1.5% of expected expenditures for which an APM entity is responsible under an APM.

CMS believes that instances where an APM entity is one component of a larger health care provider organization, the revenue of the larger organization is a more accurate measure of the resources available to the APM entity and should be used as the basis for setting the revenue-based nominal amount standard. This applies even if only a portion of the organization is participating as an APM entity. CMS does not believe this is feasible in the first two QP performance periods, but is considering the feasibility of implementing such a measure in lieu of the APM entity revenue for the third year of the program. Under this approach, they anticipate using the total Medicare Parts A and B revenues across the APM entity, any parent organizations, subsidiary organizations, and any subsidiaries of parent organizations for all ECs and groups participating as an APM entity.

CMS seeks comment on this approach and how such an approach could be implemented while minimizing the burden on participants.

AAFP Response

The AAFP appreciates the inclusion of a revenue-based standard, but believes CMS should continue to monitor it before deciding to increase required levels of risk. As this is a relatively new program, it should be viewed as a work in progress, and therefore assessed as the program matures. Prematurely setting this standard at high levels may inadvertently prevent APMs from becoming Advanced APMs and force ECs who may have joined an APM to remain in MIPS. CMS should review the impact of this standard in the first two years of the program and only increase it when CMS has confirmed it is appropriate. Any increases in this standard should be monitored for their appropriateness before being set as permanent requirements.

Additionally, the AAFP believes that the revenue-based risk nominal amount standard should be applied at the same organizational level that quality is reported.

F.4.b.(4)(b) Medical Home Model Standard

Summary

CMS is finalizing its proposal that a Medical Home Model must require the total annual amount an Advanced APM entity potentially owes CMS or forgoes under the Medical Home Model must be at least the following amounts in a given performance year:

- In 2017, 2.5% of the APM entity's total Medicare Parts A and B revenue.
- In 2018, 3% of the APM entity's total Medicare Parts A and B revenue.
- In 2019, 4% of the APM entity's total Medicare Parts A and B revenue.
- In 2020 and beyond, 5% of the APM entity's total Medicare Parts A and B revenue.

If the financial risk arrangement is not based on revenue (for example, based on total cost of care or a per beneficiary per month dollar amount), CMS will make a determination for the APM based on the risk under the Medical Home Model compared to the average estimated Medicare Parts A and B revenue of its participating APM entities using the most recently available data.

CMS is finalizing its proposed limitation on the applicability of the Medical Home Model financial risk and nominal amount standard to APM 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 organization with more than 50 ECs, participation in a Medical Home Model Advanced APM would not offer an opportunity to attain QP status unless the Medical Home Model met the generally applicable Advanced APM financial risk criterion.

AAFP Response
It remains unclear to the AAFP to how CMS determined 50 ECs was the appropriate number for this threshold. An arbitrary threshold should not be used 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.** The decision to assume financial risk of any amount is not taken lightly by the entities. CMS should develop an appropriate way to determine whether an entity is capable of taking on risk. To foster an environment in which a small practice or solo physician can succeed, CMS needs to remove this provision.

In addition, the 50 EC threshold policy seems contradictory to CMS' stated desire to encourage and expand participation in Advanced APMs. The size limit discourages participation in CPC+, which is currently the only Medical Home Model available to participants. Participants in CPC+ who exceed this threshold will be forced back into MIPS APMs because CPC+ does not satisfy the generally applicable Advanced APM financial risk criterion. As a result, those who applied to CPC+ with the expectation that they would qualify for the 5% bonus will feel misled and discouraged to be back in the MIPS track.

5. Qualifying APM Participant (QP) and Partial QP Determination
Summary
CMS finalized a policy that moves away from a single end-of-year snapshot to instead use three snapshots throughout the year. CMS believes that these snapshots will better represent EC participation in Advanced APMs over the course of a year for purposes of QP determinations.

AAFP Response
The AAFP supports the policy that uses multiple snapshots throughout the year. If an Advanced APM entity group meets the threshold in any of the three snapshots, CMS should recognize that the group meets the QP threshold. Even if an EC only meets the threshold for QP status in the last snapshot, CMS should consider the clinician a QP.

6. Qualifying APM Participant Determination

Summary

CMS discusses methodologies for defining the attributed beneficiary population.

AAFP Response

Patient attribution methodology is critical to measuring performance on payment, quality, and cost, as well as defining accountability in a primary care medical home. A reliable, prospective, and transparent attribution method is important for the payer, the physician, and the patient. With a fine-tuned attribution process, a payer knows it is providing payment for services to the correct physician for the correct patient population. Physicians can predict revenues for their businesses as the attribution process builds trust that they are receiving payment for the appropriate patients in their care. In addition, physicians know up front which patients they are accountable for in terms of quality and cost. Accurate attribution also may help patients understand the importance of their relationship with their primary care physician, and the need to include a primary care physician in decisions about anything that impacts patients' health and health care (e.g., when and how to seek medical care, lifestyle choices that will affect their health).

The AAFP recommends a patient-based, prospective, four-step process that includes a 24-month lookback period for attribution. Patients attributed through this process should be the focus of payment and performance measurement under the recommended payment model. Using a prospective methodology allows physicians to know up front which patients they are responsible for and facilitate proactive care planning and management. Similar to the CPC+ initiative, payers should attribute patients on a quarterly basis. For attribution purposes, a primary care physician should be defined as a physician who is in a family medicine, general internal medicine, geriatric medicine, general pediatrics, or general practice setting.

The four-step attribution process

1. Patient selection of a primary care physician and team
    a. This is the acknowledgement that patient selection is the best choice in attribution and, as such, should be prioritized as such.
2. Primary care visit events: wellness visits
    a. If a patient is not attributed by patient selection of a primary care physician, payers should use wellness visits, including Welcome to Medicare visits, physicals, and Annual Wellness Visits (AWV) provided by the patient's primary care physician or the practice team as the next step in the attribution process.
3. Primary care visit events: all other E/M visits
    a. If a patient is not attributed by a wellness visit, the next incremental step is to consider all other E/M visits to a primary care physician. The payer should attribute the patient to the primary care physician who provides the plurality of E/M visits.
4. Primary care prescription and order events
    a. If the patient is not attributed by a wellness visit or any other E/M visits, the payer should consider claims related to medication prescriptions, durable medical equipment prescriptions, and lab and other referral orders made by primary care physicians. Payers should require a minimum of three such events before attributing a patient on this basis.

No patient attribution methodology is perfect. The four-step methodology recommended above may still produce errors in assignment. Physicians should have the option to engage in a reconciliation process in which they may review, add, and remove patients from the formal list

the payer supplies to them. Like the attribution process, review and reconciliation should occur quarterly and include enough time to adequately review the list of attributed patients.

7. Combination All-Payer and Medicare Payment Threshold Option
a. Overview
Summary
CMS believes that the Other Payer Advanced APM criteria allows for flexibility in the design of Medicaid APMs that can be considered Other Payer Advanced APMs. However, CMS is interested in conducting further analysis and seeking further comment on the appropriate criteria for certain payers.

CMS seeks additional comments on the creation of an optional pathway for states to seek a determination from CMS on whether a Medicaid payment arrangement is an Other Payer Advanced APM.

AAFP Response
The AAFP believes the criteria for Other Payer Advanced APMs should be uniform and not vary by payer. The AAFP urges CMS to use its leadership role in the Health Care Payment Learning and Action Network (LAN) to continue to drive the convergence of APM frameworks to align incentives, performance measures, and other components of value-based arrangements between public and private payers. According to a 2015 AAFP/Humana study on value-based payments, more than six in 10 (61%) of family physician practices submitted claims to seven or more payers over a 12-month study period. It is imperative that qualifying physicians are able to execute value-based arrangements within APM frameworks that are similar in nature and easy-to-understand, and that deliver on the promise of population health management. Physicians already face huge administrative burdens with claims adjudication, pre-authorizations, and other tasks that do not contribute to directly improving clinical outcomes, but are part of the unreimbursed FFS system. Physicians will be confronted by far greater complexity within APM frameworks. Public and private payers must act to reduce the administrative burden and needless variability among their APM frameworks so that qualifying physicians can concentrate on practicing medicine, regardless of payer.

We appreciate that CMS will include Medicaid in the all payer definition moving forward. The AAFP supports CMS' current definition to define a Medicaid APM as a payment arrangement under title XIX that meets the criteria to be an Other Payer Advanced APM. The broad definition provides some flexibility for states to implement new payment models and align core requirements for Medicaid APMs with the broader Advanced APM and Other Payer Advanced APM criteria.

CMS also intends to generally defer to states in their design of payment arrangements. Deferring to states is highly problematic because of their historic and repeated violation of the equal access clause of Medicaid statute. Federal law requires that payments allow for access that is equivalent to private payers in the region. However, states have historically paid about two-thirds of Medicare rates in Medicaid programs. **Granting states deference in designing payment arrangements without a floor that is at least equal to Medicare payment is ill-advised and will undermine the chance for success in all payer models**.

CMS also seeks comments on the overall process for reviewing payment arrangements in order to determine whether they are Other Payer Advanced APMs**.** To support the development and implementation of APMs, the AAFP has developed a set of principles to guide evaluation of

proposed models to ensure that they place patients—and not clinicians—at the center. These principles are:

- APMs must provide longitudinal, comprehensive care.
- APMs must improve quality, access, and health outcomes.
- APMs should coordinate with primary care teams.
- APMs should promote evidence-based care.
- APMs should be multi-payer in design.

Further, the AAFP adamantly opposes that CMS require APM entities and/or ECs to submit information for CMS to assess whether other payer arrangements meet the Other Payer Advanced APM criteria. The onus of submitting relevant information on payer arrangements should be the burden of the payer. Private payers have a better understanding of what information CMS needs in order to consider and determine whether a payer arrangement satisfies the Other Payer Advanced APM criteria. Further, data submission by a smaller number of private payers, rather than a large number of physicians would ease CMS' burden to assess whether other payer arrangements meet the Other Payer Advanced APM criteria by the nature of lower volume and more congruent data. For example:

- The AAFP has a membership containing over 69,000 active/practicing family physicians, with 61% reporting submission of claims to 7 to 10 payers. Assuming the average number of payers with whom family physicians have a relationship is seven, then CMS could receive 483,000-plus disparate submissions from family physicians. Add to that total the number of submissions from other physicians and APM entities, and the danger of CMS receiving duplicative, flawed, and otherwise accurate data is too great for CMS to require submission from APM entities and/or ECs.
- The transverse of the calculation reveals a more manageable number for CMS. According to a 2014 National Association of Insurance Commissioners (NAIC) report card, there were 366,089 direct health and medical insurance carriers. That means CMS would be required to process no more than that amount each year when assessing whether other payer arrangements meet the Other Payer Advanced APM criteria.

The burden on private payers to make submissions to CMS on payer arrangements would be minimal. On November 17, 2015, a national payer sent a response to CMS's RFI on MACRA. It stated, "As a committed participant in the move to value-based payment, [payer] is willing and able to support providers in documenting non-Medicare, APM revenue. In establishing documentation requirements for the all-payer model, we encourage CMS to minimize the administrative burden on providers and on the other entities implementing APMs." Another national payer's letter from November 17, 2015, expressed a similar statement: "EPs [eligible professionals] will need to obtain data and information from the private payers to submit qualifying information to CMS. This invariably raises concerns about the administrative burden of providing data and information in general, the risks of revealing proprietary information, and the potential for CMS to audit or judge private payers' APMs."

The AAFP offers an alternative to CMS for receiving data to assess whether other payer arrangements meet the Other Payer Advanced APM criteria—similar to CMS's proposal for Medicaid. In the interest of public and private payer alignment and convergence on APM frameworks, payers should be required to submit: 1) the payment amounts and/or number of patients furnished any service through each Advanced APM; 2) the sum of their total payment amounts and/or number of patients furnished any service; and 3) any additional, relevant information the payer believes would help CMS gain a better understanding of the mechanics of APM frameworks. The information should be submitted at least 60 days before the beginning of

the QP performance period. CMS should, to the extent permitted by federal law, maintain confidentiality of certain information that the Advanced APM entities and/or ECs submit regarding Other Payer Advanced APM status in order to avoid dissemination of potentially sensitive contractual information or trade secrets. Other payers are in a better position to deliver the necessary and relevant information to CMS on their own payer arrangements, and they would be able to submit "batch" reports on their arrangements, which should include the corresponding clinicians. CMS would then have more accurate and granular data about which clinicians are participating in specific payer arrangements with whichever payer, thereby allowing for an increase in program integrity. In addition, it would remove the second-step attestation requirement CMS has finalized for payers to confirm the accuracy of all submitted information from clinicians. Under the original proposal, payers are the final arbiter on payer arrangements. This alternative makes them the initial filer. Clinicians should be able to challenge a determination that a payer arrangement in which they are participating does not qualify as an Other Payer Advanced APM, and provide additional information for review and revision of the initial determination. This would ensure clinicians are not dependent on a payer to attest the accuracy of submissions, over which they have limited control.

Lastly, the AAFP urges CMS to make this a periodic process where, after a payer submits information on its payer arrangement(s), CMS would assess whether the payer arrangement(s) meets the Other Payer Advanced APM criteria. If it does, the payer arrangement(s) is certified for a period of time (e.g., three years). The certification would last for a period of time or until the payer makes substantive changes to the arrangement that would disqualify it as an Other Payer Advanced APM. CMS should allow maximum flexibility for private payers to innovate new APM frameworks and not inadvertently create regulations that have a chilling effect on private payers' ability to innovate. The certification process for Other Payer Advanced APMs would add much-needed regulatory certainty and eliminate unnecessary administrative burdens on clinicians. The AAFP believes it would be more manageable for CMS to receive a lower number of submissions from payers than clinicians and to have those submissions contain more accurate and relevant information.

CMS also proposed that for Advanced APM entities and ECs participating in Medicaid, CMS will initiate a review and determine in advance of the QP determination period the existence of Medicaid Medical Home Models and Medicaid APMs based on information obtained from state Medicaid agencies and other authorities, such as professional organizations or research entities. The AAFP supports this determination process for the reasons laid out in the preceding paragraph and would urge CMS to apply a similar process for determining whether other payer arrangements meet the Other Payer Advanced APM criteria.

(6) Financial Risk for Monetary Losses

Summary

After considering public comments, CMS finalized proposals for the Medicaid Medical Home Model financial risk standard without changes. The Medicaid Medical Home Model financial risk standard requires that if the APM entity's actual aggregate expenditures exceed the expected aggregate expenditures during a specified performance period, the payer will:

- Withhold payment for services to the APM entity and/or the APM entity's ECs;
- Reduce payment rates to the APM entity and/or the APM entity's ECs;
- Require direct payment by the APM entity to the Medicaid program; or
- Require the APM entity to lose the right to all or part of an otherwise guaranteed payment or payments.

AAFP Response
The AAFP continues to adamantly oppose and urge CMS to remove the financial risk and nominal risk standard from all medical home models. These requirements limit the number of medical home models available to ECs and will deter participation in the models due to the risk requirements.

(b) Nominal Amount of Risk
(i) Generally Applicable Other Payer Advanced APM Nominal Amount Standard
Summary
Although states design and implement Medicaid APMs that are generally subject to federal approval processes, such as state plan amendment approvals, CMS has no direct or indirect control over the payment arrangements of private payers. By including marginal risk as a component of the nominal amount standard, it would prevent the consideration of payment arrangement designs that could contribute to the attainment of QP status through arrangements far less rigorous than those in Advanced APMs. There may be other ways of achieving the same program integrity goals and we seek comment on this policy. For instance, CMS is considering ways to issue guidance or design federal approval processes to promote Medicaid APMs focused on high-value care to Medicaid beneficiaries that also align with our program integrity objectives.

AAFP Response
The AAFP continues to adamantly oppose and urge CMS to remove the financial risk and nominal risk standard from all medical home models. These requirements limit the number of medical home models available to ECs and will deter participation in the models due to the risk requirements.

We appreciate the simplification in the first few years of the program, which makes the program easier for physicians to understand. However, when the all-payer arrangement begins, the nominal amount standard again becomes complicated, convoluted, and too difficult for physicians to grasp.

The AAFP appreciates the inclusion of a revenue-based standard, but believes CMS should continue to monitor it before deciding to increase required levels of risk. We note that eligible professionals already face an increasing threshold of APM involvement to be qualified APM participants. This increasing threshold represents an increasing level of risk, in and of itself. As Medicare's QPP is brand new, it should be viewed as a work in progress, and therefore assessed as the program matures. Prematurely setting this standard at high levels may inadvertently prevent APMs from becoming Advanced APMs and force ECs who may have joined an APM to remain in MIPS. CMS should review the impact of this standard in the first two years of the program, and only increase it when CMS has found it appropriate. Any increases in this standard should be monitored for their appropriateness before being set as permanent requirements.

The AAFP believes that the revenue-based risk nominal amount standard should be applied at the same level that quality is reported.

(ii) Medicaid Medical Home Model Nominal Amount Standard
Summary
CMS finalized the Medicaid Medical Home Model nominal amount standard as proposed. In order to be an Other Payer Advanced APM, the minimum total annual amount that a Medicaid Medical Home Model must require an APM entity to potentially owe or forego must be at least:

- 4% of the APM entity's total revenue under the payer in 2019.
- 5% of the APM entity's total revenue under the payer in 2020 and later.

AAFP Response
The AAFP continues to adamantly oppose and urge CMS to remove the financial risk and nominal risk standard from all medical home models. These requirements limit the number of medical home models available to ECs, and will deter participation in the models due to the risk requirements.

Medicaid APM participants should not be subject to the same risk as those that take Medicare or private insurance. Payment under Medicaid is significantly lower with a higher risk population. In order to ensure access and quality, all Medicaid programs and associated payments should be considered in the all-payer option.

(1) Use of Methods
Summary
CMS finalized the proposal to calculate threshold scores for ECs in an APM entity under both the payment amount and patient count methods for each QP performance period. CMS will make QP determinations using the more advantageous of the APM entity's two scores.

AAFP Response
We appreciate CMS's decision to modify the low-volume threshold. Raising the threshold to $30,000 in Medicare Part B allowed charges, or 100 Medicare Part B beneficiaries will appropriately exclude more individual physicians who might otherwise be subject to MIPS.

8. APM Incentive Payment
(2) Timeframe of Claims
Summary
CMS is finalizing its proposal to use three months of claims run-out when calculating the amount of APM incentive payment, and CMS is finalizing its proposal to make the APM incentive payment no later than one year from the end of the incentive payment base period.

AAFP Response
The AAFP supported the proposal to use a full year of claims, plus a three-month claims run-out in calculating the APM payment incentive. As noted in the proposed rule, on average, 99.3% of Medicare claims are processed within three months of the end of the calendar year, which is more than sufficient for calculating the APM payment incentive. We appreciate CMS's decision to finalize this proposal.

We remain disappointed that CMS does not feel confident enough in its abilities and the abilities of its contractors to commit to actually paying the APM incentive payments before the end of the payment year. We continue to think six months is a reasonable length of time for CMS to calculate and provide APM incentive payments. We would urge CMS to commit that APM incentive payments be made not later than September 30 of the payment year in future rulemaking.

(d) Payments made to an APM Entity Instead of to an Eligible Clinician
Summary
CMS is finalizing its proposal regarding payments paid to an APM entity (instead of to an individual EC) and those payments are not attributable to an individual EC. CMS will divide the amount of such payments equally across all ECs who are on the participation list for that APM

entity. Each EC who is a QP will be considered to have been paid that portion of the payments for purposes of the APM incentive payment amount calculations.

AAFP Response
As in our response to the proposed rule, we support this approach, as long as the ECs are limited to those actually providing care management. Equally dividing these payment amounts among the ECs is the simplest approach, and is an attractive feature in an otherwise complicated payment system.

c. **Payment of the APM Incentive Payment**
(1) Payment to the QP
Summary
CMS is finalizing its proposal to make the APM incentive payment to the TIN affiliated with the Advanced APM entity through which an EC becomes a QP. CMS further clarifies that the APM incentive payment would be sent to the Medicare enrolled billing TIN associated with the Advanced APM entity. CMS is also finalizing its proposal to make the APM incentive payment to the TIN provided on the EC's CMS-588 EFT application, in the event that an EC no longer practices at the TIN affiliated with the Advanced APM entity at the time of payment.

AAFP Response
We continue to strongly disagree with CMS in this regard. Section 1833(z)(1)(A) of the Act explicitly states, "…there also shall be paid to such professional an amount equal to 5% 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 APM incentive payment to be made to the QP, not the TIN that is affiliated with the Advanced APM entity through which the EC met the threshold during the QP performance period. It is highly predictable that this CMS decision will be litigated and will create needless uncertainty for the program overall.

We agree with CMS that the intent of section 1833(z) of the Act is to incentivize participation in APMs. However, the way to do that, as the law clearly states, is to directly pay QPs, not their affiliated TINs. Thus, the incentive payment must be made to the QP (as identified by his or her NPI) that earned it. Anecdotally, we understand that other Medicare incentive payments earned by ECs and paid to TINs often do not find their way to the ECs in question. There is no reward to a QP for participating in an Advanced APM if the QP does not receive the APM incentive payment. If a TIN wants to avail itself of a QP's APM Incentive Payment, that is a contractual matter between the TIN and the QP. It is not something for CMS to decide by executive fiat.

Accordingly, we continue to strongly urge CMS to make APM incentive payments directly to QPs (i.e. "to such professional") as identified by either the QP's NPI or TIN/NPI combination. This will incentivize eligible professionals to participate in Advanced APMs. CMS's approach will not. Further, CMS will not need to worry about scenarios in which a QP changes his or her affiliation, because the incentive payment will follow the QP.

(2) Exception for Eligible Clinicians in Multiple Advanced APMs
Summary
CMS is finalizing its proposal to split the APM incentive payment amount proportionally, based on the payment amounts used to make the QP determination across all of the QP's TINs associated with Advanced APM entities when the QP determination is made at the individual

level. CMS also further clarifies that in the event an EC participates in more than one Advanced APM entity, and that EC meets the QP threshold through more than one Advanced APM entity (as determined at the group level), CMS would split the total amount of the APM incentive payment in the same manner.

AAFP Response
Again, we believe the law clearly states that the APM incentive payment is to go to the professional, not to any of the TINs of associated Advanced APM entities. Thus, regardless of how CMS determines that an individual EC is a QP, we believe the APM incentive payment should go to the QP.

(3) Notification of APM Incentive Payment Amount
Summary
CMS is finalizing its proposal to send a notification to both Advanced APM entities and QPs of the APM incentive payment amount as soon as CMS has calculated the amount of the APM incentive payment and performed all necessary validation of the results as proposed.

AAFP Response
We agree with CMS' decision to send notification of the APM incentive payment amount to both the Advanced APM entities and their individual participating QPs as soon as CMS has calculated the amount of the APM incentive payment and performed all necessary validation of the results. We continue to believe that CMS should notify QPs of their APM incentive payment in the same manner that CMS usually notifies such individuals of payments made to them. In addition to the APM incentive payment amount, we would encourage CMS to include information clearly describing how the payment incentive was calculated and the amounts used in that calculation, so an individual QP has the information necessary to verify that the payment is correct.

10. Physician-Focused Payment Models
Summary
CMS does not plan to set deadlines via regulations for the Physician-Focused Payment Model Technical Advisory Committee's (PTAC's) comments and recommendations on proposed Physician-Focused Payment Models (PFPMs), the Secretary's response to the PTAC's comments and recommendations, and CMS's testing of PFPMs. CMS believes that setting a deadline for the PTAC's comments and recommendations would interfere with the PTAC's freedom to govern itself, and develop its own process and timeline for reviewing proposed PFPMs. CMS wishes to preserve the PTAC's independence and to give it the freedom to determine how and when it would review proposed PFPMs without rulemaking. CMS believes that setting a deadline through rulemaking for the Secretary's review of the PTAC's comments and recommendations, publication of a response to them, and CMS's potential testing of a proposed PFPM submitted to the PTAC is inappropriate because these tasks would take varying amounts of time depending on factors that CMS cannot predict.

AAFP Response
The AAFP agrees that it is not CMS's place to set a deadline for the PTAC's comments and recommendations. However, **we still disagree with CMS that it should not set a deadline for the Secretary's review of PTAC comments and recommendations and publication of a response to them.** Section 1868(c)(2)(D) requires the Secretary to review PTAC comments and recommendations and post a detailed response to the CMS website. Without a self-imposed deadline, CMS could effectively avoid this responsibility. **We still believe that individuals and entities who submit PFPMs to the PTAC using criteria set by CMS should**

have a reasonable idea when CMS will respond to PTAC comments and recommendations on those PFPMs. We understand that things do not always go as planned and sometimes the unpredictable happens. In such circumstances, CMS may need to extend its deadline. However, such unusual circumstances should not prevent CMS from establishing a deadline that will work for the typical comment and recommendation from the PTAC.

We agree that CMS need not establish a deadline in regulations for potential testing of a proposed PFPM. However, when CMS posts its response to PTAC comments and recommendations, it should include a general timeline for testing those PFPMs that it agrees merit testing, so such PFPMs have some idea of what to expect in this regard.

a. Definition of PFPM
(1) Definition of PFPM
(2) Relationship between PFPMs and Advanced APMs
Summary
CMS believes it is appropriate to change the definition of PFPMs to include models that include any of the following ECs: physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwifes, clinical social workers, clinical psychologists, registered dietitians or nutrition professionals, physical or occupational therapists, qualified speech language pathologists, and qualified audiologists. CMS is revising the definition of PFPM to include this group of clinicians.

In response to comments on the proposed rule, CMS has also changed the definition of PFPM to not require that physician group practices or individual physicians be included as APM entities. Instead, PFPMs must give ECs a core role in implementing the payment methodology. CMS is finalizing its proposal not to limit PFPMs to Advanced APMs, but instead to include models that, if tested, would be APMs and could potentially be Advanced APMs.

In sum, CMS is finalizing the definition of PFPM to mean an APM: 1) in which Medicare is a payer; 2) in which ECs that are eligible professionals as defined in section 1848(k)(3)(B) of the Act (see above) are participants and play a core role in implementing the APM's payment methodology; and 3) which targets the quality and costs of services that ECs participating in the Alternative Payment Model provide, order, or can significantly influence.

AAFP Response
The AAFP supported CMS' original proposals in this regard. **With respect to the revised definition finalized by CMS, we note that a "physician-focused payment model" may not include any physicians at all. CMS will not require physician group practices or individual physicians to be included as APM entities, and they have expanded the list of ECs to include a host of non-physician providers.** Under CMS' final definition, an APM in which: Medicare is a payer; only ECs play a core role in implementing the APM payment methodology (e.g., clinical social workers); and targets the quality and costs of services that the EC provides, orders, or can significantly influence is considered a "physician-focused payment model." We fail to understand the tortured logic that allows CMS to arrive at this conclusion.

Noted in our principles to support patient-centered APMs, as discussed above, we believe that APMs must provide longitudinal and comprehensive, coordinated care with the primary care team through agreements with primary care physicians if the APM is not already primary care focused. The final CMS definition of "physician-focused payment model" seems to ignore both of these principles. We do not object to the inclusion of non-physician ECs in physician-focused payment models. We do object to shifting the focus from physicians in general and primary care

physicians, in particular, to non-physician ECs. From our perspective, "physician-focused" means exactly that, it should be focused on physicians, and we do not think it is appropriate for the PTAC to consider models that do not satisfy this basic requirement. **We urge CMS to return to its originally proposed definition so that the APMs in question are indeed "physician-focused," as the law requires.**

b. Finalized PFPM Criteria

Summary

CMS proposed PFPM criteria as follows:

- Incentives: pays for higher-value care.
    - Value over volume: provides incentives to practitioners to deliver high-quality health care.
    - Flexibility: provides the flexibility needed for practitioners to deliver high-quality health care.
    - Quality and Cost: anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both to improve health care quality and decrease cost.
    - Payment methodology: pays APM entities with a payment methodology designed to achieve the goals of the PFPM criteria. Addresses, in detail, the methodology of how Medicare (and other payers, if applicable) pay APM entities; how the payment methodology differs from current payment methodologies; and why the PFPM cannot be tested under current payment methodologies.
    - Scope: aims to either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM entities whose opportunities to participate in APMs have been limited.
    - Ability to be evaluated: maintains goals that can be evaluated for quality of care, cost, and any other goals of the PFPM.
- Care delivery improvements: promotes better care coordination, protects patient safety, and encourages patient engagement.
    - Integration and care coordination: encourages greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM.
    - Patient choice: encourages greater attention to the health of the population served, while also supporting the unique needs and preferences of individual patients
    - Patient safety: aims to maintain or improve standards of patient safety.
- Information enhancements: improves the availability of information to guide decision making.
    - Health information technology: encourages the use of health information technology to inform care.

CMS is finalizing its proposed criteria with one modification. CMS is broadening the proposed scope criterion. The final scope criterion now requires that PFPMs aim to broaden or expand the CMS APM portfolio by addressing an issue in payment policy in a new way or including APM entities whose opportunities to participate in APMs have been limited. CMS is finalizing the other PFPM criteria as proposed.

AAFP Response

In general, the finalized criteria are a reasonable place to start. We especially appreciate CMS' decision to broaden the proposed scope criterion. As finalized, we believe this criterion addresses the concerns we expressed in response to the proposed rule.

As noted earlier, the AAFP has developed a set of principles to guide our evaluation of proposed models to ensure that they place patients—and not clinicians—at the center. Those principles are:

- APMs must provide longitudinal, comprehensive care.
- APMs must improve quality, access, and health outcomes.
- APMs should coordinate with the primary care team.
- APMs should promote evidence-based care.
- APMs should be multi-payer in design.

We ask that CMS consider these principles when considering criteria for physician-focused payment models in the future to ensure that patient-centered, longitudinal, and comprehensive care is being promoted across providers and care settings.

We appreciate the opportunity to comment and make ourselves available for your questions. Please contact Shawn Martin, Senior Vice President for Advocacy, Practice Advancement and Policy at smartin@aafp.org or 888-794-7481 ext. 2500.

Sincerely,

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