modifier and developed for use at the community or hospital level. These measures tend to have low statistical reliability when applied at the individual physician level and at times at the group level. Instead, CMS should make the measures optional under the CPIA component or exempt small practices from all of the administrative claims quality measures.

- **Eliminate costs measures developed for other settings.** Replace measures like total cost of care and Medicare Spending per Beneficiary (MSPB) that were developed for use in hospitals and other settings with measures that have been developed for and tested for use in physician offices.

- **Focus on methodological improvements.** Making resource use workable requires CMS to focus on various methodological improvements, including more sophisticated risk-adjustment, more granular specialty comparison groups, and improved attribution methods. CMS should direct special effort at eliminating flaws that have made practices with the most high-risk patients more susceptible to penalties than other physicians.

- **Adopt virtual groups.** The MACRA statute included the concept of virtual groups to help assist small practices; however, CMS proposes not to implement such groups until the 2018 performance period. We strongly urge CMS to act on forming these groups as soon as possible. Without this assistance, we believe small practices may face even greater challenges when attempting to move into the MIPS program structure.

- **Grant credit for each reported ACI measure.** The proposed rule retains a pass-fail element in the base ACI score. Instead of keeping this approach, CMS should provide credit for each measure reported, even when it is a simple yes/no or attestation measure. The final rule should also maintain all existing Meaningful Use (MU) program exclusions and hardships, including for physicians who do not refer patients and have insufficient broadband availability.

- **Encourage alternative ACI measures.** Rather than maintaining the current MU Stage 3 measures, CMS should allow proposals for more relevant measures. This would ensure that practices can select tools in innovative ways and not be limited by existing technology barriers. Further flexibility can be provided by allowing physicians to utilize both 2014 and 2015 edition technologies in 2018 and subsequent years.

- **Expand high-weighted CPIAs.** The proposed rule identifies few high-weight CPIAs and lists key patient quality activities as only medium weight. Given the patient benefit associated with these activities, CMS should provide more credit for these important care activities.

- **Reduce the number of required CPIAs.** Under the proposed rule, physicians could be required to report on as many as six different activities in order to receive the full CPIA score. While the activities vary, six different requirements may quickly become overly burdensome, especially given the low-weight of this performance category compared to others. CMS should reduce the total number of required CPIAs to avoid additional burden on practices.

- **Work with affected physicians and medical societies to determine how to reweight performance categories**. CMS should not over emphasize the quality category when determining how to reweight a missing MIPS component. Rather, the rule should allow for flexibility in how to redistribute the different performance weights, and CMS should work with affected physicians and medical societies to determine a more appropriate approach.