



December 19, 2017

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

Dear Administrator Verma:

On behalf of the American Academy of Family Physicians (AAFP), which represents 129,000 family physicians and medical students across the country, I write in response to the [interim final rule with comment period](#) titled, “Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year” (CMS–5522–FC and CMS–5522–IFC) as published by the Centers for Medicare & Medicaid Services (CMS) in the November 16, 2017, *Federal Register*.

We appreciate the changes CMS made in this interim final rule—many of which were significant steps to improve the ability of family physicians to participate successfully in payment reforms envisioned by the bipartisan *Medicare Access and CHIP Reauthorization Act (MACRA)*. We offer the following recommendations to continue to strengthen primary care for Medicare beneficiaries, to enable more physicians to participate in Advanced Alternative Payment Models (AAPMs), and to further reduce the administrative and regulatory burdens family physicians face in the Merit-based Incentive Payment System (MIPS). The AAFP appreciates the opportunity to comment on this interim final rule with comment period, and looks forward to being a resource and partner to CMS in achieving the goals of MACRA.

About Family Medicine

Family physicians are dedicated to treating the whole person. These residency-trained, primary care specialists provide a wide variety of clinical services. They treat babies with ear infections, adolescents with depression, adults with hypertension, and seniors with multiple chronic illnesses. With a focus on prevention, primary care, and overall care coordination, they treat illnesses early and, when necessary, refer their patients to the right specialist and advocate for their care.

One out of every five office visits in the United States are with family physicians. This translates to more than 192 million office visits with family physicians each year. This is 66 million more office visits than the next largest medical specialty. More Americans depend on family physicians than on any other medical specialty.

AAFP Summary

To improve the Quality Payment Program (QPP), in summary, the AAFP:

- Remains supportive of an opt-in pathway for those MIPS-eligible clinicians who find themselves below the low-volume threshold.

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- Believes it would be both beneficial and logical if those in similar practices that might be part of a larger, multi-specialty group could report as a smaller sub-group, specifically for quality reporting.
- Believes CMS should retain cross-cutting measures in specialty sets with fewer than six measures to ensure parity in quality reporting across all eligible clinicians. There should be parity in quality reporting, and all eligible clinicians should submit data on six measures using cross-cutting measures, if necessary.
- Remains opposed to the use of Medicare Spending per Beneficiary (MSPB) and total per capita cost. These measures were developed for use at the tax identification level (TIN) level. Their validity at the solo/small practice level is questionable.
- Asks CMS to find ways to hold harmless, for purposes of the cost category, physicians who cannot be reliably measured against at least one episode-based cost measure, until such time when CMS can create a more even and meaningful playing field in terms of cost measurement.
- Remains very concerned about the complexity of scoring in MIPS performance categories.
- Thanks CMS for finalizing its proposal to exempt any APM entities enrolled in round 1 of CPC+ from the Medical Home Model-eligible clinician limit. We urge CMS to extend this exemption provision across the board and not apply it to any future medical home model APMs.
- Generally agrees with the potential definition of “Other Payer Medical Home Model,” and offers a few suggestions intended to strengthen the primary care emphasis of that definition.
- Calls for the submission of relevant information on payer arrangements to be the responsibility of the payer. CMS should automatically determine whether payers with other payer arrangements in a CMS multi-payer model are Other Payer Advanced APMs, since these plans choose to participate in Medicare and multi-payer models.
- Remains fully supportive of the Physician-Focused Payment Model Technical Advisory Committee’s (PTAC’s) role in evaluating physician-focused payment models (PFPMs) and sees significant value in broadening the PFPM definition to include any public and private payment model.
- Fully supports CMS establishing a policy that applies the extreme and uncontrollable circumstance policies for the MIPS performance categories without requiring a MIPS-eligible clinician to submit an application.

MIPS Program Details

II. C. 2. Exclusions

Summary

For the 2018 performance period, CMS finalized their proposal to increase the low-volume threshold to exclude individual MIPS-eligible clinicians or groups with less than or equal to \$90,000 in Part B allowed charges, OR less than or equal to 200 Part B beneficiaries.

Though CMS recognized the need for practices to opt in to the MIPS program in the 2019 performance year, in comments sent in response to the proposed rule, the AAFP urged CMS to offer a MIPS opt-in pathway for practices otherwise excluded from MIPS based on the low-volume threshold exclusions in the 2018 performance period.

In the interim final rule, CMS seeks comment on ways to implement an opt-in policy in 2019 without adding burden to physicians. CMS seeks feedback on ways to mitigate the concern that only high

performers will opt in. The agency seeks input on whether the current application of the low-volume threshold to groups is appropriate.

AAFP Response

The AAFP remains supportive of an opt-in pathway for those MIPS-eligible clinicians who find themselves below the low-volume threshold. Specifically, the AAFP believes any clinician who is below one, or both, of the set thresholds should have the option to participate in MIPS.

While CMS has cited concerns with only high performers opting in, the AAFP is concerned that practices that may be high performing and should be rewarded, are currently excluded. As CMS has stated, the low-volume threshold was set to exclude small practices and those in rural areas. If these practices find themselves as high performers, they should be rewarded as such, and not arbitrarily excluded from a program based on their size or location. In addition, we would point out that MIPS APMs are a group of potentially very high performers that will be included in the program and could also potentially skew the final score. Since MIPS is a relatively new program, CMS should monitor which practices opt in over time to understand patterns of participation and identify ways to incent practices—regardless of size or location—to be able to participate.

As a method for operationalizing the ability to opt in, CMS could choose to use the same methods as those for partial qualifying participants (QPs) who are opting in to MIPS. Alternatively, eligible clinicians could opt in through the CMS portal where they check their eligibility status.

II.C.3. Group Reporting

Background

CMS received feedback that groups would like portions of their group to report as a subset. In future rulemaking, CMS looks to establish group-related policies that would permit subgroup reporting. The agency seeks comment on additional ways to define a group not solely based on TIN (e.g., practice sites).

AAFP Response

The AAFP is supportive of CMS' position to allow for subgroup reporting and appreciates the agency is attempting to offer flexibility in this regard. However, current policy does not allow TINs to split. **The AAFP believes it would be both beneficial and logical if those in similar practices that might be part of a larger, multi-specialty group could report as a smaller sub-group, specifically for quality reporting.** We encourage CMS to consider practice location as a possible definition for a subgroup. To maintain the integrity of TIN accountability and support of team-based care, TIN subgroup scores could be rolled up to the TIN level, using methodology like that previously used under the Value Modifier for rolling up individual scores to the group level.

c. Selection of MIPS Quality Measures for Individual MIPS-Eligible Clinicians and Groups

Background

CMS continues to consider cross-cutting measures important and seeks comment on future ways to incorporate cross-cutting measures into MIPS.

AAFP Response

The AAFP believes CMS should retain cross-cutting measures in specialty sets with fewer than six measures to ensure parity in quality reporting across all eligible clinicians. Requiring every eligible clinician to report six measures gives Medicare beneficiaries a greater assurance of the

quality of care they are receiving. This would also allow for better comparison between MIPS participants and would give CMS greater confidence in their comparison of eligible clinicians. Also, if every eligible clinician reports the same number of measures, this would significantly streamline the complicated internal processes CMS uses for measure validation.

CMS may also consider identifying a cross-cutting measure that all clinicians report, based on current priority issues facing health care, and incorporating a collaborative improvement activity to support it. For example, the current environment may suggest the need for all clinicians to examine the use of opioids, or the need to close the referral loop. Such a measure may be introduced as pay for reporting, but not pay for performance. Prior initiatives with a national collaborative focus, such as those conducted by the Institute for Healthcare Improvement (IHI) to reduce hospital-acquired infections, have had impressive results. This approach would be more aligned with quality improvement methodology and would help encourage clinicians and measurement experts to improve the concept.

c. Scoring Flexibility for ICD-10 Measure Specification Changes During the Performance Period

Background

CMS is concerned about instances where clinical guideline changes, or other changes to a measure, occur during a performance period that might render the measure no longer comparable to a benchmark. CMS seeks comment on whether they should apply similar scoring flexibility to such measures.

AAFP Response

The AAFP applauds CMS for recognizing the challenges associated with reporting measures that have undergone a change in guidelines. We encourage CMS to apply scoring flexibility as described for International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) changes to these measures. The AAFP encourages CMS to ensure there are at least six months within the performance period for which the measure had consistent guidelines to be scored for the quality category. This process would need to be evaluated to ensure desired outcomes over time.

II.C.6.d Cost performance category

Summary

CMS is not finalizing its proposal to reweight the cost category to zero percent for the 2018 performance period. Instead, it is finalizing its alternative proposal to increase the weight to 10%. In response to comments, CMS notes it does not feel that the statute provides the flexibility to reweight the cost category again in the 2019 performance period. Therefore, it is expected to increase to 30% beginning in 2019. CMS also notes that it does not have the statutory authority to exempt small practices from the cost category. CMS is finalizing its proposal to include total per capita costs and Medicare Spending per Beneficiary (MSPB) in the calculation of the cost category score. In response to comments, CMS states that it believes the measures are the best measures available for the cost performance category as they are considered tested and reliable for the Medicare population. CMS also writes that it does not believe it would be appropriate to remove Medicare Part B drugs from the cost measures.

CMS is finalizing its proposal to not include ten episode-based measures previously adopted. CMS will continue its development and outreach as it develops new episode-based measures.

AAFP Response

The AAFP remains opposed to the use of Medicare Spending per Beneficiary (MSPB) and total per capita cost. These measures were developed for use at the TIN level, and their validity at the solo/small practice level is questionable. We reiterate that a measure may be considered reliable, but can still lack validity. We refer CMS to our [comments](#) about the 2018 QPP proposed rule for our concerns with the reliability and validity of these measures. In addition, the National Quality Forum (NQF) did not endorse CMS' total per capita cost measure (CMS Measure #2165). NQF questioned the utility of the measure to improve cost performance due to concerns with its attribution method. NQF noted that primary care providers may have limited ability to meaningfully influence the cost of specialists, inpatient care, and post-acute care, but would ultimately be held responsible for these costs. The AAFP encourages CMS to explore alternatives to these measures and offers the two utilization measures of the Comprehensive Primary Care Plus (CPC+) program (inpatient hospital utilization and emergency department utilization) as such alternatives.

Further, the AAFP believes more meaningful cost measures are needed—especially when payment is partially based on these measures. As a result, the AAFP continues to urge CMS to find pathways to ease the transition to include cost measurement until meaningful cost measures can be implemented. We remain highly concerned with the impact of the finalized measures, which will hold primary care more accountable for costs than other sub-specialties. An example of this is the current contours of the total per capita cost measure, where patient attribution methodology relies on primary care services provided by primary care. Not only does this measure hold primary care physicians accountable for costs they cannot control, it holds them more accountable for costs than others. This disparity will be even more impactful when cost increases to 30% in the 2019 performance period.

We believe CMS' intent is to create a level playing field for all eligible clinicians, regardless of specialty. However, using two cost measures that hold primary care more accountable than others will result in an unlevel playing field—which is especially problematic given the compounding undervaluation of primary care services. This inequity is exacerbated by the exceptions that specialists and subspecialists receive in the quality category. Specialists and subspecialists can report on less than six measures if there are not enough available. Since there is a wealth of primary care measures, this will not affect primary care. Therefore, primary care physicians will be more heavily measured on quality and cost than other specialties. **Until such time when CMS can create a more even and meaningful playing field, we ask CMS to find ways to hold harmless physicians who cannot be reliably measured against at least one episode-based cost measure.**

7.(2) Scoring the Quality Performance Category for Data Submission via Claims, EHR, Third-party Data Submission Options, CMS Web Interface and Administrative Claims

Summary

Currently, benchmarks are drawn from performance in the prior two years and they are not stratified (by specialty, practice size, location, etc.). CMS believes stratifying benchmarks according to practice size could have unintended negative consequences for the stability of benchmarks, equity across practices, and quality of care for beneficiaries. They note, that for many measures, stratification is not needed as the measures are only meaningful to certain specialties and only submitted by those specialties. In most instances, the current benchmarking approach compares like clinician to like clinician. CMS seeks comment on how they can improve their benchmarking methodology, whether the current methodology has been successful in achieving the goals they aimed to achieve, and if not, what CMS could do differently.

AAFP Response

It is difficult to evaluate the effectiveness of current benchmarks without feedback on measures submitted for the 2017 performance period. Once enough data have been submitted, CMS will need to evaluate whether to stratify according to size and specialty, and determine if there is a difference in performance that would warrant a change in benchmarks.

The AAFP is concerned that the current approach to scoring the quality category in QPP undermines the concept of using benchmarks to indicate value. Benchmarks should serve the purpose of motivating improvement to patient care by applying best practices used by top performers. The scoring mechanisms used in QPP, with multiple benchmarks for various methods of reporting, have reduced benchmarking to be reflective of practice characteristics, such as documentation practices, reporting mechanisms, degree of electronic health record (EHR) adoption, capability of technology to extract data, and/or ability of reporters to afford well-trained staff to carry-out quality reporting. The definition of quality should not depend on these or other practice characteristics, such as size or location of practice. The AAFP believes CMS must avoid creating a two-tier health care system where lower quality is acceptable, depending on practice/clinician characteristics. Patient characteristics are a valid reason to risk-adjust quality measures, but not practice characteristics. Patients need valid, reliable data to help them determine where they can receive the best care.

The current QPP scoring approach is not capable of detecting meaningful differences in clinician performance. Clinicians have an incentive to report measures where their performance falls into the higher decile to maximize their score. Specialties with “easier” measures will score higher. Clinicians working for systems with well-developed information and analytic systems will score higher. Reporting measures with very high-performance levels (such as topped-out measures) will cause very small differences in performance to appear as though they represent important differences in quality. We remind CMS that many clinicians will be excluded from MIPS, so data is incomplete.

Ideally, quality measures (drawn from the core measure sets developed by the multi-stakeholder Core Quality Measure Collaborative) should address only the most important aspects of care within that specialty. Benchmarks should be set for those key measures and be consistent for all. Since performance may, in fact, depend on characteristics of the patient population, quality measures should be adjusted for severity of illness, comorbidities, patient choice, and socioeconomic factors.

(e) Scoring for MIPS-Eligible Clinicians that Do Not Meet the Quality Performance Category Criteria Summary

MIPS-eligible clinicians who fail to submit any measures under the quality performance category will receive zero points for the category. CMS will validate that eligible clinicians who submit less than six measures did not have at least six measures to submit using their chosen reporting mechanism. CMS seeks comment about how to modify the validation process in year three when eligible clinicians may use multiple submission mechanisms within each MIPS category.

AAFP Response

The AAFP again suggests that there should be parity in quality reporting and all eligible clinicians should submit data on six measures, using cross-cutting measures, if necessary. In the future, since there will be multiple ways to report within the quality category, every specialty should have six measures to report. Because of this, no validation process should be needed, thus decreasing the burden of program administration for CMS and physician practices.

2. Final Score Calculation

Summary

CMS finalized many policies as proposed. Each category receives a score, and that score is multiplied by the category weight. These scores are added together to calculate the MIPS final score. CMS seeks comment on approaches to simplify the scoring system, display scores, and provide feedback so MIPS-eligible clinicians can easily understand how their scores are calculated.

AAFP Response

The AAFP remains very concerned about the complexity of scoring MIPS performance categories. To simplify, CMS should consider having the points for each category equal the percentile weight for the category. For example, in the improvement activities category, CMS should use three activities that each carry a weight of five points. Also, having consistency in naming nomenclature would reduce confusion in scoring. Scores should be displayed in a location familiar to clinicians, like the portal used to confirm MIPS-eligibility status. CMS could add to the National Provider Identifier (NPI) look-up tool a feature to confirm the clinician's MIPS score. In addition, CMS could provide the scoring formulas when feedback is given to eligible clinicians to remind them how scores were calculated.

3. Final Score Performance Category Weights

Summary

For the 2018 performance period, CMS finalized category weights as follows: quality is weighted at 50%, cost is weighted at 10%, advancing care information (ACI) is weighted at 25%, and improvement activities is weighted at 15%. Cost will increase to 30% and quality will decrease to 30% beginning in the 2019 performance period. CMS seeks comment on alternatives to category weight policies, such as shortening the performance period rather than reweighting.

AAFP Response

The AAFP is concerned about the MIPS final scores that have been assigned the threshold due to reweighting policies. This could potentially alter the next year's mean or median MIPS scores, which would alter the performance threshold. As an alternative, CMS could assign a null score to these practices, or not factor these scores into the mean or median when calculating the subsequent year performance threshold.

II.D. Overview of the APM Incentive

c. Bearing Financial Risk for Monetary Losses

(1) Medical Home Model Eligible Clinician Limit

Summary

CMS is finalizing its proposal to exempt any entities in round 1 of the CPC+ Model as of January 1, 2017, from the requirement that, beginning in the 2018 QP performance period, the Medical Home Model financial risk standard applies only to an APM entity that is participating in a Medical Home Model if it has fewer than 50 eligible clinicians in its parent organization.

AAFP Response

We thank CMS for finalizing its proposal to exempt any APM entities enrolled in round 1 of CPC+ from the Medical Home Model-eligible clinician limit. We continue to believe that limit is arbitrary and hinders CMS' goal to both encourage and expand participation in AAPMs. The assumption of risk should not be determined by a general threshold number of eligible clinicians

within the organization, but should be based on each entity's demonstrated capabilities. We remain troubled that CPC+ participants in round 2 will not be exempt from this requirement, and ask that CMS consider exempting round 2 participants, as well as any future rounds of the CPC+ program, from the limit as well. **We urge CMS to extend this exemption provision across the board and not apply it to any future medical home model APMs.**

b. Other Payer Advanced APM Criteria

Summary

In summary, CMS is finalizing the following policies:

- CMS is finalizing that an “other payer” arrangement would meet the generally applicable revenue-based nominal amount standard CMS is finalizing if, under the terms of the other payer arrangement, the total amount that an APM entity potentially owes the payer or foregoes and amount equal to at least: 8% of the total combined revenues from the payer to providers and other entities in the payment arrangement only for arrangements that are expressly defined in terms of revenue for the 2019 and 2020 QP performance periods. CMS is finalizing its proposal that, under the generally applicable nominal amount standard for Other Payer Advanced APMs, an “other payer” arrangement would need to meet either the benchmark-based nominal amount standard or the revenue-based nominal amount standard, but need not meet both.
- CMS is finalizing that a Medicaid Medical Home Model would meet the benchmark-based Medicaid Home Model nominal amount standard if, under the terms of the other payer arrangement, the total annual amount that an APM entity potentially owes or foregoes under the Medicaid Medical Home Model must be at least:
 - 3% of the average estimated total revenue of the participating providers or other entities under the payer for 2019 QP performance period.
 - 4% of the average estimated total revenue of the participating providers or other entities under the payer for QP performance period 2020.
 - 5% of the average estimated total revenue of the participating providers or other entities under the payer for QP performance period 2021 and later.

CMS is not establishing a definition of Other Payer Medical Home Model. However, CMS may consider creating such a definition in future rulemaking. CMS welcomes further public comment on this topic.

AAFP Response

Regarding a potential definition of “Other Payer Medical Home Model,” the AAFP generally agrees with the CMS definition and offers a few suggestions intended to strengthen the primary care emphasis of that definition. The AAFP defines a medical home as one that is based on the [Joint Principles of the Patient-Centered Medical Home](#) (PCMH) and the five key functions of the Comprehensive Primary Care Plus (CPC+) initiative. These key functions are:

1. **Access and Continuity** - Medical homes optimize continuity and timely, 24/7 first-contact access care supported by the medical record. Practices track continuity of care by physician or panel.
2. **Planned Care and Population Health** - Medical homes proactively assess their patients to determine their needs and provide appropriate and timely chronic and preventive care, including medication management and review. Physicians develop a personalized plan of care for high-risk patients and use team-based approaches to meet patient needs efficiently.

3. Care Management - Medical homes empanel and risk stratify their whole practice population and implement care management for patients with high needs. Care management has benefits for all patients, but patients with serious or multiple medical conditions benefit more significantly due to their needs for extra support to ensure they are getting the medical care and/or medications they need.
4. Patient and Caregiver Engagement - Medical homes engage patients and their families in decision making in all aspects of care. Such practices also integrate into their usual care both culturally competent self-management support and the use of decision aids for preference sensitive conditions.
5. Comprehensiveness and Coordination - Primary care is the first point of contact for many patients, and therefore is the center of patients' experiences with health care. As a result, primary care is best positioned to coordinate care across settings and among physicians in most cases. Primary care medical homes work closely with patients' other health care providers to coordinate and manage care transitions, referrals, and information exchange.

The functions of a medical home depend on the support of enhanced and prospective accountable payments, continuous quality improvement driven by data, and optimal use of health information technology.

Given that one out of every five office visits in the U.S. are made with family physicians, we believe it is critical that CMS require primary care as an essential element in other payer arrangements for promoting patient-centered, high-quality care. We further encourage CMS to strengthen the essential elements it otherwise proposed in the following manner:

- Model participants are either primary care medical home practices or multispecialty practices that provide medical homes staffed by primary care physicians and offer primary care services.
- Empanelment of each patient to a primary care physician.

Primary care is 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, general internal medicine, or general 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.

c. Determination of Other Payer Advanced APMs

Summary

CMS seeks comment regarding the current duration of the contracts governing Other Payer Advanced APMs, how frequently relevant portions of those contractual arrangements may change, and whether creating some multi-year determination would encourage the creation of more multi-year payment arrangements, as opposed to payment arrangements that are one year. CMS also seeks comment on what kind of information should be submitted annually to update an Other Payer Advanced APM determination or to otherwise determine there have been no changes to an other payer arrangement that would affect CMS' prior determination that the arrangement is an Other Payer Advanced APM. CMS will consider in future rulemaking whether to introduce an option where Other Payer Advanced APM determinations could be extended for more than one year a time.

AAFP Response

The AAFP supports the concept of introducing an option where Other Payer Advanced APM determinations could be extended for more than one year at a time. Ideally, this would involve a periodic process in which, after a payer (or APM entity or eligible clinician) 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 (e.g., three years). The certification would last for the designated period or until the payer makes substantive changes to the arrangement that would disqualify it as an Other Payer Advanced APM. This is an opportunity for CMS to minimize burden on practices and payers.

The AAFP is disappointed it is voluntary for payers to submit information about payer arrangements. If eligible clinicians want to submit relevant information, they should have the opportunity, but it should not be required due to physician burden. **Ultimately, the AAFP calls for the submission of relevant information on payer arrangements to be the responsibility of the payer.** Physician practices are already deeply overburdened by paperwork and red tape, as the agency recognizes through the recently launched “Patients over Paperwork” initiative. Private payers have a better understanding and access to the information CMS needs to consider and determine whether a payer arrangement satisfies the Other Payer Advanced APM criteria. Payer submission would also prevent CMS from receiving multiple applications for the same payer arrangement from all providers participating in the arrangement, ease and speed CMS review, and support CMS’ stated goal of administrative simplification for all involved.

To decrease the burden on physician practices, the AAFP believes CMS should automatically determine whether payers with other payer arrangements in a CMS multi-payer model are Other Payer Advanced APMs, since these plans choose to participate in Medicare and multi-payer models. This is an opportunity for CMS to decrease the amount of administrative burden placed on eligible clinicians and payers by using information CMS has already received when other payers agreed to participate in the multi-payer model.

d. Calculation of All-Payer Combination Option Threshold Scores and QP Determination

Summary

CMS is finalizing that an eligible clinician may request a QP determination at the eligible clinician level, and that an APM entity may request a QP determination at the APM entity level. CMS is requesting comments on whether, in future rulemaking, it should also add a third alternative to allow QP determinations at the TIN level when all clinicians who have reassigned billing to the TIN are included in a single APM entity. CMS is interested in whether submitting information to request QP determinations under the All-Payer Combination Option at the TIN level would more closely align with eligible clinicians’ existing recordkeeping practices, and thereby be less burdensome.

AAFP Response

The AAFP supports making QP determinations at the TIN or group level. This would encourage alignment between Medicare AAPMs and Other Payer Advanced APMs. Making QP determinations at the TIN level is consistent with the concept of team-based care that APMs otherwise support, and it reflects the fact that individual eligible clinicians often benefit from improvements made at the practice (i.e., TIN or group) level. Furthermore, we believe practices participating in APMs are sufficiently advanced and have certified electronic health record technology that permits reporting information at the APM entity group level to facilitate the ability to make QP determinations at the group (i.e., TIN) level.

The AAFP appreciates that CMS decided to use the county level to determine whether a state operates a Medicaid APM or a Medicaid Medical Home Model at a sub-state level. However, the AAFP remains concerned with burdening eligible clinicians with identifying and certifying where they saw the most patients during the relevant All-Payer QP performance period. Physicians already spend an excessive amount of time on administrative duties. If states (or payers) calculated this, the state/payer could write one program/software report to extract data for all physicians, instead of each physician having to pay IT consultants to write a report to extract their own data.

7. Physician-Focused Payment Models (PFPMs)

Summary

MACRA established a process for stakeholders to propose physician-focused payment models (PFPMs) to the Physician-Focused Payment Model Technical Advisory Committee (PTAC), a federal advisory committee that provides advice to the Secretary of the Department of Health and Human Services (HHS). MACRA requires the PTAC to review stakeholders' proposed PFPMs, prepare comments and recommendations regarding whether such proposed PFPMs meet the PFPM criteria established by the secretary, and submit those comments and recommendations to the secretary. MACRA also requires the Secretary to review the PTAC's comments and recommendations on proposed PFPMs and to post "a detailed response" to those comments and recommendations on the CMS website.

In the proposed 2018 QPP regulation, CMS sought comments on changing the definition of PFPM to include payment arrangements with Medicare, Medicaid, or CHIP, or any combination of these, as a payer. CMS also sought comments on revising the definition to require that a PFPM be an APM or a payment arrangement operated under legal authority for Medicaid or the Children's Health Insurance Program (CHIP) payment arrangements. Finally, CMS sought comments on how current PFPM criteria pertain exclusively to payment arrangements, and as such, are not yet focused on care delivery reforms without a payment component.

In the 2018 QPP interim final rule with comment period, CMS summarized public comments received on these areas and noted that many commenters were in favor of changing the definition of PFPM to include payment arrangements with Medicaid, CHIP, Medicare Advantage, or a combination of public and private payers. However, since CMS did not actually propose any changes, the agency did not make changes to the current definition of PFPM, which is an APM in which Medicare fee-for-service is a payer, and thus does not include an APM in which Medicaid or CHIP is the only payer. CMS will consider the feedback on the PFPM definition and PFPM criteria received from commenters in future rulemaking.

AAFP Response

As articulated in the AAFP's response to the proposed 2018 regulation, **the AAFP remains fully supportive of the PTAC's role in evaluating PFPMs.** Considering that the PFPM submitted by the AAFP to the PTAC ([Advanced Primary Care: A Foundational Alternative Payment Model \(APC-APM\) for Delivering Patient-Centered, Longitudinal, and Coordinated Care](#)), is overtly multi-payer in design, we maintain full support for CMS expanding PTAC's purview to examine PFPMs that include Medicaid and CHIP, and a combination of public and private payers, even if Medicare fee-for-service is not one of those payers. The AAFP supports the PTAC considering PFPMs that fall outside of the traditional Medicare population's conditions because:

- Multi-payer APMs are important to align incentives across payers and populations.

- Cost and quality impacts are likely to be greater when incentives are aligned.
- Doing so would reduce burden for practices and physicians.

Though CMS currently defines a PFPM as an APM, because CMS recognizes APMs are defined under 1115A authority, and payment arrangements under Medicaid or CHIP do not necessarily meet the definition of APM, we nevertheless support CMS broadening the scope of PFPMs to foster payment models that would serve a wide variety of patient populations.

The AAFP sees significant value in broadening the PFPM definition to include any public and private payment model. Delivery reform should be included as a component in such proposals. We encourage CMS to include Medicaid or CHIP in PFPMs, since doing so should encourage payment and delivery innovations.

III. Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year Interim Final Rule with Comment Period

Summary

CMS established a reweighting policy for the quality, cost, and improvement activities performance categories beginning with the 2018 performance period. Under the policy, MIPS-eligible clinicians affected by extreme and uncontrollable circumstances may submit a request for reweighting of the quality, cost, and/or improvement activities performance categories for the second year of MIPS by the deadline of December 31, 2018. The policy does not apply to APM entities under the APM scoring standard.

CMS recognizes that the events of Hurricanes Harvey, Irma, and Maria impacted large regions of the U.S. in 2017. Due to the broad impact of these hurricanes, and given no policies are currently in place for performance period 2017, CMS believes changes are needed to policies for extreme and uncontrollable circumstances for the transition year for individual MIPS-eligible clinicians.

CMS is establishing a policy for the 2017 MIPS performance period under which CMS would automatically apply the extreme and uncontrollable circumstance policies for the MIPS performance categories without requiring a MIPS-eligible clinician to submit an application when CMS determines a triggering event has occurred and the clinician is in an affected area. CMS will determine if an individual MIPS-eligible clinician is in an impacted area based on the practice location address listed in the Provider Enrollment, Chain and Ownership System (PECOS). CMS invites comments on applying the automatic extreme and uncontrollable circumstance policy based on triggering events that affect an entire region or locale, on a case-by-case basis.

The policy does not apply to groups for the transition year, although CMS may address its application to groups in future rulemaking. CMS requests comments on the automatic extreme and uncontrollable circumstance policy for individual MIPS-eligible clinicians for the 2017 MIPS performance period. CMS will consider expanding this policy to include groups in future years, but CMS believes there are some policy questions that need to be addressed through rulemaking first. For example:

- How should we determine whether a group, which may have multiple practice sites, should qualify for the automatic extreme and uncontrollable circumstance policy?
- Should it be based on whether a certain percentage of the clinicians in the group are located in an affected area?

It is possible that some MIPS-eligible clinicians in the affected areas may not be significantly impacted by the extreme and uncontrollable circumstance. Therefore, CMS is adopting a policy that if a MIPS-eligible clinician in an affected area submits data for any of the MIPS performance categories by the applicable submission deadline for the 2017 performance period, they will be scored on each performance category for which they submit data, and the performance category will not be reweighted to zero percent in the final score.

For the 2017 MIPS performance period, it is possible CMS may receive data from MIPS-eligible clinicians in affected areas that does not represent the entire performance period. In those cases, CMS will score the submitted data, even if does not represent the entire performance period. However, due to the policy CMS adopted that a MIPS-eligible clinician with fewer than two performance category scores will receive a final score equal to the performance threshold, the clinician would also have to submit data for the improvement activities or the ACI performance categories to receive a final score higher than the performance threshold. CMS invites comments on these policies related to scoring the performance categories.

CMS believes the recent Hurricanes Harvey, Irma, and Maria are triggering events for the automatic extreme and uncontrollable circumstance policy.

CMS had finalized the APM scoring standard, which is designed to reduce reporting burden for participants in certain APMs by minimizing the need for them to make duplicative data submissions for both MIPS and their respective APMs. CMS is not modifying the APM scoring standard policies that apply in 2017 for MIPS-eligible clinicians who have been affected by extreme and uncontrollable circumstances.

CMS seeks comment on the policy to determine which MIPS-eligible clinicians are in affected areas based on practice location addresses listed in PECOS, and how CMS should apply the automatic extreme and uncontrollable circumstance policies for groups and virtual groups in future years.

AAFP Response

The AAFP appreciates and supports CMS' policy efforts that recognize extreme and uncontrollable circumstances pertaining to hurricanes, fires, tornados, and other natural disasters. We concur with CMS that extreme and uncontrollable circumstances are rare events entirely outside the control of the clinician and of the facility in which the clinician practices that cause the MIPS-eligible clinician to be unable to collect information that the clinician would submit for a performance category or to submit information that would be used to score a performance category for an extended period.

We fully support CMS establishing a policy that applies the extreme and uncontrollable circumstance policies for the MIPS performance categories without requiring a MIPS-eligible clinician to submit an application. The application of the extreme and uncontrollable circumstances policies should be available when CMS determines a triggering event has occurred and the clinician is in an affected area. The AAFP agrees with the agency that doing so will reduce burden for clinicians who have been affected by these catastrophes.

The AAFP also supports that the types of events that could trigger this policy would be events designated as Federal Emergency Management Agency (FEMA) major disasters or a public health emergency declared by the Secretary.

Furthermore, we agree that some MIPS-eligible clinicians in the affected areas may not be significantly impacted by a qualifying disaster and thus we appreciate CMS allowing these eligible clinicians to participate in MIPS.

We agree that CMS should determine if an individual MIPS-eligible clinician is in an impacted area based on the practice location address listed in PECOS. To help CMS develop this policy to include groups in future years, the AAFP encourages CMS to determine whether a group, which may have multiple practice sites, should qualify for the automatic extreme and uncontrollable circumstance policy by determining whether more than 50% of NPIs billing under the group's TIN are in an impacted area. If more than 50% of NPIs under the TIN practice in the impacted area, CMS should automatically apply the extreme and uncontrollable circumstance policies for the MIPS performance categories without requiring the group to submit an application. Conversely, if the group is determined to be in an impacted area, yet still submits MIPS performance category data, CMS should allow the group to participate in MIPS.

However, groups that do not meet the 50% threshold for automatic exemption should be allowed to submit an application. This may be necessary, for example, if the administrative headquarters is incapacitated, even though the majority of NPIs are not impacted. As for scoring, if a group is not automatically excluded based on the 50% threshold, then only those NPIs within the group that are not in the affected areas should be required to submit data, and data completeness should be based on data submitted for unaffected practices.

We believe it is critical for CMS to notify groups as well as all NPIs that are automatically eligible for exemption as soon as possible after CMS makes the determination. This could be accomplished through use of the CMS portal, written notice, and/or use of other means.

Finally, we concur with CMS to dispense with normal rulemaking requirements and that there is good cause to waive the notice and comment requirements due to the impact of Hurricanes Harvey, Irma, and Maria.

TABLE G: Improvement Activities with Changes for the Quality Payment Program Year 2 and Future Years

IA CC 4 TCPi participation

Summary

The 2018 QPP final rule changed the weight of this improvement activity from high to medium, against the recommendations of the AAFP.

AAFP Response

Based on the AAFP's assessment, TCPi does not meet the criteria for an APM or a MIPS APM. The CMS rationale given for the change incorrectly states that TCPi is a MIPS APM. CMS has also published a document, titled "CMS Alternative Payment Models in the Quality Payment Program." The document lists TCPi as an APM. CMS has listed TCPi as both an APM and a MIPS APM. However, this is generating confusion given that TCPi is not a payment model and does not meet the statutory definition of an APM or the MIPS APM criteria finalized in the 2017 QPP final rule. By listing TCPi as both an APM and as an improvement activity, it appears that TCPi participants would automatically receive one half of the total points for the MIPS improvement activities performance category score for that year, and will also be allowed to claim IA CC 4 as an additional

improvement activity because it is listed on the improvement activities list. The AAFP recommends that CMS issue a clarification that TCPi is not an APM or a MIPS APM.

We feel TCPi participation should be rewarded—and that participation in TCPi should continue to be a high-weighted improvement activity because TCPi participation directly addresses areas with the greatest impact on beneficiary care, safety, health, and well-being, including patient and family-centered care design, team-based relationships, population management, community partnerships, care coordination, evidence-based care, enhanced access, continuous data-driven quality improvement, optimal use of health IT, and culture of quality. Other IAs that address only one of these elements are rated as high (e.g., IA_EPA_1). Furthermore, in Section II.C.7.a.(5)(a) of the final rule CMS uses TCPi as an example of an activity that should be rated high. This section reads, *“Additionally, activities that require performance of multiple actions, such as participation in the Transforming Clinical Practice Initiative (TCPI), participation in a MIPS eligible clinician’s state Medicaid program, or an activity identified as a public health priority (such as emphasis on anticoagulation management or utilization of prescription drug monitoring programs) are justifiably weighted as high (81 FR 77311 through 77312).”* We ask that CMS change the weighting to high for participation in TPCi and also clarify that it is not an APM or MIPS APM to address any confusion.

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

Sincerely,

A handwritten signature in black ink, appearing to read 'John Meigs, Jr.', with a stylized flourish at the end. The signature is written in a cursive style.

John Meigs, Jr., MD, FFAFP
Board Chair