



August 18, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445–G, Hubert H. Humphrey Building
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 “Medicare Program; CY 2018 Updates to the Quality Payment Program” [proposed rule](#), published by the Centers for Medicare & Medicaid Services (CMS) in the June 30, 2017, *Federal Register*.

Family medicine plays a critical role in delivering care to patients in communities across the country. Family physicians are the most visited specialty—especially in underserved areas. Family physicians conduct approximately one in five of all office visits in the United States. This represents more than 192 million visits annually.

We are generally pleased with this proposed rule since CMS took 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)*. However, we offer recommendations in this letter to support two of MACRA’s key goals—to strengthen primary care for Medicare beneficiaries, and to support more physicians to participate in alternative payment models (APMs). Many of the proposed modifications are consistent with recommendations the AAFP has provided CMS, and we are pleased that the agency followed our advice and recommendations. We appreciate that CMS proposed policies to reduce administrative and regulatory burden for family physicians that seek participation in either the Merit-based Incentive Payment System (MIPS) or Advanced Alternative Payment Model (AAPM) tracks.

To improve the final 2018 Updates to the Quality Payment Program regulation, in summary the AAFP:

- Strongly urges CMS to offer the ability for a practice to appeal the agency’s small practice size determination.
- Encourages CMS to use 50 percent of NPIs billing under the group’s TIN as the rural practice threshold for the 2018 performance period.
- Adamantly demands CMS offer a MIPS opt-in pathway for practices otherwise excluded from MIPS based on the low-volume threshold exclusions in the 2018 performance

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period. We strongly assert that practices of any size should, if they wish, participate fully in MIPS independently or via virtual groups.

- Is pleased to see that CMS is not adding unneeded administrative and regulatory complexity by treating virtual groups different than non-virtual groups under MIPS.
- Is concerned that CMS is prematurely requiring a full year of quality reporting for the 2018 performance year. We encourage CMS to continue to allow 90-day reporting periods for the quality, ACI, and improvement activities performance categories in the MIPS 2018 performance period.
- Urges CMS to withhold the option for submission through multiple mechanisms in one MIPS category for future implementation, or until CMS has become comfortable with the data received in year one of the program.
- Is supportive of reweighting the quality category to 60 percent, while the cost category remains at zero. The AAFP supports CMS' proposal to reweight the cost category to zero percent for the 2018 performance period. Additionally, we strongly urge CMS to continue a gradual introduction of cost into the MIPS final score and increase it to 10 percent beginning with the 2019 performance period.
- Supports CMS' proposal to reweight the cost category to zero percent for the 2018 performance period (2020 payment year). Additionally, we strongly urge CMS to continue a gradual introduction of cost into the MIPS final score and increase it to 10 percent beginning with the 2019 performance period.
- Ask that CMS not assess clinicians in small practices (defined as 15 or fewer clinicians) on cost at least until valid and reliable measures are developed.
- Continues to believe family physicians cannot and should not be held accountable for the total cost of care. Both measures should be removed from the cost category. We also hold that clinicians in practices with 15 or fewer clinicians should not be assessed on cost.
- Urges CMS to test all episode-based measures prior to implementing them. The AAFP cautions CMS on implementing and scoring clinicians on measures that have never been used and may lack reliability. By introducing more change into the program, CMS will cause clinicians to continue to struggle with understanding exactly what CMS is measuring and why. CMS should continue to provide feedback on all measures, including providing feedback prior to a measure's implementation. The AAFP strongly urges CMS to make the timeline transparent for developing episode-based cost measures, especially those for chronic conditions.
- Strongly supports addition of accredited performance improvement continuing medical education programs that meet the specified criteria as a medium-weighted improvement activity.
- Strongly supports addition of this activity as a high-weighted improvement activity for adopters of the appropriate use criteria (AUC) program.
- Strongly urges revision of this proposal to enable reporting to one alternate public health agency or registry to satisfy the requirements for immunization registry reporting.
- Strongly recommends to CMS that physicians should be held harmless, in an automated fashion, by CMS if their CEHRT becomes decertified. We have concern about the vagueness of "made a good faith effort" and "through supporting documentation," in regard to the application process for this exception.
- Reiterates our steadfast opposition to the entire MIPS APM category. This entire category was created outside of the statutory requirements and introduces an unnecessary level of complexity to an already complex program. The AAFP strongly

encourages consistency and equal reporting standards among all MIPS-eligible clinicians.

- Is concerned that eligible clinicians may intentionally remain in MIPS APMs, given the scoring advantage they have been given, instead of progressing towards AAPMs, which is the intent of the QPP. We urge CMS to closely monitor participants who may be intentionally avoiding the progression to AAPMs.
- Is frustrated and disappointed that CMS continues to create new terminology, not based on statute, and that serves only to confuse clinicians and make this program more complicated. We object to the MIPS APMs. We object to the new term, “Other MIPS APMs,” due to the inconsistent use of this term in the proposed rule and the confusion this leads to when interpreting requirements for clinicians.
- Encourages CMS to not allow multiple submission mechanisms within each MIPS category. The AAFP is unsure of how CMS intends to administrate this part of the program. CMS should consider withholding this portion of the proposed rule until they can demonstrate the ability to receive data and send feedback in a timely and accurate fashion.
- Is concerned that if a clinician is in MIPS and reports a measure that does not meet the case minimum or have a benchmark, the measure will receive three points. This inconsistency within the program and confusing and overly complex.
- Is concerned that using dual-eligible status as an indicator of patient complexity may severely underestimate the number of truly complex patients.
- Urges CMS to consider that not all states have expanded Medicaid. These two issues would create an uneven playing field from state to state. Dual eligibility cannot be consistently applied and would not be an accurate indicator of patient complexity.
- Believes all specialists and subspecialists should be required to meet the same program expectations as other MIPS participants.
- Agrees with the proposal to permit third-party intermediaries to submit data on behalf of not only individual eligible clinicians and groups, but also on behalf of virtual groups.
- Does not support the inclusion of five open-ended questions on the Physician Compare website. Adding these questions would only contribute to the already lengthy and administratively burdensome CAHPS survey.
- Encourages CMS to consolidate and simplify the QPP whenever possible, and establishing multiple benchmarks is unnecessary and confusing for physicians and for CMS.
- Encourages CMS to not delete the defined term for “Advanced APM Entity” in §414.1305 in favor of the more generic term “APM Entity.” If CMS proceeds to delete the term “Advanced APM Entity,” then it needs to further revise the definition of “APM Entity” to include AAPMs.
- Reminds CMS that the MACRA statute only offers CMS the ability to determine if an APM is an AAPM. This is addressed by CMS’ regulation that APMs must require APM entities to bear nominal risk. CMS has previously defined this as either eight percent of revenues or three percent of expected expenditures. Any additional calculations such as how revenue is calculated for the revenue-based standard, how risk is shared, paid back, or otherwise distributed among APM participants should be determined by the APM contracts and is outside of the purview of MACRA. CMS should not impose restrictions on how APMs carry out their contracts. Anything outside of strict criteria to determine AAPM status is non-statutory and is an overstep of CMS.
- Believes it is appropriate for primary care physicians in Medical Home Models to accept performance risk—not financial risk—based on the original MACRA statute, which

reflects Congressional intent regarding the qualification of Medical Home Models as AAPMs.

- Adamantly opposes putting APM entities and their eligible clinicians at financial risk for anything beyond their own performance.
- Believes the wording for “primary clinician” should be modified. The AAFP supports the term physician or primary care physician. Patients should be empaneled to a primary care physician.
- Strongly recommends that CMS remove the Medical Home Model financial standard in its entirety from the proposed rule and reiterates our strong belief that medical homes should not be subject to any financial risk.
- Objects to the application of a nominal amount standard to Medical Home Models. Further, the AAFP does not understand CMS’ logic in creating separate risk standards for AAPMs and Other Payer AAPMs. The AAFP believes the risk standard should be the same for all AAPMs, with the exception of Medical Home Models.
- Is disappointed that CMS chose to make it voluntary for payers to submit for the payer arrangements. If eligible clinicians want to submit the relevant information, they should have the opportunity, but it should not be required because payers choose not to submit the information. The AAFP calls for the onus of submitting relevant information on payer arrangements to be the burden of the payer.
- Believes that maintaining submitted records for 10 years is an excessive amount of time to keep records for auditing purposes.
- Fully supports expanding PTAC’s purview to examine PFPMs that include Medicaid and CHIP and a combination of public and private payers.
- Is concerned that CMS assumes that all practices have an office manager, IT support, LPN, and billing clerk to assist physicians in carrying out reporting requirements. In reality, for many small offices this work is done by the clinicians themselves, at a higher cost than CMS estimates.

II. Provisions of the Proposed Regulations and Analysis of Responses to Comments

II.C.1.c. Small practices

Summary

In the 2017 Quality Payment Program (QPP) final rule, CMS defined small practices as 15 or fewer eligible clinicians and solo practitioners. Though CMS previously considered establishing an attestation process for small practices, in the 2018 QPP proposed rule, CMS asserts the need to account for small practice size in advance of a performance period. CMS proposes to determine practice size by examining historical claims data. A small practice size determination period would include a 12-month assessment of claims from the last four months of a calendar year two years prior to the performance period, and the first eight months of the next calendar year that includes a 30-day claims run out. CMS asserts this method would allow the agency to inform practices of their status near the beginning of a performance period. Therefore, for the 2018 performance period (2020 MIPS payment year), CMS would identify small practices based on claims from September 1, 2016, to August 31, 2017. CMS then declares the agency would not change an eligibility determination regarding the size of a small practice once the determination is made for a given performance period and MIPS payment year. The proposed rule discusses how CMS considered a 24-month small practice size determination period but how that was problematic for CMS’ systems. CMS also contemplated a second option that would include attestation by a small practice, but how that would require the agency to make operational improvements and potentially would be burdensome to a practice.

AAFP Response

The AAFP supports the agency's proposal to use historical claims data to make a small practice size determination. We also support CMS informing practices of small practice size determinations prior to a performance period. However, **we strongly urge CMS to offer the ability for a practice to appeal the agency's small practice size determination.** Claims data might not accurately reflect the size of a practice, and the agency's determination could inadvertently exclude small practices as well as include practices with more than 15 eligible clinicians—especially since the determination would be made four months prior to the start of the 2018 performance year. Therefore, the AAFP urges CMS to offer a practice's recourse in this regard, by offering all practices the ability to attest to being a small practice and appeal the agency's small practice size determination.

II.C.1.d. Rural and Health Professional Shortage Areas

Summary

The 2017 QPP final rule defined rural areas as ZIP codes designated as rural by the Health Resources and Services Administration's (HRSA's) most recent area health resource file and Health Professional Shortage Areas (HPSAs) as areas designated under section 332(a)(1)(A) of the Public Health Service Act. CMS proposes to modify the definition of rural areas as ZIP codes designated as rural by HRSA. Recognizing that some MIPS-eligible clinicians could have multiple practice sites in both urban and rural areas, the 2017 QPP final rule established that one practice site with a tax identification number (TIN) in a rural ZIP code would designate that MIPS-eligible clinician as rural. For the 2018 and future performance periods, CMS believes that a higher threshold than one practice site as rural is necessary and more appropriate. CMS proposes that 75 percent of the National Provider Identifiers (NPIs) billing under the group's TIN must practice within a rural ZIP code for the practice to be considered rural.

AAFP Response

The AAFP supports using HRSA designated rural ZIP codes to determine rural practices. However, we are concerned that CMS is raising the threshold too quickly between the 2017 and 2018 performance periods by proposing that 75 percent of NPIs billing under the group's TIN be considered rural. **Instead, we encourage CMS to use 50 percent of NPIs billing under the group's TIN as the rural practice threshold for the 2018 performance period.** Though CMS noted that the 75 percent threshold matches criteria for non-patient facing MIPS-eligible clinicians, the AAFP reminds CMS that they proposed using 50 percent as the threshold for determining the number of practices within a TIN that need to be recognized as patient-centered medical homes (PCMH) for the TIN to get the full credit for the MIPS improvement activities performance category.

C.2.c. Low-Volume Threshold

Summary

The 2017 QPP final rule excluded individual MIPS-eligible clinicians or groups with less than or equal to \$30,000 in Part B allowed charges OR less than or equal to 100 Part B beneficiaries during the low-volume threshold determination period that occurs during the performance period and a prior period. In this regulation, CMS proposes to increase the 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 during the low-volume threshold determination period that occurs during the performance period and a prior period. CMS proposes this, citing the recognition that small and rural practices face unique dynamics and challenges, such as fiscal limitations and workforce shortages. This proposal would exclude approximately 134,000 additional clinicians from the current and estimated excluded 700,000 clinicians.

The proposed rule also discusses how MACRA provides authority for CMS to establish a low-volume threshold based on the following three criteria:

- The minimum number of Part B-enrolled individuals who are treated by the MIPS-eligible clinician for a performance period;
- The minimum number of items and services furnished to Part B-enrolled individuals by the MIPS-eligible clinician for a performance period; and
- The minimum amount of allowed charges billed by the MIPS-eligible clinician for a performance period.

CMS has utilized the minimum number of Part B-enrolled individuals treated by the MIPS-eligible clinician and the minimum amount of allowed charges to establish low-volume thresholds. Citing concerns that using the minimum number of items and services could incentivize clinicians to focus on volume of services, rather than the value of services provided to patients, CMS has not used the minimum number of items and services furnished criterion. However, CMS seeks comments on that unit of measurement.

AAFP Response

The AAFP appreciates that CMS recognizes the unique challenges of small practices in complying with MIPS requirements. Some of our practices that bill less than \$90,000 in Part B allowed charges or treat less than 200 Part B beneficiaries will appreciate not being subject to MIPS requirements or potential payment cuts.

However, many of our members have begun participating in MIPS in the 2017 performance period based on the current 2017 MIPS low-volume thresholds of \$30,000 in allowed charges and 100 Part B beneficiaries. By significantly raising the low-volume threshold and prohibiting those below the threshold from opting into and having their payments adjusted under MIPS, CMS is preventing practices that are above the threshold in 2017, but below the proposed threshold in 2018 from continuing to participate in MIPS and potentially receiving positive MIPS payment adjustments in future years. Also, moving practices in and out of MIPS with no clear direction for what may happen in 2019 sends mixed messages to physicians on whether they should further invest in practice transformation. It also stalls their progress towards value-based payment and APMs, which is contrary to the Congressional intent of MACRA and goals established by CMS.

Furthermore, and of grave concern to the AAFP, the proposed changes in the low-volume thresholds entirely thwart impacted practices from participating in virtual groups. Congress expressly established virtual groups in MACRA for solo and small groups to aggregate their data in order to remove any methodology biases due to their potential small number of Medicare beneficiaries. Congress included language establishing virtual groups to provide a plausible mechanism for solo and small group practices to participate and compete in the MIPS pathway against larger groups that would inherently benefit from larger numbers of beneficiaries, upon which CMS would calculate their evaluation.

Though the proposed rule eventually recognizes the need for practices to opt in to the MIPS program in the 2019 performance year, **the AAFP adamantly demands CMS offer a MIPS opt-in pathway for practices otherwise excluded from MIPS based on the low-volume threshold exclusions in the 2018 performance period.** The AAFP does not understand why CMS concedes the need to offer an opt-in for future performance years, but does not offer it for performance period 2018. **We strongly assert that practices of any size should, if they**

wish, participate fully in MIPS independently or via virtual groups. We remind the agency the 2017 final QPP rule offers partial QPs the ability to opt in to the MIPS program, albeit without being subject to a payment adjustment. Thus, precedence and agency experience—as well as a mechanism for opting in—already exist for an opt-in policy.

Excluding low-volume threshold practices in the 2018 performance period, and then potentially subjecting them to future years where the MIPS cost component could be included would put these practices at a significant disadvantage compared to practices that have experience with the 2017 and 2018 MIPS performance periods. This approach may also further create disparities between small and large practices. The latter, which are more likely to exceed the low-volume threshold, will have experience with MIPS in the early years, when the negative payment adjustments are still relatively low. In comparison, if small practices, which are more likely to fall below the current and proposed low-volume threshold, are brought in to MIPS later, payment adjustments will be larger and could be more devastating for small practices.

Many family physician practices prepared for and participated in the 2017 MIPS performance period, and will want to participate in the 2018 MIPS performance period. Needlessly ejecting them from the 2018 performance period by raising the low-volume threshold is entirely counter to the concept of increasing physician participation, understanding, and comfort with the MIPS payment pathway. Furthermore, CMS changing the low-volume threshold in the second year of the QPP program creates further uncertainty and instability with the program.

By raising the low-volume threshold and not offering an opt-in ability, CMS is further and needlessly delaying practices from payment based on value over volume, as well as the intent behind the establishment of virtual groups. Bluntly, and as discussed further in this comment letter, the virtual group option should already be in place, yet CMS was unwilling or unable to implement it for the 2017 MIPS performance period. We also support allowing solo clinicians and TINs who meet or exceed the low-volume threshold (i.e., those eligible to participate) and those who fall below the threshold (i.e., those who are excluded) the option of joining a virtual group, and be subject to MIPS payment adjustments, as long as the virtual group collectively exceeds low-volume thresholds.

However, the AAFP concurs with the agency's proposal and reasons cited by CMS to not use the minimum number of items and services as a criterion for establishing the low-volume threshold.

4. Virtual Groups

a. Background

Summary

Virtual group-level reporting is one of three ways to participate in MIPS (individual-level and group-level being the other two). Section 1848(q)(5)(I)(i) of MACRA provides that MIPS-eligible clinicians electing to be a virtual group must: (1) have their performance assessed for the quality and cost performance categories in a manner that applies the combined performance of all the MIPS-eligible clinicians in the virtual group to each MIPS-eligible clinician in the virtual group for the applicable performance period; and (2) be scored for the quality and cost performance categories based on such assessment. Section 1848(q)(5)(I)(iii) of the Act provides that the virtual group election process must include the following requirements: (1) an individual MIPS-eligible clinician or group electing to be in a virtual group must make their election prior to the start of the applicable performance period and cannot change their election during the performance period; (2) an individual MIPS-eligible clinician or group may elect to be in no more

than one virtual group for a performance period, and, in the case of a group, the election applies to all MIPS-eligible clinicians in the group; (3) a virtual group is a combination of TINs; (4) the requirements must provide for formal written agreements among individual MIPS-eligible clinicians and groups electing to be a virtual group; and (5) such other requirements as the Secretary determines appropriate.

AAFP Response

MACRA established virtual groups with a few principles and goals in mind, including: 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.

The AAFP sees great value and promise in the use of virtual groups as a means of allowing solo and small practices to aggregate patient populations, align resources, and form a structure to help them to improve their performance while maintaining their independence. As early as 2015, the AAFP urged CMS to implement virtual groups as required in statute. We are disappointed that virtual group regulations were not included in the prior final rule promulgated by CMS in 2016. The timelines for physicians to assemble into virtual groups are now extremely challenging for the 2018 performance period. Yet again, small practices with limited resources to manage the administrative work to create and join a virtual group will be disadvantaged. Some AAFP members have shown great interest in this provision and are ready and willing to participate. However, not being able to join (either due to lack of regulatory action or exclusion due to the low-volume threshold) could mean a missed opportunity to include and support small practices that want to move to value/accountability. Therefore, **the AAFP adamantly demands CMS offer a MIPS opt-in pathway for individuals below the low volume threshold so they may participate in virtual groups.**

b. Definition of a Virtual Group

Summary

CMS proposes to define a virtual group as a combination of two or more TINs composed of a solo practitioner (a MIPS-eligible clinician, as defined at §414.1305) who bills under a TIN with no other NPIs billing under such TIN, or a group (as defined at §414.1305) with 10 or fewer eligible clinicians under the TIN that elects to form a virtual group with at least one other such solo practitioner or group for a performance period for a year. While entire TINs participate in a virtual group, including each NPI under a TIN, and are assessed and scored collectively as a virtual group, only NPIs that meet the definition of a MIPS-eligible clinician would be subject to a MIPS payment adjustment. Additionally, any MIPS-eligible clinician who is part of a TIN participating in a virtual group and participating in a MIPS APM or AAPM under the MIPS APM scoring standard would not receive a MIPS payment adjustment based on the virtual group's final score, but would receive a payment adjustment based on the MIPS APM scoring standard.

The statute states that the Secretary of the U.S. Department of Health and Human Services (HHS) provide discretion in establishing characteristics (classifications) which are valid to use to construct virtual groups, such as geographic area or specialty. The proposed rule would not place any characteristic restrictions and provides physicians and practices with the flexibility to determine whom should assemble into a virtual group. Also, the proposed rule does not restrict the size of a virtual group. The rule states that CMS will monitor the size of virtual groups, as there is a concern that if they become too large it would interfere with appropriate comparisons across physicians.

AAFP Response

The AAFP applauds the Secretary and CMS in supporting flexibility by physicians to self-assemble into virtual groups without restrictions. We also agree that CMS should monitor virtual groups for potential issues arising from this flexibility (i.e., alignment within disciplines, geography, etc.). Given how new virtual groups are for CMS and for interested practices, we believe it would be premature to yet impose any restricting policies.

In our letter in response to the 2016 MACRA final rule, we recommended against the establishment of minimum standards for virtual groups. We are pleased to see CMS did not require any minimum standards for virtual groups in this proposed rule. In that same letter, we recommended against allowing partial TINs to participate in virtual groups. We are pleased to see that partial TINs are not able to be part of a virtual group.

It is not clear whether the opt-in option will apply to participants in a virtual group (i.e., a solo or TIN that meets only one of the low-volume criteria would be allowed to opt in to MIPS participation). The AAFP supports allowing this for virtual group participants. We strongly assert that practices of any size should, if they wish, participate fully in MIPS independently, as part of a group, or via virtual groups. Small practices that are willing to innovate and move towards greater accountability should not be barred from the program. CMS should remove the low-volume threshold for practices wishing to join together into a virtual group.

c. MIPS Virtual Group Identifier for Performance

Summary

CMS is proposing that each participant in a virtual group would be identified by a unique virtual group participant identifier. This identifier would consist of the following three parts: (1) virtual group identifier assigned by CMS; (2) their TIN; and (3) their NPI.

AAFP Response

We recommended in our letter in response to the 2016 MACRA final rule that CMS maintain a list of virtual groups and participants to allow each verification and updating of participants in the virtual groups. The establishment of a virtual group unique participant identifier will help make that possible. We are supportive of the proposed identifier.

d. Application of MIPS Group Policies to Virtual Groups

Summary

CMS is proposing to modify the definition of a non-patient facing MIPS-eligible clinician to include clinicians in a virtual group provided that more than 75 percent of the NPIs billing under the virtual group's TINs meet the definition of a non-patient facing individual MIPS-eligible clinician during the non-patient facing determination period. Section II.C.4.f. of this rule lays out the proposed modification. CMS notes that other policies previously established and presented in this proposed rule for non-patient facing groups would apply to virtual groups. For example, as discussed in section II.C.1.e. of this proposed rule, virtual groups determined to be non-patient facing would have their advancing care information (ACI) performance category score automatically reweighted to zero. In regard to the application of small practice status to virtual groups, CMS is proposing that a virtual group would be identified as having a small practice status if the virtual group does not have 16 or more members of a virtual group (i.e., NPIs). They refer readers to section II.C.4.d. of this proposed rule for discussion regarding how small practice status would apply to virtual groups for scoring under MIPS. CMS is proposing that a virtual group with 75 percent or more of the virtual group's TINs designated as rural areas or

HPSA practices would be designated as a rural area or HPSA practice at the virtual group level. CMS proposes to apply MIPS group policies to virtual groups, except as otherwise specified.

AAFP Response

We are pleased to see that CMS is not adding unneeded administrative and regulatory complexity by treating virtual groups different than non-virtual groups under MIPS.

Instead of 75 percent, we encourage CMS to finalize policy that a virtual group need 50 percent or more of the virtual group's TINs designated as rural areas or HPSA practices be designated as a rural area or HPSA practice at the virtual group level. This would be consistent with our recommendations regarding MIPS designations for rural areas and HPSAs.

e. Election Process

Summary

CMS proposes a virtual group must make an election (electronic, if feasible) by December 1 of the year prior to the performance period. The virtual group cannot change that election during the performance period; individuals and groups are limited to only one virtual group; and election applies to all MIPS-eligible clinician in the group (TIN). Election would be the following two-stage process:

- Stage 1: An optional stage where groups could contact CMS to determine eligibility. Claims would be analyzed on a rolling basis beginning with July 1 of the current year and ending as late as November 30 (including a 30-day run out). If at any time a TIN is determined to be eligible, then that status is retained for the performance period and the analysis stops.
- Stage 2: The virtual group executes formal written agreements and the group's representative submits formal registration. If the group did not participate in Stage 1, then size is determined at the time the formal election is submitted. Groups may begin election for 2018 in mid-Sept 2017, prior to publication of final rule to allow more time, but still be subject to the final rule. Groups must re-elect every year. CMS analyzes submission and notifies group of eligibility. Low-volume threshold eligibility is determined at the individual level for solo and at the TIN level for virtual group participants.

Technical assistance will be available for virtual groups. Virtual groups that add NPIs during the performance period will still retain their eligibility for that period. If a TIN merges, is acquired, or closes during the performance year, their data is still attributed to the virtual group. Groups must notify CMS of any changes to the virtual group composition. A virtual group could be one solo NPI who practices under multiple TINs (so the NPI would form a virtual group with him/herself).

AAFP Response

We support the proposed process for election of virtual groups. The process offers maximum flexibility and eligibility potential to physicians, technical assistance, and minimal burden. However, we would ask that CMS notify groups of eligibility within seven business days of formal election following stage 2 so they can move forward (especially if they make elections late in the calendar year), and be prepared for the upcoming performance year.

Given the challenging time frame for assembly of virtual groups, it is imperative that technical assistance by highly-trained experts be made available as quickly as possible to those interested in forming a virtual group.

We also support allowing solo clinicians and TINs who meet or exceed the low-volume threshold (i.e., those eligible to participate) and those who fall below the threshold (i.e., those

who are excluded) the option of joining a virtual group and being subject to MIPS payment adjustments, as long as the virtual group collectively exceeds low-volume thresholds.

f. Virtual Group Agreements

Summary

CMS requires virtual groups to execute formal written agreements with each member and to designate a group representative. Any changes would require an update to the agreement and notification made to the QPP Service Center. The agreement must:

- Include that the only parties to the agreement are the TIN and NPIs (e.g., not an individual practice association, management company, or third parties);
- Be made by authorized individuals;
- Expressly require participation and compliance with all applicable laws and regulations;
- Include notification of all NPIs associated with the TIN of their participation as a virtual group;
- Set forth NPI's rights and obligations, including reporting requirements and impact on MIPS participation;
- Describe how payment adjustments will encourage quality performance and improvement;
- Notification of any changes;
- Specify the term of at least one performance period; and
- Specify a close-out process, including furnishing all data for virtual group's data needs.

CMS states they will provide a model agreement.

AAFP Response

The requirements outlined by CMS appear to be necessary and reasonable. The AAFP supports this proposal and appreciates CMS offering a model agreement.

g. Virtual Group Reporting Requirements

Summary

CMS proposes that virtual groups are treated the same as other groups. In particular, performance is assessed for all categories at the group level; the group must aggregate their data across multiple TINs; groups must adhere to the election process.

AAFP Response

We concur that virtual groups be treated similar to other groups for reporting purposes.

h. Virtual Group Assessment and Scoring for MIPS Performance Categories

Summary

CMS proposes that virtual group performance will be assessed and scored at the group level for all categories using current MIPS scoring methodology. Payment adjustments would be applied at the individual TIN/NPI level, and all members of the virtual group would receive the same score. In the case that some MIPS-eligible clinicians are in both a virtual group and are also members of an APM, the virtual group would include data from those APM clinician's performance data, but the APM clinician's APM entity score would be used to determine their payment adjustments. Thus, MIPS-eligible clinicians would be assessed both under the virtual group and the APM, but would receive payment adjustment based only on the APM entity score.

AAFP Response

We agree that assessing and scoring virtual groups at the virtual group level will reduce burden and support comprehensive measurement, shared responsibility, and coordination of resources. We agree that performance data for all clinicians, including those that also participate in an APM, should be used to assess the virtual group's performance, as we believe it would be difficult for a TIN to separate and exclude data for some NPIs. We agree that clinicians that are part of both a virtual group and an APM should have their payment adjustments based on the APM entity score.

5. MIPS Performance Period

Summary

In the 2017 final QPP rule, CMS established that for the 2018 MIPS performance period, the performance period for the quality and cost categories would be a full year. For the improvement activities and ACI categories, CMS would use a minimum of a continuous 90-day period.

For the quality and cost categories, CMS proposes for the MIPS payment year 2021 and future years, the performance period for quality and cost would be the full calendar year occurring two years prior to the payment year. CMS proposes that for 2021 MIPS payment year, the performance period for improvement activities and ACI categories would be a minimum of a continuous 90-day period, or up to and including the full 2019 calendar year.

AAFP Response

Considering that CMS graciously offered MIPS-eligible clinicians the ability to "Pick Your Pace" for the 2017 performance period, **the AAFP is concerned that CMS is prematurely requiring a full year of quality reporting for the 2018 performance year.** Since over 70 percent of AAFP members participate in the Meaningful Use Program and over 50 percent of member in the Physician Quality Reporting System (PQRS), family physicians are experienced in reporting quality measures. However, CMS is not yet adept in providing prompt and actionable feedback reports to these practices, such that some practices continue to struggle to correct inadvertent reporting mistakes. **We encourage CMS to continue to allow 90-day reporting periods for the quality, ACI, and improvement activities performance categories in the MIPS 2018 performance period.** We urge CMS to offer flexibility to practices, such that the reporting of these three categories is not required to be concurrent, (i.e. not the same continuous 90-day period for the three categories). We urge CMS to grade a practice's performance on the highest scoring period should the practice choose to report further than a continuous 90-day period. In doing so, CMS will allow practices to continue to learn how to properly report, perform mid-year upgrades, make corrections in their reporting capacities, and generally become more familiar with MIPS requirements. We urge CMS to use the 2018 performance period and continuous 90-day periods for the MIPS categories to continue learning how to receive and process this volume of data, and to significantly improve the clinical utility and promptness of feedback reports sent to MIPS-eligible clinicians.

6. MIPS Performance Category Measures and Activities

a. Performance Category Measures and Reporting

Summary

In the 2017 QPP final rule, CMS finalized that MIPS-eligible clinicians can submit data using multiple mechanisms across MIPS categories, but not within individual MIPS categories. Only one submission mechanism can be used per MIPS category in the 2017 performance period. For the 2018 performance period, CMS proposes to allow individual MIPS-eligible clinicians to submit data using multiple data submission mechanisms for a single performance category.

Virtual groups would be allowed to utilize multiple submission mechanisms for the quality category, but virtual groups would be required to use the same submission mechanism for the improvement activity and ACI categories.

Submission deadline in 2017 was finalized as March 31. CMS is not proposing any changes to the submission deadline.

AAFP Response

The AAFP is concerned with the feasibility of handling data from multiple submission mechanisms within a single MIPS category. For example, in the Physician Fee Schedule Final Rule 2017, CMS acknowledged that errors were made when calculating PQRS and Value Modifier (VM), and that these errors "...create uncertainty for groups and solo practitioners about their final VM payment adjustment making it difficult for them to plan and make forecasts." CMS also "...learned that re-running QRURs and recalculating the quality composite is not always practical or possible, given the diversity and magnitude of the errors, timing of when we become aware of an error, and practical considerations in needing to compute a final VM upward payment adjustment factor after the performance period has ended, based on the aggregate amount of downward payment adjustments."

Due to this experience with PQRS and Value Modifier, **the AAFP urges CMS to withhold the option for submission through multiple mechanisms in one MIPS category for future implementation, or until CMS has become comfortable with the data received in year one of the program.** We also suggest both groups and virtual groups have the same submission requirements.

b. Quality Performance Category

Summary

For 2017, quality accounts for 60 percent of the MIPS final score. Statutorily, the Secretary has the authority to reweight performance categories in the first two years of the program. CMS is using this authority to reweight cost to zero for the 2017 and 2018 performance periods. Due to this, the quality category will remain at 60 percent for the 2018 performance period.

Due to the reweighting of cost to zero, there will be a sharp increase in the cost category in performance period 2019, when it increases to 30 percent. Cost is statutorily required to account for 30 percent of the MIPS score starting with the 2019 performance period.

Moving forward, if an EC fails to report on a measure or activity, the EC will receive a zero for each measure or activity they should have reported.

AAFP Response

The AAFP is supportive of reweighting the quality category to 60 percent, while the cost category remains at zero. The AAFP supports CMS' proposal to reweight the cost category to zero percent for the 2018 performance period. Additionally, we strongly urge CMS to continue a gradual introduction of cost into the MIPS final score and increase it to 10 percent beginning with the 2019 performance period. However, we caution against a steep ramp up in the cost category from zero percent to 30 percent, especially using measures that have yet to be developed and that have never been tested. This would be especially problematic for small groups caught in the shifting low-volume thresholds who would not have as much experience with MIPS.

(i) Submission Criteria for Quality Measures Excluding Groups Reporting via the CMS Web Interface and the CAHPS for MIPS Survey

Summary

As finalized in the 2017 QPP final rule, the quality category will still require six measures, one being an outcome measure. CMS is not proposing the addition of a cross-cutting measure requirement. No changes were made to CMS Web Interface submission requirements. Additionally, there were no proposed changes to the performance criteria for quality measures for groups electing to report through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey.

AAFP Response

The AAFP is supportive of continuing to allow eligible clinicians to choose six measures that are applicable to their practice, regardless of National Quality Forum (NQF) domain. We also support, for simplicity, the continuation of the requirement for one outcome measure and no cross-cutting measure.

The AAFP encourages retaining cross-cutting measures in specialty/subspecialty sets with fewer than six measures to reach parity in quality measure reporting across all clinicians. We believe this is critically important and would provide incentives for all specialties/subspecialties to develop enough quality measures to adequately assess their performance. The current approach does not hold all specialties/subspecialties equally accountable for high-value care or high-value measurement.

(ii) Submission Criteria for Quality Measures for Groups Reporting via the CMS Web Interface and

(iii) Performance Criteria for Quality Measures for Groups Electing to Report CAHPS for MIPS Survey

Summary

Groups (of 25 or more ECs) reporting through the CMS Web Interface must report on all the measures included in the Web Interface and the first 248 consecutively ranked beneficiaries for each measure.

For the 2017 performance period, CMS utilized the administration period for CAHPS for MIPS that they had been using for PQRS (November to February). CMS notes this makes it difficult to administer the MIPS program, as data is needed earlier. CMS is proposing to change the administration period to span more than eight weeks, ending no later than February 28, following the applicable performance period.

CMS is proposing to remove two measure from CAHPS for MIPS. "Helping You Take Medication as Directed" is being removed due to low reliability. "Between Visit Communication" is being removed because the question can be answered by other questions already on the survey.

CMS is seeking comment on expanding the patient experience data available for the CAHPS for MIPS Survey. CMS wants to add five open-ended questions to the survey.

CMS also seeks comment on how to incorporate data from other payers into the CAHPS for MIPS Survey, and the challenges groups face identifying members to whom they provide care

in a calendar year, such as the feasibility of groups providing a list of patients seen by individual clinicians within the group.

AAFP Response

The AAFP is supportive of moving the administration period for CAHPS for MIPS to allow CMS to have adequate time to collect the data needed to administer the MIPS program. We also agree with the removal of measures that do not add value to the CAHPS for MIPS Survey. However, we do not support the addition of five open-ended questions to be used on Physician Compare. Adding these questions would only contribute to the already lengthy and administratively burdensome CAHPS survey. Also, in existence outside of the MIPS program, there are a multitude of websites that allow for this type of feedback.

The AAFP does not support CMS asking groups to provide additional information to MIPS. The amount of information asked for is currently administratively burdensome and overly complex. The AAFP would not support a new provision adding administrative complexity to the program. However, if necessary, CMS could solicit lists of patients seen by individual clinicians within the group from payers.

(b) Data Completeness Criteria

Summary

CMS is proposing to modify the previously finalized quality category data completeness criteria. CMS will continue to require 50 percent of all patients, regardless of payer, be reported for those submitting through Qualified Clinical Data Registries (QCDRs), qualified registries, or EHR. Those reporting through claims must report on 50 percent of Medicare Part B patients (instead of increasing to 60 percent as was previously finalized). This threshold will increase to 60 percent beginning with the 2019 performance period. CMS seeks comment on what data completeness criteria should be used in future years.

CMS proposed that eligible clinicians who submit measures that fall below the data completeness criteria will receive one point for these measures. However, they established an exception for small practices who will still receive three points for measures that do not meet data completeness. These policies will apply to virtual groups, as well.

AAFP Response

The AAFP agrees with keeping the data completeness threshold at 50 percent for payment year 2020 and increasing to 60 percent for payment year 2021, but urges CMS to continue with a data completeness criteria of 60 percent thereafter, until it can assess the current data it is receiving and the impact of raising the threshold, especially on small practices. We do appreciate the exception given for practices with 15 or fewer clinicians that will still get three points for measures submitted that do not meet that data completeness criteria. We would encourage CMS to continue to give exception to these practices in future years. We also encourage CMS to develop a real-time feedback mechanism that allows clinicians to know if they have met the data completeness criteria in time for them to remedy any shortcomings, since failures of data completeness are usually unintentional. The AAFP would also encourage transparency from CMS on how data completeness will be verified.

c. Selection of MIPS Quality Measures for Individual MIPS-Eligible Clinicians and Groups Under the Annual List of Quality Measures Available for MIPS Assessment

Summary

CMS proposes to add new quality measures to MIPS, revise specialty measure sets, remove some measures from specialty sets, and remove other measures from the MIPS program. CMS seeks comment on whether measures should be classified in different NQF domains or should be classified as a different measure type. CMS also proposes to remove cross-cutting measures from most of the specialty sets because they may not be relevant to their practices.

AAFP Response

Of the new measures added to the MIPS program (Table A), three apply to family physicians. They are all appropriately classified.

The AAFP encourages CMS to use only the core measure sets developed by the multi-stakeholder Core Quality Measures Collaborative to ensure alignment, harmonization, and the avoidance of competing quality measures among payers. CMS should also require all physicians participating in the MIPS program to meet the same program expectations and report on the same number of measures.

For these reasons, the AAFP encourages retaining cross-cutting measures in specialty/subspecialty sets with fewer than six measures to reach parity in quality measure reporting across all clinicians. We believe this is critically important and would provide incentives for all specialties/subspecialties to develop enough quality measures to adequately assess their performance. The current approach does not hold all specialties/subspecialties equally accountable for high-value care or high-value measurement.

The AAFP is concerned with the removal of quality measure #312 (previously NQF 0052), "The Use of Imaging Studies for Low Back Pain." This measure is in the Core Measure Set developed by the Core Quality Measure Collaborative. We encourage CMS to not remove this measure from MIPS until the collaborative removes it from the core set.

The AAFP is also concerned about the restructuring of NQF measure #0028 ("Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention"). CMS has changed it from one performance rate to three performance rates, and has done this outside of the NQF process and without the measure steward, Physician Consortium for Performance Improvement® (PCPI). In addition, the current measure specifications laid out do not align with the proposed updated measure specifications under review by NQF, and this measure does not promote measure harmonization.

The AAFP opposes the proposed substantive changes to measure #374, "Closing the Referral Loop: Receipt of Specialist Report," and requests this measure to be removed from MIPS. This measure has inherent problems in that the denominator includes patients referred by a physician (frequently the primary care provider), while the numerator measures actions taken by the clinician to whom the patient was referred (frequently a specialist). This leads to a confusion about which clinician is being held responsible for the measure. The primary care provider (PCP) has no control over whether the specialist sends a timely report back to them. Other problems with the measure include that reports should be received for each referral, not just once per patient; the measure does not allow adequate time to receive reports back for patients seen late in the year; the measure does not allow an exclusion for patients who choose to not follow through with the referral; the measure excludes telehealth, which is an acceptable means of conducting a referral in many instances; and the measure should apply only to the physician to whom the patient is referred, and not to the referring physician.

(2) Topped Out Measures

Summary

CMS is proposing a three-year timeline to identify topped-out measures, with removal from MIPS in year four after a period of comment and rulemaking. CMS will start with six quality measures this year. The first year a measure could be removed due to being topped out is the 2021 MIPS performance period. If a measure is found to not be topped out during one of the three years of topped-out evaluation, the topped-out lifecycle process would stop and the clock would reset. If a measure is topped out via one submission mechanism and not another, the measure would only be removed from the submission mechanism that has reached topped-out status (the measure could still be reported via other mechanisms). CMS Web Interface measures will not be considered topped out because they are being used in APM programs.

CMS seeks comment on whether they should automatically remove the measures after they have been topped out for the specified number of years, or if CMS should review the measures and consider certain criteria before removing the measure. If so, CMS seeks input on what criteria should be used.

AAFP Response

The AAFP encourages CMS to consider if removing a topped-out measure would disadvantage small/rural practices. The AAFP also believes topped-out measures should be removed from the CMS Web Interface for the same reasons they are being removed from other reporting mechanisms. We realize this will have an impact on APMs, but feel this is a necessary change to avoid the reporting of measures that are not useful simply for the sake of reporting, and to avoid giving an unfair reporting and scoring advantage to CMS Web Interface reporters. APM reporting should be adjusted to align with any changes made to the CMS Web Interface measures.

(3) Non-Outcome Measures

Summary

CMS had initially proposed to remove non-outcome measures from MIPS. However, CMS is ultimately not proposing to remove them. CMS seeks comment on the best time line for removing measures that cannot be scored against a benchmark.

AAFP Response

The AAFP urges CMS to use consistent time lines when applicable within the MIPS rule. In this case, we suggest using the same timeline to remove measures that cannot be scored against a benchmark that is used to remove topped-out measures.

(4) Quality Measures Determined to be Outcome Measures

Summary

Measures are designated outcome measures currently by the NQF designation process and by the CMS blueprint for determining outcome measures. CMS seeks comment on this. Also, should different criteria be applied for MIPS measures vs. QCDR measures?

AAFP Response

The AAFP supports the current methodology for designating an outcome measure. QCDRs and MIPS measure criteria should align. Clinicians using QCDRs should not be given an unfair scoring advantage over clinicians using other reporting mechanisms. Applying the same criteria to MIPS measures and QCDR measures, rather than applying different criteria, would

encourage QCDRs to develop more meaningful measures that have more potential for improvement.

6.d MIPS Performance Category Measures and Activities: Cost

d.(2) Weighting in the Final Score

Summary

CMS is proposing to reweight the cost performance category to zero percent for the 2020 payment year, as it continues to have concerns regarding the level of familiarity and understanding of cost measures among clinicians. CMS will use the additional year for outreach to clinicians and to develop more episode-based measures.

While CMS is reweighting the cost category to zero percent for the 2020 payment year, it is statutorily required to increase the weight to 30 percent for payment years 2021 and beyond. In addition, assigning a zero percent to the cost category for 2020 payment year may not provide enough encouragement for clinicians to review their cost performance. CMS seeks comment on maintaining the weight of the cost performance category at 10 percent for the 2020 payment year.

AAFP Response

The AAFP supports CMS' proposal to reweight the cost category to zero percent for the 2018 performance period (2020 payment year). Additionally, we strongly urge CMS to continue a gradual introduction of cost into the MIPS final score and increase it to 10 percent beginning with the 2019 performance period. While the AAFP understands CMS' intent to act according to the statute by increasing the cost category weight to 30 percent beginning in 2019, we would remind CMS that it has already diverged from statute in several areas. For example, the statute required CMS to develop and implement a system to allow clinicians to come together to form virtual groups, yet CMS chose not to operationalize this important provision prior to the first performance period. Further, CMS has strayed from statute by instituting several other policies not included in the statute to begin with. These include MIPS APMs and applying arbitrary size limits that restrict AAPM participation in Medical Home Models. The agency also chose to change the name of several terms listed in the statute, including renaming the performance categories and composite performance score. Given these precedents, we believe it is entirely reasonable for CMS to phase in the weighting of the cost category beginning at 10 percent in the 2019 performance period and eventually ending at 30 percent some years after that.

The AAFP believes holding an individual clinician and small practices accountable for cost introduces disparities into the program. Therefore, when cost is weighted and added to the final score, **we ask that CMS not assess clinicians in small practices (defined as 15 or fewer clinicians) on cost at least until valid and reliable measures are developed**, as discussed in our comments below. The cost category for these clinicians should be reweighted to the quality category. All other clinicians and groups should be measured on cost only if CMS can reliably score at least one episode-based measure. If CMS is unable to score at least one episode-based measure, the cost category weight should be redistributed to the quality category.

d.(3)(a) Measures Proposed for the MIPS Cost Performance Category

Summary

For the 2017 MIPS performance period, CMS finalized 12 cost measures. Two measures (Total per Capita Costs and Medicare Spending per Beneficiary) were included in the Value-based

Payment Modifier (VBM) program and 10 were included in the Supplemental Quality and Resource Use Report (sQRUR). MACRA requires the development of care episode and patient condition groups to account for a target estimate of one-half of expenditures under Medicare Parts A and B. CMS posted a draft list of care episode and patient condition groups and codes for comment in December 2016 and is reviewing the feedback, and will share plans to work with clinicians and others on the further development of these episodes. CMS plans to post an operational list of care episode and patient condition groups in December 2017. This list must be revised through rulemaking no later than November 1 of each year (beginning with 2018).

AAFP Response

The AAFP is concerned that posting the list of care episode and patient condition groups in December 2017 will not allow clinicians sufficient time to become familiar with the list and related codes and adjust workflows to incorporate their use. As CMS noted, development of this list was mandated by MACRA. MACRA was passed in April of 2015. The AAFP finds it disconcerting that CMS has taken more than two years to develop this list for implementation in 2018. The AAFP strongly urges CMS to publish the final list as soon as possible and provide widespread education to clinicians. This education should be tailored to the specialties most likely to be heavily impacted by the implementation of these codes.

d.(3)(a)(ii) Total per Capita Cost and MSPB Measures

Summary

CMS is proposing to include the previously finalized Total per Capita Cost and MSPB measures in the 2018 performance period and future performance periods. CMS is not proposing any changes to the methodologies for payment standardization, risk adjustment, and specialty adjustment for these measures. CMS seeks comment on these proposals.

AAFP Response

The AAFP continues to believe family physicians cannot and should not be held accountable for the total cost of care. Both measures should be removed from the cost category. We also hold that clinicians in practices with 15 or fewer clinicians should not be assessed on cost. It is incredibly difficult (impossible at times) for clinicians in these practices to have a significant impact on health care costs. Large practices and those participating in APMs are in a better position to have a meaningful impact on costs. CMS should also focus its cost containment efforts on high-cost centers, such as hospitals and surgical centers. Finally, CMS should only assess cost when they can reliably score at least one episode-based measure.

Concerning risk adjustment, we understand that CMS intends to continue to rely primarily, if not exclusively, on the Hierarchical Condition Category (HCC) scoring method. Regarding HCC, we note that it has methodological problems that may not make it useful in the long run. First, under HCC as used by CMS, there is an 18-month delay in the update to risk scores. We believe that CMS needs to shorten that delay. Also, HCC does not reflect social determinants of health. We advocate that payers use risk-adjustment methodologies that also factor in social determinants of health. Risk-adjustment methodologies that do not, are inadequate in our opinion. We note that the state of Rhode Island is looking at the creation of an assessment that incorporates social determinants of health into risk. CMS and other users of HCC may want to look at this methodology as an alternative. In any case, we offer to work with CMS and other payers to identify or develop a risk-adjustment methodology that works for them as payers and is useful over time in a way that HCC may not be.

d.(3)(a)(iii) Episode-Based Measures

Summary

For the 2018 performance period, CMS is not proposing to include the 10 episode-based measures that were adopted for the 2017 performance period. It will instead work to develop new episode-based measures and intends to have as many measures as possible available for the 2019 performance period. CMS anticipates covering similar clinical topics as the previously developed measures. Clinicians will continue to receive feedback on their cost performance as new measures are developed. The feedback will be specific to the new measures developed and provided as available, approximately by the summer of 2018. If CMS is unable to calculate episode-based measures for a clinician, he or she may not receive feedback. CMS invites feedback on this proposal.

AAFP Response

The AAFP is pleased that CMS will continue to engage stakeholders as it works to develop new episode-based measures. As articulated by the AAFP in a [letter](#) to CMS on episode groups, the AAFP encourages CMS to initially develop measures that encapsulate high-cost centers, such as hospitals and surgical centers. Even though services provided by family physicians are not high cost when compared to subspecialty services, family physicians have nevertheless been held responsible for the total cost of care. CMS could rectify this imbalance as episode measures are selected that hold those truly responsible for high-cost care more accountable.

As CMS moves forward with its development of chronic condition episodes, the AAFP asks CMS to carefully address our many concerns with these episodes. By definition, a chronic condition is not an episodic illness. It is a continuous health problem that is identified at diagnosis and often lasts for the patient's life time. Arbitrarily dividing that continuum into "episodes" is problematic and will likely misrepresent the cost of caring for those patients, especially for primary care physicians who provide ongoing care of those conditions. In addition to the complexity of trying to develop an episode using multiple chronic conditions, there is a challenge to develop an episode that encompasses multiple chronic condition specialists. Often, patients see multiple clinicians to manage different parts of their chronic disease. However, in family medicine, we treat most, if not all, of these conditions. We question whether an episode group be constructed fairly to assign cost to one physician caring for three to four chronic conditions versus three to four physicians caring for the same type of patient. Family physicians should be rewarded for managing these patients, not held to a higher standard than colleagues who refer every patient to a specialist, thus over utilizing care and overburdening the system. That approach perpetuates the fragmentation in the care that beneficiaries often experience today. Instead, measurement and payment should promote continuous, coordinated, comprehensive, and longitudinal care.

Additionally, the AAFP recommends CMS factor in socioeconomics and social determinants of health into chronic condition episode groups since they can add significant cost variables that are difficult to quantify, but clearly impact care.

To allow for meaningful measurement, CMS needs to test all episode-based measures prior to implementing them. The AAFP cautions CMS on implementing and scoring clinicians on measures that have never been used and may lack reliability. By introducing more change into the program, CMS will cause clinicians to continue to struggle with understanding exactly what CMS is measuring and why. CMS should continue to provide feedback on all measures, including providing feedback prior to a measure's implementation.

The AAFP strongly urges CMS to make the timeline transparent for developing episode-based cost measures, especially those for chronic conditions.

d.(3)(a)(iv) Attribution

Summary

In the 2017 MACRA final rule, CMS updated the list of primary care services used for attribution in the Total per Capita Cost measure to include transitional care management codes (CPT codes 99495 and 99496) and chronic care management codes (CPT code 99490). In the 2018 proposed rule, CMS is proposing to add the complex care management codes (CPT codes 99487 and 99489) to the list of primary care services. CMS is not proposing any changes to the attribution methodology for the MSPB measure. CMS seeks comment on this proposal.

AAFP Response

The AAFP is supportive of the addition of the complex care management codes to the list of primary care services.

d.(3)(a)(v) Reliability

Summary

CMS is not proposing any adjustments to its reliability policies. CMS will continue to use a 0.4 reliability threshold.

AAFP Response

A reliability score of at least 0.8 is generally recognized as good if a measure is to be used for decision making. We are not certain which reference was used by CMS to determine that a reliability score of 0.4 to 0.7 is moderate, as the sources we consulted stated otherwise (see below), and which suggest a reliability coefficient lower than 0.6 should not be considered at all, and should definitely not be applicable to the individual level or to small groups. We remain concerned not only of the low reliability of the measure, but also of the impact this has on the validity of the measure.

We point out that a measure may be reliable, but not valid. A measure cannot be valid unless it is reliable. **Reliability is necessary, but not a sufficient condition of validity.** This leads to the conclusion that the cost measures being used by CMS may, in fact, not be valid, particularly for individuals and small groups. CMS' statement that, "we are concerned that placing too much of an emphasis on reliability calculations could limit the applicability of cost measures to large group practices..." clearly demonstrates that CMS is willing to overlook reliability, and as a result, validity, in order to retain the ability to measure. It is entirely likely that the measure itself is flawed (wrong, or invalid) and a different measure is needed to score cost, and that these flawed measures are inappropriately rewarding or penalizing physicians being measured.

CMS must determine cost measures that are both reliable and valid before using them to rate and pay physicians.

| Evaluation of Reliability Coefficient | |
|---------------------------------------|--|
| .9 or higher | High reliability. Suitable for making a decision about an examinee based on a single test score. |

| | |
|---|---|
| .8 to .89 | Good reliability. Suitable for use in evaluating individual examinees if averaged with a small number of other scores of similar reliability. |
| .6 to .79 | Low/moderate reliability. Suitable for evaluating individuals only if averaged with several other scores of similar reliability. |
| .40 to .59 | Doubtful reliability. Should be used only with caution in the evaluation of individual examinees. May be satisfactory for determining average score differences between groups. |
| Source: http://ericae.net/ft/pug/reliabil.txt ; https://www.nap.edu/read/1862/chapter/8 Robert Frary is an expert in reliability, with multiple peer-reviewed articles on the subject. | |

d.(3)(e) Application of Measures to Non-Patient Facing MIPS-Eligible Clinicians

Summary

CMS is not proposing any changes to its policy to attribute measures to non-patient facing clinicians. Additionally, CMS is not proposing to create alternative measures for non-patient facing clinicians or groups. It is unlikely non-patient facing clinicians or groups will be attributed any cost measures that are generally attributed to patient-facing clinicians. CMS will continue to consider opportunities to develop alternative cost measures for these clinicians and solicit comment on this topic.

AAFP Response

The AAFP encourages CMS to develop episode-based measures that are applicable to non-patient facing clinicians. This will allow for parity amongst participating clinicians.

II. C. 6.e. Improvement Activity Criteria

Summary

CMS proposes that the improvement activities performance category will continue to account for 15 percent of the final score for payment year 2020 and the 90-day reporting period for improvement activities will continue for payment years 2020 and 2021. Furthermore, CMS proposes that all improvement activities policies will apply to virtual groups. Twenty new improvement activities were proposed and some changes were made to existing activities. CMS proposes clinicians and groups may use as many submission mechanisms as necessary to meet requirements within the improvement activities category.

For 2018, CMS retained the current performance threshold of requiring only one MIPS-eligible clinician in a group to complete an improvement activity for at least 90 days for the entire group to receive credit, but requested comment on whether this threshold should increase in the future and whether it should differ based on size of the group. CMS is seeking comment on how to score the improvement activities category based on performance and improvement, rather than attestation.

CMS clarified that “certified” and “recognized” PCMH are equivalent and includes the CPC+ APM model and the round 2 CPC+ control group as recognized medical homes. CMS has proposed a 50 percent threshold for 2018 for the number of practices within a TIN that need to be recognized to receive full credit under the improvement activities category. This is an increase from only one practice site in 2017.

Non-patient-facing, small, rural, or HPSA clinicians continue to earn double points for each activity. CMS proposes to formalize a “call for activities” with an annual deadline date of March 1. CMS is requesting comments on criteria that should be used to remove activities from the improvement activities category inventory and is also requesting comment on adding an improvement activities subcategory for health information technology (IT).

Participants in CMS’ “Study on Burdens Associated with Reporting Quality Measures” will continue to receive full improvement activities credit. CMS proposed minor changes to increase the number of participants, decrease the number of surveys and focus group sessions required, and allow data submission from one to four times, as desired by participants.

AAFP Response

The AAFP appreciates the addition of several new improvement activities and offer the following comment on specific activities:

- IA_PSPA_XX “Completion of an Accredited Safety or Quality Improvement Program”
The AAFP strongly supports addition of accredited performance improvement continuing medical education programs that meet the specified criteria as a medium-weighted improvement activity. The criteria reflect a proven, scientific approach to improvement methodology that is practical and effective in the clinical office setting.
- IA_PSPA_XX “Consulting Appropriate Use Criteria (AUC) Using Clinical Decision Support when Ordering Advanced Diagnostic Imaging”
We strongly support addition of this activity as a high-weighted improvement activity for adopters of the appropriate use criteria (AUC) program. In repeated recommendations, the AAFP expressed significant concerns about the disproportionate burden primary care physicians will face when trying to comply with AUC requirements, and strongly urged CMS to align AUC with the MIPS program.
- IA_CC_4 “TCPi Participation”
We oppose reweighting this activity from high to medium. Participation in the Transforming Clinical Practice initiative (TCPi) requires multiple actions and significant time and resources. Furthermore, CMS states in Section II.7.a(5)(a), “Additionally, activities that require performance of multiple actions, such as participation in the Transforming Clinical Practice Initiative (TCPI)... are justifiably weighted as high.” We also point out an error in the rationale for this measure in table G, which states, “However, we note that MIPS eligible clinicians that participate in the CMS Transforming Clinical Practice Initiative (TCPI)—which is an APM (as defined in section 1833(z)(3)(C) of the Act)—will automatically earn a minimum score of one-half of the highest potential score for this performance category, as required by section 1848(q)(5)(C)(ii) of the Act.” In fact, TCPi is not an APM and participants do not automatically earn one-half of the highest potential score for the improvement activities category.
- IA_EPA_1 “Provide 24/7 access to MIPS Clinicians”
We oppose reweighting this activity from high to medium because convenience and expanded access to primary care is extremely important to patients and requires substantial change and continuous expense for practices. In addition, enhanced access helps decrease costs to the overall health care system, particularly for emergency department (ED) visits.
- IA_PSPA_15 “Implementation of an Antibiotic Stewardship Program (ASP)”
We urge CMS to clarify that this activity is appropriate for the physician office setting, even though most of the examples of activities pertain to the inpatient setting. We suggest adding examples for the physician office setting, such as:

- Implement at least one evidence-based policy or practice aimed at improving antibiotic prescribing practices for high-priority conditions, assess whether it is working, identify barriers leading to deviation, and modify as needed.
- Track antibiotic prescribing practices and provide regular feedback to clinicians.
- Develop and implement evidence-based protocols and decision support for diagnosis and treatment of common infections.

The AAFP encourages CMS not to implement multiple submission mechanisms for the improvement activity category until year three to avoid unnecessary complexity and because it is unlikely that clinicians will choose to complete attestation for improvement activities using multiple mechanisms.

We agree that more than one MIPS-eligible clinician in a group should complete an improvement activity for at least 90 days for the entire group to receive credit because improvement must be spread widely within a group to realize the desired impact. We suggest setting a threshold of 50 percent beginning in the 2019 performance period to maintain consistency with the level of participation needed for other improvement activities, such as medical home participation.

We believe attestation should continue as the sole method for scoring the improvement activity category. Additional documentation, measurement and scoring would impose significant burden on clinicians who are already overburdened with measurement. Also, the improvement activities category represents only 15 percent of the final score, so the overall risk associated with retaining attestation is small, and performance can be authenticated through the existing audit process.

We agree that participants in the CPC+ initiative, including practices assigned to the control group, should receive full credit as medical homes for the improvement activities category. The AAFP generally opposes requiring practices to incur the significant time and expense of proprietary third-party PCMH recognition and encourages CMS to determine a no-cost method available to all clinicians to recognize medical homes for the purpose of MIPS scoring. However, we support raising the threshold to 50 percent for the number of sites that must be recognized within a TIN to receive full credit, as this will encourage a strong primary care and medical home base.

We support retaining the 90-day performance period through 2021, and formalizing the annual call for activities to ensure stakeholders are aware of the opportunity for submission of activities. We oppose the addition of a separate improvement activity subcategory for health IT, and view it as unnecessary. We believe the current policies that award bonus points for improvement activities that utilize electronic capabilities, along with the separate ACI category, sufficiently promote the use of health IT, and we do not wish to place excessive emphasis on health IT. We suggest removing activities that have become obsolete or that are not claimed by any participants for three consecutive years from the improvement activities category listing through rulemaking, similar to the approach used for removal of quality measures.

f. Advancing Care Information Performance Category

(a) Base Score

Summary

No changes are proposed for the 2018 performance year. Specifically, MIPS-eligible clinicians must report a numerator of at least one for numerator/denominator measures, or a “yes” for the

yes/no measure to earn 50 percentage points for the base score. The all-or-nothing requirement continues to persist, in that if base score requirements are not met, a score of zero would be received for the entire ACI category.

AAFP Response

The AAFP supports allowing clinicians to receive credit for all their efforts. We particularly support elimination of all-or-nothing approaches in the QPP. We must point out that the ACI base score requirements from 2017, and proposal to continue the same within the 2018 performance period, do not support elimination of all-or-nothing, since a score of zero will be assigned for the entire ACI category unless clinicians meet every requirement for the base score. Therefore, in accordance with CMS's previously stated intentions to drop the all-or-nothing measurement approach, we continue to urge more flexibility in this category.

(b) Performance Score

Summary

There are no proposed changes to the maximum performance score that a MIPS-eligible clinician can earn, which remains "90 percent." Changes are being proposed to the public health reporting objective, specifically to add flexibility associated with the Immunization Registry Reporting Measure in an attempt to avoid disadvantaging eligible clinicians in regions where immunization registry reporting is not available. It is proposed to allow eligible clinicians who are unable to fulfill the immunization registry reporting measure (worth 10 percentage points) to instead earn 5 percentage points for each public health agency or clinical data registry (if using 2018 ACI objectives and measures), or specialized registry (if using 2018 ACI transition objectives and measures) up to a maximum of 10 percentage points. Available points associated with the immunization registry reporting measure (or the newly proposed option to earn those points by reporting to two separate public health agencies or registries) remains at 10 percentage points, and the overall performance score remains worth the same value of 90 percent. The added flexibility, however, of enabling eligible clinicians unable to fulfill immunization registry reporting to instead earn those 10 percentage points via reporting to two separate public health agencies and/or clinical data registries or specialized registries results in proposed changes to the bonus score, as detailed in the section below.

AAFP Response

We appreciate the added flexibility proposed to enable those unable to fulfill the immunization registry reporting measure for 10 points toward the performance score, to instead earn those points by reporting to public health agencies and/or registries. However, we strongly oppose the proposed "two-for-one" requirement, in that the proposed rule calls for successfully reporting to two alternate public health agencies and/or registries for a points value of only 5 points for each. Due to the level of complexity and resource investment commonly associated with linking to and enabling reporting to public health agencies and/or registries, reporting to one other public health agency or registry should suffice. **We strongly urge revision of this proposal to enable reporting to one alternate public health agency or registry to satisfy the requirements for immunization registry reporting.**

(c) Bonus Score

Summary

In 2017, a 5 percent bonus is available under the public health reporting objective (for those using 2017 ACI transition measures) for reporting to one or more public health agencies or registries beyond the Immunization Registry Reporting Measure, by attesting yes to either syndromic surveillance reporting or specialized registry reporting. For those using the 2017 ACI

measures, the public health reporting objective is referred to as the “public health and clinical data registry reporting” objective, and allows a 5 percent bonus to be earned for reporting to one or more public health agencies or registries beyond the Immunization Registry Reporting Measure by attesting yes to: syndromic surveillance reporting, electronic case reporting, public health registry reporting, or clinical data registry reporting.

For 2018, the ability to earn a 5 percent bonus for reporting to at least one additional public health agency or registry remains available. However, since beginning in 2018 it is proposed to allow those unable to fulfill the immunization registry reporting measure of the performance score to instead earn an equivalent 10 percentage points by reporting to two public health agencies or registries for five points each, there is now a perceived need to specify there can be no double counting. This proposed rule proposes that to earn the bonus score, an eligible clinician must be in active engagement with one or more additional public health agencies or registries that is/are different from the public health agencies or registries they may have identified toward earning the performance score.

AAFP Response

We caution, in moving toward accurate attestations tied to the bonus score, there is significant opportunity for eligible clinicians to fail to understand a “yes” attestation to reporting to at least one additional different public health agency or registry actually means in addition to/separate from any public health agency or registry reporting that contributed toward fulfillment of the performance score. We strongly caution that it must be made expressly clear, at the point of bonus score attestation, that an eligible clinician cannot receive credit under both the performance score and bonus score for reporting to the same public health agency or registry. We also caution that eligible clinicians will need readily available and transparent CMS frequently asked questions (definitions and descriptions) to clarify definitively what forms of reporting count toward an additional form of public health agency reporting, additional specialized registry reporting, or additional clinical data registry reporting to support accurate bonus score attestation.

(3) Performance Periods for the Advancing Care Information Performance Category

Summary

This section notes that while the 2017 QPP final rule established a one-year performance period for the ACI performance category, to align the overall MIPS performance period and all four performance categories, it was also stated that for QPP year one and two, a minimum of any 90 consecutive days of data would be acceptable. The proposed rule seeks to maintain this policy as previously finalized for the performance period in calendar year (CY) 2018 (rendering a minimum of 90 consecutive days of data acceptable for 2018), and also proposes to extend the same to the 2019 (QPP year three) to render a minimum of 90 consecutive days of data acceptable for 2019.

AAFP Response

The AAFP appreciates finalization of 2018 ACI reporting requirements as a minimum of 90-consecutive days of data, and supports the extension of a minimum of 90-consecutive days of ACI data reporting for 2019. It remains imperative that such a methodical, incremental approach to implementation of MACRA be employed, especially within the ACI category. Specifically, methodical implementation is needed as many eligible clinicians are in the process of upgrading to 2015 edition CEHRT. Also, some of those unsatisfied with their current CEHRT functionality

are also choosing to switch vendors at the juncture when updating to 2015 edition CEHRT in an attempt to minimize multiple significant clinical workflow disruptions.

(4) Certification Requirements

Summary

In the 2017 QPP final rule, a definition of CEHRT was adopted at §414.1305 for MIPS-eligible clinicians based on the definition that applies in the EHR Incentive Programs under §495.4. For 2017, it was previously finalized that eligible clinicians could use EHR technology certified to the 2014 edition, 2015 edition, or a combination of the two. It was also previously stated eligible clinicians would be required to use 2015 edition CEHRT in 2018 to meet ACI objectives and measures reporting. Significant stakeholder concerns were voiced regarding a requirement to use 2015 edition CEHRT in 2018, ranging from lack of widespread vendor readiness, significant cost and time involved with upgrading, significant burdens involved with combining outputs from multiple CEHRTs, and potential to jeopardize patient safety if rushed as staff training and workflow investments are required. Additionally, some noted switching to 2015 edition CEHRT is cost prohibitive for small practices. It is noted that ONC is working with health IT developers to analyze and monitor the status of developer readiness for 2015 edition CEHRT. While several analyses indicated progress was on track, both stakeholder feedback and market trend factor analysis strongly indicated a slower, more measured approach is required.

In light of conservative readiness estimates, analyses that support a potential need for a longer timeline for implementation for eligible clinicians, and a desire to support solo/small practices that are more likely to use health IT from small developers with less demonstrated readiness, it is proposed to allow eligible clinicians to use 2014 edition CEHRT, 2015 edition CEHRT, or a combination of the two for 2018, with proposal to amend §414.1305 to reflect this change.

Adoption and use of 2015 edition CEHRT is still felt highly beneficial for health information exchange and interoperability, and due to changes incorporated including application programming interface (API) certification criteria, which are expected to spur innovation and provide more choices for physicians and health care providers. Due to the benefits associated with continued progress toward use of 2015 edition CEHRT, it is proposed to offer a bonus of 10 percentage points for eligible clinicians who report ACI objectives and measures in 2018 using only 2015 edition CEHRT. This is proposed to be a one-time bonus for 2018. With the addition of a 10-percentage point bonus for 2015 edition CEHRT use, eligible clinicians would have the ability to earn a bonus score of up to 25 percentage points in 2018 (up from a 15 percentage point bonus score in 2017).

AAFP Response

The AAFP applauds CMS for recognizing both stakeholder feedback and market trend factor analysis strongly indicated a slower, more measured approach is necessary regarding certification requirements. We also agree that changes present in 2015 edition CEHRT are beneficial, especially API criteria which have the potential to spur health IT market innovations, which could provide greater choice for clinicians and more usable and useful health IT. Thus, we strongly support the proposal for 2018 to allow clinicians to use 2014 edition or 2015 edition CEHRT. To encourage continued progress toward adoption of 2015 edition CEHRT, we support incentivizing adoption via a 10-percentage point bonus for those who have adopted 2015 edition CEHRT. However, as previously noted, the AAFP supports allowing clinicians to receive credit for all their efforts. We do not support offering a bonus to only those clinicians reporting ACI objectives and measures using only 2015 edition CEHRT. We strongly feel a 5 percentage point

bonus should be offered to clinicians using a combination of 2014 and 2015 edition CEHRT, in recognition of their investments and continued progress toward adoption and use of CEHRT.

(5) Scoring Methodology Considerations

Summary

This section relates to the statutory ability of the Secretary to estimate what proportion of eligible physician are meaningful EHR users. If 75 percent or greater of eligible physician professionals are meaningful EHR users, then the percentage weight of the ACI category in the MIPS final score would be reduced (not to fall below 15 percent). In this scenario, other category weights would increase, so that the total percentage points of the increase equals the total percentage points of the reduction. It is anecdotally noted that those who have received a zero percent reweighting of the ACI performance category (including those granted a hardship exception) and those who are hospital based or ambulatory surgery center based are not included in the Secretary's estimation of the percentage of eligible physician who are meaningful EHR users.

This section focuses on which performance period these estimates will be based upon, and which specific payment adjustment year the reweighting of performance categories by the Secretary will be applied to. Currently, the Secretary's estimation of the percentage of meaningful EHR users is possible only mid-year during the year lying between the performance year and the payment adjustment year, following the data reporting deadline of March 31. The concern expressed by CMS is that if 75 percent or greater of eligible physician are meaningful EHR users, and the ACI performance category weighting for the associated payment year will be reduced, this allows a very brief window of notification and potential confusion among all eligible clinicians who are expecting the ACI category to be worth 25 percent of the overall total MIPS score. Thus, it is proposed to modify existing policy so that CMS would base the estimation of physicians who are meaningful EHR users for a MIPS payment year. This would be based on data from the performance period that occurs four years before the MIPS payment year when ACI category reweighting will occur. For example, data from the 2017 performance year would be used to estimate the proportion of physicians who are meaningful EHR users for purposes of reweighting the ACI performance category for the 2021 payment year.

AAFP Response

The AAFP supports the proposed changes to allow for an extended period of time for notification to eligible clinicians of a proposed reduction in weighting of the ACI category and equivalent increased reweighting of other performance categories. It is appropriate to allow the proposed additional time to ensure clinicians are aware of the percentage weightings of each MIPS performance category.

(6) Objectives and Measures

(a) Advancing Care Information Objectives and Measures Specifications

Summary

This section outlines specifications for all ACI objectives and measures, which is largely a proposal to maintain for 2018 the ACI objectives and measures finalized for 2017, with a few proposed modifications as outlined below.

Provide Patient Access Measure: A definition of "timely" is being added to clarify the term in the description of the numerator, where the numerator equals "The number of patients in the denominator (or patient authorized representative) who are provided *timely* access to health information to view online, download, and transmit to a third party" It is proposed, beginning with

2018, that timely be defined as within four business days of the information becoming available to the MIPS eligible clinician.

View, Download, or Transmit (VDT) Measure: Proposed change to correct the description of this measure to accurately describe the view, download, or transmit action as being taken by the patient or authorized patient representative, rather than by the eligible clinician. Proposed change aligns the measure description with measure numerator and denominator specifications.

Health Information Exchange (HIE) Objective: Change to correct inadvertent usage of inaccurate terminology, changing “health care clinician” to “health care provider.” Specifically, correcting terminology in this context... “and incorporates summary of care information from other health care clinicians into their EHR using the functions of CEHRT.”

Send a Summary of Care Measure: Correcting inadvertent usage of inaccurate terminology, changing “health care clinician” to “health care provider,” specifically in the context of “the MIPS eligible clinician that transitions or refers their patient to another setting of care or health care clinician...”

Syndromic Surveillance Reporting Measure: Correcting (simplifying) the description of this measure to align with what was finalized rather than what was proposed for this measure description.

Clinical Data Registry Reporting: The MIPS-eligible clinician is in active engagement to submit data to a clinical data registry. Regarding this, on page 198-199, it is clarified that CMS has “split the Specialized Registry Reporting Measure that was adopted under the 2017 ACI Transition Objectives and Measures into two separate measures, Public Health Registry and Clinical Data Registry Reporting, to ‘better define’ [e.g., draw a distinction between] the registries available for reporting.” CMS proposes to continue to allow public health reporting and specialized registry reporting (an ACI ‘transition’ objective and measure) to be counted toward the ACI public health reporting or clinical data registry reporting measure if the eligible clinician has achieved the level of active engagement described in “active engagement option 3: production,” of the 2015 EHR Incentive Program final rule. This means the eligible clinician has completed testing and validation of electronic submission and is actively submitting production data.

AAFP Response

The majority of the proposed modifications to the ACI objectives and measures are reasonable, to which the AAFP has no objections.

However, we strongly disagree with CMS’ proposal to continue to allow public health reporting and specialized registry reporting (an ACI ‘transition’ objective and measure) to be counted toward the ACI public health reporting or clinical data registry reporting measure if (but only if) the eligible clinician has achieved the level of active engagement described in “active engagement option 3: production,” and is actively sharing production data. We have heard from members who have completed all necessary steps which they have been asked to complete in the process to begin sharing data with public health agencies. In many cases, the public health agencies are simply not ready to begin accepting data. Under such conditions, clinicians would be unfairly disadvantaged by this proposed change. We note it is too early to move toward option 3, production only to satisfy public health reporting requirements. Therefore, we ask that option 1 status be continued.

We caution CMS of the unintended consequences related to the ‘provide patient access’ measure and the proposed definition of providing ‘timely’ access for patients or their authorized representatives. Since this is a required base score measure, it is possible that this definition of timely may inappropriately result in an inability for the MIPS-eligible clinician to achieve the base score, and thus result in a zero for the entire ACI category score. The proposed definition of timely, as 4 business days, may result in the inability of clinicians to achieve the base score and thus any ACI score. This further reinforces our earlier comments that the all-or-nothing component of the base score methodology be revised. We believe the definition of timely access as already available under the Health Insurance Portability and Accountability Act (HIPAA) is appropriate.

(b) 2017 and 2018 Advancing Care Information Transition Objectives and Measures Specifications

Summary

Several changes are proposed to the ACI transition objectives and measures for the 2017 and 2018 performance periods, as outlined below. The ACI transition objectives and measures were previously outlined for those using 2014 edition CEHRT, which was previously permitted through the 2017 performance period only. As it has been proposed to permit continued use of 2014 edition CEHRT through the 2018 performance period, it is now also proposed to extend the option to use the ACI transition objectives and measures through the 2018 performance period. Proposed changes include:

Patient Electronic Access Measure: The proposal is to remove the word electronic from the measure name (though not from the description or specifications), to be called, provide patient access. The numerator for this measure equals “the number of patients in the denominator (or patient authorized representative) who are provided timely access to health information to view online, download or transmit to a third party.”

Patient-Specific Education Objective: CMS inadvertently finalized the definition of the patient electronic access objective here, attached to the patient-specific education objective. The change proposed is to provide the correct definition (adopted under modified stage 2) to be effective beginning with the 2017 performance year.

HIE Objective and HIE Measure: Changes are proposed to correct inadvertent usage of inaccurate terminology, changing “health care clinician” to “health care provider.” Specifically, correcting terminology in this context... “and incorporates summary of care information from other health care clinicians into their EHR using the functions of CEHRT.” Also, propose to replace reference of “EP” to “MIPS eligible clinician.”

Medication Reconciliation Objective: The proposal adds a description of this objective, which was inadvertently omitted from 2017 final rule, which will read “The MIPS eligible clinician who receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation. This description aligns with the objective adopted for Modified Stage 2 at 80 FR 62811.”

Change to Numerator of the Medication Reconciliation Measure: The proposal changes the requirements/specifications for the numerator (effective as of the 2017 performance period) from being required to perform three separate clinical information reconciliations (medication list, medication allergy list, and current problem list) to instead being required to perform only

medication reconciliation. This correction is recommended because only medication reconciliation is associated with modified stage 2. The other clinical information reconciliation requirements previously specified were associated with stage 3 requirements.

AAFP Response

The majority of the proposed modifications to the ACI transition objectives and measures are reasonable, to which the AAFP has no objections.

We caution CMS of the unintended consequences related to the 'provide patient access' measure and the proposed definition of providing 'timely' access for patients or their authorized representatives. Because this is a required base score measure, it is possible that this definition of timely may inappropriately result in an inability for the MIPS-eligible clinician to achieve the base score, and thus result in a zero for the entire ACI performance category. The proposed definition of timely (four business days) may result in the inability of clinicians to achieve the base score and thus any ACI score. This further reinforces our earlier comments that the all-or-nothing component of the base score scoring methodology be revised. We believe the definition of timely access is already available under HIPAA is appropriate.

The AAFP supports other proposed changes associated with the ACI transition objectives and measures, especially aligning the numerator specifications for the medication reconciliation measure with modified stage 2, rather than stage 3 requirements.

(7) Additional Considerations

(i) MIPS-Eligible Clinicians Facing a Significant Hardship

Summary

Under current regulation, MIPS-eligible clinicians facing a significant hardship, such as those who lack sufficient internet connectivity, face extreme and uncontrollable circumstances, lack control over the availability of certified electronic health record technology (CEHRT), or do not have face-to-face interactions with patients may have the ACI performance category reweighted to zero in their final score (required an application and approval process). CMS is not substantively changing this, but the agency would use the new authority under the 21st Century Cures Act. CMS is proposing, though, to not apply the five-year limitation of the significant hardship exception for the ACI performance category under MIPS.

AAFP Response

The AAFP believes the significant hardship exception is still needed as certain circumstances, outside of the control of the eligible clinician, and which cause the hardship, may not be rectified within a five-year period. Therefore, we are supportive of this proposed change.

(ii) Significant Hardship Exception for MIPS-Eligible Clinicians in Small Practices

Summary

Section 1848(q)(2)(B)(iii) of the act requires the Secretary to give consideration to the circumstances of small practices (consisting of 15 or fewer professionals) and practices located in rural areas and geographic HPSAs in establishing improvement activities under MIPS. Due to the recognized potential challenges of small practices in succeeding in the ACI category, CMS is proposing a significant hardship exception—eligibility determinations would be made for the 2018 and future performance years. CMS is proposing to reweight the ACI category to zero percent of the MIPS final score for MIPS-eligible clinicians who qualify for this hardship exception. MIPS-eligible clinicians seeking to qualify for this exception would submit an application in the form and manner specified by CMS by December 31 of the performance

period or a later date specified by CMS. Clinicians must demonstrate in the application that there are overwhelming barriers that prevent them from complying with the requirements for the ACI category.

AAFP Response

We agree with the commenters CMS mentioned regarding the significant challenges of small, rural, and HPSA located practices. We are supportive of the additional significant hardship for small practices. While we appreciate the deadline for application being set at December 31, we would urge CMS to begin accepting the hardship exception applications before the 2018 performance period. We believe MIPS-eligible clinicians should be able to submit their hardship applications throughout the performance period and receive a timely response from CMS. In addition to those MIPS-eligible clinicians in rural, small, or in HPSA practices, we believe eligibility for these significant hardship exceptions should be extended to practices in medically-underserved areas, or caring for a medically underserved population. We urge CMS to expand those eligible for these hardship exceptions.

Under the EHR Incentive Program (Meaningful Use), an eligible professional who believed they qualified for a hardship exception could submit the application and go through the attestation process. If they qualified for the exception, they received the exception regardless of their attestation. This policy held eligible professionals harmless for submitting data in case their exception application was not approved. Because of that precedence by CMS, we are concerned some MIPS-eligible clinicians may still submit data even after applying for an exception. We urge CMS not to penalize those eligible clinicians for submitting data and apply the exception if the eligible clinician qualifies (reweighting ACI to zero percent and increasing quality performance category by 25 percent), regardless of whether they submitted data to CMS for the ACI category.

(v) Exception for MIPS-Eligible Clinicians Using Decertified EHR Technology

Summary

Section 4002(b)(1)(A) of the *21st Century Cures Act* provides the Secretary with authority to exempt a MIPS-eligible clinician from a payment adjustment should the clinician's CEHRT become decertified. CMS is proposing that a MIPS-eligible clinician may demonstrate through an application process that reporting on the measures specified for the ACI category is not possible because the CEHRT used by the MIPS-eligible clinician has been decertified under the Office of the National Coordinator's (ONC's) Health IT Certification Program. A successful application and granted exception would reweight the ACI category to zero. CMS is proposing that the MIPS-eligible clinician must demonstrate in their application and through supporting documentation, if available, that the MIPS-eligible clinician made a good faith effort to adopt and implement another CEHRT in advance of the performance period.

AAFP Response

We are supportive of the exception. **We strongly recommend to CMS physicians should be held harmless, in an automated fashion, by CMS if their CEHRT becomes decertified. We have concern about the vagueness of "made a good faith effort" and "through supporting documentation," in regard to the application process for this exception.** Due to the lack of interoperability, the impact on productivity, and large financial burden of switching EHRs, CMS should be extremely broad in their interpretation of "good faith" and be lenient on the level of "supporting documentation" needed. We also urge CMS to provide further guidance that better defines these terms. We recommend evidence of good faith effort to secure other CEHRT not be requested until one calendar year following date of decertification. It is highly

unlikely an eligible clinician would have sufficient time to secure funding necessary to purchase other CEHRT within the year or time for significant decision making and assessment of other CEHRT to inform timely purchasing decisions.

(d) Scoring for MIPS-Eligible Clinicians in Group Practices

Summary

The proposed rule states that CMS “noted that these MIPS eligible clinicians may choose to submit advancing care information measures; however, if they choose to report, they will be scored on the advancing care information performance category like all other MIPS eligible clinicians and the performance category will be given the weighting prescribed by section 1848(q)(5)(E) of the Act regardless of their advancing care information performance category score. This policy includes MIPS eligible clinicians choosing to report as part of a group practice or part of a virtual group.”

CMS states that the data submission for groups reporting for the ACI category should be aggregated for all MIPS-eligible clinicians within the group practice. This includes those MIPS-eligible clinicians who may qualify for a zero percent weighting of the ACI category due to the circumstances as described in the previous subsections, such as a significant hardship or other type of exception, hospital-based or ASC-based status, or certain types of non-physician practitioners (NPs, PAs, CNSs, and CRNAs). If these MIPS-eligible clinicians report as part of a group practice or virtual group, they will be scored on the ACI category like all other MIPS-eligible clinicians and the performance category will be given the weighting prescribed by section 1848(q)(5)(E) of the act, regardless of the group practice’s ACI category score.

AAFP Response

Under the EHR Incentive Program (Meaningful Use) an eligible professional who believed they qualified for a hardship exception could submit the application and go through the attestation process. If they qualified for the exception, they received the exception, regardless of their attestation. This policy held eligible professionals harmless for submitting data in case their exception application was not approved. Due to that precedence by CMS, we are concerned some MIPS-eligible clinicians may still submit data even after applying for an exception. We urge CMS not to penalize those eligible clinicians for submitting data and apply the exception if the eligible clinician qualifies (reweighting ACI to zero percent and increasing quality performance category by 25 percent), regardless of whether they submitted data to CMS for the ACI category.

(e) Timeline for Submission of Reweighting Applications

Summary

Current regulations state that MIPS-eligible clinicians must submit applications for reweighting of the ACI category before the end of the submission period for the relevant performance year or at later time specified by CMS. The application must be submitted annually, as well. CMS is proposing to change the submission deadline as they believe the current deadline may disadvantage MIPS-eligible clinicians. CMS proposes to change the 2017 performance period deadline to December 31, 2017, or a later date specified by CMS. CMS believes this will allow the clinician to learn whether their application is approved prior to the data submission deadline (currently March 31, 2018). Application availability is planned for mid-2017. CMS also proposed December 31, 2018, as the deadline for the 2018 performance period.

AAFP Response

The AAFP agrees MIPS-eligible clinicians need to know if they will have their ACI category reweighted prior to the submission deadline. We believe MIPS-eligible clinicians should be able to submit their application throughout the performance period and receive back from CMS a timely disposition of their application. We do not see a need or advantage to shortening the application deadline.

6.g APM Scoring Standard for MIPS-eligible Clinicians in MIPS APMs

(1) Overview

Summary

In the 2017 QPP final rule, CMS 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. To be a MIPS APM, an APM must satisfy three criteria: (1) APM entities participate in the APM under an agreement with CMS or by law or regulation; (2) the APM requires that APM entities include at least one MIPS-eligible clinician on a participation list; and (3) the APM bases payment on incentives on performance (either at the APM entity or eligible clinician level) on cost/utilization and quality measures. Under the APM scoring standard, eligible clinicians are scored at the APM entity group level, and each eligible clinician receives the entity group's final score. The payment adjustment is then applied at the TIN/NPI level for each eligible clinician within the entity group. CMS seeks comment on whether there may be potential conflicts or inconsistencies between the generally applicable MIPS policies and those under the APM scoring standard. Of particular note concerns where these could impact CMS' goals to reduce duplicative and potentially incongruous reporting requirements and performance evaluations that could undermine CMS' ability to test or evaluate MIPS APMs, or whether certain generally applicable MIPS policies should be made explicitly applicable to the APM scoring standard.

AAFP Response

The AAFP reiterates its steadfast opposition to the entire MIPS APM category. This entire category was created outside of the statutory requirements and introduces an unnecessary level of complexity to an already complex program. The AAFP strongly encourages consistency and equal reporting standards among all MIPS-eligible clinicians.

The AAFP is also concerned that eligible clinicians may intentionally remain in MIPS APMs, given the scoring advantage they have been given, instead of progressing towards AAPMs, which is the intent of the QPP. We urge CMS to closely monitor participants who may be intentionally avoiding the progression to AAPMs. These participants are likely to perform well under MIPS. This creates an unfair playing field for the rest of MIPS-eligible clinicians. Therefore, we request CMS institute a one-term limit on MIPS APMs. Once an entity has completed one term, for example under MSSP Track 1, the group must either proceed to an AAPM track or participate in MIPS without the APM scoring standard. We believe participants will be prepared to move to a more advanced risk-bearing model after one term of participation.

While we disagree with MIPS APMS, if CMS chooses to proceed, the AAFP would support a policy to reweight the cost category to zero for MIPS APMs participants. This would apply to partial QPs who may elect to participate in MIPS to encourage consistency in the program. In the 2018 performance period, the general MIPS final score will be comprised of three performance categories which excluded cost and would make sense for MIPS APM participants.

We believe, if CMS continues with MIPS APMs moving forward, they should have the same weighting structure as the current general MIPS structure.

(2) Assessment Dates for Inclusion of MIPS-eligible clinicians in APM Entity Groups Under the APM Scoring Standard

Summary

The entity group for the purposes of the APM scoring standard is based on the eligible clinicians included on the participation list on at least one of three dates (March 31, June 30, and August 31). If an eligible clinician is not on the participation list during one of these three dates, they would need to submit data to MIPS using one of the MIPS submission methods, and would be assessed using the generally applicable MIPS reporting and scoring criteria. CMS will continue to use the three assessment dates. Beginning in 2018, CMS is proposing a fourth assessment date of December 31 to identify MIPS-eligible clinicians who participate in a full TIN APM. The proposed definition for a full TIN APM is an APM where participation is determined at the TIN level and all eligible clinicians who have assigned their billing rights to a participating TIN are therefore participating in the APM. The additional determination date will not be used for QP determinations. CMS is not proposing a fourth assessment date for all MIPS APMs as it believes that would allow eligible clinicians to inappropriately leverage the fourth assessment date to avoid reporting and scoring under the generally applicable MIPS scoring standard when they were part of the MIPS APM for only a limited portion of the performance period. CMS seeks comment on the proposed addition of a fourth assessment date to identify MIPS-eligible clinicians who participate in full TIN APMs.

AAFP Response

The AAFP supports the addition of a fourth assessment date to identify eligible clinicians who participate in full TIN APMs.

(3)(a) Cost Performance Category

Summary

In the 2017 QPP final rule, CMS used its authority to reduce the weight of the cost category to zero percent for MIPS APMs. CMS also used its authority to waive the requirements to specify and use cost measures in the MIPS final score for MIPS-eligible clinicians participating in MIPS APMs. CMS is not proposing changes to this policy and seeks comments on the proposal to continue waiving the weight of the cost category for the 2020 payment year forward.

AAFP Response

While we disagree with MIPS APMS, the AAFP would support a policy to reweight the cost category to zero for MIPS APMs. However, we encourage CMS to continue providing feedback on the cost category to eligible clinicians participating in MIPS APMs.

(3)(a)(i) Measuring Improvement in the Cost Performance Category

Summary

CMS is proposing to use its authority to waive the requirement to take improvement into account for performance scores in the cost performance category beginning with the 2018 MIPS performance period. CMS seeks comment on this proposal.

AAFP Response

The AAFP would support CMS using its authority to waive the requirement to measure improvement in the cost category for MIPS APMs.

(3)(b)(i)(A) Quality Measures (MSSP, Next Gen ACO)

Summary

Participants in the Medicare Shared Saving Program (MSSP) and Next Generation ACO Model will be assessed using the quality measures submitted through the CMS Web Interface. CMS will use MIPS benchmarks for the measures to score eligible clinicians in these MIPS APMs. Data not submitted via the CMS Web Interface (e.g., CAHPS for ACOs) will not be included in the MIPS APM quality performance score for 2017.

AAFP Response

The AAFP believes topped-out measures should be removed from the CMS Web Interface for the same reasons they are being removed from other reporting mechanisms. We realize this will have an impact on APMs, but feel this is a necessary change to avoid the reporting of measures that are not useful simply for the sake of reporting, and to avoid giving an unfair reporting and scoring advantage to CMS Web Interface reporters. APM reporting should be adjusted to align with any changes made to the CMS Web Interface measures.

(3)(b)(i)(D) Scoring Quality Improvement

Summary

CMS proposes to calculate quality improvement scoring using the methodology described in section II.C.7.a.(1)(i) for scoring quality improvement for eligible clinicians submitting quality measures through the CMS Web Interface.

AAFP Response

The AAFP supports the proposed formula for scoring quality improvement, and urges CMS to maintain consistency among its calculations for all MIPS-eligible clinicians, including those reporting via CMS Web Interface or as part of a MIPS APM.

(3)(b)(i)(E) Total Quality Performance Category Score for CMS Web Interface Reporters

Summary

CMS proposes to calculate the total quality percent score for MIPS-eligible clinicians using the CMS Web Interface according to the methodology described in section II.C.7.(1)(h)(2) of this proposed rule. CMS seeks comment on its proposed quality category scoring methodology for CMS Web Interface reporters.

AAFP Response

The AAFP supports the proposed quality category percent score formula.

(ii) Other MIPS APMs

Summary

CMS is proposing the creation of another term, "Other MIPS APMs." An Other MIPS APM is a MIPS APM that does not require reporting through the CMS Web Interface. These include the End-Stage Renal Disease (ESRD) Care Model, CPC+, and the Oncology Care Model.

In performance period 2017, quality was weighted at zero percent for Other MIPS APMs (of note, MSSP and Next Gen, which are not Other MIPS APMs, were scored at 50 percent). Due to this, CMS did not finalize a list of quality measures nor did it use quality measures in the final MIPS score for MIPS APMs (CMS did not specify "Other"). CMS anticipated being able to use quality data submitted to the APM to calculate the quality score in year two of the program.

AAFP Response

The AAFP is frustrated and disappointed that CMS continues to create new terminology, not based on statute, and that serves only to confuse clinicians and make this program more complicated. We object to the MIPS APMs. We object to the new term, “Other MIPS APMs,” due to the inconsistent use of this term in the proposed rule and the confusion this leads to when interpreting requirements for clinicians. A goal of this administration, which the AAFP supports, is administrative simplification. This introduces complexity and undermines that overall goal.

The above section is a good example of why we caution CMS to not use new terms at this stage of rulemaking. It seems that MIPS APMs and Other MIPS APMs have been used interchangeably, leading to confusion. An excerpt from the QPP website that seems to contradict what is stated above: “For MIPS APMs that are under the Medicare Shared Savings Program or Next Generation ACO Model...the Quality performance category is weighted at 50 percent for the 2017 performance period. For all other MIPS APMs for the 2017 performance period, the Quality performance category weight is zero and no score is calculated for this category.” Clearly, quality measures are being used to account for 50 percent of the MIPS score under the APM scoring standard for MSSP and Next Generation ACO. It might have been the intent of CMS to refer to Other MIPS APMs in this section of the proposed rule, but it is not clear, and it is confusing when the language jumps between MIPS APMs and Other MIPS APMs with no explanation.

6.g APM Scoring Standard for MIPS-eligible Clinicians in MIPS APMs

(4) Calculating Total APM Entity Score

Summary

CMS proposes to weight the quality category score to 50 percent, the improvement activities score to 20 percent, and the advancing care information score to 30 percent of the final score for all APM entities in Other MIPS APMs. As noted previously, CMS is proposing to use its authority to waive scoring the cost performance category for MIPS APMs. These weights will align with the category weights assigned to CMS Web Interface reporters in MIPS APMs. In the event an Other MIPS APM has no measures available to score for the quality performance category, CMS is also proposing to reassign the quality category to the improvement activities (25 percent) and advancing care information categories (75 percent). Should the advancing care information be reweighted to zero, the quality weight would be increased to 80 percent. CMS seeks comment on the proposed reweighting for APM entities in MIPS APMs.

AAFP Response

The AAFP would support CMS’ proposal to align the performance category weights for MIPS APMs and Other MIPS APMs. The AAFP would agree with the proposed reweighting methods.

3.b.e.ii.A.aa. APM Measures for MIPS

Summary

CMS proposes to establish a list of measures for MIPS APMs (CMS did not specify “Other”) that would reflect the APM program requirements. These would be the quality measures for the APMs to report.

AAFP Response

Should CMS proceed with MIPS APMs, the AAFP would agree with using the APM measures as the quality measures needed to report to satisfy the APM scoring standard. However, we thought this was the intent in the 2017 QPP final rule.

3.b.e.ii.B. Measure Requirements for Other MIPS APMs

Summary

Each Other MIPS APM has unique quality measure sets. For the purposes of the APM scoring standard, CMS will only score measures that are tied to payment, available for scoring near the close of MIPS submission period, have a 20-case minimum, and have a benchmark. CMS discusses the following requirements for Other MIPS APM quality measures:

- A measure is tied to payment if the APM entity group will receive a payment adjustment based on performance.
- The measure must be available for scoring, meaning data must be submitted by the close of the MIPS submission period.
- Measures must have at least 20 cases.
- Benchmarks would be based on MIPS APM quality measurement. If there is not a benchmark, then benchmarks would be drawn from regular MIPS measures. If neither exist, the measure would get a null score and would be removed from the numerator and denominator.

AAFP Response

The AAFP is concerned that under the APM scoring standard measures that do not meet the case minimum or have a benchmark are removed from the numerator and denominator and the eligible clinician is essentially held harmless. However, under the generally applicable MIPS standards, measures that do not meet the case minimum or have a benchmark receive three points, thereby potentially lowering the MIPS-eligible clinician's score. This is inconsistent. The AAFP would encourage CMS to have consistency between the scoring of measures that do not meet case minimums and benchmarks. CMS should have consistent policies between all MIPS and APM programs, which seemed to be Congressional intent when they required APMs to provide "...payment for covered professional services based on quality measures comparable to measures..." in MIPS.

3.b.e.ii.C. Calculating the Quality Performance Category Percent Score

Summary

The minimum number of measures required will be the number required by the APM program. CMS explains that APM entities that do not submit all required measures will receive a zero for the measures not submitted. If no measures are submitted, the APM entity will receive a zero for the quality category. If APM entities submit more than the required measures, only the highest scoring measures will count towards their quality category score.

AAFP Response

The policy described here is consistent with the general MIPS quality category. However, in the beginning of this section, CMS is referring specifically to Other MIPS APMs, and then changes to MIPS APMs with no explanation. It is unclear if this is intentional or an oversight. Again, we caution the establishment of another category not based on statute that will lead to confusion.

3.b.e.ii.C.aa. Quality Measure Benchmarks

Summary

An APM entity's MIPS quality measure score will be calculated by comparing the APM entity's performance on a given measure with a benchmark performance score. The benchmark will be the benchmark used by the MIPS APM for calculation on payments within the APM. If that benchmark is not available, then the regular MIPS benchmark will be used. If neither exists, then the APM entity will get null for that measure, and it will be removed from the numerator and

denominator. Benchmarks are then broken into deciles. Entities will get a range of points based on where they fall in the decile.

AAFP Response

This methodology is consistent with general quality benchmark scoring. However, CMS has made it very unclear what entity they are referring to. CMS skips between MIPS APMs and Other MIPS APMs without distinction. There is not a clear definition of which of these entities in this section refers to. The AAFP opposed the establishment of MIPS APMs and we are opposing Other MIPS APMs for this reason. If CMS cannot clearly communicate intention, clinicians will not be successful in this program. Also, the AAFP would encourage CMS to have consistency between the scoring of measures that do not meet case minimums and benchmarks. CMS should have consistent policies for all MIPS-eligible clinicians, regardless of if they are reporting under the generally applicable MIPS standards or as part of a MIPS APM or Other MIPS APM.

3.b.e.ii.C.bb. Assigning Quality Measure Points Based on Achievement

Summary

MIPS APMs can earn bonus points for reporting on high-priority measures or measures submitted with end-to-end electronic reporting. Other MIPS APMs can earn bonus points if CMS identifies that their measures qualify. Bonus points for both are capped at 10 percent of quality performance score. CMS requests comment.

AAFP Response

The AAFPs does not disagree with the proposed bonus structure, but cautions CMS because a duplicity of scoring options for MIPS, MIPS APMs, and Other MIPS APMs is confusing and overly burdensome for clinicians to understand and for CMS to administrate.

3.b.e.ii.D. Quality Improvement Scoring

Summary

Beginning in performance period 2018, CMS plans to score on improvement as well as performance in the quality category. The formula is this: quality improvement score = (absolute improvement/prior year quality score before bonus)/10.

AAFP Response

The AAFP does not understand why the improvement score is different for MIPS APMs, Other MIPS APMs, and General MIPS-eligible clinicians. The AAFP believes CMS inadvertently divided by 10 when they should have multiplied by 10, as was used in the general MIPS formula.

3.b.e.ii.E. Calculating the Total Quality Performance Category Score

Summary

CMS proposes to calculate the quality category score using the following formula: quality performance category score = [(achievement points + bonus points)/total available achievement points] + quality improvement score. CMS seeks comment on quality scoring for MIPS APM and Other MIPS APMs.

AAFP response

The AAFP agrees with CMS' proposal for the MIPS APMs and Other MIPS APMs quality category score. We appreciate the consistency shown here with the scoring methodology and encourage CMS to carry this consistency throughout the proposal.

3.b.e.ii.c. Improvement Activities Performance Category

Summary

CMS will assign a score to each APM entity based on the activities involved in participation in a MIPS APM. Minimum points will be half of the total possible points.

AAFP Response

The AAFP understands this is consistent with previous language and appreciates the continuity. However, CMS fails to mention Other MIPS APMs in this statement. We are unclear if this is an oversight or an intentional exclusion. We again encourage CMS to abolish the term “Other MIPS APMs.”

5. MIPS Performance Feedback

Summary

In performance period 2018, MIPS-eligible clinicians scored according to the APM scoring standard will receive feedback on quality, ACI and improvement activities categories, but not the cost category. CMS requests feedback.

AAFP response

The AAFP would encourage CMS to give feedback on cost to all eligible clinicians, regardless of APM, MIPS APM, or Other MIPS APM status. Clinicians value this feedback and could use this data as they try to improve performance. Clinicians’ APM participation status may change and having feedback on all category scores will help them succeed if they should become general MIPS reporters. This will be increasingly important as the category weight for cost increases to potentially 30 percent.

II. C. 7. MIPS Final Score Methodology

Summary

In this section, CMS references “MIPS” and “MIPS APMs” without a reference to “Other MIPS APMs.”

AAFP Response

The AAFP would appreciate consistency within the rule from CMS when referring to MIPS and MIPS APMs. It is difficult to determine if Other MIPS APMs has been intentionally left out of this list, or if it has just been overlooked.

II.C.7.a.1.b. Policies Related to Scoring Improvement/Background

Summary

MACRA requires improvement in quality and cost to be factored in by performance period 2018, and the agency seeks comment on this.

AAFP Response

The AAFP is supportive of CMS scoring improvement for quality at the category level and cost at the measure level, as required by statute.

II.C.7.a.1c. Scoring Flexibility for ICD-10 Measure Specification Changes During the Performance Period

Summary

CMS acknowledges an ICD-10 code that is modified could impact a measure numerator, denominator, or exclusion. They propose to determine the following: if a measure is significantly

impacted by a more than 10 percent change in the codes in the numerator, denominator, exclusions, and exceptions; the impact of guideline changes, new products, or procedures reflected in ICD-10 code changes; and feedback on measures received from developers and stewards. CMS proposes to only use data from the measures impacted by these changes from the first nine months of the 12-month performance period. CMS states, they will ideally notify providers of affected codes by October 1, but no later than January 1.

AAFP Response

The AAFP appreciates the acknowledgement that changes in ICD-10 will impact measure performance. However, the AAFP is concerned that the time line proposed by CMS provides no lead time for system adjustment or provider education. ICD-10 updates are typically posted to the CMS website mid-June. Therefore, we suggest an October 1 clinician notification when ICD-10 updates are effective every year. At a minimum, clinicians will need a 30-60 day window of lead time, such as November 1 or December 1.

However, the AAFP cautions CMS that certain measures, like “Diabetes: Medical Attention for Nephropathy” (NQF#0062) and “Diabetes: Foot Exam” (NQF#0056), could be included in the list of ICD-10 impacted measures. Due to the measure logic, these measures, along with many others, will be negatively impacted by a shorter reporting window since it can take a full year to capture the data needed to successfully report these measures. The AAFP encourages CMS to identify measures that require an action being taken or reported during the performance period where performance rates could be negatively impacted by the shortened reporting period, and either eliminate them from scoring, or adjust the benchmark rate accordingly.

II.C.7.a.2. Scoring Quality for Submission via Claims, EHR, Third Party (QCDR, Qualified Registry, CAHPS for MIPS), Web Interface, and Administrative Claims

Summary

CMS is has revised its terminology and refers to points from performance on a measure as “measure achievement points” and the bonus points earned “measure bonus points.” The total possible points available for a measure is now called “total available measure achievement points.” Measure achievement points would be added to measure bonus points and divided by total available measure achievement points to calculate the quality category score. The resulting score is now referred to as the “quality performance category percent score.”

AAFP Response

The AAFP is frustrated and disappointed that CMS continues to create and change terminology not based on statute. It only serves to confuse clinicians and further complicate the QPP.

II.C.7.a.2.a. Quality Measure Benchmarks

Summary

CMS proposes that each benchmark must have a minimum of 20 individual clinicians or groups who report on the measure that also meets data completeness and case minimums with performance greater than zero. Since CMS proposed to change the low-volume threshold, this will have an impact on their benchmarks. The agency seeks comments on this approach.

In the 2017 QPP regulation, benchmarks were not stratified according to characteristics, such as practice size. However, different benchmarks were developed for different submission mechanisms. CMS is not proposing to change this policy. However, it seeks comment on ways to stratify benchmarks by specialty or place of service. Also, CMS seeks comment on how it

should stratify submissions by multi-specialty practices or by practices that operate in multiple places of service.

AAFP Response

The AAFP strongly urges CMS to allow clinicians the opportunity to opt in to MIPS, regardless of their low-volume threshold status. If more clinicians are MIPS participants, benchmarks are less likely to be affected. However, we encourage CMS to exclude voluntary reporters who are not subject to MIPS payment adjustments from benchmark calculation. Facing no real negative adjustments, it is difficult to predict how accurate these clinicians' reporting rates may be, thus potentially skewing the benchmarks.

The AAFP does not support stratifying benchmarks beyond what is already in place. If groups that report as a group are not satisfied with the benchmarks available for the measures they are reporting, they can choose to report as individuals and select measures with more favorable benchmarks. The AAFP sees no need to further complicate this system with more complex benchmarking methodology for any reason.

II.C.7.a.2.b.i. Floor for Scored Quality Measures

Summary

In performance period 2017, CMS finalized a three-point floor for reported quality measures that could be scored against a benchmark and meet the data completeness criteria. CMS plans to apply this three-point floor again for quality measures in the 2018 performance period, and seeks comment on that approach.

AAFP Response

Extending the three-point floor for reported quality measures that meet data completeness criteria and also have a benchmark is supported by the AAFP, and will be beneficial for our members, especially those in small practice. We encourage CMS to evaluate how many measures met the criteria to receive the three-point floor score. If there was an excessive number of measures that met criteria, CMS might consider extending this floor to future program years.

II.C.7.a.2.b.ii. Additional Policies for the CAHPS for MIPS Measure Score

Summary

There are 10 summary survey measures (SSMs) on the CAHPS for MIPS survey. CMS calculates performance on all 10 measures, but will only use eight with high reliability to calculate the CAHPS for MIPS score.

AAFP Response

The AAFP supports eliminating from scoring any measure that does not have high reliability.

II.C.7.a.2.c. Identifying and Assigning Measure Achievement Points for Topped-Out Measures

Summary

Based on 2015 historic benchmark data, approximately 45 percent of the quality measure benchmarks currently meet the definition of topped out. Some submission mechanisms are more topped out than others: 70 percent of claims measures, 10 percent of EHR measures, and 45 percent of registry/QCQR measures are topped out. In the 2017 performance period, topped-out measures were scored the same as other measures. CMS requested comment on how to move forward with topped-out measure scoring. Earlier in this rule, CMS proposed a three-year life cycle for topped-out measure removal.

In this section, CMS proposes to phase in special scoring for topped-out measures starting in the 2018 performance period, provided it is the second year the measure benchmark is identified as topped out. CMS proposes to cap the score of topped-out measures at six measure achievement points since the agency believes this is simpler than other approaches proposed, and it is also the median score that any measure can earn. Topped-out measures are still eligible for bonus.

CMS identified six measures to start the topped-out scoring approach within performance period 2018. In performance period 2019, topped-out scoring will be applied to all topped-out measures, provided it is at least the second consecutive year the measure is identified as topped out. CMS seeks comment on these proposals and on a proposal to apply the topped-out policy to summary survey measures in CAHPS for MIPS Survey, and not apply it to CMS Web Interface reporters.

AAFP Response

The AAFP appreciates the simplified approach to assigning points to topped-out measures, and supports the six points cap for measures that are topped out. This approach will encourage reporting of other measures that are more meaningful. The AAFP encourages CMS to make it apparent on the QPP website and through other communication channels which measures are topped out, and that these will have a six-point cap.

The AAFP is supportive of the measures selected as topped out for performance period 2018. We are also supportive of applying the topped-out methodology beginning in performance period 2019.

The AAFP encourages CMS to apply the topped-out policy to the CMS Web Interface measures. Allowing clinicians reporting through the CMS Web Interface to earn full points for reporting topped-out measures will unfairly advantage the final score for these reporters compared to other clinicians, as a high score will be much easier to achieve. Instead, more meaningful questions should be designed for the CMS Web Interface and the CAHPS for MIPS Survey using an iterative approach. A measure cap should not be applied to topped-out measures in the CAHPS for MIPS Survey since clinicians do not have control over CAHPS measure selection, and until better CAHPS measures are developed and implemented.

II.C.7.a.2.d. Case Minimum Requirements and Measure Reliability and Validity

Summary

In the 2017 performance period, all measures must have 20 cases (except all-cause hospital readmission, which had a 200-case minimum). In performance period 2018, if a measure is submitted, but does not meet the case minimum or does not have a benchmark (class 2 measures) it will still get three points. If the measure does not meet data completeness (class 3 measure) the measure would receive one point (small practices will still receive three points).

AAFP Response

The AAFP is supportive of CMS' proposal to maintain a point floor for measures, understanding the floor score is lower for measures that do not meet data completeness. We are appreciative of the concession given here to small practices, allowing them to earn three points even if their measure does not meet data completeness. We encourage CMS to develop a way to inform reporters if data completeness is not met, and allow them to correct/supplement their

submissions, because this is usually unintentional. We would also encourage CMS to extend the point floor for small practices past performance period 2018.

(g) Incentives to Use CEHRT to Support Quality Performance Category Submissions

Summary

For the first two years of the program, current regulation gives MIPS-eligible clinicians one bonus point for each quality measure submitted with end-to-end electronic reporting, with a maximum of 10 percent of the denominator of the quality performance category percent score. Also, the CEHRT bonus would be available for all submission mechanisms except claims submission. CMS is not proposing any changes to this bonus, but they are seeking comment on the use of health IT in quality measurement and how HHS can encourage the use of CEHRT in quality measurement.

AAFP Response

We believe the industry needs to move to electronic reporting of quality and performance measures, yet there are significant challenges to physicians in implementing end-to-end electronic reporting. For these reasons, the AAFP is supportive of the current bonus, although a duration of two performance periods may not be sufficient. Instead of a time limit for this bonus, CMS should consider a threshold-based limit. The AAFP would recommend that the bonus be continued until at least 75 percent of MIPS-eligible clinicians report electronically end-to-end. At this time, the AAFP supports a single method for measure submission per category. We believe that this bonus could be simplified by simply giving the MIPS-eligible clinician a 10 percent bonus if all quality measures are submitted electronically end-to-end.

Another incentive CMS could provide for end-to-end electronic reporting is to provide those MIPS-eligible clinicians with more timely access to data on their patients. CMS should work with CEHRT to provide electronic end-to-end reporting back to MIPS-eligible clinicians on cost data and other data relevant to the patients for which the MIPS-eligible clinicians provides care. It should be noted that the AAFP believes all MIPS-eligible clinicians should receive timely feedback from CMS. Electronic end-to-end reporting provides an opportunity for CMS to provide that feedback in an even shorter delay than some other submission methods.

II.C.7.a.2.h.i. Calculating Total Measure Achievement and Measure Bonus Points for Non-CMS Web Interface Reporters

Summary

In 2017, CMS finalized that if a MIPS-eligible clinician reports more than six measures only the highest six scores will be used to calculate the quality score. CMS is not proposing any changes to this policy. Since CMS is proposing to allow multiple mechanisms for data submission within a category (also allowing for one measure to be reported more than once using different submission mechanisms each time), it has come up with criteria for how to score these quality measures that are submitted across multiple mechanisms. The criteria is as follows:

- Measures can only be scored across multiple mechanisms if they are reported in the same way (individual or group) via each mechanism.
- CMS will not aggregate data from multiple TINs within a virtual group to produce a virtual group measure score. The virtual group must do this aggregation themselves and submit the data as a virtual group to CMS.
- CMS Web Interface and facility-based measurement cannot be combined with other mechanisms of reporting (with the exception of CAHPS for MIPS).
- If a measure is submitted through two mechanisms, it will be scored under both, but only points from the highest scoring mechanism will be added to the quality score.

- Measure bonus points can only be added to the score once. If the same measure is submitted through multiple mechanisms, the bonus points are applied only once.
- Bonus points for end-to-end electronic reporting are also only applied once, regardless of how many times the measure is submitted.

AAFP Response

As stated in previous comments, the AAFP is encouraging CMS to not allow multiple submission mechanisms within each MIPS category. The AAFP is unsure of how CMS intends to administrate this part of the program. CMS should consider withholding this portion of the proposed rule until they can demonstrate the ability to receive data and send feedback in a timely and accurate fashion. However, the AAFP is supportive of the scoring proposals for non-CMS Web Interface reporters. We specifically support only counting a measure achievement score once, regardless of how many times it was submitted through differing mechanisms. We also support only providing bonus points to measures one time, regardless of multiple submissions.

II.C.7.a.2.h.ii. Calculating Total Measure Achievement and Measure Bonus Points for CMS Web Interface Reporters

Summary

In performance period 2017, CMS Web Interface reporters must report on all 14 measures, but are scored on 11 (three of the measures did not have a benchmark). Measures would have a three-point floor if they met data completeness, case minimum, and have a benchmark. CMS is not proposing any changes to this policy for the 2018 performance period. If a measure is not submitted, or is below data completeness, it will receive a zero score.

To increase alignment with MSSP, CMS is proposing to exclude CMS Web Interface measures from scoring if the measure is redesignated from pay-for-performance to pay-for-reporting for all MSSPs ACOs. CMS also clarified that CMS Web Interface reporters could report CAHPS for MIPS and receive bonus points for doing so.

AAFP Response

The AAFP agrees with the scoring outlines for CMS Web Interface reporters. We do not believe it is consistent with the goals of the program to be scored on measures that are simply pay-for-reporting and believe they should be removed.

The AAFP would encourage CMS to align MIPS and APM programs. When describing scoring for MIPS APMs, CMS stated that if a clinician is in an APM, measures that do not meet the case minimum or do not have a benchmark will be removed and the clinician is essentially held harmless. **We are concerned that if a clinician is in MIPS and reports a measure that does not meet the case minimum or have a benchmark, it will receive three points. This inconsistency within the program is confusing and overly complex.** The AAFP would encourage CMS to have consistency between the scoring of measures that do not meet case minimums and benchmarks. If a measure does not have a benchmark or does not meet the case minimum, it should not be removed from the numerator and denominator, regardless of MIPS or various APM status.

II.C.7.a.2.i.i. Scoring Improvement for the MIPS Quality Performance Category Percent Score/Calculating Improvement at the Quality Performance Category Level

Summary

Beginning with the 2018 MIPS performance period, performance improvement will be scored in the quality and cost categories. For quality, improvement will be scored at the category level and not the individual measure level. CMS proposes to add improvement points to the achievement percent score and divide by the total possible achievement points, which is limited to not more than 10.

AAFP Response

The AAFP is supportive of CMS' proposal to score improvement.

II.C.7.a.2.i.ii. Data Sufficiency Standard to Measure Improvement for Quality Performance Category

Summary

It is statutory to measure improvement in the quality category beginning in performance period 2018. CMS is measuring improvement in quality at the category level and not the measure level. The agency is concerned that by doing this, some eligible clinicians or groups might change from one year to the next from low performing measures to higher performing measures to just to get the benefit from improvement points. The agency seeks comment on if it should require consistency in measure selection year-to-year in order to qualify for improvement points.

To measure improvement, CMS has identified multiple scenarios where current year and previous year MIPS scores need to be compared to each other for the purposes of scoring improvement. Of note, if a new group forms, its improvement can be scored. CMS will compare the current group score to the average of the scores from the prior performance period of the individuals who make up the new group. Also of note, if an individual was not eligible for MIPS in the prior performance period, they are not eligible for improvement scoring. An alternative would be to only allow improvement scores for those who submit the same identifier for two consecutive years.

AAFP Response

The AAFP agrees with CMS that changing to higher performing measures would lead to a perception of improvement without actually improving on previously reported measures. However, this type of improvement cannot be sustained and is administratively burdensome for practices that must build new infrastructure to report new measures. Therefore, we do not support requiring consistency on measure selection year over year in order to qualify for improvement scoring.

The AAFP agrees with CMS' proposals to score improvement year over year. However, we would not support only scoring improvement for those who submit with the same identifier for two consecutive years. Specifically, we believe this would unfairly penalize clinicians changing jobs and would discourage the establishment of virtual groups.

II.C.7.a.2.i.iii. Additional Requirement for Full Participation to Measure Improvement for Quality Performance Category

Summary

To qualify for improvement scoring, eligible clinicians must participate in the quality category by meeting data completeness and by submitting all required measures. To account for the transition year, CMS proposes to only score improvement if the quality category achievement percent score exceeds 30 percent for the transition year. For example, this represents an eligible clinician who submitted six quality measures, and scored the minimum score for each measure (i.e., $6 \times 3 = 18 \div 60 = 30$ percent). CMS believes this approach recognizes those who

participated in the transition year while not awarding for an increase in participation rather than an increase in achievement.

AAFP Response

The AAFP is supportive of CMS' approach to have additional requirements for improvement scoring including meeting data completeness, submitting all required measures, and participating during the transition year at a level to achieve a quality category achievement percent score of at least 30 percent.

II.C.7.a.2.i.iv. Measuring Improvement Based on Changes in Achievement

Summary

When calculating improvement, bonus points will not be considered in the calculation. The formula for quality category achievement percent score would be: total measure achievement points divided by total available measure achievement points.

The current quality category achievement percent score is then compared to the previous year's score.

AAFP Response

The AAFP is supportive of CMS' methodology to calculate the quality category achievement percent score. We agree with not including bonus points in the calculation.

II.C.7.a.2.i.v. Improvement Scoring Methodology for the Quality Performance Category

Summary

CMS is trying to award a higher rate of increase in improvement. The improvement percent score would be calculated using the following formula:

- Improvement percent score = increase in the quality performance category achievement percent score from prior performance period to current performance period divided by prior year quality category achievement percent score multiplied by 10 percent.

CMS proposes to cap the number of improvement points at 10. CMS considered another approach for improvement scoring based on the improvement scoring methodology of the MSSP. CMS ultimately decided not to adopt this approach. However, CMS seeks comments on the proposal to calculate improvement scoring using a methodology that rewards improvement points based on the rate of improvement and on its alternative approach based on the MSSP.

AAFP Response

The AAFP is supportive of CMS' proposal to calculate improvement scoring using a methodology that awards points based on the rate of improvement, and agrees this approach is simpler and easier to understand than the alternative banded approach stated in the rule. The AAFP would point out that the quality improvement score methodology for Other MIPS APMs is similar to this formula, but uses different terminology and mathematically divides by 10 instead of multiplying by 10. We ask CMS to provide clarification and would encourage consistency.

II.C.7.a.2.j. Calculating the Quality Performance Category Percent Score Including Improvement

Summary

The formula for calculating the quality category percent score would be:

- Quality performance category percent score = ([total measure achievement points plus measure bonus points] divided by total available measure achievement points) plus improvement percent score.

This same logic will be applied for CMS Web Interface and non-CMS Web Interface reporters.

AAFP Response

The AAFP is supportive of CMS' proposal to score the quality category.

II.C.7.a.3.a.i. Measuring Improvement/Calculating Improvement at the Cost Measure Level
Summary

In the cost category, improvement will be measures at the measure level and not the category level as it was with quality. Eligible clinicians would need to meet data sufficiency standards for cost to be scored on improvement. To be scored for improvement, the eligible clinician would need to report for MIPS using the same identifier for two consecutive periods. The same cost measures would need to be reported for two consecutive periods, and these measures would need to meet case minimums. The only two cost measures for payment year 2020 that qualify for improvement scoring are MSPB and Total per Capita Cost.

AAFP Response

The AAFP is supportive of the data sufficiency standards and the approach to calculating the cost category.

II.C.7.a.3.a.ii. Improvement Scoring Methodology
Summary

CMS proposes to compare the number of measures with statistically significant improvement in performance to the number of measures with a statistical significant decline in performance. CMS would subtract the number of measures with decline from the number of measures with improvements, then divide by the total number of measures, and multiple by the maximum cost improvement score. CMS will determine statistical significance using a t-test. CMS seeks comment on whether it should adopt this method or another method, such as the method used in the quality category.

CMS proposes to calculate a cost performance improvement score for the 2020 payment year, but it will not contribute points to the category score, as cost is proposed to be weighted at zero percent. If cost is increased to 10 percent for payment year 2020, CMS proposes to have the maximum cost improvement score available at one percentage point.

AAFP Response

Anytime the QQP program policies can be aligned, the AAFP would encourage CMS to do so. Given that, we would suggest CMS use a methodology such as the quality performance category improvement scoring methodology to calculate cost performance improvement.

The AAFP is supportive of the cost category weight remaining at zero percent for performance period 2018, and therefore having the improvement score not contribute any points to the cost category for performance period 2018.

II.C.7.a.3.b. Calculating the Cost Performance Category Percent Score with Achievement and Improvement
Summary

The cost performance category percent score with achievement and improvement would be calculated based on the following formula:

- Cost performance category percent score = cost achievement points divided by available achievement points, plus cost improvement score.

AAFP Response

The AAFP is supportive of the proposed formula to calculate the cost category percent score with achievement and improvement.

7.a.(5) Scoring the Improvement Activities Performance Category

Summary

Points within the improvement activities category will be assigned based on PCMH recognition, APM participation, and activities reported by the clinicians with the highest possible score equal to 40. Those will be scored as either medium- or high-weighted activities.

Activities for clinicians in small, rural, HPSA practices, and non-patient facing MIPS-eligible clinicians will receive double the weight. APMs will automatically earn at least one-half of the highest potential score for the improvement activities category, and may be assigned a higher score based on the extent to which the requirements of the specific APM model meets the list of improvement activities inventory. Participants in the CMS study on improvement activities and measurement will also receive the highest possible improvement activities category score.

A MIPS-eligible clinician who is in a certified PCMH/comparable specialty practice will also receive the highest potential score in the improvement activities category, subject to meeting the threshold for groups.

The improvement activities category score will be calculated by summing the points for all reported medium- and high-weighted activities and dividing by 40. The improvement activities score is capped at 100 percent. Certain improvement activities also qualify for bonus points in the ACI category. Clinicians that do not report at least one activity, including MIPS-eligible clinicians that do not identify to CMS that they are participating in a certified PCMH, will receive a score of zero for the improvement activities category.

MIPS-eligible clinicians and groups participating in an APM are not required to self-identify, but participants in certified PCMHs/comparable specialty practices are required to self-identify. Beginning in performance period 2018, CMS proposes to no longer require self-identification for non-patient facing clinicians, small practices, rural and HPSA practices, or any combination thereof, as CMS is technically capable of doing this.

AAFP Response

The AAFP appreciates the minimal changes made to scoring of the improvement activities category. We refer to our previous comments regarding the PCMH group threshold in section II.C.6.e. We appreciate CMS' ability and willingness to make status determinations for APM participants and small and rural and HPSA practices, as this will lower the burden of reporting.

II.C.7.b Calculating the Final Score

(1)(a) Consideration for Social Risk

Summary

CMS is currently reviewing reports prepared by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academies of Sciences, Engineering, and Medicine, and are considering options on how to address accounting for social risk in quality reporting programs. CMS continues to seek comment on whether it should account for social

risk in MIPS and what method or combination of methods would be most appropriate. Examples include: adjustment of MIPS-eligible clinician scores (stratifying based on proportion of dual-eligible patients); confidential reporting of stratified measure rates to MIPS-eligible clinicians; public reporting of stratified measure results; risk adjustment of a particular measure; and redesigning payment incentives. CMS seeks comment on whether any of these methods should be considered.

CMS is also seeking comments on which social risk factors might be most appropriate for stratifying measure scores and/or potential risk adjustment of a particular measure. Examples include: dual-eligibility/low-income subsidy; race and ethnicity; and geographic area of residence. CMS seeks comment on which social risk factors could be used and whether other data should be collected to better capture the effects of social risk. This includes current data sources where this information is available.

AAFP Response

The AAFP supports the development of a strategy to operationalize the integration of intersectionality theory into CMS' design method to account for social risk. For more information on this concept, we recommend two related articles, [The promise of intersectionality theory in primary care](#) and [Incorporating intersectionality theory into population health research methodology: Challenges and the potential to advance health equity](#).

Instead of determining social risk at the individual level, the AAFP recommends CMS use broader health equity assessments of communities to determine individual risk. After assessing at the population level, CMS could apply the community's assessment to individual beneficiaries living within the ZIP codes covered by the community. CMS should already have access to demographic information, including ZIP codes of Medicare beneficiaries. We direct CMS to a [Social Deprivation Index](#) developed by the Robert Graham Center as an example of how to determine social deprivation at the community level.

If CMS is unable to implement health equity assessment at the community level, we recommend CMS begin a stepwise strategy in which multiple social determinants of health will be integrated into health care processes and payment methodologies. The use of a single social determinant (race, gender, geography, etc.) is unable to comprehensively consider the unique interactions between multiple social determinants of health. We strongly urge CMS to start with small steps to create traction in the market, and to further the evidence base to inform the integration of social determinants of health into payment models. We believe a first step could be to leverage the existing demographic data already available to CMS (e.g., ZIP code and race) and integrate that with an existing federal measure of poverty (e.g., enrollees in the Supplemental Nutrition Assistance Program, recipients of Pell Grants, income, etc.). CMS may be able to access this data through inter-agency agreements, similar to that which CMS has with the Internal Revenue Service for the Medicare Secondary Payer Data Match.

The AAFP urges CMS to review and incorporate the findings from the ASPE report, "Social Risk Factors and Performance Under Medicare's Value-based Purchasing Programs."

(1)(b) Complex Patient Bonus

Summary

CMS is proposing a complex patient bonus only for the 2018 MIPS performance period, and will assess on an annual basis whether to continue the bonus and how it should be structured.

CMS has identified two potential indicators for patient complexity: 1) Hierarchical Condition Category (HCC) risk scores and 2) social risk as measured through the proportion of patients with dual-eligible status. CMS evaluated both indicators using the 2015 PQRS and Other Suppliers Public Use File (PUF), and determined there is a modest correlation between the two indicators. This is to say, there is some overlap but the indicators cannot be used interchangeably.

There were high average simulated scores for each quartile for both indicators. As such, CMS is proposing a small complex patient bonus for the 2020 payment year. The bonus will be based on the average HCC risk score, as this was used in the VM. CMS is proposing to add the bonus to the final score for clinicians who submit data for at least one performance category (do not have to meet submission requirements for quality to receive bonus).

CMS proposes to calculate the average risk score for a MIPS-eligible clinician or group by averaging the risk scores for beneficiaries cared for by the MIPS-eligible clinician or clinicians within the group during the 12-month segment of the eligibility period (last four months of the one year prior to the performance period, followed by the first eight months of the performance period in the next calendar year). The HCC risk scores would be calculated based on the calendar year immediately prior to the performance period.

For MIPS APMs and virtual groups, CMS proposes to use the beneficiary weighted average HCC risk score for all MIPS-eligible clinicians, and if technically feasible, TINs for models and virtual groups which rely on complete TIN participation, within the APM entity or virtual group, respectively, as the complex patient bonus.

CMS proposes the complex patient bonus cannot exceed three points. Based on analysis, CMS estimates the bonus will range from 1.16 to 2.49 for individuals and from 1.26 to 2.23 for groups.

CMS also proposed an alternative method where the bonus would be based on the ratio of patients who are dual eligible (both full and partial Medicaid beneficiaries).

CMS seeks comments on the proposed bonus for complex patients based on average HCC risk scores and the alternative option of using a ration of dual-eligible patients. CMS also seeks comments on alternative methods to construct a complex patient bonus.

AAFP Response

The AAFP supports the use of HCC risk scores to determine patient complexity as it is an accepted route for communicating severity of illness by utilizing ICD-10-CM. We strongly encourage CMS to increase educational efforts surrounding use of HCC risk scores as it is not currently widely understood. Clinicians will need to understand the “grading” of the different diagnoses and how one diagnosis may be more important than another.

The AAFP is concerned that using dual-eligible status as an indicator of patient complexity may severely underestimate the number of truly complex patients. There are currently 8.3 million beneficiaries considered dual eligible. However, the total Medicare beneficiary pool is 55.5 million. Additionally, while CMS determines the financial ceiling for eligibility, states have the ability to impose a lower income threshold, which can vary among states. **CMS must also consider that not all states have expanded Medicaid. These two issues would create an uneven playing field from state to state. Dual eligibility cannot be consistently applied and would not be an accurate indicator of patient complexity.**

The AAFP asks that CMS consider continuing the complex patient bonus in future program years. This would add consistency to the program. Additionally, it would continue to factor in patient complexity, which does not resolve after one year.

(1)(c) Small Practice Bonus for the 2020 MIPS Payment Year

Summary

CMS is proposing a five-point small practice bonus to be added to the final score. To receive the bonus, eligible clinicians must submit data on at least one performance category. Clinicians would not need to meet the submission requirements for the quality category. They could submit for the improvement activities or ACI measures only, or submit fewer than the required quality measures. This bonus would also be available to group practices, virtual groups, and APM entities that consist of 15 or fewer eligible clinicians. The bonus is a short-term strategy and is proposed only for the 2018 performance period. CMS will assess the bonus on an annual basis. CMS seeks comment on the small practice bonus. CMS also seeks comment on a possible rural practice bonus in future program years.

AAFP Response

The AAFP appreciates and supports the five-point small practice bonus. We ask that CMS re-evaluate this bonus in future program years to ensure that the small practice bonus is sufficient to overcome any discrepancies due to practice size. We agree that this bonus should be extended to practices in rural HPSAs where at least 50 percent of the NPIs under the TIN practice in a rural practice. We ask that CMS add practices in medically-underserved areas to this list.

The AAFP asks that CMS clarify its scoring example provided in this section. CMS states small practices that receive the small practice bonus could achieve the performance threshold (15 points) “by reporting two quality measures or one quality and one improvement activity.” CMS provides an example in a footnote in which a practice received a hardship exception for the ACI category resulting in quality comprising 85 percent of the final score. Based on this, each quality measure submitted would be worth 4.25 points towards the final score. A practice that submits two quality measures (and receives scoring as in CMS’ example) would receive 8.5 points toward the final score (4.25 + 4.25). Adding in the small practice bonus gives the practice a final score of 13.5, which is below the proposed performance threshold of 15 points. Based on this example, the AAFP is concerned that a practice may erroneously believe it can meet the performance threshold by submitting for only two quality measures. We ask that CMS clarify what it means by stating a practice could meet the performance threshold by submitting two quality measures and receiving the small practice bonus. We caution CMS about providing misinformation to eligible clinicians.

(2) Final Score Calculation

Summary

CMS is proposing to revise the finalized 2017 policy. It failed to codify the policy that assigns MIPS-eligible clinicians a final score equal to the threshold when they have only one scored performance category. This revision accounts for the proposal for extreme and uncontrollable circumstances, if finalized, could result in a clinician not being scored on any performance categories. CMS is proposing to add that a MIPS-eligible clinician with fewer than two performance category scores would receive a final score equal to the performance threshold. CMS seeks comment on this proposal and revision.

AAFP Response

The AAFP is supportive of the revision and proposed addition to the final score methodology. The AAFP asks CMS to clarify that a clinician with fewer than two performance categories scores must have received the extreme and uncontrollable circumstances reweighting to receive a final score equal to the threshold. A clinician would have fewer than two performance category scores if they fail to participate at all. According to the proposed policy, this would result in a final score equal to the threshold.

(3) Final Score Performance Category Weights
(3)(b) Flexibility for Weighting Performance Categories

Summary

CMS proposes that having sufficient measures applicable and available means CMS can calculate a quality performance category percent score for the MIPS-eligible clinician because they had at least one quality measure applicable and available. If CMS receives no quality performance category submission from a MIPS-eligible clinician, the clinician would receive a performance category score of zero (unless all-cause hospital readmissions is calculated). In rare situations, CMS may determine an eligible clinician does not have any measures applicable and available, or the clinician is approved for reweighting based on extreme and uncontrollable circumstances. In these situations, the quality category will be reweighted.

For the cost category, CMS believes having sufficient measures applicable and available means which CMS “can reliably calculate a score for the cost measures that adequately captures and reflects the performance of a MIPS eligible clinician...” If an eligible clinician has not attributed enough cases, the clinician would not be scored for the cost category. Since CMS has proposed to reweight the cost category to zero percent for the 2018 performance period, it is not proposing to redistribute the cost category weight.

CMS continues to believe all clinicians will have sufficient measures applicable and available for the improvement activities category. CMS seeks comment on the interpretation of sufficient measures available and applicable.

AAFP Response

The AAFP believes all specialists and subspecialists should be required to meet the same program expectations as other MIPS participants. We strongly encourage CMS to maintain cross-cutting quality measures within specialty sets to allow parity among all MIPS reporters. This would provide all MIPS-eligible clinicians with ample quality measures to report and relieve the need to reweight the quality category due to an insufficient number of measures applicable and available to report.

The AAFP supports CMS' proposal to reweight the quality category based on extreme and uncontrollable circumstances.

The AAFP believes MIPS-eligible clinicians in small practices (defined as practices with 15 or fewer clinicians) should not be scored on cost. The cost category for these clinicians should be reweighted to the quality category. In addition, CMS should not calculate a cost score for clinicians or groups unless at least one episode-based measure can be calculated. As such, the AAFP asks CMS to revise its policy regarding the reweighting of the cost category to redistribute the category weight for clinicians in small practices, and clinicians and groups that cannot be measured on at least one episode-based measure.

We agree with CMS that all clinicians should be able to report at least one improvement activity.

(3)(c) Extreme and Uncontrollable Circumstances

Summary

In the 2017 final rule, CMS finalized a policy to reweight the ACI category for clinicians affected by extreme and uncontrollable circumstances. Beginning in the 2018 performance period, CMS is proposing an extreme and uncontrollable circumstances policy for the quality, cost, and improvement activities categories. CMS will review the circumstances and the timing independently and the impact on the performance categories independently. This policy does not include issues with third-party intermediaries, but would include measures derived from administrative claims. CMS seeks to align the requirements for submitting an application for reweighting due to extreme and uncontrollable circumstances with the requirements for requesting a significant hardship exception for the ACI category (such as the application deadline). Virtual groups would need to request reweighting in the same manner as groups, and CMS would assess whether sufficient measures and activities were available to the majority of the TINs within the virtual group. CMS believes it is important to measure performance for virtual group members unaffected by extreme and uncontrollable circumstances. CMS would assign a final score equal to the performance threshold in the event an eligible clinician or group is scored in two or fewer performance categories. This reweighting policy would not be available for APM entities in the APM scoring standard.

CMS seeks comments on this proposal, additional considerations for virtual groups, and types of extreme and uncontrollable circumstances to be considered.

AAFP Response

The AAFP supports the addition of an extreme and uncontrollable circumstances policy for all MIPS performance categories. The AAFP asks CMS to clarify that a clinician with fewer than two performance categories scores must have received the extreme and uncontrollable circumstances reweighting to receive a final score equal to the threshold. A clinician would have fewer than two performance category scores if they fail to participate at all, which according to the proposed policy, would result in a final score equal to the threshold.

(3)(d) Redistributing Performance Category Weights

Summary

CMS is proposing to refine its policy to assign a final score equal to the performance threshold for MIPS-eligible clinicians and groups with only one scored performance category. CMS is proposing that a MIPS-eligible clinician with two or fewer performance category scores would receive a final score equal to the threshold. This is to account for the proposed extreme and uncontrollable circumstances policy, which could result in an eligible clinician not being scored in any performance category.

For the 2020 payment year, CMS proposes to continue its transition year policy to redistribute the weight of the ACI category to the quality category. Should the cost category weight be finalized at zero percent, CMS would not redistribute the weight from any other category to the cost category. If the cost category is not finalized as zero percent, CMS would redistribute the cost category weight to the quality category if there are not sufficient measures applicable and available, or the clinician is facing extreme and uncontrollable circumstances. If an eligible clinician is not scored on at least one quality measure, CMS proposes to continue its policy from the transition year to redistribute the quality category weight to the improvement activities and ACI categories so that each category is weighted at 50 percent. If the improvement activities

category qualifies for reweighting due to extreme and uncontrollable circumstances, CMS would redistribute the weight to the quality category.

CMS considered an alternative approach to redistribute the weight of the ACI category to the quality and improvement activities categories. Under this approach, 15 percent would be redistributed to the quality category and 10 percent to the improvement activities category. If the quality category has been reweighted to zero, then the full 25 percent would be redistributed to the improvement activities category.

CMS seeks comment on its proposal for reweighting performance categories and the alternative option for reweighting the ACI category.

AAFP Response

The AAFP supports CMS' reweighting proposals as they relate to extreme and uncontrollable circumstances, as well as the proposed reweighting of the ACI and improvement activities categories.

The AAFP believes all specialists and subspecialists should be required to meet the same program expectations as other MIPS participants. We strongly encourage CMS to maintain cross-cutting quality measures within specialty sets to allow parity among all MIPS reporters. This would provide all MIPS-eligible clinicians with ample quality measures to report and relieve the need to reweight the quality category due to an insufficient number of measures applicable and available to report.

The AAFP believes MIPS-eligible clinicians in small practices (defined as practices with 15 or fewer clinicians) should not be scored on cost. The cost category for these clinicians should be reweighted to the quality category. In addition, CMS should not calculate a cost score for clinicians or groups unless at least one episode-based measure can be calculated. As such, the AAFP asks CMS to revise its policy regarding the reweighting of the cost category to redistribute the category weight for clinicians in small practices, and clinicians and groups that cannot be measured on at least one episode-based measure.

The AAFP asks CMS to clarify that a clinician with fewer than two performance categories scores must have received the extreme and uncontrollable circumstances reweighting to receive a final score equal to the threshold. A clinician would have fewer than two performance category scores if they fail to participate at all, which according to the proposed policy, would result in a final score equal to the threshold.

8. MIPS Payment Adjustments

c. Establishing the Performance Threshold

Summary

CMS proposes to increase the performance threshold from three points for the 2019 MIPS payment year to 15 points for the 2020 MIPS payment year. CMS believes 15 points represents a meaningful increase in the performance threshold while maintaining flexibility for MIPS-eligible clinicians in the pathways available to achieve this performance threshold. CMS then illustrates multiple ways an eligible clinician could achieve 15 points under MIPS. CMS believes it is important to keep the performance threshold low, so small practices can learn to participate and perform well in MIPS for future years without excessive financial risk.

CMS invites comments on the proposed increase in the performance threshold, especially relative to two alternatives that CMS also considered: six points and 33 points. CMS also seeks public comments on principles and considerations for setting the performance threshold beginning with the 2021 MIPS payment year, which will be the mean or median of the final scores for all MIPS-eligible clinicians from a prior period.

AAFP Response

The AAFP supports CMS' proposal to increase the performance threshold to 15 points for the 2020 MIPS payment year. We agree with CMS that it represents a meaningful increase in the performance threshold while maintaining flexibility for MIPS-eligible clinicians in the pathways available to achieve this performance threshold. We also agree that it represents an attainable threshold for small practices which will further facilitate their participation and performance in MIPS.

Regarding principles and considerations for setting the performance threshold beginning with the 2021 MIPS payment year, which will be the mean or median of the final scores for all MIPS-eligible clinicians from a prior period, the AAFP believes the performance threshold should be set at a level where approximately half of the eligible clinicians would be below the performance threshold and half would be above it. This principle would support use of the median of the final scores for all MIPS-eligible clinicians from a prior period. The median is a better measure of central tendency than the mean, which can be skewed by outlier values.

d. Additional Performance Threshold for Exceptional Performance

Summary

CMS proposes to maintain the additional performance threshold for exceptional performance at 70 points for the 2020 MIPS payment year. CMS invites public comment on this proposal. CMS also seeks feedback on whether it should raise the additional performance threshold to a higher number, which would in many instances, require the use of an EHR for those to whom the ACI category requirements would apply. Finally, CMS also seeks public comment on which of the following two methods it should use to compute the additional performance threshold beginning with the 2021 MIPS payment year:

- The 25th percentile of the range of possible final scores above the performance threshold for the year, or
- The 25th percentile of the actual final scores for MIPS-eligible clinicians with final scores at or above the performance threshold for the prior period.

AAFP Response

The AAFP supports CMS' proposal to maintain the additional performance threshold for exceptional performance at 70 points for the 2020 MIPS payment year. We supported this number of points for the additional performance threshold for the 2019 MIPS payment year. We continue to believe this number is a reasonable additional performance threshold, because it is high enough to necessitate what could be construed as "exceptional performance" and low enough to be reasonably attainable.

Regarding the method CMS should use to compute the additional performance threshold beginning with the 2021 MIPS payment year, the AAFP encourages CMS to use the 25th percentile of the actual final scores for MIPS-eligible clinicians with final scores at or above the performance threshold for the prior period. We believe "exceptional performance" is defined relative to the performance of others, which argues for using actual final scores rather than the range of possible final scores. The range of possible final scores could lead to a situation in

which everyone is above average, which we do not believe was the intent of this provision. To put it another way, if everyone's performance is exceptional, then no one is.

g.(1) Application of the MIPS Payment Adjustment Factors: Application to the Medicare Paid Amount

Summary

For each MIPS payment year, the MIPS payment adjustment factor (and if applicable, the additional MIPS payment adjustment factor) are applied to Medicare Part B payments for items and services furnished by the MIPS-eligible clinician during the year. Thus, CMS proposes to apply the MIPS payment adjustment factor (and if applicable, the additional MIPS payment adjustment factor) to the Medicare paid amount for items and services paid under Part B and furnished by the MIPS-eligible clinician during the year. This would mean that beneficiary cost-sharing and coinsurance amounts would not be affected by the application of the MIPS payment adjustment factor and the additional MIPS payment adjustment factor. The MIPS payment adjustment applies only to the amount otherwise paid under Part B for items and services furnished by a MIPS-eligible clinician during a year.

AAFP Response

The AAFP supports CMS' proposal to hold Medicare beneficiaries harmless in the application of MIPS payment adjustment factors to physician payments under the Medicare physician fee schedule.

II.C.9 Review and Correction of MIPS Final Score

a.(1)(a) MIPS-Eligible Clinicians

Summary

CMS is proposing, beginning July 1, 2018, to provide performance feedback to MIPS-eligible clinicians and groups for the quality and cost categories for the 2017 performance period. If technically feasible, CMS will also provide feedback on the ACI and improvement activities categories. CMS proposes to provide this feedback at least annually, and more frequently if technically feasible. CMS proposes to include in the performance feedback the measures and activities along with the MIPS final score. CMS requests comment on proposals. CMS requests comment on whether it would be helpful to provide more frequent feedback on the cost category using rolling 12-month periods or quarterly snapshots of the most recent 12-month period; how frequent feedback should be; and format of the feedback. CMS is considering, for cost measure feedback, utilizing parts of the QRUR, which users have identified as beneficial, while making the overall look and feel usable to clinicians. CMS seeks comment on whether this format is appropriate or if other formats or revisions to the format should be used to provide feedback on the cost measures.

AAFP Response

The AAFP is supportive of CMS' proposal to provide feedback on the quality and cost categories, and urges CMS to ensure it can provide feedback on the ACI and improvement activities categories. We encourage CMS to provide data on every field that contributes to the final score.

The AAFP believes CMS should provide frequent, actionable feedback to clinicians on all performance categories, as technically feasible, not just the cost category. To meet the goals of the program, feedback needs to be provided to physicians more frequently than annually. We believe the information provided should be in an easy-to-understand format that includes the ability for clinicians to drill down to make the reports actionable. The information provided in the

QRUR can be a good starting point for CMS, but CMS should engage stakeholders to assess the usability of these reports on a regular basis. We encourage CMS to provide information on steps clinicians can take to improve their score.

As important as the format of reports, is making feedback reports easily accessible to all physicians participating in reporting programs, whether as individuals or as part of a group. Currently it is very difficult and frustrating to access the QRUR, and physicians that participate as part of a group (especially large groups) often are not even aware of the existence of the feedback report. Access is restricted to administrative personnel who have limited bearing on actual patient care and ultimate quality outcomes, and may or may not share feedback with physicians. Reports should be directly accessible by any physician that is part of a TIN.

a.(1)(c) Voluntary Clinician and Group Reporting

Summary

CMS proposes to provide feedback reports to clinicians who do not meet the definition of MIPS-eligible clinician, but voluntarily report measures and activities to MIPS. This would be available beginning July 1, 2018, and contain information on data submitted in the 2017 performance period. CMS seeks comment on this proposal.

AAFP Response

The AAFP supports this proposal.

a.(2) Mechanisms

Summary

CMS will use a CMS-designated system as the mechanism for making performance feedback available. CMS anticipates this will be a web-based application. It is anticipated to be released around July 1, 2018. CMS is seeking comment on how health IT, either in the form of EHR or as a supplemental module, could better support the feedback. Specifically, by answering the following questions:

- Are there specific health IT functionalities that could contribute significantly to quality improvement?
- Are there specific health IT functionalities that could be part of a certified EHR technology or made available as optional health IT modules in order to support the feedback loop related to QPP participation or participation in other HHS reporting programs?
- In what other ways can health IT support clinicians seeking to leverage quality data reports to inform clinical improvement efforts? For example, are there existing or emerging tools or resources that could leverage an API to provide timely feedback on quality improvement activities?
- Are there opportunities to expand existing tracking and reporting for use by clinicians? For example, would expanding the feedback loop for patient engagement tools to support remote monitoring of patient status and access to educational materials improve tracking and reporting?

CMS intends to leverage and continue working with third-party intermediaries as a mechanism to provide performance feedback. CMS is exploring options with an API, which could allow authenticated third-party intermediaries to access the same data CMS uses to provide confidential feedback to the individual clinicians and groups on whose behalf the third-party intermediary reports. CMS seeks comments on this approach.

AAFP Response

The AAFP notes there are indeed specific health IT functionalities that could contribute significantly to quality improvement efforts. These should be available at little to no cost to clinicians, and include:

- 1) Quality measure dashboards that demonstrate the big picture of performance on selected measures are highly recommended for inclusion in all CEHRT. They should be designed with high usability and utility principles (so these dashboards are actually useful), and are reasonably priced, including for small/solo practices to afford.
- 2) Provision of “advanced” or customized reporting capabilities within all CEHRT would be helpful, including the ability to:
 - generate reports tied to selected quality measures that provide individual patient-level detail, and include relevant critical patient-level data elements present on the report to enable identification of needed care interventions or preventive care.
 - generate population-health focused reports that enable identification of care interventions or preventive care needed to close the gap between actual performance and best practice/gold standard of care for the specified patient population.
- 3) Advancements in health IT functionalities supportive of receiving and managing patient-generated health data, including device-generated data, would be useful to clinicians for quality improvement efforts. Such functionalities should also include the capability for clinicians to specify settings for clinical decision support to enable safe and efficient management of these data. It is important that not only health IT functionality enables the capture of voluminous patient-generated health data and device-generated data, but that decision support settings enable clinicians to leverage health IT capabilities to help differentiate between the “noise” versus data points that truly require the clinician’s attention. Such capabilities for both management of device-generated data and remote monitoring use cases, as well as patient-generated data from patient engagement tools can often enable needed care interventions in the outpatient setting, as opposed to emergency department or acute care settings.

The AAFP notes the importance of policy that incentivizes the use of APIs to enable data sharing in regards to specific health IT functionalities that could support the feedback loop for QPP participation and performance, and/or is tied to other HHS reporting programs, either as a component of CEHRT or as health IT modules. Eligible clinicians, and especially those in small- and medium-sized practices, are currently almost completely dependent on their CEHRT vendor to provide them the needed functionality to improve care and support the migration to APMs. By requiring CEHRT vendors to support an open API to their products, dependency on a single CEHRT vendor can be dramatically lessened. We need CMS to continue to incentivize innovation in health IT and driving the requirement of open APIs for CEHRT can go a long way toward doing just that.

The AAFP recommends CMS work collaboratively with the Office of the National Coordinator for Health IT (ONC) to identify the health IT capabilities which are needed to support clinicians’ quality improvement efforts. A workgroup may be beneficial to prioritize the needed health IT capabilities. We have identified 49 necessary capabilities across six principle domains (many of these are tied to needed health IT capabilities), which are necessary components of advanced primary care, and supportive of continuous quality improvement initiatives.

A standardized format of performance feedback on the QPP website should include filters that enable clinician views of performance at the measure level and individual patient level for all

patients in the measure, regardless of whether performance data is provided at an individual or group level. This would provide clinicians with strong positive performance and missed opportunities. It would be helpful if trending data is made available among performance feedback so clinicians can easily identify quality improvements opportunities without needing to employ and pay for advanced reporting and analytics capabilities beyond the capabilities provided by CEHRT. This recommendation is especially helpful for independent medical practices with limited resources. This advanced reporting capability should include the raw data for eligible clinicians to employ third-party intermediaries to consume and analyze the information.

We also urge CMS to use analytic software as part of feedback report generation to help clinicians identify trends and highlight performance findings that are significantly different from peers on each individual/group feedback report. Physicians need help interpreting the data. The current collection of data isn't useful without interpretation, particularly for smaller practices. Requiring practices to purchase analytic software or modules to assist with data interpretation would be cost-prohibitive for many small practices. Additionally, small practices do not possess the time and expertise required to vet such software applications.

a(3) Receipt of Information

Summary

Under the act, the Secretary has the authority to use mechanisms to receive information from professionals. In the 2017 QPP final rule, CMS stated it intends on exploring the possibility of a CMS-designated system, such as a portal, in future years of the program. CMS is not making any proposals at this time, but seeks comment on the features that could be developed for the expanded use of the feedback mechanism.

AAFP Response

The MIPS LEAN design team from the CMS Quality Summit in December 2015 spent significant resources and time to identify approaches to streamlining data reporting, accessing reports, and establishing help desk and technical assistance for providers. We encourage CMS to re-visit these recommendations in the design of the information system. In particular, the MIPS LEAN team identified issues with the existence of multiple help desks, multiple CMS information systems that are not integrated, multiple log ins, inability of first-line help desk personnel to address all but the simplest questions, contradictory responses from help desk personnel, long turn-around time for answers, and long telephone wait times. To remedy this, the AAFP supports a single access point and sign on to all CMS systems that a clinician may need to access. We support offering multiple routes of assistance accessible from a single access point, including:

- a searchable, knowledge database;
- phone support (with email documentation of responses) with a 24-hour turn-around window;
- immediate escalation if first-line help desk staff can't answer a question within 24 hours;
- email support with a 24-hour turn-around window; and
- live chat.

We also support maintaining a centralized, integrated database of question and response data that can be used to train help desk personnel, enrich the searchable knowledge database, and identify common areas of misunderstanding among clinicians for targeting program education. The AAFP supports creation of a dashboard for each physician/TIN that will allow them to review individual and/or group demographic information (including the Provider Enrollment,

Chain and Ownership System); data-submission status for the current reporting period; final score; performance on all measures; feedback reports; and help desk access history. Additionally, the dashboard should other timely information that will help physicians better understand how quality reporting is impacting their Medicare payment.

a.(4) Additional Information – Type of Information

Summary

CMS proposes to make available to MIPS-eligible clinicians information about the items and services for which payment is made under Title XVIII furnished to patients of MIPS-eligible clinicians and eligible clinicians by other suppliers and providers of services. CMS proposes to make available, if technically feasible, the name of such suppliers and providers of services; the types of items and services furnished and received; the dollar amount of services provided and received; and the dates that items and services were furnished. CMS proposes the information will be provided on the aggregate level, with the exception of data on items and services. CMS could consider providing this information at the patient level. The date range for making this information available would be based on what is most helpful to clinicians. Data will be made available on the QPP website as part of the performance feedback. Access would be provided only after secure credentials are obtained. CMS seeks comment on this proposal.

AAFP Response

The AAFP supports CMS providing detailed information about the items and services for which payment is made under Title XVIII. We urge CMS to make the information more robust by providing alternatives to items or services provided that would have been more cost effective to the patient while still delivering the same quality of care.

c. Data Validation and Auditing

Summary

In the 2017 QPP final rule, CMS finalized its policy to selectively audit MIPS-eligible clinicians and groups on a yearly basis. All MIPS-eligible clinicians and groups that submit data electronically must attest that the data is accurate and complete. However, CMS failed to codify in the regulation text that attestations would be part of the submission process. After reconsideration, CMS is updating the language to reflect that the requirement is more of a certification in nature, rather than an attestation. CMS is proposing to revise §414.1390 to add a new paragraph requiring all MIPS-eligible clinicians and groups that submit data to CMS for purposes of MIPS to certify to the best of their knowledge that the data submitted to CMS is true, accurate, and complete. CMS also proposes that the certification by the MIPS-eligible clinician or group must accompany the submission.

CMS also finalized in the 2017 QPP final rule that if a MIPS-eligible clinician or group were found to have submitted inaccurate data for MIPS, CMS would reopen and revise the determination. CMS neglected to codify this policy in regulation text. CMS is proposing to revise §414.1390 to add a new paragraph (c) that states CMS may reopen and revise a MIPS payment determination in accordance with the rules set forth at §§405.980 through 405.986.

The 2017 QPP final rule states MIPS-eligible clinicians and groups should retain copies of medical records, charts, reports, and any electronic data utilized for reporting under MIPS for up to 10 years after the conclusion of the performance period. CMS neglected to codify this in regulation text. CMS is proposing to revise §414.1390 to add a new paragraph (d) that states that all MIPS-eligible clinicians or groups that submit data and information to CMS for purposes

of MIPS reporting must retain such data and information for a period of 10 years from the end of the MIPS performance period.

AAFP Response

The AAFP is supportive of these proposals.

II.C.10. Third Party Data Submission

Summary

This section deals with requirements for the reporting of MIPS data by third-party intermediaries which includes a qualified registry, QCDR, health IT vendor, or a CMS-approved survey vendor. Criteria must be met by these third-party intermediaries as a condition of their qualification to participate in MIPS as third-party intermediaries, and data submission must be carried out in the form and manner specified by CMS.

CMS proposes to revise §414.1400(a)(1) to state that MIPS data may be submitted by third-party intermediaries not only on behalf of individual MIPS-eligible clinicians and groups, but also on behalf of virtual groups.

CMS also proposes to add a requirement at §414.1400(a)(5) for third-party intermediaries to certify, at the time of data submission, that all data submitted to CMS on behalf of a MIPS-eligible clinician, group, or virtual group is, to the best of its knowledge, true, accurate, and complete.

As increasing numbers of clinicians participate in value-based payment arrangements with multiple payers, CMS expects third-party intermediaries to play an important role not merely with streamlined reporting and timely feedback to clinicians. CMS also expects third-party intermediaries to be able to enable the ability to report once to all payers; more reliably calculate measures using data across multiple clinical practices caring for the same patients; and integrate and mash up data from multiple disparate sources in order to provide actionable insights in support of longitudinal care including, for example, administrative data from payers, utilization data, cost data, and clinical data from health IT systems. By integrating and analyzing such data, CMS expects third-party intermediaries can help provide a more comprehensive view of the cost and quality of care being delivered. CMS wishes to encourage third-party intermediaries that provide comprehensive data services to eligible clinicians in both MIPS and APMs, and seeks comment on how to achieve this. CMS asks the following question about how they might encourage such comprehensive data services and advance the role of intermediaries:

- Should CMS consider implementing additional incentives for eligible clinicians to use a third-party intermediary that has demonstrated substantial participation from additional payers and/or other clinical data sources across practices caring for a cohort of Medicare beneficiaries within a given geographic area?
- Should these incentives also include expectations that structured, standardized data be shared with third-party intermediaries?
- Should there be additional refinements to the approach to qualifying third-party intermediaries which evaluate the degree to which these intermediaries can deliver longitudinal information on a patient to participating clinicians (e.g., a virtual care team of primary and specialty physicians)?
- Should there be a special designation for registries that conveys the availability of longitudinal clinical data for robust measurement and feedback?

CMS seeks comment on these and other ideas that can further advance the role of intermediaries, and reduce clinician burden by enabling a streamlined reporting and feedback system.

AAFP Response

The AAFP agrees with the proposal to permit third-party intermediaries to submit data on behalf of not only individual eligible clinicians and groups, but also on behalf of virtual groups. Regarding CMS' proposal to implement incentives for eligible clinicians to use a third-party intermediary that has demonstrated substantial participation from additional payers, we recommend against this approach. It is likely that data submission vendors with products designed for larger practices and integrated delivery networks would primarily (at least initially) represent those working with multiple payers and offer integration of disparate data sources. This has the potential to perpetuate existence and viability of only large, established data submission vendors. The AAFP instead recommends CMS focus on support of the consumer (clinicians) by incentivizing transparency in the marketplace about the market share, pricing, program participation levels, etc. for each data submission vendor. This would help eligible clinician make better informed decisions around the purchase and use of data services from third-party intermediaries. Transparency would be significantly beneficial to eligible clinicians, as currently establishing electronic data sharing in an end-to-end fashion with data submission vendors can involve nontrivial effort and resources. Better informed decision can minimize the need to switch data submission vendors, and allow for more investment in establishing data-sharing capabilities.

Rather than incentivizing sharing of structured, standardized data with third-party intermediaries, the AAFP recommends raising awareness of current standardized formatting. It is important not to disincentivize or hinder other data sharing.

Regarding whether there should be refinements to the approach to qualifying third-party intermediaries or whether special designations should be introduced to identify registries offering integrated, longitudinal data, the AAFP recommends CMS focus on meeting the more immediate needs for transparency in the market. It is too early to seek to identify registries achieving integration of multiple disparate data sources, and there is not sufficient evidence yet to inform decision making on this. The AAFP cautions that light handedness in this regard is warranted, and instead recommend monitoring the market tied to development of these capabilities. Again, incentivizing transparency by data submission vendors is recommended.

(3) Information Required at the Time of Self-Nomination

Summary

CMS is not proposing any changes to the information a QCDR must provide at time of self-nomination from what was finalized in the 2017 QPP final rule. However, CMS is proposing a change in terminology to replace the term "non-MIPS measures" with "QCDR measures," beginning with the 2018 performance period.

AAFP Response

A key difference between a QCDR and qualified registry is that a QCDR vendor can define and seek CMS approval to offer its participants the ability to report on specialty-specific non-MIPS measures, which satisfies MIPS reporting requirements. There is likely to be greater understanding and familiarity with the current terminology of "non-MIPS measures," as opposed to the proposed new terminology of "QCDR measures." To promote clarity for clinicians, these measures could be referred to as "non-MIPS (QCDR defined, specialty-specific) measures."

However, “non-MIPS (QCDR-specific) measures” or “non-MIPS (QCDR-defined) measures” would also be acceptable terminology.

(5) QCDR Measure Specifications Criteria

Summary

Beginning with the 2018 performance period and continuing in future years, CMS proposes QCDR vendors may seek permission from another QCDR to use an existing measure owned by the other QCDR. To report on an existing QCDR measure owned by another QCDR, a QCDR must have permission from the QCDR that owns the measure. The owner grants permission to use the measure for the performance period. Evidence of such permission granted must be available at the time of self-nomination and submitted as proof of permission for CMS review and approval for the measure to be used in the performance period. The QCDR measure owner (i.e., QCDR vendor) would still own and maintain the QCDR measure, but would allow other QCDRs to use their measure with proper notification. The intent of this proposal is to harmonize clinically similar measures, and limit the use of measures that only slightly differ. CMS invites comments on this proposal.

Otherwise, CMS is not proposing any changes to QCDR measure specifications criteria finalized in the 2017 final rule. However, the following points of clarification are outlined:

- CMS encourages QCDR quality measures align with their measures development plan, but will consider all QCDR measures submitted by the QCDR.
- CMS will likely not approve retired measures that were previously in one of CMS' quality programs, such as PQRS, if proposed as a QCDR measure. This includes measures that were retired due to being topped out or due to high performance, or measures retired due to a change in evidence supporting use of the measure.

AAFP Response

The AAFP supports efforts toward harmonization of measures. We note that while CMS allows flexibility for QCDRs to create meaningful measures, it is important to make sure policies incentivize harmonization of measures.

e. Probation and Disqualification of a Third-Party Intermediary

Summary

CMS is not proposing any changes to the process of probation and disqualification of a third-party intermediary.

Comments were received in response to the 2017 final rule requesting CMS to provide opportunities for MIPS-eligible clinicians and groups that discover an issue with their third-party intermediary to change reporting methods and/or third-party intermediaries without restriction on the eligible clinician's. CMS notes this feedback will be taken into consideration in future rulemaking.

CMS notes cases of vendors leaving the marketplace during a performance period will be considered on a case-by-case basis, though cases will not be considered where the vendor left the marketplace prior to the performance period. Proof would be required to demonstrate the eligible clinician had an agreement in place with the vendor at the time of their withdrawal from the marketplace.

AAFP Response

Criteria for probation and disqualification of a third-party intermediary that were finalized in 2017 are largely agreeable, with a focus on corrective action plans and working with third-party intermediaries to remedy nonconformities or deficits, rather than swift movement toward disqualification. However, the AAFP notes it can be extremely resource intensive for a clinician, and especially for solo or small practices, to link their CEHRT to a third-party intermediary to enable end-to-end electronic reporting. Our members frequently ask the AAFP to provide recommendations on how to pursue linkages, which are known not to be achievable prior to the end of a reporting period, while concurrently identifying another means of reporting that will successfully enable reporting for the current reporting period. This can be a source of significant administrative burden for busy clinicians. Switching third-party intermediaries for the purpose of reporting data involves a detailed IT project requiring clinician input. As such, the AAFP would urge CMS to consider, on a case-by-case basis, instances where a vendor leaves the marketplace prior to the performance period. This is especially necessary for those eligible clinicians who have used such a vendor for third-party reporting of their data in the prior reporting period.

The AAFP continues to note CMS's policy on this matter is not complete if addressing merely the actions to be imposed upon third-party intermediaries should they fail to fulfill requirements in the manner and form established by CMS, without addressing how the participants of such third-party intermediaries will be handled. We urge CMS to hold those eligible clinicians harmless, in an automated fashion, to reduce unnecessary administrative burdens associated with a requirement to be aware of and adhere to deadlines to complete and submit a significant hardship exception application under those circumstances. Attestation questions should include the option to attest that the eligible clinician's third-party intermediary (data reporting partner) has been disqualified either during the current performance period or the immediately preceding performance period. Attestation questions should ask the eligible clinician whether they used the same third-party intermediary to successfully report their data for the prior reporting period. If yes, the eligible clinician should be exempted from reporting for the current performance year in an automated fashion. Validation of yes responses should be easily achievable by CMS, since the 2017 final rule required, as a condition to enable auditing, that all third-party intermediaries submitting MIPS data make available to CMS the contact information of each MIPS eligible clinician or group on behalf of whom it submits data. If the eligible clinician answers no to having used the same third-party intermediary to successfully report their data for the prior reporting period, the eligible clinician should then be prompted to attach supporting evidence demonstrating a contractual agreement was in place with the disqualified third-party intermediary for the performance year in which the reporting entity became disqualified. While CMS has previously noted disqualification rarely occurs, it does indeed occur. In such cases, those clinicians using the services of disqualified third-party intermediaries should be held harmless in a manner that is not administratively burdensome when such is expressly within the bounds of what is possible by CMS.

II.C.11. Public Reporting on Physician Compare

Summary

Currently, Physician Compare shows Medicare clinician's name, specialty, practice location, group affiliation, hospital affiliation, Medicare assignment status, education, residency, and board-certification information. There are also indicators to show if the clinician has performance scores available to view, and if they have participated in a CMS quality program. Physician Compare publicly reports 91 group-level measures and 90 individual-level measures. In addition, 31 total individual clinician-level QCDR, non-PQRS measures are available.

Statutorily, for MACRA, Physician Compare must include: the eligible clinician's final score, the eligible clinician's MIPS performance category scores, names of eligible clinicians in AAPMs, range of all MIPS final score, and range of all eligible clinician's MIPS performance category scores. The Secretary is required to provide an opportunity for eligible clinicians to review the information before being made public and to allow eligible clinicians to submit corrections. This will occur 30 days in advance of publication of the data.

CMS is proposing to include eligible clinician's final scores, performance category scores, aggregate information for final scores, and performance categories on Physician Compare.

AAFP Response

The AAFP is supportive of CMS reporting to Physician Compare as required by statute.

II.C.11.b. Quality

Summary

In the 2017 QPP final rule, CMS finalized a policy to make all MIPS quality measures available for public reporting on Physician Compare in the transition year, as technically feasible. That is, all measures that meet statistical public reporting standards will be included in the downloadable database. Also, CMS finalized a policy that first year measures would not be reported.

Currently, there is a minimum sample size of 20 patients for performance data to be included on Physician Compare. CMS will only report measures that meet reliability thresholds and public reporting standards, including the total number of patients reported. CMS did this for the 2017 performance period, and proposes to continue doing so for the 2018 performance period. Additionally, CMS is proposing to add five open-ended questions to Physician Compare and seeks comment.

AAFP Response

The AAFP supports consistency between the 2017 and 2018 performance period policies as it applies to reliability thresholds, public reporting standards, and minimum number of patients needed to report a measure on Physician Compare. We encourage CMS to publicly report only the top six measures reported. For example, when reporting via EHR, often the EHR submits all measures that can be calculated. The clinician may only be working on six measures and rates from the remaining measures may not reflect actual care due to data documentation. Including all measures would discourage clinicians from reporting new measures because their performance rate may be low the first year they report it. We support only publicly reporting the top six measures.

The AAFP does not support the inclusion of five open-ended questions on the Physician Compare website. Adding these questions would only contribute to the already lengthy and administratively burdensome CAHPS survey. There are also, in existence outside of the MIPS program, a multitude of websites that allow for this type of feedback.

II.C.11.c. Cost

Summary

In 2017, CMS finalized that cost measures would be available on Physician Compare. However, CMS may not have data for the transition year and recognizes that cost data can be easily misinterpreted. CMS proposes to include a subset of cost measures for the 2018 performance period and beyond that meet public reporting standards and minimum reliability thresholds. First year measures would not be included.

AAFP Response

The AAFP supports the reporting of cost measures that are not first year measures, meet public reporting standards, and have minimum reliability thresholds. We encourage thorough user testing to ensure the data is not misinterpreted. The AAFP also encourages CMS to include information on Physician Compare to help users interpret cost and quality scores together to see clinical value.

II.C.11.d. Improvement Activities

Summary

In the 2017 QPP final rule, CMS finalized that improvement activities would be included on Physician Compare, excluding activities in their first year of use. For performance period 2018, CMS proposes to include a subset of improvement activities that meet public reporting standards, if technically feasible, and to include activities in their first year of use.

AAFP Response

The AAFP is supportive of CMS' proposal to report a subset of improvement activities, including those in their first year of use. We encourage CMS to include PCMH status when that has been attested.

II.C.11.e. Advancing Care Information

Summary

Since 2011, participant performance data from the EHR Incentive Program has been publicly available. CMS proposes to add an indicator to the eligible clinician's Physician Compare site to indicate if they have met the ACI performance category metrics. CMS will indicate if they scored high on patient access, care coordination, patient engagement, and health information exchange. These will only be indicators, and not actual performance rates.

AAFP response

The AAFP is supportive of CMS' proposal for including ACI category indicators on Physician Compare as described. CMS needs to clarify how it will define "high" if this will be used to designate physicians on Physician Compare.

II.C.11.f. Achievable Benchmark of Care (ABC)

Summary

Benchmarks for Physician Compare will be determined using the achievable benchmark of care (ABC) methodology. CMS will derive the benchmark from current year data. For each measure, they will rank the reporters in order of performance from highest to lowest. They will then filter the list by taking the best performers, starting at the top of the list and moving down until they have enough reporters selected to represent 10 percent of all patients in the denominator across all reporters for that measure. The benchmark is calculated by totaling the number of patients in the highest scoring subset who received the intervention, or had the desired outcome, then dividing by the total number of patients measured by these top reporters. This benchmark would represent the best care provided. This benchmark will be used to assign stars for Physician Compare's 5-star rating system. This becomes available in late 2017.

CMS proposes to use the ABC methodology to determine Physician Compare benchmarks for quality, cost, improvement activities, and ACI (setting benchmarks from data in 2017 for 2018). CMS proposes to use this benchmark to determine a 5-star rating for each MIPS measure, as feasible and appropriate.

AAFP Response

CMS will, in effect, have one set of benchmarks for measurement and another for public reporting. **The AAFP encourages CMS to consolidate and simplify the QPP whenever possible, and establishing multiple benchmarks is unnecessary and confusing for physicians and for CMS.**

II.C.11.g. Voluntary Reporting

Summary

CMS proposes data for MIPS-eligible clinicians who voluntarily report would be available for reporting on Physician Compare. If the eligible clinician chooses they can opt to have their information not publicly displayed during their 30-day data review period.

AAFP Response

The AAFP is supportive of CMS' policy regarding voluntary reporting.

II.C.11.i. Stratification by Social Risk Factors

Summary

CMS recognizes that risk factors, such as income, race and ethnicity, education, disability, community resources, and social support play a major role in health. CMS has been reviewing ASPE's report along with the National Academies of Sciences, Engineers, and Medicine's fifth report on methods for accounting for social risk factors, including stratified public reporting, as well as recommended next steps. CMS is seeking comment on the following questions:

- Which social risk factors (dual-eligibility, race and ethnicity, social support, geographic area of residence) should be used, and from what sources?
- What process should be used to access or receive the data to facilitate stratified reporting?
- Should strategies like confidential reporting of stratified rates using social risk factor indicators be used in the initial years of QPP, in lieu of publicly reporting stratified performance rates for quality and cost measures under Physician Compare?

AAFP Response

The AAFP supports the development of a strategy to operationalize the integration of intersectionality theory into CMS' design method to account for social risk. For more information on this concept, we recommend two related articles, [The promise of intersectionality theory in primary care](#) and [Incorporating intersectionality theory into population health research methodology: Challenges and the potential to advance health equity](#).

Instead of determining social risk at the individual level, the AAFP recommends CMS use broader health equity assessments of communities to determine individual risk. After assessing at the population level, CMS could apply the community's assessment to individual beneficiaries living within the ZIP codes covered by the community. CMS should already have access to demographic information, including ZIP codes of Medicare beneficiaries. We direct CMS to a [Social Deprivation Index](#) developed by the Robert Graham Center as an example of how to determine social deprivation at the community level.

If CMS is unable to implement health equity assessment at the community level, we recommend CMS begin a stepwise strategy in which, eventually, multiple social determinants of health will be integrated into health care processes and payment methodologies. The use of a single social determinant (e.g., race, gender, or geography) is unable to comprehensively account for an

individual's or population's health. We strongly urge CMS to start with small steps to further the evidence base of social determinants of health into payment models. We believe a first step could be to leverage the existing demographic data already available to CMS (e.g., ZIP code and race) and integrate that with an existing federal measure of poverty (e.g., SNAP, Pell Grant, income, etc.), which CMS may access through inter-agency agreements, similar to the agreement that CMS has with the Internal Revenue Service, as part of the Medicare Secondary Payer Data Match.

The AAFP urges CMS to review and incorporate the findings from the ASPE report, "Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs."

Due to the lack of interoperability of available EHR systems, the AAFP proposes that a process for self-reporting of data as the only viable option.

We would encourage CMS to examine the data they currently have available to them before determining what other data would need to be sent or received by others.

The AAFP is unable to determine any potential harms to patients in establishing a public reporting strategy during the implementation period of QPP and supports transparency. We would encourage CMS to monitor for unintended consequences to physician recruitment to underserved areas and online physician reputation in publicly reporting of stratified rates.

II.C.11.j. Board Certification

Summary

Currently ABMS, AOA, and the ABO (American Board of Optometry) are included in Physician Compare. CMS proposes to add the American Board of Wound Medicine and Surgery (ABWMS). CMS proposes to establish a process for reviewing interested boards for inclusion on a case-by-case basis.

AAFP Response

The AAFP is supportive of other board certifications being added to Physician Compare, as long as they are reviewed and accepted according to criteria that has been established through a multi-stakeholder input process.

D.2. Overview of the APM Incentive Payment: Terms and Definitions

Summary

CMS proposes to add the definition of "All-Payer QP Performance Period" using the timeframe of January 1 through June 30 of the calendar year that is two years prior to the payment year. CMS also proposes to add the definition of "Medicare QP Performance Period," which would begin on January 1 and end on August 31 of the calendar year that is two years prior to the payment year. CMS would replace the definition it established in the 2017 QPP final rule for "QP Performance Period" with these two new definitions.

CMS proposes to change the definition of "Attributed Beneficiary," so it only applies to AAPMs, not to Other Payer AAPMs. CMS does not anticipate having or receiving information about attributed beneficiaries under the all-payer combination option as it does under the Medicare option. Under the all-payer combination option, APM entities or eligible clinicians would only submit aggregate payment and patient data. Thus, CMS would not have anything similar to a participation list or an affiliated practitioner list for Other Payer AAPMs.

CMS seeks comment on these terms, including how CMS has defined the terms; the relationship between terms; any additional terms that CMS should formally define to clarify the explanation; implementation of this program; and potential conflicts with other terms CMS uses in similar contexts. CMS also seeks comment on the naming of the terms and whether there are ways to name or describe their relationships to one another that make the definitions more distinct and easier to understand.

AAFP response

The AAFP supports replacement of the more general term “QP Performance Period” with the more specific terms, “All-Payer QP Performance Period” and “Medicare QP Performance Period,” especially given that those two performance periods will be of different durations. The AAFP is also comfortable with the proposed change to the definition of “attributed beneficiary” for the reasons cited by CMS.

D.3. Overview of the APM Incentive Payment: Regulation Text Changes

a. Clarifications and Corrections

Summary

CMS proposes to revise the definition of “APM Entity” in the regulation at §414.1305 to clarify that a “payment arrangement with a non-Medicare payer” is an other payer arrangement as defined in §414.1305. CMS also proposes to make technical changes to the definition of Medicaid APM in §414.1305 to clarify that these arrangements must meet the Other Payer APM criteria set forth in §414.1420, and not just the criteria under §414.1420(a) as provided under the current definition.

CMS further proposes to remove the defined term for “Advanced APM Entity” in §414.1305 and to replace “Advanced APM Entity” where it appears throughout the regulations with “APM Entity.” CMS also proposes to make this substitution in the definitions of “Affiliated Practitioner” and “Attributed Beneficiary” in §414.1305. Similarly, CMS proposes to replace “Advanced APM Entity group” with “APM Entity group” where it appears throughout the regulations.

CMS also proposes a series of technical changes elsewhere in the regulations to correct typographical errors and provide non-substantive clarifications.

AAFP response

The AAFP is concerned with CMS’ proposal to delete the defined term for “Advanced APM Entity” in §414.1305 in favor of the more generic term, “APM Entity.” We note that the term “APM Entity,” with the revisions proposed in this rule would be defined as “an entity that participates in an APM or other payer arrangement through a direct agreement with CMS or the payer or through Federal or State law or regulation.” We further note that “APM” and “Advanced APM” are distinct terms defined differently in §414.1305. To the extent that the proposed revised definition of “APM Entity” only references APMs and not Advanced APMs, it is inadequate to describe entities in both contexts.

Accordingly, we encourage CMS to not delete the defined term for “Advanced APM Entity” in §414.1305 in favor of the more generic term “APM Entity.” If CMS proceeds to delete the term “Advanced APM Entity,” then it needs to further revise the definition of “APM Entity” to include AAPMs. For example, a further revision of the definition of “APM Entity” might read, “APM Entity means an entity that participates in an APM, Advanced APM, or other payer arrangement through a direct agreement with CMS or the payer or through Federal or State law or regulation.”

D.4. Overview of the APM Incentive Payment: Advanced APMs

Summary

CMS makes proposals and seeks comments about the following topics in this section:

- To amend its regulation at §414.1415(c)(3)(i)(A) and (c)(4)(i)(A) through (D) to more clearly define the generally applicable revenue-based nominal amount standard and the Medical Home Model revenue-based nominal amount standard as a percentage of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM entities. Under this proposed policy, CMS would calculate the estimated total Medicare Parts A and B revenue of providers and suppliers at risk for each APM entity. CMS would then calculate an average of all the estimated total Medicare Parts A and B revenue of providers and suppliers at risk for each APM entity. If that average estimated total Medicare Parts A and B revenue at risk for all APM entities was equal to or greater than 8 percent, the APM would satisfy the generally applicable revenue-based nominal amount standard.
- To amend its regulation at §414.1415(c)(2) to any APM entities enrolled in an AAPM qualifying under the Medical Home Model standard as of January 1, 2017, to exempt round 1 of the CPC+ Model from the requirement that beginning in the 2018 Medicare 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.
- To amend its regulation at §414.1415(c)(3)(i)(A) to provide that the generally applicable revenue-based nominal amount standard remain at 8 percent of the average estimated total Medicare Parts A and B revenue of providers and suppliers in participating APM entities for the 2019 and 2020 Medicare QP performance periods, and to address the standard for Medicare QP performance periods after 2020 through subsequent rulemaking.
- Seeks comment on whether it should consider either a lower or higher revenue-based nominal amount standard for the 2019 and 2020 Medicare QP performance periods, and on the amount and structure of the revenue-based nominal amount standard for the 2021 Medicare QP performance periods and later periods. CMS also seeks comment on whether it should consider a different, potentially lower, revenue-based nominal amount standard only for small practices and those in rural areas that are not participating in a Medical Home Model for the 2019 and 2020 Medicare QP performance periods. For the purposes of the QPP, CMS uses the definition of small practices and rural areas in §414.1305:
 - Rural areas mean clinicians in ZIP codes designated as rural, using the most recent HRSA area health resource file data set available.
 - Small practices consist of those with 15 or fewer clinicians and solo practitioners.
- Seeks comment on whether such a standard should apply only to small and/or rural practices that are participants in an APM, or also small and, or rural practices that join larger APM entities to participate in APMs. CMS also seeks comment on how it should decide where a practice is located to determine whether it is operating in a rural area as rural area is defined in §414.1305 of the regulations.
- CMS believes that a different, potentially lower, revenue-based nominal amount standard for the 2019 and 2020 Medicare QP performance periods specifically for small practices and those in rural areas that are not participating in a Medical Home Model may allow for their increased participation in AAPMs. CMS believes such a standard should not apply to small and, or rural practices participating in a Medical Home Model, because participants in Medical Home Models with fewer than 50 eligible clinicians in

their parent organization benefit from the lower Medical Home Model nominal amount standard.

- To amend its regulation at §414.1415(c)(4)(i)(A) through (D) to provide that, to be an AAPM, a Medical Home Model must require that the total annual amount that an APM entity potentially owes CMS or foregoes under the Medical Home Model be at least the following amounts:
 - For the 2018 Medicare QP performance period, 2 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM entities.
 - For the 2019 Medicare QP performance period, 3 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM entities.
 - For the 2020 Medicare QP performance period, 4 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM entities.
 - For the 2021 Medicare QP performance periods and later periods, 5 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM entities.

Currently, the corresponding percentages are 3 percent (2018), 4 percent (2019), and 5 percent (2020 and later).

AAFP response

The MACRA statute only offers CMS the ability to determine if an APM is an AAPM. This is addressed by CMS' regulation that APMs must require APM entities to bear nominal risk. CMS has previously defined this as either eight percent of revenues or three percent of expected expenditures. Any additional calculations such as how revenue is calculated for the revenue-based standard, how risk is shared, paid back, or otherwise distributed among APM participants should be determined by the APM contracts and is outside of the purview of MACRA. CMS should not impose restrictions on how APMs carry out their contracts. Anything outside of strict criteria to determine AAPM status is non-statutory and is an overstep of CMS.

We support CMS' 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, unnecessary, and contradictory to CMS' stated desire to 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. It should be based on each entity's demonstrated capabilities. It is especially troubling that CMS is also proposing that CPC+ participants who enroll in the future (e.g, CPC+ round 2) will not be exempt from this requirement. The size limit discourages participation in CPC+, which is currently the only Medical Home Model available to participants. Participants in CPC+ beyond round 1 who exceed this threshold will be forced into MIPS APMs, because CPC+ does not satisfy the generally applicable AAPM financial risk criterion. CMS needs to remove this provision across the board, not just for CPC+ round 1.

Should CMS continue with its proposed risk standards, the AAFP would support CMS' proposal to maintain the generally applicable revenue-based nominal amount standard at 8 percent of the average estimated total Medicare Parts A and B revenue of providers and suppliers. However, this should be calculated at the APM entity level, rather than including all APM entities. We believe CMS and the physician community need actual experience with the current standard (8

percent) before any consideration is given to a lower or higher revenue-based nominal amount standard, including 2021 performance periods and later periods. Until we and CMS know how the current standard is impacting physicians, changes in either direction seems unjustified. Risk is not one size fits all across models, populations, and specialties. Changing the risk levels in the absence of better information about improving quality and reducing costs may be counterproductive to MACRA's goals.

We are confused by CMS' suggestion of a different, potentially lower, revenue-based nominal amount standard for small practices and those in rural areas that are not participating in a Medical Home Model for the 2019 and 2020 Medicare QP performance periods. We concur with CMS' perception that small practices and those in rural areas face greater challenges in participating in AAPMs, and we support CMS' inclination to better enable their participation. However, we don't understand why CMS would apply the standard to a practice or APM entity when the standard is only used to determine whether a model is an AAPM, and not to determine whether a practice or APM entity is an AAPM.

Also, the risk amounts are part of the APM design and not determined at the practice or APM entity level. As CMS states:

"We also reiterate, as we note for the generally applicable nominal amount standard, that the terms and conditions in the particular APM govern the actual risk participants experience; the nominal amount standard merely sets a floor on the level of risk required for the APM to be considered an AAPM."

Likewise, CMS stated in last year's final rule on QPP:

"We also point out that reducing the standard for what constitutes a more than nominal amount of risk for losses for purpose of deciding whether an APM is an AAPM would not reduce the level of risk under any particular APM...."

The AAFP is unclear what CMS is suggesting. We do not know if CMS is suggesting a third set of standards for APMs geared towards small practices, or whether CMS envisions a carve out within the existing AAPMs, such as MSSP, that would allow small practices to bear less risk. We encourage CMS to clarify its thinking and intent in the final rule, so we may comment in a better-informed manner. Since this is of interest to the AAFP because of the number of small practices in our membership, and due to the unique challenges they face in assuming risk, we would like to be a partner with CMS in understanding the role of risk in moving small practices in driving greater value.

The AAFP believes it is appropriate for primary care physicians in Medical Home Models to accept performance risk—not financial risk—based on the original MACRA statute, which reflects Congressional intent regarding the qualification of Medical Home Models as AAPMs. "Performance risk" refers to the risk of higher costs associated with delivering unnecessary services, delivering services inefficiently, or committing errors in diagnosis or treatment of a particular condition (i.e., those risks that are within the control of the physician).

The AAFP adamantly opposes putting APM entities and their eligible clinicians at financial risk for anything beyond their own performance. That particularly extends to insurance risk and utilization of services outside the control of the APM entity (e.g., total cost of care). "Insurance risk" is related to the patient's health status that is beyond the control of the physician, such as age, gender, and acuity differences. Insurance risk is properly borne by health plans and payers, not the APM entity and its eligible clinicians.

Consistent with this distinction, the AAFP has submitted a proposal for an advanced primary care alternative payment model (APC-APM) to the Physician-focused Payment Model Technical Advisory Committee for its consideration. Our proposed model includes performance risk—not financial risk—for participating primary care physicians through performance-based incentive payments that hold them appropriately accountable for the quality of care they provide. Given the strong connection between payment and clinical outcomes with performance risk, the APC-APM entities would be at risk for up to the entire amount of their performance-based incentive payment (depending on their level of performance). In addition, a large portion of the services provided will be capitated through a global primary care payment and population-based payment. The APM entity and its eligible clinicians will bear risk for performance related to those services. The assumption of risk for performance is based on the APM entity's demonstrated capabilities.

Finally, while we still object to the application of a nominal amount standard to Medical Home Models, we fully support CMS' proposal to revise the existing Medical Home Nominal Amount Standard and establish an even more gradual increase in risk for Medical Home Models with a lower risk floor for the 2018 Medicare QP performance period. We agree that such an approach may be better suited to the circumstances of many APM entities in Medical Home Models that have little experience with risk. We also agree that it would allow for greater flexibility at the APM level in setting financial risk thresholds that would encourage more participation in Medical Home Models and be more sustainable for the type of APM entities that would potentially participate in Medical Home Models.

D.5. Overview of the APM Incentive Payment: QP and Partial QP Determination

Summary

CMS makes the following proposals in this section:

- CMS proposes to calculate QP threshold scores for AAPMs that are actively tested continuously for a minimum of 60 days during the Medicare QP performance period and start or end during the Medicare QP performance period using only the dates that APM entities could participate in the AAPM, per the terms of the AAPM, not the full Medicare QP performance period. CMS seeks comment on whether it would be more appropriate to require that the AAPM be in active testing for at least 90 days, since 90 days is the shortest possible length of time CMS would use to make a QP determination (if the QP determination is based on January 1 through March 31). This proposed policy would not apply to Other Payer AAPMs, because CMS believes eligible clinicians have more control over the start and end dates of payment arrangements with other payers (such as through contract negotiations) than they do over CMS' start and end dates, which CMS exclusively determine. This proposed policy would also not apply to APM entities that had the opportunity to participate in the AAPM track of an APM during the entire Medicare QP performance period, but did not do so until partway through the Medicare QP performance period.
- CMS proposes to make QP determinations under §414.1425(c)(4), for eligible clinicians participating in multiple AAPMs using the full Medicare QP performance period, even if the eligible clinician participates in one or more AAPMs that start or end during the Medicare QP performance period.
- CMS proposes to amend its regulation to make clear that under §414.1425(c)(4), if an eligible clinician achieves QP status based on participation in multiple AAPMs, but any of the APM entities in which the eligible clinician participates voluntarily or involuntarily terminates from the AAPM before the end of the Medicare QP performance period, the

eligible clinician is not a QP. CMS proposes to make the same clarification for partial QP determinations under §414.1425(d)(4). This policy applies within the context of QP and partial QP determinations based on participation in multiple AAPMs, not all QP determinations. For example, if an eligible clinician is a QP through participation in each of two AAPMs under §414.1425(b)(1) and one APM entity voluntarily or involuntarily terminates from one of those AAPMs, the eligible clinician is still a QP. For an eligible clinician who is a QP [through combined participation in multiple AAPMs under §414.1425(c)(4)], if any APM entity that counts towards the QP determination voluntarily or involuntarily terminates, then the eligible clinician is no longer a QP.

AAFP response

Regarding the minimum number of days an AAPM must be in active testing for purposes of calculating the QP threshold scores, we are inclined to think 90 days may be more appropriate than 60. If, as noted, 90 days is the shortest possible length of time CMS would use to make a QP determination (if the QP determination is based on January 1 through March 31), then it's hard to understand why CMS would use an even shorter length of time for purposes of calculating the QP threshold scores. That said, 60 days is an acceptable length of time if CMS chooses to finalize that proposal.

Likewise, we find it acceptable to make QP determinations under §414.1425(c)(4), for eligible clinicians participating in multiple AAPMs using the full Medicare QP performance period, even if the eligible clinician participates in one or more AAPMs that start or end during the Medicare QP performance period.

Lastly, we support CMS' proposed clarification of the treatment of eligible clinicians whose QP status is based on participation in multiple AAPMs. We agree that if an eligible clinician is determined to be a QP or partial QP based on his or her combined participation in multiple AAPMs, and if any APM entity that counts towards the QP determination voluntarily or involuntarily terminates, the eligible clinician is no longer a QP.

D6. All-Payer Combination Option

Summary

Beginning in the 2021 payment year, in addition to the Medicare option, clinicians may become QPs through the combination all-payer and Medicare payment threshold option (all-payer combination option). This option allows eligible clinicians to become QPs by meeting the QP thresholds through a pair of calculations that assess Medicare Part B covered professional services furnished through AAPMs, and a combination of both applicable Medicare Part B services furnished through AAPMs, and services furnished through Other Payer AAPMs. CMS finalized in the 2017 QPP final rule that, beginning in payment year 2021, they will conduct QP determinations sequentially, such that the Medicare option is applied before the all-payer combination option. An eligible clinician only needs to be a QP either under the Medicare option or the all-payer combination option to be a QP for the payment year.

In the 2017 QPP final rule, CMS finalized that an other payer arrangement with any payer other than traditional Medicare, including Medicare health plans, Medicare Advantage, Medicare-Medicaid plans, 1876 and 1833 cost plans, and Programs of All Inclusive Care for the Elderly (PACE) plans, will be an Other Payer AAPM if it meets all three of the following criteria:

- Requires 50% of participating eligible clinicians in each APM entity to use CEHRT;
- Requires that quality measures comparable to measures under the MIPS quality category apply; and

- The other payer arrangement either:
 - Requires APM entities to bear more than nominal risk if actual aggregate expenditures exceed expected aggregate expenditures; or
 - Is a Medicaid Medical Home Model that meets criteria comparable to Medical Home Models expanded under section 1115A(c).

CMS does not define “medical homes,” but the act makes medical homes an instrumental piece of the QPP.

CMS recognizes that there may be medical home models that are operated by other payers that may be appropriately considered medical home models under the all-payer combination option. Examples of these arrangements may include those aligned with the Comprehensive Primary Care Plus (CPC+) model. CMS seeks comment on whether they should define the term “Other Payer Medical Home Model” as an other payer arrangement that is determined by CMS to have the following characteristics:

- The other payer arrangement has a primary care focus with participants that primarily 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 the inclusion of 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; and
- At least four of the following:
 - 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, fee-for-service payments (e.g., shared savings or population-based payments)

CMS states that similar to Medical Home Models and Medicaid Medical Home Models, they believe that Other Payer Medical Home Models could be considered unique types of other payer arrangements for purposes of the QPP. CMS anticipates that participants in these arrangements may generally be more limited in their ability to bear financial risk than other entities, because they may be smaller and predominantly include primary care physicians, whose revenues are a smaller fraction of the patients’ total cost of care than those of other eligible clinicians. Because of these factors, CMS believes it may be appropriate to determine whether an Other Payer Medical Home Model satisfies the financial risk criterion by using special Other Payer Medical Home Model financial risk and nominal amount standards, which could be different from the generally applicable Other Payer AAPM standards and would be identical to the Medicaid Medical Home Model financial risk and nominal amount standards. CMS is particularly interested in, and seeks comment on, whether there are payment arrangements that currently exist that would meet this definition.

CMS also requests comments on any special considerations that might be relevant when establishing a definition for a medical home model standard for payers with payment

arrangements that would not fit under the Medical Home Model or Medicaid Medical Home Model definitions, including how the 50-clinician cap discussed in section II.D.4.b.(1) of this proposed rule for the Medical Home Model nominal amount standard would apply.

AAFP Response

The AAFP agrees with the intent of CMS' proposal to require primary care as an essential element in other payer arrangements. We encourage CMS to strengthen its proposed essential elements along the following lines:

- 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 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.

The AAFP continues to be 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.

The AAFP believes the wording for "primary clinician" should be modified. The AAFP supports the term physician or primary care physician. Patients should be empaneled to a primary care physician. If CMS continues to include eligible clinicians under non-physician practitioner specialty codes, there should be language inserted stating that non-physician providers should be physician led.

The AAFP strongly recommends that CMS remove the Medical Home Model financial standard in its entirety from the proposed rule and reiterates our strong belief that medical homes should not be subject to any financial risk. The AAFP views this as a significant misinterpretation of the law which was designed to protect and foster medical homes. The financial standard for the Medical Home Model is an arbitrary imposition of financial risk placed upon clinicians in these models and violates the intent of the law. Furthermore, we call on CMS to eliminate the 50-clinician limitation placed on the medical home exemption. Again, nothing in the law suggests that the medical home exemption from risk should be subjected to any limiting factor. The medical home is the crux of a value-based health care system. In its most recent Annual Review of Evidence of the PCMH's impact on cost and quality, the Patient-Centered Primary Care Collaborative identifies several PCMH programs that have reduced costs and improved quality. From these findings, 21 of 23 programs reporting on cost measures found reductions in one or more measures, and 23 of 25 reporting on utilization measures found reductions in one or more measures. The definition of medical home models includes the functions of PCMH. As such, we feel imposing risk sharing on the Medical Home Model may be counterproductive and have a dampening effect on adoption of the model. Indeed, it is because

of the medical home's importance to the success of the value-based payment model that they were provided protection under the law.

(a) Generally Applicable Nominal Amount Standard

Summary

CMS discusses how they finalized the generally applicable nominal amount standard for Other Payer AAPMs, and that there are two differences between marginal risk and minimum loss rate. First, the finalized generally applicable AAPM nominal amount standard only requires an APM to meet one measure of risk—total risk. Second, the finalized generally applicable Other Payer AAPM nominal amount standard involves assessment of the following three measures of risk: marginal risk; minimum loss ratio; and total risk.

CMS reiterates the belief that using these measures of risk will ensure that payment arrangements involving other payers and APM entities or eligible clinicians cannot be engineered in such a way as to provide eligible clinicians an avenue to QP status through an Other Payer AAPM that technically meets the financial risk criterion, but carries a very low risk of losses based on performance. Since CMS does not have direct control over the design of Other Payer AAPMs, they believe the use of a multi-factor nominal amount standard to assess financial risk provides greater assurance that Other Payer AAPMs will involve true financial risk in accordance with statutory requirements. CMS requests additional comments on this approach, and on whether there are potential alternative approaches to achieving these goals.

AAFP Response

The AAFP objects to the application of a nominal amount standard to Medical Home Models. Further, the AAFP does not understand CMS' logic in creating separate risk standards for AAPMs and Other Payer AAPMs. The AAFP believes the risk standard should be the same for all AAPMs, with the exception of Medical Home Models.

(ii) Revenue-Based Generally Applicable Nominal Amount Standard

Summary

CMS proposes to add a revenue-based nominal amount standard to the generally applicable nominal amount standard for Other Payer AAPMs that is parallel to the revenue-based nominal amount standard for AAPMs. Specifically, CMS seeks comments on the proposal that an other payer arrangement would meet the revenue-based nominal amount standard they are proposing if, under the terms of the other payer arrangement, the total amount that an APM entity potentially owes the payer or foregoes is, for the 2019 and 2020 all-payer QP performance periods, equal to at least 8 percent of the total combined revenues from the payer of providers and suppliers in participating APM entities. CMS would use this standard for other payer arrangements where financial risk is expressly defined in terms of revenue in the payment arrangement. CMS also proposes that the revenue-based standard would only be applied to other payer arrangements in which risk is explicitly defined in terms of revenue, as specified in an agreement covering the other payer arrangement, as they do not have access to other payer revenue data, so they could not do the calculation without significant assistance from the payer. CMS proposes that under the generally applicable nominal amount standard for Other Payer AAPMs, an other payer arrangement would need to meet either the benchmark-based nominal amount standard or the revenue-based nominal amount standard, and need not meet both. CMS believes this proposed approach to the nominal amount standard would expand the opportunities for other payer arrangements to meet the generally applicable nominal amount standard, and would allow closer alignment between Medicare and other payers as new payment arrangements are introduced and evolve.

CMS seeks comment on whether they should consider either a lower or higher revenue-based nominal amount standard for the 2019 and 2020 all-payer QP performance periods, and on the amount and structure of the revenue-based nominal amount standard for the 2021 all-payer QP performance periods and later periods.

CMS also seeks comment on whether they should consider a different, potentially lower, revenue-based nominal amount standard only for small practices and those in rural areas that are not participating in a Medicaid Medical Home Model for the 2019 and 2020 all-payer QP performance periods. CMS believes this may allow for their increased participation in AAPMs, which may help increase the quality and coordination of care beneficiaries receive as a result. Specifically, CMS seeks comment on whether such a standard should apply only to small and/or rural practices that are participants in an APM, or also to small and/or rural practices that join larger APM entities to participate in APMs. CMS also seeks comment on how they should decide where a practice is located to determine whether it is operating in a rural area.

AAFP Response

The AAFP supports the approach to add a revenue-based nominal amount standard as proposed. However, the AAFP encourages CMS to align the other payer risk standards with the generally applicable AAPM risk standards. The AAFP further encourages CMS to apply the same risk standards only when Medicare and Medicaid payment parity exists.

We are confused by CMS's suggestion of a different, potentially lower, revenue-based nominal amount standard for small practices and those in rural areas that are not participating in a Medicaid Medical Home Model for the 2019 and 2020 all-payer QP performance periods. We concur with CMS' perception that small practices and those in rural areas face greater challenges in participating in AAPMs, and we support CMS' inclination to better enable their participation. However, we don't understand why CMS would be applying the standard to a practice or APM entity when the standard is only used to determine whether a model is an AAPM, not whether a practice or APM entity is an AAPM.

Also, the risk amounts are part of the APM design and not determined at the practice or APM entity level. As CMS states:

"We also reiterate, as we note for the generally applicable nominal amount standard, that the terms and conditions in the particular APM govern the actual risk participants experience; the nominal amount standard merely sets a floor on the level of risk required for the APM to be considered an AAPM."

Likewise, CMS stated in last year's final rule on QPP:

"We also point out that reducing the standard for what constitutes a more than nominal amount of risk for losses for purpose of deciding whether an APM is an AAPM would not reduce the level of risk under any particular APM...."

So, we are unclear what, exactly, CMS is suggesting. We do not know if CMS is suggesting a third set of standards for APMs geared towards small practices, or whether CMS envisions a carve out within the existing AAPMs, such as MSSP, that would allow small practices to bear less risk. We encourage CMS to clarify its thinking and intent in the final rule, so we may comment in a better-informed manner. This is of interest to the AAFP since the number of small practices in our membership face unique challenges, and we would like to be a partner with CMS in understanding the role of risk in moving small practices in driving greater value.

In this context, the AAFP believes it is appropriate for primary care physicians in Medical Home Models to accept performance risk—not financial risk—based on the original MACRA statute, which reflects Congressional intent regarding the qualification of Medical Home Models as AAPMs. “Performance risk” refers to the risk of higher costs associated with delivering unnecessary services, delivering services inefficiently, or committing errors in diagnosis or treatment of a particular condition (i.e., those risks that are within the control of the physician).

The AAFP adamantly opposes putting APM entities and their eligible clinicians at financial risk for anything beyond their own performance. That particularly extends to insurance risk and utilization of services outside the control of the APM entity (e.g., total cost of care). “Insurance risk” is related to the patient’s health status that is beyond the control of the physician, such as age, gender, and acuity differences. Insurance risk is properly borne by health plans and payers, not the APM entity and its eligible clinicians.

Consistent with this distinction, the AAFP has submitted a proposal for an advanced primary care alternative payment model (APC-APM) to the Physician-focused Payment Model Technical Advisory Committee for its consideration. Our proposed model includes performance risk—not financial risk—for participating primary care physicians through performance based incentive payments that hold them appropriately accountable for the quality of care they provide. Given the strong connection between payment and clinical outcomes with performance risk, the APC-APM entities would be at risk for up to the entire amount of their performance-based incentive payment (depending on their level of performance). In addition, a large portion of the services provided will be capitated through a global primary care payment and population-based payment, and the APM entity and its eligible clinicians will bear risk for performance related to those services. The assumption of risk for performance is based on the APM entity’s demonstrated capabilities.

(b) Medicaid Medical Home Model Nominal Amount Standard
Summary

CMS reiterates what they finalized in the 2017 QPP regulations, that to be an Other Payer AAPM, in the following years, a Medicaid Medical Home Model must require that the total annual amount that an APM entity potentially owes or forgoes be at least:

- In 2019, 4 percent of the APM entity’s total revenues under the payer.
- In 2020 and later, 5 percent of the APM entity’s total revenues under the payer.

CMS discusses comments received that few APM entities in Medical Home Models and Medicaid Medical Home Models have had experience with financial risk, and that many would be financially challenged to provide sufficient care or even remain a viable business in the event of substantial disruptions in revenue. While they understand these concerns, CMS believes that a final Medicaid Medical Home Model nominal amount standard of 5 percent is appropriate and that setting the standard at 5 percent of the APM entity’s total revenue under the payer appropriately reflects the meaning of nominal in the Medicaid Medical Home Model context. CMS reconsidered the incremental annual increases in the standard over several years.

- For all-payer QP performance period 2019, 3 percent of the APM entity’s total revenue under the payer.
- For all-payer QP performance period 2020, 4 percent of the APM entity’s total revenue under the payer.

For all-payer QP performance period 2021 and later periods, 5 percent of the APM entity's total revenue under the payer.

AAFP Response

The AAFP still objects to the application of a nominal amount standard to Medical Home Models, however we fully support CMS' proposal to revise the existing Medicaid Medical Home Nominal Amount Standard and establish an even more gradual risk for Medicaid Medical Home Models with a lower-risk floor for the 2018 All-Payer QP Performance Period. We agree that such an approach may be better suited to the circumstances of many APM entities in Medicaid Medical Home Models that have little experience with risk. We also agree that it would allow for greater flexibility at the APM level in setting financial risk thresholds that would encourage more participation in Medicaid Medical Home Models and be more sustainable for the type of APM entities that would potentially participate in Medicaid Medical Home Models.

c. Determination of Other Payer Advanced APMs

Summary

In the 2017 final QPP rule, CMS established a prospective AAPM determination process. CMS implemented this prospective approach to ensure that APM entities and eligible clinicians were aware of which APMs met the AAPM criteria prior to the first QP performance period. For other payer arrangements, CMS specified that an APM entity or eligible clinician must submit information necessary to identify whether a given payment arrangement satisfies the Other Payer AAPM criteria. CMS will determine which of the types of payment arrangements meets their definition of AAPMs made under Title XIX.

CMS' multi-payer models include the CPC+ model, the Oncology Care Model (OCM), and the Vermont All-Payer ACO Model.

CMS then discusses the process for payers, APM entities, and eligible clinicians to submit information, such as contracts and other relevant documents that govern the other payer arrangement, to determine whether payment arrangements meet the AAPM criteria.

CMS will develop submission forms that would be used by payers, APM entities, and eligible clinicians to request Other Payer AAPM determinations. CMS intends to include a way for payers, APM entities, and eligible clinicians to attach supporting documentation. CMS proposes that payers, APM entities, or eligible clinicians may submit requests for review of multiple other payer arrangements, though CMS would make separate determinations as to each other payer arrangement, and a payer, APM entity, or eligible clinician would be required to use a separate form for each other payer arrangement. Payers, APM entities, or eligible clinicians may submit other payer arrangements with different tracks within that arrangement as one request along with information specific to each track.

CMS proposes that APM entities or eligible clinicians may request Other Payer AAPM determinations beginning on August 1 of the same year as the relevant All-Payer QP Performance Period. CMS proposes that the submission deadline for requesting Other Payer AAPM determinations, as well as to request QP determinations under the All-Payer Combination Option, is December 1 of the same year as the relevant All-Payer QP Performance Period.

CMS proposes that the submission period opening date and submission deadline would vary by payer type to align with existing CMS processes for payment arrangements authorized under

Title XIX, Medicare Health Plan payment arrangements, and payers with payment arrangements in CMS multi-payer models to the extent possible and appropriate. CMS is proposing these dates based on operational timelines that take into account the time necessary to review submitted information, to align with other relevant deadlines in the QPP to the extent possible, and to provide payers with as much notice of what is required in the payer initiated process, and as much time to complete any Payer Initiated Submission Form as possible.

Upon timely receipt of an Eligible Clinician Initiated Submission or Payer Initiated Submission Form, CMS would use the information submitted to determine whether the other payer arrangement meets the Other Payer AAPM criteria. CMS proposes that, if they determine that the payer, APM entity, or eligible clinician has submitted incomplete or inadequate information, they would inform the payer, APM entity, or eligible clinician and allow the payer, APM entity, or eligible clinician to submit additional information no later than 10 business days from the date CMS informed the payer, APM entity, or eligible clinician. For each other payer arrangement for which the payer, APM entity, or eligible clinician does not submit sufficient information, CMS would not make a determination in response to that request submitted via the Eligible Clinician Initiated Submission or Payer Initiated Form. As a result, the other payer arrangement would not be considered an Other Payer AAPM for the year. These determinations are final and not subject to reconsideration.

Other Payer AAPM determinations would be in effect for only one year at a time. Payers and eligible clinicians would need to submit payment arrangement information each year in order for CMS to make an Other Payer AAPM determination in each year.

CMS believes this approach is appropriate since payment arrangements can change from year to year, and since CMS may modify aspects of the Other Payer AAPM criteria from one year to the next. CMS seeks comment on this approach, and they are exploring ways to streamline this process over time.

AAFP Response

The AAFP believes that 10 business days is not enough time for a physician's office to receive the information from CMS, respond to their request, and submit the missing or CMS-requested information. The AAFP believes 30 calendar days would be a more-appropriate response time.

The AAFP urges CMS to offer physicians and payers the ability to appeal determinations within 30 calendar days of the determination. There may be instances where CMS doesn't appropriately consider information submitted by the physician. Physicians should be given an opportunity to request a determination be reconsidered.

Lastly, the AAFP calls for a periodic process in which after a payer submits information on its payer arrangement(s), CMS would assess whether the payer arrangement(s) meets the Other Payer AAPM 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 AAPM. This is an opportunity for CMS to minimize the burden to practices and payers.

CMS Notification (Payer)

Summary

CMS intends to notify payers of their determinations for each request as soon as practicable after the relevant submission deadline. APM entities or eligible clinicians may submit information

regarding an other payer arrangement for a subsequent All-Payer QP Performance Period even if CMS has determined that the other payer arrangement is not an Other Payer AAPM for a prior year.

AAFP Response

Upon receipt of the payer application, the AAFP believes that CMS should set a 30-day deadline to notify payers of their determinations. The AAFP believes this would reassure payers and increase their confidence regarding when they should expect to hear from CMS.

CMS Notification (APM Entity or Eligible Clinician)

Summary

CMS proposes to notify APM entities and eligible clinicians of their determinations for each other payer arrangement for which a determination was requested as soon as practicable after the submission deadline. CMS notes that APM entities and eligible clinicians who submit complete Eligible Clinician Initiated Submission Forms by September 1 of the calendar year of the relevant All-Payer QP Performance Period may allow for CMS to make Other Payer AAPM determinations and inform APM entities or eligible clinicians of those determinations prior to the December 1 QP Determination Submission Deadline. If CMS determines that an other payer arrangement is not an Other Payer AAPM, notifying APM entities or eligible clinicians of such a determination, may help them avoid the burden of submitting payment amount and patient count information for that payment arrangement.

AAFP Response

The AAFP appreciates CMS's effort to notify APM entities and eligible clinicians by December 1 if they submit the applicable forms by September 1. However, the AAFP is concerned that CMS doesn't give a deadline to notify APM entities or eligible clinicians if they submit after the December 1 deadline. In order for APM entities and eligible clinicians to know whether they're reporting to MIPS or AAPM, APM entities and eligible clinicians will need a determination from CMS before January 1, 2020. Therefore, the AAFP believes practices should be notified within 30 calendar days if applicable information is submitted after the December 1 deadline.

- (a) Payer Initiated Other Payer Advanced APM Determination Process (Payer Initiated Process)
- (b) APM Entity or Eligible Clinician Initiated Other Payer Advanced APM Determination Process (Eligible Clinician Initiated Process)

Summary

CMS proposes to allow certain other payers to request that CMS determine whether their other payer arrangements are Other Payer AAPMs starting prior to the 2019 All-Payer QP Performance Period and each year thereafter. CMS refers to this process as the payer initiated process which is voluntary for all payers. CMS would further create a process for APM entities and eligible clinicians to request Other Payer AAPM determinations.

AAFP Response

The AAFP is disappointed that CMS chose to make it voluntary for payers to submit for the payer arrangements. If eligible clinicians want to submit the relevant information, they should have the opportunity, but it should not be required because payers choose not to submit the information.

Ultimately, the AAFP calls for the onus of submitting relevant information on payer arrangements to be the burden of the payer. Private payers have a better understanding of what information CMS needs to consider and determine whether a payer arrangement satisfies

the Other Payer AAPM 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 expedite the process of CMS review, and support administrative simplification for all involved.

(3) CMS Multi-Payer Models

Examples of CMS multi-payer models include the Comprehensive Primary Care Plus (CPC+) Model, the Oncology Care Model (OCM) (2-sided risk arrangement), and the Vermont All-Payer ACO Model.

Other payer arrangements that are in a CMS multi-payer model, by definition, are not APMs and thus cannot be AAPMs under the Medicare Option. CMS recognizes, though, that these other payer arrangements could be Other Payer AAPMs. CMS therefore proposes that beginning in the first All-Payer QP Performance Period, payers with other payer arrangements in a CMS multi-payer model may request that CMS determine whether those aligned other payer arrangements are Other Payer AAPMs.

Since there may be differences among the other payer arrangements that are aligned with an AAPM in a CMS multi-payer model, CMS proposes to make separate determinations about each of those other payer arrangements on an individual basis. In other words, an other payer arrangement aligned with an AAPM in a CMS multi-payer model is not automatically an Other Payer AAPM by virtue of its alignment.

CMS acknowledges that there can be payment arrangements authorized under Title XIX or Medicare Health Plan payment arrangements that are aligned with a CMS multi-payer model. CMS proposes that payers, APM entities, or eligible clinicians who want to request that CMS determine whether those arrangements are Other Payer AAPMs would use the processes specified for payment arrangements authorized under Title XIX and Medicare Health Plan payment arrangements discussed in sections II.D.6.c.(2) and II.D.6.c.(4) of this proposed rule.

AAFP Response

The AAFP believes CMS should automatically determine whether payers with other payer arrangements in a CMS multi-payer model are Other Payer AAPMs since these plans sign up to be a part of the multi-payer model in which Medicare is also involved. This is an opportunity for CMS to decrease the amount of administrative burden placed on eligible clinicians and payers by using information CMS already acquired when other payers agreed to participate in the multi-payer model.

The AAFP is disappointed that CMS chose to make it voluntary for payers to submit for the payer arrangements. If eligible clinicians want to submit the relevant information, they should have the opportunity, but it should not be required because payers choose not to submit the information.

Ultimately, the AAFP calls for the onus of submitting relevant information on payer arrangements to 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. Payer submission would also prevent CMS from receiving multiple applications for the same payer arrangement from all providers participating in the arrangement, would ease and expedite the process of CMS review, and would support administrative simplification for all involved.

(4) Medicare Health Plans

Summary

CMS is considering a way for those participating or who could participate in AAPMs that include Medicare Advantage to receive credit for that participation in QP determinations under the Medicare Option.

AAFP Response

The AAFP supports CMS's consideration of allowing physicians in Medicare Advantage plans that meet AAPM criteria to receive credit for AP participating under the Medicare Option. Further, the AAFP supports CMS using their waiver authority to allow inclusion of Medicare Advantage patients under the Medicare option. Lastly, the AAFP believes the performance year should begin 2018 instead of waiting for the 2019 performance year.

The AAFP is disappointed that CMS chose to make it voluntary for payers to submit for the payer arrangements. If eligible clinicians want to submit the relevant information, they should have the opportunity, but it should not be required because payers choose not to submit the information.

Ultimately, the AAFP calls for the onus of submitting relevant information on payer arrangements to 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. Payer submission would also prevent CMS from receiving multiple applications for the same payer arrangement from all providers participating in the arrangement, would ease and expedite the process of CMS review, and would support administrative simplification for all involved.

(5) Remaining Other Payers

(a) Payer Initiated Process

Summary

CMS proposes to allow the remaining other payers not specifically addressed in proposals above, including commercial and other private payers that are not states, Medicare Health Plans or payers with arrangements that are aligned with a CMS multi-payer model, to request that CMS determine whether other payer arrangements are Other Payer AAPMs starting prior to the 2020 All-Payer QP Performance Period and each year thereafter. CMS seeks comment on this proposal, and they also seek comment on potential challenges to these other payers submitting information to us for Other Payer AAPM determinations. CMS intends to discuss this process in more detail in future rulemaking.

AAFP Response

CMS acknowledges there would be potential challenges to other payers submitting information to CMS for the Other Payer AAPM determinations. CMS should also appreciate the potential challenges physicians will face submitting determinations. Physicians currently experience a tremendous amount of administrative burden on behalf of regulatory agencies and payers. The AAFP believes providers will have a much greater challenge submitting these determinations.

(7) Submission of Information for Other Payer Advanced APM Determinations

(a) Required Information

(i) Payer Initiated Process

Summary

CMS discusses the information needed to make a determination whether a payment arrangement meets the requirements of an Other Payer AAPM. For CMS to make determinations, CMS proposes to require that payers submit the following information for each other payer arrangement:

- Arrangement name;
- Brief description of the nature of the arrangement;
- Term of the arrangement
- Participant eligibility criteria;
- Locations (nationwide, state, or county) where this other payer arrangement will be available;
- Evidence of CEHRT criterion;
- Evidence that the quality measure criterion set forth in 414.1420(d) is satisfied;
- Evidence that the financial risk criterion set forth in 414.1420(d) is satisfied; and
- Other documentation as may be necessary for CMS to determine that the other payer arrangement is an Other Payer AAPM.

CMS proposes to require that payers submit documentation that supports the information they provided in the Payer Initiated Submission Form and that is sufficient to enable CMS to determine whether the other payer arrangement is an Other Payer AAPM. Examples of such documentation would include contracts and other relevant documents that govern the other payer arrangement that verify each required information element, copies of their full contracts governing the arrangement, or some other documents that detail and govern the payment arrangement.

CMS seeks comment on ways to reduce burden on states, payers, APM entities, and eligible clinicians while still allowing CMS to receive the information necessary to make such determinations.

AAFP Response

The AAFP believes this should be 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 AAPM 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 AAPM.

(b) Certification and Program Integrity

(i) Payer Initiated Process

Summary

CMS proposes that payers must certify that the information submitted is true, accurate, and complete. The information could be subject to audit by CMS. CMS proposes that information submitted must be maintained for 10 years after submission.

CMS is eliminating the requirement that payers attest that the information submitted by eligible clinicians is accurate. CMS proposes that APM entities and eligible clinicians, must certify that the information submitted is true, accurate, and complete. In the case of an APM entity, CMS proposes that the certification be made by a person with the authority to bind the APM Entity. APM entities and eligible clinicians could be eligible for audits. CMS proposes that information submitted must be maintained for 10 years after submission.

AAFP Response

The AAFP believes that maintaining submitted records for 10 years is an excessive amount of time to keep records for auditing purposes. Similar to IRS rules, the AAFP believes seven years is a sufficient amount of time that would benefit APM entities and eligible clinicians in terms of administrative burden in the storage and retrieval of records.

(c) Use of Information Submitted

Summary

CMS will post on their website about the other payer arrangements that CMS determines are Other Payer AAPMs: the names of payers with Other Payer AAPMs. CMS believes making this information publicly available is particularly important for Medicaid APMs and Medicaid Medical Home Models, so eligible clinicians can assess whether their Medicaid payments and patients would be excluded in calculations under the All-Payer Combination Option. CMS believes that making this information publicly available would help eligible clinicians to identify which of their other payer arrangements are Other Payer AAPMs, so they can include information on those Other Payer AAPMs in their requests for QP determinations; and to learn about, and potentially join, Other Payer AAPMs that may be available to them. CMS seeks comment on whether posting this information would be helpful to APM entities or eligible clinicians.

AAFP Response

The AAFP agrees that making the names of payers with Other Payer AAPMs publicly available is important and would be helpful to physicians.

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

(1) Overview

(2) Timing of QP Determinations Under the All-Payer Combination Option

(a) All-Payer QP Performance Period and Medicare QP Performance Period

Summary

CMS proposes to establish a separate QP Performance Period for the All-Payer Combination Option, which would begin on January 1 and end on June 30 of the calendar year that is 2 years prior to the payment year. The QP Performance Period for the Medicare Option will remain the same as previously finalized, so it would begin on January 1 and end on August 31 of the calendar year that is two years to the payment year.

CMS believes that an additional 60 days after the claims run out is a reasonable amount of time for the eligible clinician to collect and submit the payment and patient data. CMS seeks comment on this proposal, specifically regarding an appropriate claims run-out standard for other payers.

CMS is also considering whether to establish the All-Payer QP Performance Period from January 1 through March 31 of the calendar year that is two years prior to the payment year. CMS believes this option would provide the most-ample time possible for eligible clinicians to prepare and submit information to enable CMS to make a QP determination under the All-Payer Combination Option. CMS seeks comments on the establishment of a January 1 through March 31 All-Payer QP Performance Period and whether additional requirements may be needed to ensure the appropriate implementation of this proposal.

CMS seeks comment on the feasibility or difficulty in gathering and submitting this information for each of the potential performance period time frames.

AAFP Response

The AAFP calls for the onus of submitting relevant information on payment and patient data to be placed on the payer. Private payers have a better understanding of what information CMS needs and are better able to provide this information. Physicians are already overburdened with administrative tasks that reduce face-to-face patient care.

The AAFP prefers the submission dates for the All-Payer Combination and the Medicare Option QP performance period be the same to promote consistency. However, if CMS chooses to create different performance periods, the AAFP prefers January 1 through June 30 performance period.

(b) Alignment of Time Periods Assessed Under the Medicare Option and the All-Payer Combination Options

Summary

In the 2017 Quality Payment Program final rule, CMS finalized that they will make QP determinations under the Medicare Option using three snapshot dates during the QP Performance Period on March 31, June 30, and August 31. Consistent with their proposal to make the All-Payer QP Performance Period from January 1 through June 30 of the calendar year that is two years prior to the payment year, CMS proposes to make QP determinations based on eligible clinicians' participation in AAPMs and Other Payer AAPMs between January 1 through March 31 and January 1 through June 30 under the All-Payer Combination Option.

CMS also proposes that an eligible clinician would need to meet the relevant QP or Partial QP Threshold under the All-Payer Combination Option, and they would use data for the same time periods for Medicare payments or patients and that of other payers. For example, CMS would not assess an eligible clinician under the All-Payer Combination Option using their AAPM payment amount and patient count information from January 1 through March 31 and their Other Payer AAPM payment amount and patient count information from January 1 through June 30. CMS is proposing to align the time period assessed for the Medicare and other payer portions of the calculations under the All-Payer Combination Option because they believe that would support the principle that QP determinations should be based on an eligible clinician's performance over a single period of time, and that lack of alignment, comingling participation information from multiple time periods for the purposes of making QP determinations, would not appropriately reflect the structure of QP assessment using the All-Payer Combination Option. CMS seeks comment on this proposal.

AAFP Response

The AAFP supports aligning the time period assessed for the Medicare and other payer portions of the calculations under the All-Payer Combination Option.

(c) Notification of QP Determinations Under the All-Payer Combination Option

(3) QP Determinations Under the All-Payer Combination Option

(a) QP Determinations at the Individual Eligible Clinician Level

Summary

Upon further consideration, CMS proposes to make QP determinations under the All-Payer Combination Option at the individual eligible-clinician level only. CMS seeks comment on this proposal, specifically on the possible extent to which APM entity groups in AAPMs could agree to be assessed collectively for performance in Other Payer AAPMs. CMS also seeks comment on whether there is variation, and the extent of that variation, among eligible clinicians within an APM entity group in their participation in other payer arrangements that they may determine to

be Other Payer AAPMs. CMS seeks comment on whether there are circumstances in which QP determinations should be made at a group level under the All-Payer Combination Option.

To make QP determinations at the APM entity group level under the All-Payer Combination Option, CMS would need to collect for each APM entity group all of the payment amount and patient count information for all eligible clinicians. CMS anticipates also needing participation lists or similar documentation to identify eligible clinicians within each APM entity group that participate in an Other Payer AAPM. CMS seeks comment on whether APM entities in Other Payer AAPMs could report this information at the APM entity group level to facilitate their ability to make QP determinations at the group level.

CMS notes that when an affiliated practitioner list defines the eligible clinicians to be assessed for QP determination in the Advanced APM, CMS makes QP determinations under the Medicare Option at the individual level only. To promote consistency with the Medicare Option where possible, if in response to comments on this proposed rule CMS may adopt a mechanism to make QP determinations under the All-Payer Combination Option at the APM entity group level, CMS proposes that eligible clinicians who meet the criteria to be assessed individually under the Medicare Option would still be assessed at the individual level only under the All-Payer Combination Option. CMS seeks comment on whether there are alternative approaches to making QP determinations under the All-Payer Combination Option for eligible clinicians who meet the criteria to be assessed individually under the Medicare Option.

AAFP Response

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

(b) Use of Individual or APM Entity Group Information for Medicare Payment Amounts and Patient Count Calculations under the All-Payer Combination Option

Summary

Since CMS is proposing to make QP determinations at the individual eligible-clinician level only, they are proposing to use the individual eligible-clinician payment amounts and patient counts for the Medicare calculations in the All-Payer Combination Option. CMS believes that matching the information they use at the same level for all payment amounts and patient counts—for both the Medicare and all-payer calculations under the All-Payer Combination Option—is most consistent because these provisions require calculations that add together the payments or patients from Medicare and all other payers (except those excluded).

CMS also proposes a modified methodology when the eligible clinician's Medicare Threshold Score calculated at the individual level would be a lower percentage than the one that is calculated at the APM entity group level to which CMS would apply a weighted methodology. This methodology would allow CMS to apply the APM entity group level Medicare Threshold Score (if higher than the individual eligible-clinician level Medicare Threshold Score), to the eligible clinician, under either the payment amount or patient count method, but weighted to reflect the individual eligible clinician's Medicare volume.

CMS would multiply the eligible clinician's APM entity group Medicare Threshold Score by the total Medicare payments or patients made to that eligible clinician.

In the Title XIX Excluded Payments and Patients section, CMS discusses how the agency plans to exclude payments made under Title XIX in a state where no Medicaid Medical Home Model or Medicaid APM is available under that state program. To carry out this exclusion, in the 2017 Quality Payment Final Rule, CMS finalized that for both the payment amount and patient count methods, Title XIX payments or patients will be excluded from the numerator and denominator for the QP determination unless:

- (1) A state has in operation at least one Medicaid APM or Medicaid Medical Home Model that is determined to be an Other Payer AAPM; and
- (2) The relevant APM entity is eligible to participate in at least one of such Other Payer AAPMs during the QP Performance Period, regardless of whether the APM entity actually participates in such Other Payer AAPMs.

CMS proposes that they will use the county level to determine whether a state operates a Medicaid APM or a Medicaid Medical Home Model at a sub-state level. CMS seeks comment on this proposal.

CMS proposes that, in states where a Medicaid APM or Medicaid Medical Home Model only exists in certain counties, they would exclude Title XIX data from an eligible clinician's QP calculations unless the county where the eligible clinician saw the most patients during the relevant All-Payer QP Performance Period was a county where a Medicaid APM or Medicaid Medical Home Model determined to be an Other Payer AAPM was available. CMS would require eligible clinicians to identify and certify the county where they saw the most patients during the relevant All-Payer QP Performance Period. If this county is not in a county where a Medicaid APM or Medicaid Medical Home Model was available during the All-Payer QP Performance Period, then Title XIX payments would be excluded from the eligible clinician's QP calculations. CMS seeks comment on this proposal.

In addition to excluding payments based on county-level geography, CMS proposes to exclude Title XIX payments and patients from the QP determination calculation when the only Medicaid APMs and Medicaid Medical Home Models available in a given county are not available to the eligible clinician in question based on their specialty. CMS seeks comment on this proposal.

AAFP Response

The AAFP believes whether a state operates a Medicaid APM or a Medicaid Medical Home Model at a sub-state level should be determined at the county level. However, the AAFP has concern 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) were held accountable for calculating 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.

Further, the AAFP believes it is reasonable to exclude Title XIX payments and patients from the QP determination calculation when the only Medicaid APMs and Medicaid Medical Home

Models available in a given county are not available to the eligible clinician in question based on their specialty.

(4) Submission of Information for QP Determinations under the All-Payer Combination Option
(a) Required Information

Summary

CMS discusses what they would need to make QP determinations under the All-Payer Combination Option using either the payment amount or patient count method, CMS would need to receive all of the payment amount and patient count information: (1) attributable to the eligible clinician through every Other Payer AAPM; and (2) for all other payments or patients, except from excluded payers, made or attributed to the eligible clinician during the All-Payer QP Performance Period.

To make calculations for the snapshot dates, CMS will need payment amount and patient count information from January 1 through June 30 of the calendar year two years prior to the payment year. CMS states they will need this payment amount and patient count information submitted in a way that allows them to distinguish information from January 1 through March 31 and from January 1 through June 30, so they can make QP determinations based on the two snapshot dates as discussed above.

To meet the need for information in a way that CMS believes minimizes reporting burden, CMS proposes to collect this payment amount and patient count information aggregated for the two proposed snapshot time frames: from January 1 through March 31 and from January 1 through June 30. CMS seeks comment on this approach, particularly as to the feasibility of submitting information in this way and suggestions on how to further minimize reporting burden. If CMS finalized an All-Payer QP Performance Period of January 1 through March 31, they would need payment amount and patient count information only from January 1 through March 31. If they retain the current finalized QP Performance Period, CMS would need information aggregated for three snapshot timeframes: from January 1 through March 31, January 1 through June 30, and January 1 through August 31.

As previously discussed, CMS proposes to make QP determinations under the All-Payer Combination Option only at the eligible-clinician level. As a result, CMS proposes that all of this payment and patient information must be submitted at the eligible-clinician level, and not at the APM entity group level as CMS finalized in rulemaking last year. CMS proposes to allow eligible clinicians to have APM entities submit this information on behalf of any of the eligible clinicians in the APM entity group at the individual eligible-clinician level. CMS seeks comments on these proposals.

AAFP Response

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

The AAFP also supports making QP determinations at TIN or group level. This would encourage alignment between Medicare AAPMs and Other Payer AAPMs. Making QP determinations at the individual eligible-clinician level is contrary to the concept of team-based care that APMs otherwise support, and it ignores the fact that individual eligible clinicians often benefit from improvements made at the practice (i.e. TIN or group) level. Furthermore, we

believe that practices that participate in APMs are sufficiently advanced and have CEHRT that permits reporting information at the APM entity group level to facilitate the ability to make QP determinations at the group level. In any case, the AAFP supports allowing eligible clinicians to have APM entities submit information on their behalf.

(b) QP Determination Submission Deadline

Summary

CMS proposes that APM entities or eligible clinicians must submit all of the required information about the Other Payer AAPMs in which they participate December 1 of the calendar year that is two years prior to the payment year, which CMS refers to as the “QP determination submission deadline.”

CMS believes that December 1 is the latest date in the year that they could receive information in order to be able to complete QP determinations and notify eligible clinicians of their QP status in time for them to report to MIPS as needed.

CMS will not make QP determinations for an eligible clinician under the All-Payer Combination Option if they do not receive information sufficient to make a QP determination under either the payment-amount or patient-count method by the QP determination submission deadline. CMS seeks comment on these proposals.

AAFP Response

The AAFP also believes that APM entities or eligible clinicians should have the ability to appeal determinations. There may be instances where CMS doesn't appropriately consider information submitted by the APM entity or eligible clinicians.

(c) Certification and Program Integrity

Summary

CMS proposes that a new requirement be added stating that the APM entity or eligible clinician that submits information to request a QP determination under the All-Payer Combination Option must certify to the best of its knowledge that the information that they submitted to CMS is true, accurate, and complete. In the case of information submitted by the APM entity, CMS proposes that the certification must be made by an individual with the authority to legally bind the APM entity. CMS seeks comment on these proposals.

CMS proposes to revise the monitoring and program integrity provisions to further promote the integrity of the All-Payer Combination Option. CMS proposes to add a paragraph stating that an APM entity or eligible clinician who submits information to CMS must provide such information and supporting documentation upon request. CMS seeks comments on these proposals.

AAFP Response

The AAFP believes APM entity or eligible clinician should be given 30 calendars days to provide supporting documentation.

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), which is a federal advisory committee that provides advice to the Secretary. 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 seeks comment 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 seeks comment on revising the definition to require that a PFPM be an APM or a payment arrangement operated under legal authority for Medicaid or CHIP payment arrangements. CMS seeks broad comments on criteria and stakeholders' needs in developing PFPM proposals. Finally, CMS seeks 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.

AAFP Response

The AAFP is 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 fully support expanding PTAC's purview to examine PFPMs that include Medicaid and CHIP and a combination of public and private payers**. Furthermore, we support the PTAC considering PFPMs that fall outside of 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 alignment
- 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 and including delivery reform as a component in such proposals. We concur with CMS that including Medicaid or CHIP in PFPMs should encourage payment and delivery innovations.

III. Collection of Information Requirements

Summary

Among other requirements, CMS is required seek public comment on the agency's estimated burden calculations, the quality, utility, and clarity of the information collected, and CMS' effort to minimize the information-collection burden on the affected public.

AAFP Response

The burden does not even begin to estimate the true public burden on the federal and governments, federal grants, and all affiliated organizations that are being paid to write, analyze, present, explain the rules, perform technical assistance, test new payment models, edit and review quality measures, or participate in many costly activities related to the QPP. Nor does it consider the burden on physicians, who can see fewer patients because they must spend time documenting and following rules, rather than offering care.

III.C. ICR Re: Burden for Virtual Group Election

Summary

CMS describes the process for virtual group election, including submission of TINs and NPIs associated with the group, detailed information for the virtual group representative and confirmation of a written formal agreement. CMS assumes only 16 virtual groups will participate in the first year due to the short lead time, with an average of five TINs per virtual group with 9.5 clinicians each, or 48 clinicians per group. CMS estimates 10 burden hours per group—eight from computer systems analysts and two for legal support—which it offers up as a reduction in burden from other forms of data submission.

AAFP Response

There was no allocation of costs for physician time, which could be substantial since many physicians own small practices and are closely involved with business decisions. We therefore believe CMS woefully underestimated the time and cost involved in making the decision to form and create a virtual group. There is also the added burden associated with a virtual group reporting as a group due to the potential heterogeneity within the groups involved.

III. F, ICR Re: Quality Performance Category

Summary

CMS estimates that 92 percent of MIPS-eligible clinicians not in MIPS APMs will submit quality performance category data, most under the same mechanism as in the past, except for facility-based clinicians. CMS estimates 364,002 clinicians will submit through claims; 225,569 via qualified registries or QCDR; 115,241 via EHR; and 101,939 via CMS Web Interface. CMS further breaks this down into those that will submit as individuals versus as a group. CMS considers time spent reviewing measure specifications, selecting measures, incorporating into office workflow, and data submission.

AAFP Response

CMS assumes that all practices have an office manager, IT support, LPN, and billing clerk to assist physicians in carrying out reporting requirements. In reality, for many small offices this work is done by the clinicians themselves, at a higher cost than CMS estimates. Furthermore, CMS doesn't consider the direct cost of qualified registry/QCDR submission (which can be substantial), nor does it include the direct—often considerable—cost of data mapping and maintaining the interface with qualified registry/QCDR.

For EHR submissions, CMS does not recognize time to train personnel in data capture, designing templates for data capture, documentation time, or time to review data submission reports and work with vendors to correct submissions. CMS also doesn't include IT consulting fees for small groups that lack internal IT departments and fails to consider direct fees from the EHR vendors submitting on behalf of clinicians (approximately \$300/physician).

For CMS Web Interface submission, CMS incorrectly states each group reports on 248 beneficiaries. In fact, they report on 248 beneficiaries per measure x 15 measures. (While some patients may be represented in more than one measure, this is not the norm.) Also, CMS does not consider the time in manual hours needed to abstract data that is not readily available electronically. This can be an enormous cost.

For CAHPS, CMS does not consider direct costs of contracting with a CAHPS vendor.

For the above reasons, the AAFP feels the costs are grossly underestimated for the quality performance category.

III.H. ICR Re: Burden for Improvement Activities Submission

Summary

CMS estimates 524,488 clinicians that are not part of APMs will submit improvement activities taking one hour each.

AAFP Response

While we do not dispute the time estimation, we note that CMS is not considering the direct costs charged by vendors for submitting improvement activities via qualified registry and/or EHR, which can be substantial as reflected in the updated qualified registries and QCDR lists for performance period 2017.

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 that reads "Wanda D. Filer, MD". The signature is written in a cursive style with a large initial "W" and a distinct "D" for the middle name.

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