American Academy of Physical Medicine and Rehabilitation

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Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1645–P
Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

RE: Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models

Dear Mr. Slavitt:

On behalf of the more than 9,000 physiatrists of the American Academy of Physical Medicine and Rehabilitation (AAMP&R), we appreciate the opportunity to submit comments to the proposed rule: Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models**.** Physical Medicine and Rehabilitation (PM&R) physicians, also known as physiatrists, treat a wide variety of medical conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. PM&R physicians evaluate and treat injuries, illnesses, and disability, and are experts in designing comprehensive, patient-centered treatment plans. Physiatrists utilize cutting-edge as well as time-tested treatments to maximize function and quality of life. **In addition to our detailed comments below, we are in full support of The American Medical Association's comment letter as well.**

II. Provisions of the Proposed Regulations

E. Program Details
3. Exclusions.
c. Low-Volume Threshold

Since the release of the MACRA proposed rule, many concerns have been voiced about the potential impact of MIPS on solo and small physician practices. To help mitigate adverse effects on small practices, CMS has proposed a low-volume threshold, exempting physicians with less than $10,000 in Medicare allowed charges and fewer than 100 unique Medicare patients per year**. AAPM&R urges CMS to raise the low-volume threshold significantly from the proposed level, which would exempt only clinicians and groups with less than $10,000 in Medicare allowed**

charges AND fewer than 100 unique Medicare patients per year. Instead, we recommend that clinicians with less than $30,000 in Medicare allowed charges per year OR fewer than 100 unique Medicare patients be exempt from MIPS. The less than $30,000 OR fewer than 100 patients threshold should apply to claims for each eligible clinician identified with a National Provider Identifier (NPI) and not be applied at the group level. In addition, physicians in small practices who are providing care to patients in rural areas and Health Professional Shortage Areas should be provided opportunities to be exempt from MIPS.

By raising the threshold to $30,000 in Medicare allowed charges OR fewer than 100 unique Medicare patients seen by the physician, and applying the threshold to each clinician, CMS would provide a better safety net for physicians in solo and small practices. We believe changing the low-volume threshold is warranted based on several provisions of MACRA that were intended to assist small practices but will not be finalized by the proposed start date. For example, MACRA outlined a requirement for virtual groups that would allow small practices to join together and be judged on aggregate data rather than individually under MIPS. CMS, however, has signaled that these groups will not be available for the proposed first performance year. Without this and other key assistance, we urge CMS to expand the low-volume threshold to avoid inadvertently penalizing small practices.

Finally, CMS' own data indicates that a $30,000 threshold is more reasonable. Looking at the data from the 2015 and 2016 PQRS program, over 25 percent of physicians with Medicare Part B charges less than $40,000 were subject to a negative payment adjustment. In contrast, once physician Medicare revenues reach the $40,000-$100,000 range, physicians were considerably less likely to earn an adjustment.

4. MIPS/APM Performance Period

After careful review, AAPM&R believes the proposed start date is too early and will create significant problems for the launch of the MACRA programs. We believe it is necessary for CMS to recognize the fundamental changes enacted as part of MACRA and treat the first year as a transitional period that allows physicians to move away from the existing Medicare reporting requirements, learn about MIPS and APMs, and implement workflow and system changes to become successful MACRA participants. **We therefore urge CMS to not begin the first MACRA performance period until July 1, 2017 and should allow for an initial six-month reporting period.**

CMS has noted that it chose the proposed January 1, 2017 start date based on previous experiences with quality programs and that there are significant trade-offs in selecting a later date, including the calculation of outcome- and claim-based

measures, and the capability of CMS' own internal processes. **We, however, believe that the benefits of creating an initial transition period vastly outweigh these concerns.**

As a practical matter, starting the program on July 1, 2017 rather than January 1, 2017 provides additional time between the issuance of the MACRA final rule and the start of the reporting period. Physicians need to be educated about the new requirements and change their practice models to accommodate the MIPS and APM programs. CMS is unlikely to publish the final rule before the fall of this year, leaving participants with minimal time before the proposed start date. **Without adequate notice of final program requirements, a final list of qualified APMs, specified program thresholds, and other details, CMS is setting up the program for potential failure.**

We are also concerned by statements made by CMS that physicians do not have to begin reporting at the start of the performance period, indicating that physicians will actually have more time to collect data, change workflows, and implement required MIPS and APM changes. This is completely misleading given that many of the quality measures require actions to be taken at the point-of-care and cannot be completed at a later date. **CMS should realize that physicians need to prepare several months before the performance date in order to successfully participate, and that these statements simply create more confusion.**

Setting the performance year too soon will also compromise the ability for vendors, registries, Electronic Health Records (EHRs), and others to update their systems to meet program requirements. The MIPS program asks that these entities incorporate a significant number of new measures, including an entirely new category of Clinical Practice Improvement Activities (CPIAs). We have serious concerns that there will be inadequate time to not only include new measures but also to test and ensure the data submitted is accurate and reliable. The timeframe proposed simply does not allow for these entities to validate new data entry and testing tools, which can also worsen usability and add to the existing problems with this technology.

Finally, a later start date would provide CMS with more time to address several issues that were omitted from the proposed rule, including the development of virtual groups, improved risk-adjustment and attribution methods, further refinement of episode-based resource measures and measurement tools, and enhanced data feedback to participants. Statements in the proposed rule indicate that CMS did not have sufficient time, was waiting on report findings, or needed to upgrade its systems before it could fully implement these changes that were required as part of the MACRA statute. If this is the case, we believe CMS should take such time and provide a later start date. To be clear, we are not asking that CMS continue

the existing programs (PQRS, MU, and VBM) in 2017; the current programs should still end, which avoids having CMS and physicians try to report and calculate performance twice for 2017.

It is in the interest of patients, physicians and the Medicare program that MACRA implementation goes smoothly. To do this, we strongly believe that a transitional period will help all of the stakeholders that are working towards implementing MACRA. In the past, CMS has used transitional periods at the start of new programs, providing accommodations for the first year as participants learn and adjust to new requirements. MACRA creates a similar challenge for practices that will require adjustments and a learning curve. **We therefore urge CMS to create an initial transitional period for the MACRA program from July 1, 2017 – December 31, 2017.**

5. MIPS Category Measures and Activities

A key factor in medicine's support for MACRA was the law's promise to create a new Merit-Based Incentive Payment System that would be less complex and more meaningful to the majority of physicians and their patients.

While AAPM&R sees several positive changes in the proposed rule, our main concern is that CMS continues to view the four MIPS components as separate programs, each with distinct measures, scoring methodologies, and requirements. MIPS is not proposed as a single unified program; rather, the four components operate alone and lack commonality in areas with significant overlap. **AAPM&R strongly urges CMS to work to establish a more holistic approach and not maintain the divide between different MIPS categories.**

To create a more unified program, we believe that CMS should identify clear connections across the four MIPS categories. Specific examples of how to initially transform MIPS into a more comprehensive approach include:

- Unifying definitions across all MIPS categories.
    - As proposed, small practice generally means 15 or fewer clinicians; however, there is a variation in the quality component for the all-cause hospital readmission measure for practices with *fewer than 10 clinicians*. While CMS' reasoning for this exclusion is based on reliability and not merely an accommodation for practice size, few physicians will know or appreciate this difference, and participants will perceive that there are some accommodations for groups of one size and separate accommodations for groups of another. CMS should use the 15 or fewer clinician threshold, as defined in MACRA, throughout the rule.

- Streamlining scoring so that each category does not create a system that has multiple complex components and exceptions.

- Implementing a call for new MIPS measures—CMS should expand the call for new quality measures to reach all other MIPS categories, allowing proposals for new Advancing Care Information (ACI), CPIAs, or resource use measures and to promote a pathway towards APMs.

- Highlighting specialty designations in the quality component throughout the MIPS program to create specific pathways for specialties and subspecialties.

Overall, physicians should feel that each MIPS category builds off of and mirrors the other categories. MIPS should then tie into APMs, creating a pathway for moving to more advanced models. This could be done by implementing the APM proposals for some of the MIPS categories. For example, the certified technology requirement for APMs requires a certain percentage of physicians to use certified EHRs but allows them to use the technology as they see fit. The ACI category could build up to this approach, creating a way for physicians to move towards using technology in this manner and becoming an APM. Similarly, the quality category of MIPS could build up to the same approach adopted for advanced APMs, which allows models to choose their own approach to measuring quality as long as they include at least one quality measure from the MIPS program. Our understanding is that the MACRA statute offers enough flexibility to implement this more comprehensive approach and will reduce the complexity found in the proposed program.

Since initially a large number of physicians will be participating in MIPS, we believe that the first perception of the program will be an important one to establish. The more streamlined and unified the MIPS program is, the more physicians will see it as one that can be accomplished and adopted into their practice.

b. Quality Performance Category

AAPM&R urges CMS to reduce the reporting threshold to 50 percent.
CMS proposes to increase the threshold for successfully reporting on a measure from 50 percent to 80 percent via claims and 90 percent via EHR, clinical registry, Qualified Clinical Data Registry (QCDR) or web-interface. If a physician fails to meet the data completeness threshold, they do not receive points for reporting on the measure.

The proposal is almost a two-fold increase in data completeness requirements compared to the current PQRS program. AAPM&R finds the proposed thresholds are not only unrealistic but incorrectly assume that a physician will not run into any

administrative problems, and practices will be ready to begin reporting on a measure on day-1 of the reporting period. Creating such high thresholds creates an environment with little room for error and will jeopardize the success of many participants.

For example, physicians may perform a form of chart extraction where either a physician or third-party can submit the information to CMS after the close of the reporting period. However, a physician reporting on an outcome measure, shared decision making measure, or patient reported outcome (PRO) measure, cannot go back in time to collect or document the information. PRO measures and patient satisfaction are important aspects of care and sought after information by patients and other stakeholders, but, based on CMS' data completeness requirement, many of these measures would most likely not be calculated in a physician's quality score and potentially appear as if the physician provided poor care.

Such a high threshold will also create a disincentive from reporting on certain high priority measures due to the large administrative cost and burden with collecting information, especially when coupled with the new requirement of reporting on "all-payer" data using a QCDR, registry, EHR, or web-interface. CMS states that it wants to incentivize electronic reporting, especially registries and QCDRs; however, its proposal does the opposite—by placing the highest thresholds for these data submission methods—physicians will be deterred from using them and may prefer to stay with claims and other types of reporting mechanisms.

In addition, this threshold and the all-payer data requirement are especially burdensome for small practices that do not have the resources to hire a full-time or part-time employee to collect and document such information.

If CMS is concerned that a 50 percent threshold lends itself to possible gaming, then it is misinformed. A 50 percent threshold still requires reporting on a majority of patients and does not lend itself to cherry picking. They do not divert resources to deciding which patients to include for each measure. A 50 percent threshold is simply a more realistic reporting level that acknowledges potential problems, such as a vendor not updating measure specifications at the start of the reporting period, a practice switching EHR vendors, power outages, inaccurate coding or natural disaster. **Therefore, we urge CMS to reduce the quality reporting threshold back to 50 percent.**

AAPM&R urges CMS to reduce the number of required quality measures from six to four.

AAPM&R is pleased to see that CMS has eliminated the domain requirement and reduced the number of required quality measures to achieve the maximum points

under the quality category compared to the PQRS program. We continue to be concerned, however, that the requirements CMS has put forward are overly restrictive and emphasize compliance over quality improvement. We are troubled that there is a misperception by CMS that a physician must be overly measured in order to demonstrate value and care improvement.

To allow physicians to focus on improvement efforts that better suit their area of practice and patient population, physicians should be able to choose a few measures that will have a high impact on care improvements. Yet, under the quality proposal, a physician's time will still be consumed with finding relevant measures. In addition to the six quality measures, a physician will also potentially be assessed on three population health measures (acute and chronic composites and all-cause hospital readmission measures), and will be held accountable for the various other activities under the three other MIPS categories.

The six random measures a physician or group must report on may not meet the needs of a physician's practice to achieve the maximum potential points under the quality category. **Therefore, we recommend that CMS further reduce the number of required quality measures to four.** Allowing for such flexibility will reduce administrative burden and provide time for physicians to focus on quality improvement. It will also lend itself to more accurate measurement and a better snapshot of quality.

AAPM&R urges CMS to remove the Physical Medicine Specialty Measure Set. While AAPM&R appreciates that CMS introduced specialty measure sets in the proposed rule, the Physical Medicine Measure Set is not something that any physiatrist would find helpful when looking for quality measures to report. The measures in this set are irrelevant because:

1) All of the measures in the Physical Medicine Set are process measures so physiatrists would still need to find a cross-cutting measure or high-priority measure to complete the reporting requirements. The proposed rule states that these sets were created to reduce burden, however by not covering all of the requirements, CMS has not reduced any burden on the physician;
2) Reporting/submission mechanisms are not consistent in the specialty set meaning that PM&R physicians would again, have to go searching for additional measures that meet their reporting needs.
3) Although the measures *could be* applicable to *some* PM&R physicians, this set is ***not*** applicable to ALL PM&R physicians. We recognize the need to assist physicians and steer them to appropriate measures based on their specialty, but the sets are initially much better suited as educational materials. Many of the sets are categorized by general specialty and not broken down by sub-specialization.

Therefore, AAPM&R urges CMS to remove the Physical Medicine Specialty Measure Set and work with AAPM&R on identifying better measures for our specialty.

c. Selection of Quality Measures for Individuals and Groups

AAPM&R is concerned with the number of measures CMS has proposed for removal under MIPS, and believes it is premature and short-sighted to continue to remove measures considered "topped out," especially since reporting rates within PQRS are quite low and there remains a lack of relevant measures for specialists, particularly PM&R specialists. We do support the removal of measures when clinical evidence has changed, but we are concerned with the growing gap that has been created in the measure portfolio due to the number of measures CMS has removed over the last few years as well as the measures slated for removal in 2017.

Going forward, we urge CMS to provide a three-year phase out period for any new measures being proposed for removal to allow for the submission of new measures within the current Call for Measures timeframe.

In addition, we are extremely opposed to the removal of Measures Groups and believe CMS should reinstate them for 2017 reporting. We also strongly urge the reinstatement of Measures Groups that were removed prior to the 2016 reporting year, especially the Low Back Pain Measures Group. Measures groups are designed as composite measures to provide an overall picture of patient care for a particular condition or set of services. Allowing physicians to report on a measures group for a sampling of their patients is a less burdensome yet meaningful way for a physician or practice to meet their quality reporting requirements and encourages the use of the harder, more resource-intensive outcome measures. This reporting option also provides smaller practices and individual physicians without an EHR a less costly and administratively burdensome reporting option. By removing these measures groups, CMS has skewed quality reporting policy to favor large group practices given that the majority report through the GPRO web-interface that allows for and requires reporting on a sampling of patients.

e. Resource Use

AAPM&R believes the proposed resources use category of MIPS carries over many of the problematic areas of the Value Based Modifier (VBM), including measures that we know are inappropriate. The proposal also fails to make needed improvements in several key areas, such as attribution and risk adjustment, which are necessary to make this category valid for physicians. Furthermore, the addition of new episodes measures appears premature and CMS has not yet developed needed patient

condition groups and patient relationship categories nor established the creation of the virtual group option.

AAPM&R urges that the Per Capita Cost and Medicare Spending Per Beneficiary (MSPB) measures should be removed.

In determining which resource measures it would use in the MIPS resource section, CMS commented that it will eliminate four condition-specific per capita cost measures because physicians saw them as irrelevant. On the other hand, the agency intends to retain a total per capita cost measure and a Medicare spending measure that most physicians also view as irrelevant and unfair. **While we support elimination of the condition-specific measures, we strongly believe that the agency should remove the other two general cost measures as well.**

AAPM&R believes it is inappropriate to use broad measures such as total per capita costs and MSPB to evaluate the resource use of individual physicians. Many Medicare beneficiaries have multiple health problems, and in most cases, those different health problems are treated by multiple physicians and other providers. QRURs consistently show that the services delivered by an individual physician represent a tiny fraction of the total cost of care for their patients. Moreover, under Medicare rules, beneficiaries have the freedom to see any physicians they wish to obtain treatment for their health problems. Even if each of the individual physicians whom a patient sees is "efficient" in the services they deliver and order, the overall spending on the patient's care may be higher than for other patients because of the number and types of physicians and other providers the patient chooses to use.

AAPM&R believes the use of untested episode measures is premature and must be delayed.

We agree with the many comments cited by CMS that it would be more appropriate to use measures of resource use based on episodes of care than broad measures such as total per capita costs and MSPB. However, it is important to note that those who supported use of episode measures supported the use of "properly selected and designed" episode measures that would be used instead of, not in addition to, the existing cost measures.

Many of the episode-based measures listed in Tables 4 and 5 have only recently been developed and/or made widely known to practicing physicians. More time is needed to fine-tune and test the proposed episodes and to consider potential alternatives that relevant specialties believe would be more appropriate and better aligned with episodes being used or developed by other payers such as Medicaid. **To maintain credibility with the physician community and create confidence in the measures, CMS must solicit and incorporate input from practicing physicians and the**

professional organizations that represent them. The proposed rule refers to evaluation of the episodes by CMS and an outside contractor, but makes no mention of input from physician specialties either during the development process or a comment period that concluded earlier this year. Some physicians have invested substantial time and effort to help CMS come up with relevant and valid episode groups. That these efforts did not warrant a mention in the rule is discouraging to say the least. **We strongly suggest that these efforts be mentioned to assure physicians that their perspectives were acknowledged and incorporated into these measures.**

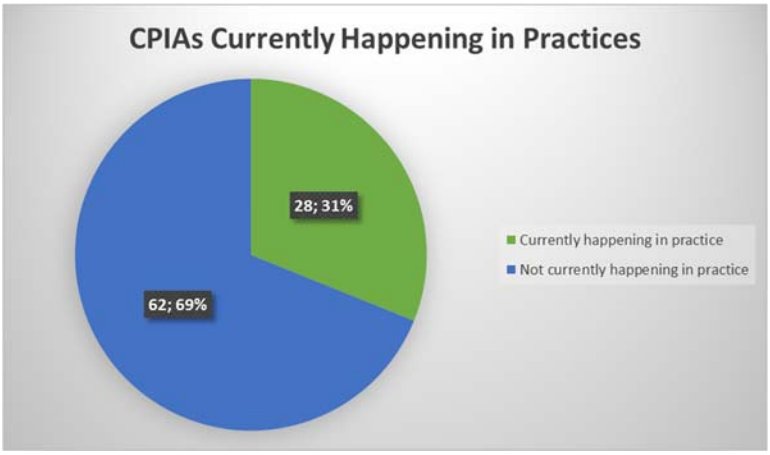
It is also inappropriate to begin using these episodes for MIPS in ways that could potentially penalize physicians before CMS has provided additional information needed to evaluate their suitability. Although CMS has released lists of the diagnosis and procedure codes used to define these episode measures, to achieve true transparency and facilitate insightful input, additional information must be made available. Rather than just a generic discussion of the risk adjustment methodology, for example, **CMS must release the actual variables, coefficients, and equations used for the risk adjustment process, as well as the predictive accuracy of the methodology.**

f. Clinical Practice Improvement Activities

CMS, as required by MACRA, must score clinicians in this new category as part of MIPS. AAPM&R questions the value of the CPIAs because evidence on whether these activities lead to improved health outcomes is limited. While we support the simple reporting process, we are still concerned that reporting in a new category will create a burden on physicians. Therefore:

AAPM&R urges CMS to decrease the number of required CPIAs.
Under the proposed rule, physicians would be required to report on as many as six different activities in order to receive the full CPIA score. While the activities vary in their time and cost burden, the resources involved in meeting six different activities can quickly add up and create new challenges for physicians.

CMS has stated that CPIAs are quality improvement efforts that they know have been happening for years at the local and regional level, but that this will be the first time that these activities would be required under a national-scale program. AAPM&R conducted a survey of their membership to see how many of these activities are currently happening. Of the 90 proposed activities, only 28 are currently “relevant” in PM&R practices.



AAPM&R strongly believes believe the CPIA activities are heavily geared towards primary care providers and do not account for specialists. Therefore, we urge CMS to decrease the number of required CPIAs.

AAPM&R urges CMS to expand the number of "high-weighted" activities. While AAPM&R is generally pleased with CMS' broad proposal for the CPIA category, we are concerned that the agency identifies only 11 out of the more than 90 listed CPIAs as "high-weighted." This categorizes certain high quality patient activities as only "medium," ignoring the potentially significant patient benefit and care improvements associated with certain activities. In particular, listing activities as "medium" and not "high" may deter physicians from selecting these activities. For example, there are no "high-weighted" activities for the emergency response and preparedness CPIA subcategory, which creates a perverse incentive for physicians to not select any of these important care activities. In addition, CMS ignores the time commitment, cost, and effort to implement and complete many of the "medium-weighted" activities.

AAPM&R request that CMS explicitly recognize continuing medical education (CME) activities provided by a nationally-recognized accreditor as a clinical practice improvement activity. CME has long been recognized as an effective means by which physicians can pursue their continued professional development. Consistent with the intent of the MACRA, as well as the "Three Aims of Healthcare," the National Quality Strategy (NQS), and the CMS Quality Strategy, CME encourages physicians to develop and maintain the knowledge, skills, and practice performance that leads to improved performance with optimal patient outcomes. Utilizing accredited CME to further physician awareness and compliance with best practices represents an intelligent and efficient use of our nation's network of CME providers. We believe lifelong learning, assessment, and improvement are integrally related.

g. Advancing Care Information

Prior to the release of the proposed MACRA rule, CMS recognized that many physicians and patients were frustrated with the current state of EHRs as well as the EHR Incentive/Meaningful Use (MU) program and announced that the proposed rule would make a course correction to refocus the program. CMS' statements, however, do not align with what it is proposing in the rule. In many instances the Advancing Care Information (ACI) category is largely unchanged from MU Stage 3—for example, it remains a pass-fail program and retains the same prescriptive measures. Many in the physician community find the ACI performance category to be confusing and compliance-driven rather than physician- and patient-centric. **CMS should therefore take immediate action to reduce the overall complexity of the ACI category while also establishing a clear path away from process-oriented measures.** To that end, AAPM&R recommends the following significant changes to the ACI category.

Base Score

AAPM&R urges CMS to grant credit for each reported measure under the base score.

As proposed, the base score carries over the problematic all-or-nothing structure of the current MU program: if a physician fails to report/attest to just one requirement, the physician earns a zero for not only the base category, but the *entire* ACI category. Missing one base measure earns a zero score regardless of whether that physician achieved 100 percent on every other ACI requirement. CMS' justification for retaining this approach is that the base score only requires simple yes/no or one patient reporting for each measure. Yet, by using this scoring, CMS maintains a structure where failure to report does not simply harm your performance but renders all of your other efforts meaningless. The potential for complete failure due to inadvertent error or mistake continues to dominate the program, and the incentive to try is diminished.

To remedy this problem, **CMS should award credit for each measure reported under the base score, and make clear that a physician will not fail the entire ACI category if they fail to report all base measures.** This allows the base score to reflect a physician's actual success in achieving requirements, rather than simply awarding zero or fifty points with no differentiation. **We urge CMS to not add to the complexity of the base score but maintain its intent—to show functionality or the capability of doing each measure.** The score should continue to use yes/no or one patient reporting, and measures should be equally weighted across the base score so that physicians do not become confused or burdened by an intricate system of points and weights.

Performance Score
AAPM&R believes the proposed performance score is extremely complex and creates significant barriers to achieving CMS' goals of a program that is simplified, allows flexibility in selecting measures, and encourages innovation. As such, **we believe this portion of the ACI category requires significant changes and should not be finalized in its current form.**

AAPM&R believes success in performance scoring should include a physician's improvement from year-to-year. The performance score is problematic because it forces physician practices of varying size, resources, and manpower to compete against one another for percentage points, rather than encouraging physicians to compete against themselves and improve from year-to-year. Whereas there exist accommodations for small practices in the quality and CPIA categories of the proposed rule, the ACI category does not include similar accommodations. This lack of modification places small practices, new users of health IT, and those first trying an ACI measure at a disadvantage. These participants will most likely score lower than those that have implemented and previously adopted the tasks required by an ACI measure. Knowing that they will likely earn only one to two points for a new performance measure, clinicians may simply maintain their current activities and not try to adopt new tasks. **AAPM&R believes the performance score must take into account a physician's improvement. We propose that CMS allow participants to use the first performance period to measure their current levels of performance and receive full credit in the performance score for this level-setting. Subsequently, CMS will consider whether the physician has improved his or her performance compared to the previous reporting year.**

AAPM&R believes performance should measure a majority of patients rather than the total patient population. While the proposed performance score removes the arbitrary thresholds of the MU program, it now requires physicians to report on their total patient population. This approach fails to recognize the many valid reasons why a patient or physician may not perform an ACI measure. For example, a patient may prefer to not have their health information shared on a patient portal for privacy concerns. Yet, under the current proposal, respecting this patient request will negatively impact the physician's performance score.

6. MIPS Composite Score Methodology
(2) Scoring the Quality Performance Category

MACRA requires that CMS develop performance standards for each quality measure that take into consideration historical performance standards and improvement. To

accomplish this, CMS proposes to assign one to 10 points to each quality measure based on how a MIPS EC's performance compares to measure benchmarks. In order for the measure to be scored, it must have the required case minimum. If a MIPS EC fails to submit a measure required under the quality performance category criteria, then the clinician would receive zero points for that measure.

Given that the benchmarking methodology for each quality measure is a new, complicated scoring calculation, we ask that CMS keep the scoring of the remainder of the quality category as simple and straightforward as possible. This becomes overly complex as requirements vary based on group size. For example, a physician in a practice of 10 or more ECs is scored on 90 points versus a physician in a practice of nine or less ECs is scored on 80 points. Furthermore, creating subcategories for physicians in practices of nine or less appears to create different definitions of "small practices" throughout the MIPS program as noted in our comments in the first paragraph under Provisions for the Proposed Regulations. Physicians will not understand the subtly of why certain practice sizes have fewer measures than others and will simply see this as another added complexity when trying to figure out what requirements they need to meet. **Therefore, we urge CMS to simplify the scoring for the quality performance category so that physicians have a reasonable chance of meeting the new requirements. At a minimum, CMS should provide accommodations based on the statute's definition of a small practice, meaning 15 or fewer professionals.**

AAPM&R urges CMS to expand protections for reporting on new measures.
To encourage reporting on new measures and help mitigate potential unintended consequences, CMS should create protections for reporting on new and innovative measures. **Therefore, we support CMS' alternative proposal to not score a MIPS EC lower than three points when reporting on a new measure**. This policy should also apply to physicians who change reporting mechanisms. Furthermore, the proposal should not only be applicable to the first year the measure is available in MIPS but should apply to the first time the physician reports on the measure.

AAPM&R urges CMS to remove point limits on "topped out" measures
We are concerned with CMS' proposal for scoring measures it considers "topped out." Based on the proposal, CMS is essentially punishing high achievers by limiting the maximum points a physician can receive by reporting on a "topped out" measure. CMS' own analysis highlights that over half of the quality measures currently proposed for the MIPS program would be considered "topped out," raising the concern that most physicians will be less likely to achieve the highest scores possible in the Quality component of MIPS, especially since this category has the greatest weight (50 percent).

A physician may not have the option to report on alternative measures that have lower success rates. PM&R has a limited number of applicable measures and are constrained to a small set of measures that may be in the "topped out" range compared to other specialties. CMS is also making the blanket assumption that, when a measure is reported in the 95 percent range, that it is a negative as opposed to a positive. Instead of encouraging physicians to be striving towards providing the best possible care and rewarding top quality, CMS is overly scrutinizing physicians and arbitrarily assigning a poor quality designation when a difference may be less than one percent. The proposal also adds complexity to the quality scoring system. Therefore, **we urge CMS to abandon its proposal of creating truncated coefficient benchmarks and instead treat all measures equally.**

AAPM&R urges CMS to develop a transparent Measure Applicability Validation (MAV) process. CMS states that it intends to develop a validation process to review and validate a MIPS EC's inability to report on the quality performance requirements, and that the process will function similar to the MAV process. CMS should consult with the physician stakeholders as it develops the new validation process. We have had previous concerns related to the MAV, including the lack of clarity in how the MAV actually functions. The MAV clusters have historically occurred within a black box and often physicians are inappropriately held accountable for measures. **Before CMS holds a physician accountable for reporting on less than the required number of measures, CMS must build a process that includes a case minimum requirement.**

(3) Scoring the Resource Use Performance Category

AAPM&R urges CMS to not base benchmarks on the performance period. It is inappropriate for CMS to define resource use benchmarks based on the performance period rather than a baseline period prior to the performance period. As CMS indicates, it is important for physicians to know in advance how they would be scored under MIPS, but the proposed approach would not allow for physicians to know the resource use benchmarks. Telling physicians the methodology for calculating their resource use score but not providing them the actual data to determine what level of performance needs to be achieved does not enable them to determine whether or how much they need to improve or give them sufficient time to make the changes needed to succeed.

CMS indicates that it is "challenging" to compare resource use in a performance period with an historical baseline period, but it can also be challenging to compare quality measures with a baseline period, particularly if the gap between the two periods is long. **Because the resource use measures are based on claims data, benchmarks can and should be established using a baseline period that is prior to but close to the performance period, and because the benchmarks are based on all**

physicians' performance, not an individual physician's performance, they can be established using a time period shorter than a year. Since the benchmarks would already be based on "standardized payment data," it should be feasible for CMS to also adjust for any changes in payment rates and methodologies that occur between the baseline period and the performance period in ways that ensure physicians are not unfairly penalized.

CMS indicates that the benefits of earlier benchmarks are "more limited" for resource use measures because physicians "would not be able to track their daily progress because they would not have all the necessary information to determine the attribution, price standardization, and otherwise adjust the measures." This is a problem that CMS needs to solve because it is unreasonable to expect that physicians can improve on any measure without having timely, detailed feedback on their progress. Moreover, as discussed earlier, resource use measures should be defined in ways in which differences in physicians' performance result from differences in how they manage care and how they deliver and order services, not based on attribution rules or price adjustments. Attribution rules and other methodological features should also be clear enough that the average physician can understand and apply them.

AAPM&R urges CMS to not define benchmarks based solely on deciles.
AAPM&R has reservations about CMS's proposal to assign points to physicians based on where their measured resource use falls among the deciles of resource use distribution by all physicians. We note that in Table 21, CMS provides an example that has spending on patients in the lowest cost quintile for the measure at $15,000 versus $100,000 for those in the highest spending quintile. It is difficult to imagine how a properly risk-adjusted measure of actual spending on comparable patients could have such a large spending spread and raises real questions about the potential impact of moving forward with such an approach before resource use measurement tools are improved and physicians can have more confidence that comparisons are based on cost variation that physicians can control rather than other factors such as patient mix and community resources that CMS has not adjusted for.

Awarding the maximum points to physicians in the lowest-spending decile in a distribution like this would raise serious questions as to whether CMS was rewarding physicians for undertreating patients or encouraging physicians to focus their care on patients whose low treatment needs were not accurately reflected in the risk adjustment methodology for the measure.

MACRA requires the Secretary to "establish performance standards" for resource use measures. The distribution shown in Table 21 is not a "performance standard," but is merely a report on the actual spending on the measure in a prior period. The implicit

assumption is that the best performance is spending that is $15,000 or less**.** If CMS believes lowest cost should define its performance standards, then the agency should provide evidence for each measure that the physicians who are delivering care at that level of spending are doing so with high quality and for patients with an average risk profile.

(5) Scoring the Advancing Care Information Category

AAPM&R urges CMS to maintain existing measure exclusions and hardships. CMS proposes to maintain only the exclusions for the electronic prescribing and immunization registry measures and limits the available hardship categories**. We strongly disagree with this significant change in the program.** The measure exclusions and hardship categories were established to recognize that different practices and specialties may be unable to report on specific measures and those certain measures may not be relevant to all practices. Indeed, MU participants actively called for additional, not fewer, exclusions and hardship categories. **Because CMS has chosen not to change the measures, or make them more inclusive and practical for physicians, the exclusions and hardships should also be maintained.**

CMS suggests that the MIPS low-volume threshold and flexibility in the ACI performance score eliminates the need for such accommodations. We strongly disagree since the low-volume threshold has no explicit correlation with the ACI measures. For example, the low-volume threshold is unlikely to exclude all physicians who do not transfer or refer patients. Without exclusion, these physicians will now need to provide a summary of care document despite this being irrelevant to their practice. In addition, as described above, the flexibility highlighted by CMS in the performance category is doubtful—most physicians will continue to report on all of the measures in the performance score and remain far from achieving more than thirty points.

b. Calculating the Composite Performance Score

The complexity of the rule becomes quickly apparent when trying to understand how the composite score is calculated. We believe that most physicians will not be able to understand the numerous point systems, how they interrelate with one another to result in a final score, and what this final score actually means in terms of their Medicare reimbursement. For example, the quality performance category by itself has four different point calculations for the measures, ranging from 80 to 210 points. Physicians then must further understand how bonus points are determined within the quality component and then factor in how benchmarks impact this final quality score (which vary based on how the data is submitted). Understanding this process is not only difficult but becomes extremely challenging when you consider that this is only

one of the four categories that a clinician must understand to comprehend their final MIPS score. **To reduce confusion, AAPM&R recommends the following:**

1) **Focus on a single total score rather than creating multiple scoring subcomponents**
2) **Provide information about score calculations in advance of the performance period so that physician can anticipate what is required under MIPS**
3) **Wait to evaluate overall MIPS improvement**

AAPM&R therefore believes that CMS should work on securing a successful launch of the program and encouraging participation before it begins to evaluate future improvement.

8. Review and Correction of MIPS Composite Performance Score
a. Feedback and Information to Improve Performance

We appreciate CMS' efforts to conduct MIPS user assessments but are concerned these efforts fall short and do not address the complexity of accessing feedback reports. We are also concerned with the timeliness of the release of feedback reports and benchmarking information. **CMS should consult with stakeholder groups to determine the best presentation and most meaningful format for sharing ongoing, actionable performance feedback with physicians and practices.** As technology is constantly changing, it is critical that CMS take an ongoing approach to improving the way performance information is disseminated to physicians and practices. While, QCDRs have the ability to provide more timely and actionable information, the information they produce is only relevant to quality and limited to a single source—physician participants within a single QCDR. **Therefore, we encourage CMS to move towards a more iterative process where physicians and vendors submit data more routinely to CMS.** This will allow CMS to produce more frequent feedback information in terms of how a physician is performing throughout MIPS, including their composite score and not just with quality.

9. Third Party Data Submission
a. Qualified Clinical Data Registries

AAPM&R supports the comments of the American Medical Association and the Physician Clinical Registry Coalition relating to QCDRs.

10. Public Reporting on Physician Compare

While AAPM&R supports public reporting of physician data when it is valid, reliable, and meaningful to both consumers and physicians, we have a few concerns regarding to the plans CMS lays out in the proposed rule:

1) Expand the preview period: Physicians need at least 90 days to review and ensure accuracy of their information. **AAPM&R urges CMS to extend the current 30-day period to 90 days.**
2) Increase public reporting gradually. There have been previous issues with the accuracy of published data. Since MIPS is a new program, **we encourage CMS to be cautious and thoughtful before expanding information included on the physician compare website.**
3) Limit public reporting to composite score and performance category participation. In the proposed rule, CMS proposes to publicly report not only the composite score and performance category of each physician, but also performance on all quality and resource use measures. We have concerns that many of the resource use and ACI measures have not yet been tested. Given MIPS is a new program for both CMS and physicians, we believe CMS should not publicly report physicians' performance on any specific measures within any of the performance categories at this early time. **Instead, AAPM&R recommends that CMS indicate whether a physician satisfied the reporting requirements for each of the performance categories with a green check mark, as it has done previously for the EHR Incentive Program.**

F. Overview of Incentives for Participation in Advanced Alternative Payment Models

4. Advanced APMs

(1) Use of Certified EHR Technology

According to the proposed rule, in the first year, Advanced APMs must require at least 50% of participating clinicians to use certified EHR technology to document and/or communicate clinical care to their patients or other health care providers. **CMS discusses raising the requirement to 75% in year 2, but we recommend that this policy <u>not</u> be adopted. Instead, regulations should keep requirement at 50% unless and until experience indicates it is practical to move to a higher threshold.** CMS should also be open to the possibility that the current EHR requirements may not be the most effective means for implementing the value based payment system and, indeed, may be coming between patients and their physicians. One size does not fit all, and systems that work well for primary care physicians may be useless for certain specialties. Improvements may not be sought as long as everyone is scrambling to meet the current requirements.

There is still too much uncertainty about the value that EHR use adds to the equation – in fact, in the proposed rule, CMS states (on page 28370) that "At present, evidence on EHR benefits in either improving quality of care or reducing health care

costs is mixed…" In addition, there is still a large problem with interoperability, as well as funding issues for smaller practices.

(2) Comparable Quality Measures

Among the requirements for an APM to be considered an Advanced APM, eligible APM entities must tie payments to MIPS-comparable quality measures.

The proposed rule allows for Advanced APMs to choose their own approach to measuring quality, with a requirement to choose at least one quality measure from the various categories of MIPS-comparable quality measures listed in the proposed rule, as well as one outcomes measure if one is available. **AAPM&R recommends some flexibility in letting the model designer also select and/or design the most appropriate outcomes measure. We also recommend increased flexibility be allowed in the design of APMs that incorporate specialty practices.**

(3) Financial Risk for Monetary Loss

MACRA does not require that risk be defined solely in terms of CMS losses. A physician practice will "bear financial risk for monetary losses in excess of a nominal amount" if the cost of participating in the APM or the amount by which the practice's payments could vary represent a large proportion of the practice's revenues, regardless of how large or small the loss is to CMS. Under one-sided shared savings models, physician practices could experience significant financial losses even if CMS saves money. Costs that APM participants incur for APM participation and for delivering APM patients' care that are not paid for directly, such as delivery of care coordination, patient education, and non-face-to-face services that are not billable under the Physician Fee Schedule, as well as staff and systems needed to gather and analyze data for quality and cost reporting and performance improvement, should count as potential losses to the APM. Although the term "APM benchmark" is not defined in the proposed regulations, the requirement that financial risk be linked to the APM benchmark or episode target price means that the risk to which physicians would be subject could be tied to the total costs of care for the patients treated under the APM, and this likely includes inpatient and outpatient hospital, post-acute care, drug and other costs that are beyond physicians' control.

(4) Nominal Amount of Risk

In outlining the principles that formed the basis for the Advanced APM policies in the proposed rule, CMS states that "Our goals…are to expand the opportunities for participation in APMs, maximize participation in current and future Advanced APMs,

create clear and attainable standards for incentives, promote the continued flexibility in the design of APMs, and support multi-payer initiatives across the health care market." While we agree that the standards for incentives should be clear and attainable, the proposed definition of "more than nominal risk" falls far short of meeting this goal.

AAPM&R urges CMS to define "more than nominal financial risk" for all Advanced APMs similar to the currently proposed risk standards for primary care medical homes, which means that for all APMs: (a) the potential loss of guaranteed payments should count as a loss, and (b) the minimum amount of losses needed to be considered "more than nominal" should be tied to a percentage of physician revenues, not a percentage of Medicare expenditures in the APM. It is not appropriate for the regulations to tie nominal risk requirements to the total cost of care for patients as the proposed rule does by linking it to expenditures under the APM. The Regulatory Impact Analysis notes that HHS has long defined "significant" impact as the loss of 3% of physicians' revenue, and the 4% of total expenditures standard proposed in the rule could represent 20% or more of a physician practice's revenue. "More than nominal risk" should be set at a small percentage of the organization's revenue, not APM expenditures, as these include costs beyond physicians' control.

AAPM&R believes the definition of how one meets nominal risk also needs to be simplified and set at a level that is more realistic, appropriate and attainable. With multiple components including total risk, marginal risk and minimum loss rate, it would be difficult for physicians contemplating participation in Advanced APMs to understand their financial risks or know how much to set aside to cover potential repayments.

Most physician offices, especially smaller offices, do not have actuaries to calculate their risk. In addition, many of them do not have the data on which to calculate risk or the IT infrastructure to support it. They also don't have the number of lives under their care to facilitate spreading the risk that one or two patients will have much higher than expected medical issues. Isn't that the point of insurance? Yet, reportedly, many of the insurance companies on the Exchange are experiencing severe losses due to underestimating the risk and setting their premiums accordingly. **We would recommend not requiring return of monies if the APM entity falls short of their anticipated revenues, as calculated by the physicians, for at least the first 2 years. Simply not receiving a bonus should be sufficient incentive for improving the ability to calculate risk and physicians should not be additionally penalized while learning how to work within this new paradigm.**

5. Qualifying APM Participant (QP) and Partial QP Determination
Patient Thresholds and QP Determination

MACRA outlines payment and/or patient count thresholds that physicians participating in Advanced APMs must meet to qualify for the annual 5% lump sum APM payments. We believe that CMS should, in its final rule, set these threshold, no matter by which method they are structured well below the thresholds listed in the proposed rule in order to make participation in an Advanced APM more realistic for a variety of providers**. AAPM&R urges CMS to provide as much flexibility as possible for APM participants to meet thresholds so that they may achieve the participation levels.**

In addition, **we find the number of the lists and requirements to be very confusing and it doesn't seem realistic to think that many physicians will truly understand what is required to receive the Advanced APM bonus**. In order to do so, the physician must become a QP, which entails joining an advanced APM. A regular APM must be one of the following:

- A model under section 1115A (other than a health care innovation award);
- The Shared Savings Program under section 1899;
- A demonstration under section 1866C; or
- A demonstration required by Federal law. The demonstration must meet the following (so this entity has certain additional requirements to be met to qualify as an APM)
    - The demonstration must be compulsory under the statute, not just a provision of statute that gives the agency authority, but one that requires the agency to undertake a demonstration
    - There must be some ''demonstration'' thesis that is being evaluated;
    - The demonstration must require that there are entities participating in the demonstration under an agreement with CMS or under a statute or regulation.

For it to be considered an Advanced APM, it must also meet the following additional 3 criteria:

- The APM must require participants to use certified EHR technology;
- The APM must provide for payment for covered professional services based on quality measures comparable to those in the quality performance category under MIPS

- The APM must either require that participating APM Entities bear risk for monetary losses of a more than nominal amount under the APM, or be a Medical Home Model expanded under section 1115A(c) of the Act.

To be considered a QP, the eligible clinicians in the Advanced APM Entity collectively must have at least a specified percentage of their aggregate Medicare Part B payments for covered professional services, or patients who received covered professional services, through the Advanced APM. The outline of how this is determined is unbelievably complicated – there are 20 separate threshold percentages proposed, depending on which combination of characteristics the APM has. It depends on the year, whether calculation is by payment method or patient count method, and whether the Medicare Option or the All-Payer Combination Option is being used. Once one has figured out which threshold applies, then one needs to determine the threshold score, which can be done in one of four ways, again determined by which characteristics meet the Advanced APM's circumstances There are also multiple caveats and exceptions, such as certain payments not being included under one of the Threshold Scores, different rules for participating in one versus many ACOs, whether the physician will be considered an APM entity as an individual (which is rare) or as part of a group, how to determine the numerator and denominator for assessing the Threshold Score, etc. **We recommend that these threshold determinations be made much simpler and more transparent to the physician.**

AAPM&R recommends that CMS finalize its proposed approach to calculating the percentages of revenues or patients for purposes of making QP or partial QP determinations. For this purpose, CMS proposes a methodology for calculating the ratio of payments for "attributed" patients to payments for "attribution-eligible" patients. As we understand it, this means that for an APM targeting patients with a particular disease, condition or episode, the denominator would be payments for Medicare Part B professional services provided to all the patients seen by participants in the APM entity group with that disease, condition or episode, and the numerator would be Part B professional services payments for all the patients with the disease, condition or episode who were actually attributed to the APM.

CMS should also finalize its proposal to sum an individual physician's participation levels across multiple APM entities to allow the physician to achieve QP or partial QP status even if none of the APM entities in which the physician participates is able to achieve QP status for its participant group as a whole. At least in the early years to assist with transitioning to APMs, CMS should also consider whether it would be possible for a participating medical practice that meets the thresholds to achieve QP status even if its APM entity as a whole falls short.

CMS should finalize its proposal to make determinations of QP and partial QP status for all of participants in an Advanced APM entity group as a whole, instead of making separate determinations for each practice participating in an APM entity. However, we also recommend some consideration be given to allowing the lone qualifying physician under the single ACO to take advantage of the exception set out for physicians who are part of multiple ACOs, none of which meet the pertinent threshold, by qualifying as an individual. This would allow for the benefits of using a collective system in most instances, but giving a physician who can meet the standard on his own, though not through the APM entity, a chance to become a QP.

c. Partial QP Decision to Report to MIPS

The rationale for allowing Partial QPs to decide on whether or not to participate in MIPS would be more equitable if the decision did not have to be made before the physicians who are part of the APM entity even know whether they will be QPs, Partial QPs, or simply remain as eligible clinicians. Otherwise, the value of becoming a Partial QP is blunted – the Partial QP does not know which alternative would be more financially beneficial. **We recommend that a partial QP be allowed to wait for the possible ramification of participating or not participating in MIPS before having to decide.**

7. Combination All-Payer and Medicare Payment Threshold Option
b. Other Payer Advanced APMs Criteria

AAPM&R recommends further clarification on the Other Payer Advanced APM and how it fits with and around the concepts for a Medicare Advanced APM. Since these are, by definition, payers other than Medicare, how does CMS determine what their criteria must be? There seems to be a disconnect between what is stated in the proposed rule and the reality of how this system would work.

Another important point as to the intent of Congress is that the Other Payer APM part of the QP definition also deals with the nominal risk issue but includes a specific requirement that "the eligible professional participates in an entity that…bears more than nominal financial risk if actual aggregate expenditures exceed expected aggregate expenditures." In omitting the actual-to-expected expenditures comparison from the eligible APM entity requirement, Congress provides more discretion for Medicare APMs than it does for the Other Payer APM definition.

(3) Medicaid Medical Home Model

Medicaid patients already have difficulty finding physicians who will accept them as patients due to the low reimbursement. Adding a more than nominal risk factor, does

not make it any more attractive. **We recommend that Medicaid Medical Home Models not be subject to down-side risk unless and until it can be clearly demonstrated that they are capable of caring for patients without any decrease in access or quality under the notoriously limited payment provided by Medicaid in most states.**

APMs for Specialists
The final rule needs to provide more opportunities for specialists who are not primary care physicians to participate in MIPS APMs and Advanced APMs. Based on the APMs listed in Table 32 that would currently qualify as MIPS or Advanced APMs, the only specialist physicians who would have access to an eligible APM are oncologists and nephrologists. The entire MACRA rule appears to be geared towards primary care physicians, yet specialists are still required to somehow fit themselves into one of the new payment parameters. **We recommend that CMS investigate whether the new payment models can truly work for specialists, or whether different rules should apply. Until that has been resolved, we recommend forbearance on imposing downside risk on specialists.**

8. APM Incentive Payment
(4) Treatment of Payments for Services Paid on a Basis Other Than Fee-For-Service

CMS should withdraw its proposal to decide on a case-by-case basis whether to exclude many payments made to physicians that are not traditional Medicare Physician Fee Schedule payments from calculations of the 5% lump sum payments to participants in Advanced APMs. It is completely inappropriate to declare that "financial risk payments" should not count as physician payments for services, since under CMS shared savings models, this is the only way that physicians can be compensated for services delivered that are not directly paid under the fee schedule. These payments are not "incentives," they are compensation contingent on performance. It is also inappropriate to indicate that monthly payments for patient care are merely "cash flow mechanisms," when in most cases, they are flexible payments designed to enable physicians to deliver a range of services, including services that are not directly paid for under the fee schedule. This proposal adds unnecessary complexity and uncertainty to the calculations and could provide a disincentive for physicians who want to transition away from a fee-for-service approach.

10. Physician Focused Payment Model

Under the section in the proposed rule on Payment methodology, CMS says: "Pays APM Entities with a payment methodology designed to achieve the goals of the PFPM Criteria. This section addresses in detail through this methodology how Medicare, and

other payers if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the Physician-Focused Payment Model cannot be tested under current payment methodologies." Since the proposed criteria is not finalized, **we recommend further clarification and perhaps some concrete examples for PFPS, particularly for specialists.** PFPMs should generate a diversity of APMs with multiple designs and approaches.

We appreciate the opportunity to comment on this proposed rule. AAPM&R looks forward to continuing dialogue with CMS on these important issues. If you have any questions about our comments, please contact Beth Radtke, Manager of Quality and Research Initiatives in the AAPM&R Division of Health Policy and Practice Services. She may be reached at bradtke@aapmr.org or at (847)737-6088.

Sincerely,

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