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Via Electronic Submission (www.regulations.gov)

November 17, 2015

Mr. Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
ATTN: CMS–3321—NC
7500 Security Blvd.
Baltimore, MD 21244-8013

Dear Mr. Slavitt:

Re: Request for Information Regarding Implementation of the Merit-based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models, File Code CMS-3321-NC

The Association of American Medical Colleges (AAMC or Association) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's or the Agency's) *Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models and Incentive Payment for Participation in Eligible Alternative Payment Models*, 80 Fed. Reg. 59102 (October 1, 2015). The AAMC is a not-for-profit association representing all 145 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, and 93 academic and professional societies. Through these institutions and organizations, the AAMC represents 148,000 faculty members, 83,000 medical students, and 115,000 resident physicians.

The AAMC appreciates that CMS has given stakeholders an opportunity to provide feedback prior to the initial rulemaking on the extremely complex and challenging task of implementing the new physician payment system required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The program needs to encourage physician-hospital collaboration and should allow as many physicians as possible to be successful. This is essential for the health of the Medicare program and for ensuring that beneficiaries have the access to care that they need. There must be a recognition that the purpose of alternative payment models (APMs) is to innovate and provide team-based care, quality care so that APMs should not be measured against standards that were designed for a siloed, fee-for-service care delivery system. Further, when appropriate, risk adjustments must be incorporated so as not to disadvantage those physicians who are caring for the most complex and vulnerable patients. To achieve these ends, the program needs to allow maximum flexibility for meeting requirements, particularly in the early years as physicians adjust to a radically different payment system.

In the MIPS program CMS should:

- Use an attribution methodology that recognizes that patients of a physician group practice should not be attributed to a single physician in that group as the quality of their care relies on a team-based model.
- Initially, make minimal changes to the current quality programs that will be combined under MIPS and then streamline the program requirements so that the measures are consistent, reflect standards of care, and are minimally burdensome to report.
- As appropriate, risk adjust outcome and resource measures for socioeconomic and demographic status factors.
- Recognize that much of the work routinely done by teaching physicians fulfills the required 15% of clinical practice improvement activities (CPIA) under MIPS.
- Ensure that there is little separation between the measure performance period and the measure payment year. Currently payment adjustments are based upon a performance period that occurred two years earlier, reducing the ability of physicians to benefit from their quality improvement efforts.

In the APM program CMS should:

- Implement flexible requirements around the classification of qualified APM participants, recognize that risk in excess of a nominal amount can be demonstrated in a variety of ways, and adopt measures that create a tenable on-ramp to managing increasing levels of financial risk.
- Acknowledge that the substantial start-up and maintenance costs are "financial risk in excess of a nominal amount."
- Give credit for APM participation to physicians working with their partner teaching hospital in APM risk-based models.
- Enable providers to know whether or not an APM is a qualifying APM with sufficient time to allow those physicians and physician groups in non-qualifying APMs to participate successfully in MIPS.

The Association also asks that as CMS moves toward issuing a proposed rule, the Agency find additional pre-rulemaking opportunities to inform stakeholders of options being considered and allow for feedback.

MERIT BASED INCENTIVE PAYMENTS

MIPS EP IDENTIFIER AND EXCLUSIONS (Sub-Subsection 1)

Q: Should CMS use a MIPS EP's, TIN, NPI or a combination thereof? Should CMS create a distinct MIPS Identifier? What are the advantages/disadvantages?

CMS Should Allow Multiple Options for Assessing Eligibility, Participation, and Performance to Account for the Many Different Practice Models.

Providers should be allowed to select whether they want to be identified by a distinct MIPS identifier, by National Provider Identifier (NPI), by Tax Identification Number (TIN), or by a combination of EP's TIN and NPI. As a strong proponent of group reporting, the AAMC supports the need for a flexible definition of what constitutes a group. The current PQRS and VM policies recognize groups only by TIN. While TIN is a reasonable option to use, the AAMC encourages CMS to make available a range of options, such as use of a distinct MIPS Identifier, to allow related TINs to combine and report as a single group and a subset of physicians within a large TIN to report separately as a group.

With evolving delivery and practice models, it is important for CMS to allow multiple options for identifying providers to assess eligibility, participation and performance under the MIPS program. Some faculty practices have multiple TINs for business or legal reasons but for all other purposes the physicians in the practice are part of the same group and want to be identified for reporting purposes under the same identifier. Use of a MIPS identifier could enable these TINs to be measured as one group practice under the MIPS program. Some groups may all be under a larger TIN and may want to break into sub-specialty components to allow for more accurate and meaningful measurement under the program. A MIPs identifier could be a mechanism for allowing the smaller components under these large TINs to be measured separately from the TIN. The single TIN could attest to CMS that it would like to be measured at a smaller unit level.

Depending on the practice, there are advantages and disadvantages to reporting under a MIPS identification number, an NPI, a TIN, or a combination. Under the MIPS program, the practices should be given the opportunity to assess the advantages and disadvantages and select which option works best. Among the numerous benefits to a group reporting option are that it: 1) focuses an organization's attention on common goals and encourages investment in infrastructure; 2) encourages team-based care; and, 3) reduces administrative burden for larges practices with hundreds or thousands of physicians. For academic medical centers (AMCs) with a very large number of physicians, tracking individual performance can be very difficult.

For smaller practices, individual reporting through use of a combination of NPIs and TINs can be appealing because the performance assessment is applied separately to each provider within a group. Each physician's success or failure does not affect the success or failure of any of the other physicians within the group. Therefore, this option should also remain available.

QUALITY PEFORMANCE CATEGORY (Sub-Subsection 3)

Q: Should CMS maintain all PQRS reporting mechanisms under MIPS? Should CMS maintain the same or similar reporting criteria under MIPS as under the PQRS? What is the appropriate number of measures on which a MIPS EP's performance should be based?

A Period of Stability Is Needed During the Transition into MIPS

As CMS transitions from the current reporting and performance requirements into the new MIPS performance categories, the AAMC requests that the Agency maintains the existing reporting infrastructure and measurement collection criteria for the first year of the MIPS program. Ensuring a "period of stability" will help to minimize confusion among providers while also allowing CMS sufficient time to develop a MIPS program that promotes high-quality and high-value care for physicians.

The Quality Measurement Burden Should be Reduced

The AAMC has serious concerns that the current quality reporting requirements are overly burdensome for individual physicians and group practices. The Association encourages CMS to consider the recommendations included in the Institute of Medicine (IOM)'s April 2015 Vital Signs report on Core Metrics for Health and Health Care Progress. [1] The IOM noted that the "sheer number [of measures], as

[1] Vital Signs: Core Metrics for Health and Health Care Progress. April 2015. Retrieved from: http://iom.nationalacademies.org/~/media/Files/Report%20Files/2015/Vital_Signs/VitalSigns_RB.pdf

well as their lack of focus, consistency, and organization, limits their overall effectiveness in improving performance of the health system." In addition, the IOM cited the "significant burden" on providers to collect and examine this data. CMS should take steps to reduce overall measure burden by creating a streamlined measure set that provides the most value for patients and physicians.

As CMS designs the future MIPS performance categories, we ask that the Agency adopt the following principles to help alleviate provider burden:

- Focus on a limited number of process and outcomes measures that are broad enough to ensure participation among a range of specialties. To accomplish this goal, the Association recommends that CMS work with stakeholders to perform a holistic review of the current measures in the PQRS, VM, and Meaningful Use (MU) programs. The Agency should select those measures for the MIPS that are high-impact due to either significant variation in performance among physicians or because the measures fill a recognized gap.
- Ensure that physicians have time to adapt to new measures. As additional measures are incorporated into the MIPS performance programs, CMS should ensure that individuals and group practices have sufficient time -- a minimum of 18 months -- to implement the necessary infrastructure to capture and test such information before a measure is required under the performance categories.
- Implement a process to remove measures. The Agency should develop a process to routinely identify and remove those quality measures that are either topped-out or no longer adhere to clinical guidelines. The continued collection and submission of such measures is extremely burdensome for physician practices and does not further overall quality improvement efforts.
- Align the required measure set between the quality performance and Meaningful Use categories so that physicians will have the opportunity to meet the requirements of both at the same time.

Q: Should CMS require that reporting mechanisms include the ability to stratify the data by demographic characteristics such as race, ethnicity, and gender?

SES Factors Should Be Included in Outcome Measures

The AAMC strongly believes that outcome measures, where appropriate, should be risk adjusted to account for socioeconomic status (SES) and demographic factors, and should incorporate a beneficiary risk score. CMS should ensure that the measure risk adjustment methodology accounts for both the patient's complexity and for factors for which the physician cannot control, such as lack of adequate housing or limited access to transportation. Examples of potential SES variables could include, but should not be limited to, nine digit zip code, income, education, etc. Failure to consider these factors can cause inaccurate conclusions about quality and performance measurement that would unfairly penalize physicians who treat these patients. Physician scores on quality and cost may be lower due to differences in patient mix rather than the quality of care provided.

While the AAMC appreciates that the National Quality Forum (NQF) and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) currently are studying the inclusion of such an adjustment, a resolution on this critical issue could be far into the future. We urge CMS to adjust for these factors in the interim as evidence continues to mount that when such factors are not accounted for the providers caring for the most challenging patients are the most likely to be penalized.[2]

[2] Michael Barnett, MD, et al. "Patient Characteristics and Differences in Hospital Readmission Rates." JAMA intern Med. 2015;175(11):1803-1812.

Finally, an SES adjustment should not result in undue burden on physician data collection efforts. Any stratification for SES factors should be done at the group level and CMS should ensure that the results of such stratification are statically significant. Lack of adjustment for these factors would lead to inappropriate conclusions about quality and performance measurement and increased disparities in care.

Q: Should CMS maintain the policy that measures cover a specified number of National Quality Strategy domains?

CMS Should Include Core Measure Sets Rather than NQS Domains

As recommended by the IOM in its April 2015 Vital Signs report, the AAMC supports the inclusion of core measure sets to help reduce provider reporting burden. Core measures are high impact metrics that would be required to be reported by all physicians. Core measures sets are intended to help level the playing field by discouraging physicians from exclusively reporting low-value measures. That being said, the AAMC does not believe that the National Quality Strategy (NQS) domains are the right approach for developing a core measure set. Too often, the NQS domains lack a sufficient number of relevant measures for physicians, making achievement of these domains impossible. The AAMC asks CMS to engage stakeholders to determine appropriate core measure sets for the MIPS program.

Q: Instead of requiring that the EHR be utilized to transmit the data, should it be sufficient to use the EHR to capture and/or calculate the quality data? What standards should apply for data capture and transmission?

CMS Should Not Require Electronic Submission of EHR Data

The AAMC believes that a requirement for electronic submission of clinical quality data is premature at this time. The AAMC continues to have serious concerns about the feasibility and validity of electronic measures and urges CMS to take a more stepwise approach in implementing such an expansive and burdensome requirement for the MIPS program. Until physicians and vendors are sufficiently prepared for electronic submission of data, the Agency should allow for the reporting of any Meaningful Use quality measures via attestation.

CMS Should Use Separate Benchmarks for EHR Abstracted Data

The Association supports the creation of separate quality benchmarks for those physicians who choose to submit e-specified measures. Electronic measures often have very different specifications from the same measure using a different reporting mechanism. The AAMC also recommends that CMS model the performance rates by other reporting options, and by individual versus group reporting. Some reporting options allow providers to check the chart for incomplete information. While this performance data is likely the most accurate, it may look very different from other reporting mechanisms in which providers are not allowed to correct inaccurate information. CMS should work to understand the impact the different reporting mechanisms may have on the final quality composite score and determine if further revisions are needed.

Q: How should CMS apply the quality performance category to MIPS EPs that are in specialties that may not have enough measures to meet our defined criteria?

Specialties and Sub-Specialties Need Additional Quality Measures

The current lack of measures for specialties and sub-specialties highlights the fact that more attention must be placed on this issue. Until such measures are developed and implemented, CMS should consider assessing such physicians under appropriate hospital level measures. For example, CMS should enable hospital-based physician specialties to tie their measures to the hospital or hospitals where they work. While the AAMC recognizes that CMS has the Measure Applicability Validation (MAV) process, it is currently too burdensome and rigorous for specialties to attest to additional applicable measures. Alternatively, CMS could create an exemption for those specialties that simply do not have enough measures to meet these requirements.

RESOURCE USE PERFORMANCE CATEGORY (Sub-Subsection 4)

Overarching Comments

In comments to the CY 2016 Physician Fee Schedule (PFS) proposed rule, the AAMC highlighted concerns that certain resource use measures used in the value modifier (VM) unfairly disadvantaged groups that care for complex patients. Moving forward with the MIPS program, the AAMC requests that CMS take the following steps to address these concerns:

- Adjust all resource use measures to account for both clinical conditions and SES factors.
- Hold accountable for resource use the physician who is responsible for managing the patient's care and ensure that the resources used are within his or her control.
- Hold harmless any provider who shows a significant uptick in cost or utilization due to changes in the patient attribution methodology.
- Ensure that the resource use measures are appropriate and reliable both at the individual and group level.

Q: How should CMS consider aligning measures used under the MIPS resource use performance category with resource use based measures used in other parts of the Medicare program? What peer groups or benchmarks should be used when assessing performance?

All Resource Use Measures Should be Appropriately Risk Adjusted; Physicians Should Only Be Held Accountable for those Patients for Whom They Manage Care

Many of the patients cared for by AMCs are poorer, sicker, and more complex patients and therefore typically require higher resource utilization. In order to reasonably compare physicians who treat a range of patients with different case mixes, all resource use measures must be adjusted for both clinical and SES factors, and should incorporate a beneficiary risk score. Adjusting for both types of variables helps ensure a fair comparison among physicians.

The Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQI) are an example of a resource measure that should <u>not</u> be included in MIPS. The PQIs were originally designed to measure ambulatory sensitive conditions at a community level and the rate calculated per 100,000 population. Such a large sample size allows communities to evaluate their primary care system at a macro level. Under the VM, CMS uses these composite measures to compare providers who only need to have a minimum of 20 attributed patients. These measures have not been tested for such a small population and could lead to invalid conclusions for these physicians. The characteristics of the attributed Medicare

patients can also vary widely by physician group practice. This methodology does not allow for an apples to apples comparison. For all of these reasons, CMS should not consider the inclusion of these indicators in the MIPS program. CMS should invest time and resources to determine a fair and equitable resource use measures and appropriate method of attribution.

Physicians Who are Adversely Affected by Unanticipated Attribution Changes Should be Held Harmless for One Performance Year

Any change to a patient attribution methodology may significantly affect how a physician is assessed under a resource use measure. For example, under the VM, a tweak to the attribution methodology could result in a physician being labeled "high cost" when previously the physician was placed into the "average cost" category. For the MIPS program, we ask that CMS hold harmless any provider who is adversely affected by unanticipated attribution changes for one year.

CLINICAL PRACTICE IMPROVEMENT ACTIVITIES PERFORMANCE CATEGORY (Sub-Subsection 5)

Q: What other potential clinical practice improvement activities, subcategories of activities), and criteria should be applied as clinical practice improvement activities?

CMS Should Recognize that Teaching Physicians and Others Regularly Engage in Clinical Practice Improvement Activities and Should Receive Full Credit for their Efforts

The AAMC acknowledges that various subcategories of CPIAs outlined in the RFI are consistent with those in the legislation. However, that list is not meant to be an exclusive list. CMS should recognize that, faculty physicians regularly engage in many types of activities that should also be counted as CPIAs under MACRA. Examples include:

- Training medical students and residents. Faculty physicians are responsible for ensuring that the trainees acquire clinical knowledge and special skills in their respective disciplines while adhering to the highest standards of quality and safety in the delivery of care. This involves providing appropriate supervision during training, evaluating performance, providing feedback, and documenting achievement and competencies. Faculty physicians regularly also work with medical students and residents on quality improvement projects. Preparing future physicians to meet patient's expectations and to provide optimal care requires that they learn in a clinical setting that epitomizes the highest standard of medical practice. Faculty physicians continue to develop innovative methods to achieve these goals and should receive credit for these activities which are essential to our health care system.
- Participation in research. Physicians at academic medical centers regularly engage in research funded by the National Institutes of Health and other federal agencies, the results of which are intended to improve health and health outcomes of patients.
- Maintenance of Certification which ensures that a physician participates in certain continuous learning and education activities.
- Participation in a CMMI grant that is designed to improve quality in the delivery of care. For example, the AAMC is working with 5 AMCs to implement a new model of care delivery and technology that allows primary care providers to receive timely, electronic consultations from specialist colleagues through the CMMI Health Care Innovation Award's grant. The purpose is to

improve quality of care through better coordination and timely access to specialty input, while reducing the costs of care by fewer referrals and reduced fragmentation of care.

- Collection of data on patient experience through the use of surveys, such as the CG-CAHPS survey. These surveys provide actionable feedback to physicians that can inform their actions and contribute to high quality care in every day practice.
- Physicians who use telehealth and other innovative technologies to effectively manage the care of their patients. As payment shifts to innovative, valued based payment methods, telehealth is a valuable tool for providers to improve the quality of care. Telehealth can improve care, access, cost and quality, ad help with care coordination and prevention.

As CMS considers what constitutes CPIA, it is important to give credit to the practices that are actively involved in care improvement. For example, a teaching hospital may be the awardee of a BPCI contract but the faculty physicians are responsible for redesigning the patient care under the initiative an effort that should be considered as a CPIA. We recommend that the Agency develop a process by which practices could apply for recognition for their innovations in practice improvement by describing and documenting what they have done. This will allow CMS to understand and disseminate information about these activities.

One option is for CMS to create a "collaborator" category for CPIAs, similar to the proposal in the Comprehensive Care for Joint Replacement (CCJR) proposed rule which defines a collaborator as "directly furnishing related items or services to a CCJR beneficiary during the episode and/or specifically participate in CCJR model LEJR episode care redesign activities". For CCJR, CMS recognizes "physician group practices" among the entities that qualify as collaborators. CMS could establish a similar option for APMs.

Q: What mechanisms should be used for the Secretary to receive data related to clinical practice improvement activities?

AAMC recommends that initially physicians should attest to CMS that they have met the required CPIA activity. This attestation could occur through a registration system, a Web portal, or another mechanism. CMS should be flexible in the modes of communication of this attestation and should ensure that the submission of this information is not overly burdensome.

Q: What information should be reported and what quality checks and or data validation should occur to ensure successful completion of these activities?

The practices could report the CPIAs by briefly describing what they have done and the results of their efforts. The amount of detail required for submission to CMS should not be extensive.

Q: What threshold or quantity of activities should be established under the clinical practice improvement activities performance category?

The AAMC urges the Agency to be broad and flexible about setting thresholds or establishing a quantity of activities under the CPIA category. Some types of clinical improvement activities are extensive and involve a large commitment of resources and time. Other types of activities may be less extensive and physicians may be able to engage in several of these. Relying solely on hours spent would be burdensome and is not related to actual improvement in clinical care. CMS should consider a variety of factors, such

as innovation, investment in infrastructure, addressing the needs of the community and population, and improvements in care that result from the CPIA.

MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY PERFORMANCE CATEGORY (Sub-Subsection 6)

Q: Should the performance score for this category be based solely on full achievement of meaningful use?

Meaningful Use Performance Should Be Measured at the Group level and Should be Tiered.

The AAMC opposes the use of an all-or-nothing scoring methodology for the Meaningful Use Performance Category. The Association strongly believes that there should be an option to measure performance for this category at the group or individual level and that achievement scoring should be tiered. For example, as long as a certain percentage of physicians within a group practice have met the requirements for the MU program, they should receive a corresponding number of points.

OTHER MEASURES (Sub-Subsection 7)

Q: What types of measures (that is, process, outcomes, populations, etc.) used for other payment systems should be included for the quality and resource use performance categories under the MIPS?

There Should Be A Limited Measure set that focuses on process and outcomes measures

As stated earlier, the AAMC asks CMS to focus on a limited number of high-impact process and outcomes measures that are broad enough to ensure participation among a range of specialties. To accomplish this goal, the Association recommends that CMS work with stakeholders to perform a holistic review of the current measures in the PQRS, VM, and MU programs and only include those measures in the MIPS that meet current clinical guidelines and where there is significant variation among physicians. As additional measures are incorporated into the MIPS performance programs, CMS should ensure that individuals and group practices have sufficient time – a minimum of 18 months - to implement the necessary infrastructure to capture and test such information before a measure is required under the performance categories.

Q: How could we leverage measures that are used under the Hospital Inpatient Quality Reporting Program, the Hospital Value-Based Purchasing Program, or other quality reporting or incentive payment programs?

Hospital level measures may be appropriate for hospital-based specialties and sub-specialties that do not have sufficient volume to report physician level measures. For a physician that is not hospital based, hospital level measures should not be transplanted into the MIPS program until they are specified and tested at the physician level.

DEVELOPMENT OF PERFORMANCE STANDARDS (Sub-Subsection 8)

Q: Should CMS use the same approach for assessing improvement as is used for the Hospital Value-Based Purchasing Program? What are the advantages and disadvantages of this approach?

The MIPS Performance Scoring Methodology Should be Modeled After the Hospital VBP Program Framework with Appropriate Changes to Better Align with Physicians

The Hospital VBP Program has an established and reliable process for evaluating attainment and improvement scores and AAMC believes that this framework should be considered for the MIPS program. That being said, the AAMC continues to have concerns with some limitations in the VBP methodology which CMS should be cognizant of when designing the MIPS program criteria. For example, the resource use measure in the VBP program, Medicare Spending Per Beneficiary (MSPB), is a ratio that compares a hospital's spending compared to national spending, which makes it very difficult to "move the needle." Performance on MSPB is tightly clustered around the mean, making it difficult to obtain achievement points. Lastly, direct comparison of physician improvement and achievement performance periods may be difficult. It will take significantly longer for individual physicians and small group practices – compared to large group practices - to obtain sufficient patient volume in order to achieve reliable results. While there is much we can learn from the conceptual framework, the VBP program should not be directly transplanted onto the MIPS program.

Q: How should CMS define improvement and the opportunity for continued improvement?

For purposes of defining improvement, the AAMC recommends that physicians be measured against their own historical performance.

Q: Should CMS consider improvement at the measure level, performance category level (that is, quality, clinical practice improvement activity, resource use, and meaningful use of certified EHR technology), or at the composite performance score level?

The AAMC believes that improvement should be assessed at the category or composite level, but not at the measure level.

Q: Should improvements in health equity and the reductions of health disparities be considered in the definition of improvement? If so, how should CMS incorporate health equity into the formula?

Improvements in health equity and reductions in health disparities should be considered in the definition of improvement. NQF will be convening a panel to develop disparity-centric metrics. In the meantime it is important that each physician or physician group be measured against baseline data on inequities for their own patient population and that they are rewarded for diminution in inequities of their own patients as a result of their interventions.

Q: Should CMS use the Achievable Benchmark of Care (ABC) methodology to publicly report an item-level benchmark derived on Physician Compare?

The ABC Benchmarking Methodology Should Not Be Used to Publicly Report Physician Data

The AAMC recognizes that in the Final CY 2016 Medicare Fee Schedule Rule (80 Fed Reg 41812), CMS finalized the use of the ABC methodology. While the AAMC supports initiatives to make quality performance transparent to patients, the AAMC reiterates from our comments to the proposed CY 2016 Medicare PFS comment letter, that CMS should not utilize the proposed CY 2016 ABC methodology. The ABC methodology is not well understood by physicians, nor has it been sufficiently tested in a national program with a wide range of reporting options. Before using this methodology for MIPS, CMS should conduct more thorough analyses to ensure that this methodology addresses factors such as risk adjustments, variation in reporting mechanisms and programs, and patient complexities.

FLEXIBILITY IN WEIGHTING PERFORMANCE CATEGORIES (Sub-Section 9)

Q: Are there situations where certain EPs could not be assessed at all for purposes of a particular performance category?

The four performance category weights should be flexible enough to account for those specialists that may not be able to appropriately report on all categories. The performance scoring should not be an all or nothing approach. Physicians should have the flexibility to meet a reasonable percent of performance category requirements and still receive full credit.

FEEDBACK REPORTS (Sub-Subsection 12)

Overarching Comment

Feedback reports aim to provide performance measurement and improvement goals for physicians and other health professionals. More specifically, Quality and Resource Use Reports (QRURs) communicate objective information about performance captured through such indicators as clinical process, clinical outcome, patient experience, and resource use measures, with the broad aim of facilitating assessments and improving delivery of care. The AAMC values the feedback QRURs provide and encourages CMS to continue to provide QRURs. However, the accuracy, completeness, and timeliness of the data is critical particularly if physicians are to rely on the presented data as indicators of their need for quality improvement[3] and future payment amounts. Therefore, CMS needs to improve efforts in providing timely and accurate information.

Q: With what frequency is it beneficial for an EP to receive feedback?

Mid-Year, Supplementary, and Annual QRURs Should Be Provided but Further Guidance Is Needed on how to Best Utilize the Feedback Data

The AAMC appreciates that CMS released Mid-Year QRURs along with Supplementary data as an effort to provide timely, accurate, and actionable information to help providers understand and improve the quality and efficiency of care but CMS needs to better guide the stakeholder community on how to more effectively use the data from QRURs. Although, mid-year QRURs offer useful information for providers to gauge how they are currently performing, the reports use data from the previous performance year and is not indicative of a provider's Value Modifier payment adjustment for the following year. The

[3] ***http://www.ahrq.gov/sites/default/files/publications/files/privfeedbackgdrpt.pdf***

AAMC understands that due to time constraints CMS is unable to use the relevant performance year's data and solely relies on claims data to present the information in the Mid-Year QRURs. However, it is unclear how providers can use this information to implement changes. At a minimum, the AAMC urges CMS to provide QRURs on a quarterly basis, just as CMS does for ACOs. The AAMC encourages CMS to develop material to educate providers on how to utilize the presented data, including the Mid-year QRURs, Annual QRURs, and Supplementary data. Additionally, CMS should provide the Annual QRURs at an earlier timeframe allowing organizations to have an adequate amount of time to prepare and implement changes to improve performance for the following year.

Q: What types of information should CMS provide to EPs about their practice's performance within the feedback reports?

Feedback Reports Should Provide Information on All Areas That Are Used to Measure Physician or Practice Performance

Starting 2019, providers will receive a composite performance score determined using four performance categories: quality, resource use, CPIAs, and meaningful use of certified EHR technology (CEHRT). Providers should receive feedback on all areas on which they are being measured. CMS must be transparent about how a particular area is being evaluated, including the benchmarks, and the patient population being used to determine the provider's performance. Each physician must be provided with his/her score for each category under MIPS. It is important to ensure that physicians understand how they are performing in comparison to others, areas in which they need to improve, and where they should maintain a strong performance. Additionally, CMS should administer innovative, interactive approaches allowing clinicians to meet and discuss improvement opportunities and challenges with their peers.

Physicians Should Receive Feedback Information in an Understandable and Transparent Manner.

The AAMC appreciates CMS's efforts in hosting webinars to thoroughly educate stakeholders on accessibility and content related information for QRURs. Other information such as data errors, missing information, and assessment methodologies should be communicated more transparently. Ensuring that information is conveyed in an effective manner will aim to reduce the number of unnecessary reviews being requested and ensure that clinical efforts are cost effective and appropriately applied. Additionally, CMS should address data errors both retroactively and prospectively. While it is helpful that the stakeholders are made aware that there were errors in the submitted data, steps should be taken to correct them and to ensure that providers are not adversely affected by mistakes made by the Agency.

The AAMC has provided specific comments based on the AAMC's members concerns to date with QRURs. The Association recommends that CMS address these concerns if the Agency plans to continue providing feedback through QRURs. In the past, physicians have experienced missing information in certain QRUR exhibits. It is unclear what the reasons were (e.g., due to reporting error, missing data or being an average performer) and whether the missing information affected the payment adjustment amount. Another problem occurred when the 2014 Annual QRURs were released and CMS excluded the PREV-5 measure due to technical error. However, providers were not aware of this exclusion and misinterpreted the missing measure as a CMS error. Therefore, AAMC encourages more transparent communication to minimize confusion, alleviate administrative burden, and avoid misinterpretation of missing data.

While CMS is transparent in the benchmarking methodology for QRURs, the AAMC strongly encourages CMS to ensure that data is appropriately compared to account for variation in multispecialty TINs. Currently the benchmarks being used to calculate the quality and cost measures in the QRURs are the case-weighted average performance rates within peer groups. Peer groups is defined as all groups and solo practitioners nationwide that have at least 20 eligible cases for the measure.[4] However, there is no clear distinction between how the cases are accounted for by specialties. Nearly 50% of AMCs' faculty practice organization structure consists of multi-specialty group practices[5] and AAMC's members have continued to question how specialty variability in TINs factor into the benchmarking methodology. Other factors to consider when performing apples-to-apples comparison include: data sources (e.g. claims vs. EHRs) and TIN sizes (a group of 20 physicians should be compared to another group of 20 physicians).

As a part of the Agency's improvement efforts in publicly reporting some of the QRURs' content, CMS needs to develop a process that effectively and efficiently allows group practice managers to review and correct information concerning the group practice on Physician Compare. The AAMC continues to hear of circumstances in which either the group information is incorrect or the wrong providers are affiliated with the group. Currently, correcting information is an awkward process and it may take weeks before the information is refreshed on the website. The AAMC would be happy to work with CMS to develop a more streamlined process.

PUBLIC REPORTING (Sub-Subsection 11)

The AAMC supports public reporting that has a clear purpose, is transparent, and is valid,[6] and supports CMS's continued efforts to improve public reporting. As CMS considers making changes to public reporting (e.g., Physician Compare website) CMS needs to be mindful of all the reporting options for physicians under MIPS. For example, if a group of physicians report under one TIN then data should be presented in a way that highlights the score as a group rather than an individual physician; a similar methodology should be applied if a MIPS identifier is created.

Q: Should CMS include individual EP and group practice-level quality measures stratified by race, ethnicity, and gender in public reporting (if statistically appropriate)?

It is important to stratify by race, ethnicity and gender but that is not sufficient. The only way to identify disparities is to expand stratification to include socio-economic status which is a large driver of health inequities. In addition, stratification should include both sexual orientation and English proficiency.

[4] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2014-QRUR-FAQs.pdf
[5] Handbook of Academic Medicine: How Medical Schools and Teaching Hospitals Work (3rd Edition)
[6] https://www.aamc.org/download/370236/data/guidingprinciplesforpublicreporting.pdf

ALTERNATIVE PAYMENT MODELS

Overarching Comment

The MACRA creates strong incentives for the rapid adoption of APMs. In order to opt out of MIPS and be recognized as a "qualifying APM participant", an eligible professional (EP) must meet certain thresholds, with 25% of Medicare patients or payments being covered by an APM in 2019 and 2020. This amount is set to increase to 75% in APMs in 2023 and beyond. The desire to shift Medicare reimbursement from volume to value must be balanced with the need to provide EPs with the time required to successfully implemented payment and delivery system changes.

The AAMC strongly supports increasing the efficiency and quality of care delivery, and serves as a facilitator convener for 27 AMCs the in Bundled Payments for Care Improvement (BPCI) initiative. Furthermore, AMCs are leaders in delivery reform, with many participating in CMMI programs and commercial APMs. These experiences largely inform the content of this letter. AAMC urges CMS to implement flexible requirements around the classification of qualified APM participants and to adopt measures that create a tenable on-ramp to managing increasing levels of financial risk.

Q: How should CMS define "services furnished under this part through an EAPM"?

CMS should define "services furnished under this part through an EAPM" as Medicare Part B services only.

Q: What types of information should be used to meet the non-Medicare share of the combination all-payer and Medicare payment threshold?

CMS should work with both EPs and private payers to determine the types of data that should be submitted and to ensure that submission of this data will be done in a secure manner and will not be overly burdensome. It may be preferable for this data to be submitted by payers, with an opportunity for EPs to review and confirm that payer data is consistent with their data.

Q: How Should Revenue and Patients Be Counted to Reach the APM Threshold?

Patients Should Be Counted At Either the Individual Provider or Group Level

For the purposes of identifying qualified eligible professionals (QPs), CMS should give physicians and physician group practices the option to measure Medicare revenue at an individual provider or practice level. This flexibility is especially important for multi-specialty groups given that some types of providers offer more or fewer services depending on the clinical conditions of their patients. CMS should incentivize care delivered by the full spectrum of providers as needed, and recognize that in some settings, a single provider or specialty will be contributing to the care of the patient, and in other settings, multiple physicians and support teams will be required. Thus, flexibility is essential both in classifying qualifying APM providers and in attributing revenue to EPs.

When assessing provider participation, CMS should consider the many types of contractual obligations that exist in healthcare today and implement policies that reflect that diversity. For example, many AMCs and their partner physicians participate in BPCI, including sharing significant risk, in a model which should meet the APM eligibility criteria under MACRA. The AAMC recommends that physicians working with their partner teaching hospital in APM risk-based models should receive credit for APM participation. The physician practices are at risk because the finances of academic center entities are interdependent, with the success of one being closely tied to the success of the whole. To recognize these relationships, the AAMC recommends the creation of a "collaborator" category, similar to what was proposed in the CCJR proposed regulation. To determine the non-Medicare share of the all payer threshold, CMS should recognize many types of relationships and models as being EAPMs and the payment under those models should be counted towards the APM threshold. CMS should not set a specific target. Whether or not a physician is used for attribution purposes, the revenue and patients of all physicians participating in an APM and caring for covered patients should be counted towards the threshold.

Q: How should CMS define "use" of certified EHR technology?

Initially, CMS should rely on attestation by the APM that certified EHR technology is being used.

Q: What criteria should CMS use for assessing physician focused payment models?

The AAMC supports the American Medical Association (AMA) in their comments below regarding assessing physician focused payment models (PFPM) as APMs.

- It is critical that the MACRA regulations establish a clear pathway for models to be proposed to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and for those models that are recommended by the PTAC to HHS to be implemented by CMS as qualified APMs.
- CMS has stated that it has no obligation to test models that are recommended by the PTAC. We strongly disagree with this is extremely narrow perspective. For MACRA to succeed in reforming the delivery of care and improving value for patients and the Medicare Trust Funds, CMS must be willing to give serious consideration to proposed PFPMs that come through the PTAC and support their implementation.
- Within the MACRA law, establishment of the PTAC is under the title, "Promoting Alternative Payment Models." The PTAC subsection's purpose is stated as "increasing transparency of physician-focused payment models." This legislative language makes it clear that Congress intended for PFPMs to provide an alternative, more transparent avenue for the development of qualified APMs than the existing CMS process. It did not intend for PTAC-recommended models to receive comments from CMS and never be implemented.
- The forthcoming regulations should establish an easy pathway for PFPM proposals to be adopted as qualified APMs. CMS should clearly outline the criteria that will be used to evaluate PFPM proposals. CMS and the PTAC should work collaboratively with medical societies and other organizations developing proposals, provide feedback on drafts, and provide data up-front to help in modeling impacts.
- The regulations should also make it clear that PFPMs that are recommended by the PTAC will be accepted by CMS. Although it is reasonable to have a more advanced application phase to work out the implementation details, stakeholders should not have to go through an separate proposal

process to first have their proposed PFPMs adopted by the PTAC and then to have them accepted by CMS. HHS needs to organize a reasonable process that will allow it to get good ideas for PFPMs from specialty societies and other organizations, ensure that they meet criteria that are known up-front to those preparing proposals, and then provide pathways for implementation that will allow participating physicians to earn MACRA incentive payments.

Q: What is the appropriate type of financial risk in excess of a nominal amount?

There Should Be a Range of Financial Risk that Varies with Levels of Experience in Managing Risk

The definition of "more than nominal financial risk" should be broad and provide an on-ramp for providers to accept and manage additional risk. CMS and other payers are in the process of conducting the critical work of fine-tuning and evaluating risk-based payment models to produce models in which providers' financial performance is more heavily predicated on their care interventions, rather than factors outside of their control, such as insufficiently risk-adjusted targets. CMMI's investment in the design of multiple APM demonstration projects makes it clear that risk-based models must allow for diversity in approach. As many of the models currently are under evaluation, the AAMC urges CMS to adopt definitions that will, to the extent reasonable, encourage a large and varied number of eligible APMs under MACRA.

In October 2015, the Health Care Payment Learning and Action Network (HCPLAN) published a white paper seeking to create a common classification of APMs, which assigned payment models to four categories based on the extent to which the model shifts risk from payers to providers. Using this categorization, AAMC recommends that at a minimum, during the first several years of MACRA implementation, all up-side only models in Category 3 and 4 should be considered to fit the definition of eligible APMs. CMS should only consider introducing more restrictive definitions of financial risk once APMs are more firmly established as care delivery models. Given the early evolution of demonstrations nationally, all two-sided risk models also should be considered as qualified APMs.

Do Not Use A Specific Dollar or Percent Risk to Define an EAPM.

All APMs with any down-side risk, required savings or discounts, or significant up-front investment should be considered as EAPMs. AAMC discourages CMS from defining a specific dollar or percent risk that all EAPMs must meet. By limiting types of EAPMs, CMS could actually prolong the evolution to value based payment.

Significant Upfront Investments in an APM Should Count as Financial Risk

Many of the costs incurred by providers to participate in APMs are not reimbursable by Medicare. The Agency should establish criteria that recognize the significant financial investments associated with the implementation and infrastructure support of APMs, as there is substantial financial risk that such costs will never be recouped. For example, according to a survey by the National Association of ACOs (NAACOS), the average first year start-up costs of an ACO are $2.0 million, while the ongoing operating costs are $1.5 million. CMS estimates the first year costs to be $1.8 million.

The criteria for these models should be based on an evaluation of non-billable costs associated with transitioning from a fee-for-service to a population health approach, such as:

- Losses in revenues or reductions in profit margins by preventing or avoiding the use of billable services, using alternative services that generate lower margins, or accepting a discounted payment from CMS.
- One-time initial capital investment costs for new equipment or systems.
- Ongoing human resource costs to train existing staff on new models and hiring additional staff that are not directly reimbursed (e.g. care managers).
- Obtaining loans or issuing bonds in order to form an Alternative Payment Entity or deliver services under an APM that would require repayment regardless of the success of the Alternative Payment Entity.
- Contributing equity capital to form an Alternative Payment Entity or to support the costs of delivering services under an APM that would be lost if the Alternative Payment Entity were not successful.
- Models that require savings such as CCJR and models that require quality metric thresholds.

Most Medicare APMs have started with shared-savings only and transition to risk once providers have experience in the model. The aim of the criteria should be to incentivize the increased adoption of risk over time for all types of providers.

CMS should recognize that even in an upside-only risk models a portion of physician compensation is at risk. For instance, under BPCI gain-sharing arrangements a physician's total potential compensation is equal to a contractual amount plus a gain-sharing cap, or 50% of Part B payments attributable to BPCI beneficiaries. If a physician fails to contribute to savings and meet certain quality metrics, the physician cannot receive his or her total potential compensation. As such, a portion of compensation is at more than nominal risk based on a combination of care delivery and financial metrics. This level of risk should qualify under MACRA.
AAMC believes that CMS should explore the American Medical Association's recommendation that including price warranties should be considered an appropriate type of financial risk.

Q: What criteria could be considered when determining "comparability" to MIPS of quality measures used to identify an EAPM entity?

"Comparability" should be broadly interpreted and quality measures should align with APM models

The AAMC urges CMS to allow for maximum flexibility in how quality is measured for APMs. "Comparable" should not be defined as "the same." APMs are newer and more innovative models of care. It is important that APM quality measures are consistent with this new way of delivering care. Quality in an APM may involve reductions in cost, increases in efficiency, and improved outcomes. Additionally, measures used to assess quality in an APM should ideally be reviewed by stakeholders, tested, and continuously evaluated to ensure that the quality metrics are meaningful to both the patients and providers. Finally, as noted by the AMA, quality measure reporting for an APM should be no more burdensome than under MIPS. There should be a focus on harmonizing measures so that there are not different ways to measure the same thing that must be used for MIPS vs. APMs, and Medicare vs. other payers.

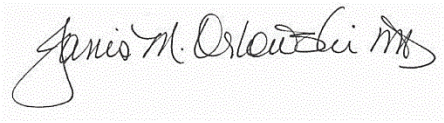
Additional Comment Regarding APMs

As CMS develops new APMs, and approves physician-focused payment models under MIPs, it should recognize that a characteristic of all APMs is that the risks are shared by many entities and individuals. Since APMs promote team care, the success under this delivery model calls for an evaluation of the entire

range of care. In addition, AAMC encourages the Agency to explore whether condition-based bundles, under which a bundle is defined by the patient's condition, rather than by the particular service the patient receives as fitting into the definition of an APM. Such a model would incentivize the broader management of chronic conditions and place greater emphasis on preventive care.

If you have additional questions on MIPS, contact Ivy Baer, ibaer@aamc.org; for additional questions about APMs contact Coleen Kivlahan, ckivlahan@aamc.org. Both Ivy and Coleen also may be reached at 202-828-0499.

Sincerely,



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