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November 17, 2015

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3321-NC
P.O. Box 8016,
Baltimore, MD 21244-8016

Submitted Electronically

Re: CMS-3321-NC; 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

Dear Administrator Slavitt,

On behalf of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), representing over 4,000 neurosurgeons in the United States, we appreciate the opportunity to provide feedback in response to the above referenced Request for Information (RFI). The AANS and CNS applaud the end of Medicare payment updates based on the flawed Sustainable Growth Rate (SGR) formula and look forward to the opportunity to work with CMS to more thoughtfully pursue payment and care delivery models that meaningfully evaluate physician quality and appropriately incentivize higher value care. As a first step, we appreciate CMS' decision to use this RFI to gather preliminary feedback from the public and strongly urge the agency to maintain an ongoing working relationship with the stakeholders who will be most directly impacted by the policies authorized under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

Below are some overarching principles that we believe are critical to the success of MACRA implementation:

Gradual, thoughtful implementation will be key to success. The Physician Quality Reporting System (PQRS), the Electronic Health Record (EHR) Incentive Program, and the Value-Based Payment Modifier were all well-intentioned programs, but implemented via strategies that were flawed on many levels. As a result, these programs became unnecessarily burdensome and resulted in largely meaningless data. We acknowledge the time constraints under which CMS is operating, particularly if the 2019 payment update is conditioned on a performance year of CY 2017. However, given the breadth and detail of the provisions that need to be addressed udner MACRA, we urge CMS to proceed cautiously. While MIPS presents an important opportunity to reinvent the wheel and fix things that are not working in current quality reporting programs, the initial transition to this new system needs to be as seamless and as undisruptive to clinical practice as possible. This will include maintaining certain elements of current programs that physicians find suitable and are familiar with, while also testing alternative strategies that allow physicians to demonstrate value in more innovative ways.

- **Flexibility will ensure meaningful engagement**. When developing MIPS and APM policies, it is critical that CMS take a flexible, rather than prescriptive, approach. This will help to not only ease the transition to these new systems, but to foster innovation, trust, and ultimately widespread

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stakeholder engagement among acute care surgical specialties such as ours. We also request that CMS give individual physicians who practice in larger groups or systems more autonomy over the selection of the most appropriate measures and participation strategies.

- **Investment in measure gaps must occur expeditiously**. For many specialties, the most significant barrier to meaningful participation in current programs is an ongoing lack of relevant quality and cost measures. CMS must quickly allocate MACRA-authorized funding to working closely with specialties to close these measure gaps. As part of this effort, CMS must accelerate the development of more specific episode-based cost measures to replace the severely flawed set of cost measures now used to calculate the Value-Based Payment Modifier (VM).
- **Meaningful use must be redefined**. Current strategies for incentivizing meaningful use of EHRs are impractical and unsustainable. Going forward, meaningful use mandates must NOT rely on all-or-nothing, pass-fail strategies, and instead account for varying practice circumstances and varying levels of physician control over EHR choice and functionalities. We also believe that neither MIPS nor APMs can succeed without a more strongly enforced national mandate for true and widespread interoperability between EHRs and between EHRs and registries.
- **Continue to promote the value of clinical data registries**. We strongly support CMS' investment and promotion of qualified clinical data registries (QCDRs) to date, and request that the agency continue to recognize the value of clinical data and encourage investments in the production of more robust data through such mechanisms.
- **CMS must monitor the regulatory burden of these new programs**. Over both the short and long term, it is critical that CMS carefully monitor the regulatory burden of these new policies on practicing physicians to ensure that compliance does not breed frustration, "meaningless" engagement, or otherwise interfere with direct patient care.

Beyond these overarching principles, **please see our detailed responses to the specific questions posed in the RFI**, which are in the attached comprehensive chart. As CMS continues to implement these complicated policies, we urge the agency to keep in mind the Congressional intent of MACRA, which was to consolidate and streamline the confusing web of federal quality reporting mandates and incentivize meaningful investments in innovative, individualized APMs.

Once again, the AANS and CNS appreciate the opportunity to provide this initial feedback, and we look forward to providing more detailed input on MACRA implementation through future rulemaking and other communications with the agency. In the meantime, if you have any questions or need additional information, please feel free to contact us.

Sincerely,

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CMS Request for Information (RFI)
Implementation of the MIPS, Promotion of APMs, and Incentive Payments for Participation in Eligible APMs

Program	Category/Criteria	Question	Response
MIPS	Eligible Professional (EP) Identifiers	Should CMS use a MIPS EP's TIN, NPI, or a combination thereof?	There are pros and cons to TIN and NPI level reporting/analyses. TINs are easier administratively, but also minimize the autonomy of individuals. On the other hand, the more granular the identifier (i.e., use of NPIs), the easier it is to understand who is actually contributing to each aspect of care. CMS must keep in mind that TINs are established for billing/business purposes. There is nothing about a TIN that consistently reflects care or high quality care- it's simply a billing system. Physicians should be allowed to align based on care decisions and treatment processes, not based on a billing entity. Another problem with the current system is that if a group participates using its TIN, every member of the group is in regardless of their desire or knowledge. Physicians in larger groups may not know whether their group is participating in PQRS and never even see the data. CMS should carefully think about: 1) The limitations of relying on an identifier, such as the TIN, that was developed for billing purposes and is not necessarily the most appropriate mechanism for assessing/capturing quality. 2) The fact that the identifier used to capture reporting/performance might need to be distinct from the identifier used to make performance-based payments

			3) The need to balance administrative simplicity with a physician's freedom to select the level of analysis that he feels is most appropriate for this practice. 4) The fact that the overarching goal should be to encourage activities and measurement that results in higher quality care rather than reporting simply to avoid a penalty.
MIPS	Eligible Professional (EP) Identifiers	What are the advantages/disadvantages associated with using existing identifiers either individually or in combination?	While not necessarily ideal, In the early stages of MIPS, using existing identifiers will avoid yet another layer of administrative complexity and all the problems that are associated with unique identifiers (e.g., registration for the IACS). At some point in the future CMS might want to consider the advantages of using a unique MIPS ID that better captures quality, but in the near term, this would only add to the confusion and administrative complexity.
MIPS	Eligible Professional (EP) Identifiers	What are the advantages/disadvantages associated with creating a distinct MIPS identifier?	The NPI is more specific to individual providers. The TIN lacks specificity in that it is applicable to multiple providers, but also minimizes problems with insufficient sample sizes.
MIPS	Eligible Professional (EP) Identifiers	Should a different identifier be used to reflect eligibility, participation, or performance as a group practice vs. an individual MIPS EP? If so, should CMS use an existing identifier or create a distinct identifier?	No comment at this time.
MIPS	Eligible Professional (EP) Identifiers	How should CMS calculate performance for MIPS EPs that practice under multiple tax ID numbers (TINs)?	Physicians should have the choice to decide the entity (ies) that they want to be associated with in regards to MIPS. This choice might even have to extend to the multiple categories of MIPS. For example, a physician might want to align with one TIN for quality and resource use measurements, but another TIN when it comes to demonstrating MU or CPIAs. Again, CMS must consider an individual EP's freedom to designate (or not participate) under the group's MIPS election. For many EPs, there are more relevant reporting options than the larger group's election. For instance, many large groups participate under the Group Practice Reporting Option (GPRO) web-interface, but a

			specialist may want to participate and report through a QCDR that is much more relevant to their patient population and site-of-service.
MIPS	Eligible Professional (EP) Identifiers	How often should CMS require an EP or group practice to update identifier(s) in PECOS (the Medicare enrollment system)? Should EPs be required to update their information in PECOS or a similar system that would pertain to MIPS on an annual basis?	Clinicians already spend too much time completing administrative tasks and not enough face-to-face time with their patients. Simplicity is key. CMS should not require physicians to update PECOS anymore than once a year, but should also give physicians the option to make updates at any time, if the physician deems it necessary. CMS should also strive to account for any changes made to PECOS in as real-time as possible in order to ensure the accuracy of analyses and accountability.
MIPS	Eligible Professional (EP) Identifiers	Where a provider is in a "split TIN" (i.e. if Medicare uses the TIN as the MIPS identifier and a portion of that TIN is exempt from MIPS due to being part of a qualifying APM), what safeguards should be in place to ensure that CMS is appropriately assessing MIPS EPs and exempting only those EPs that are not eligible for MIPS?	No comment at this time.
MIPS	Eligible Professional (EP) Identifiers	In situations where a MIPS EP could be assessed using multiple identifiers (e.g. under current PQRS assessment where an EP is assessed under each distinct NPI/TIN combination), what safeguards should be in place to ensure that MIPS EPs do not switch identifiers if they are considered "poor performing"? What safeguards should be in place to address any unintended consequences if the chosen identifier is a unique TIN/NPI combination to ensure an appropriate assessment of the MIPS EPs performance?	Before energy is wasted on trying to figure out the best safeguard, CMS should first evaluate to what extent this has been a problem in the past.
MIPS	Virtual Groups	The virtual group option under the MIPS allows a group's performance to be tied together even if the EPs in the group do not share the same TIN. How should eligibility, participation, and performance be assessed under the MIPS for voluntary virtual groups? Assuming that some, but not all, members of a TIN could elect to join a virtual group, how should remaining members of the TIN be treated under the MIPS if CMS allows TINs to split? Should there be a maximum or minimum size for virtual groups? (E.g. a	Since the overall goal is higher quality care, CMS should develop minimum standards to ensure that the members of a virtual group are caring for a common population, are responsible for decisions that could impact the group as a whole, or otherwise have a mutual interest in quality improvement. The uniting feature might be as broad as a common specialty (with a specialty-sponsored registry being the source of data), a clinical service line, or a geographic

		minimum of 10 MIPS EPs or no more than 100 MIPS EPs that can elect to be in a given virtual group?) Should there be a limit placed on the number of virtual group elections that can be made for a particular performance period for a year as this provision is rolled out? (CMS is considering limiting the number of voluntary virtual groups to no more than 100 for the first year this provision is implemented in order for CMS to gain experience with this new reporting Configuration). Are there other criteria CMS should consider? Should CMS limit for virtual groups the mechanisms by which data can be reported under the quality performance category to specific methods (e.g. QCDRs or utilizing the web interface)? If a limit is placed on the number of virtual group elections within a performance period, should this be done on a first-come, first served basis? What type of information should be required in order to make the election for a performance period for a year? What other requirements would be appropriate for the voluntary virtual group election process? Should there be limitations, such as that MIPS EPs electing a virtual group must be located within a specific 50 mile radius or within close proximity of each other and be part of the same specialty?	area. But there does need to be a minimum standard to ensure that virtual groups do not result in arbitrary alignments aimed simply at maximizing payment incentives or otherwise gaming the system. At the same time, CMS should not limit the number or size of virtual groups, adopt prescriptive geographic standards, or limit the reporting mechanisms available to these groups, so long as they are able to satisfy the minimum criteria. Such limitations would be arbitrary, would ignore the unique and diverse needs of virtual groups, and could impede collaborations that might benefit from this option. Since virtual groups might cross settings, geographic regions, specialties and patient populations (including those with varying degrees of risk), it is also critical that all of these factors are accounted for when measuring the performance of such groups. Recognizing the unique nature and composition of each virtual group, we also recommend that CMS not pit virtual groups against each other when measuring performance, and instead look at annual self-improvement (at least initially).
MIPS	**Quality**: Reporting Mechanisms & Criteria	Should CMS maintain all PQRS reporting mechanisms currently available for 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? Should CMS maintain the policy that measures cover a specified number of National Quality Strategy domains?	While MIPS presents an important opportunity to reinvent the wheel and fix things that are not working in current quality reporting programs, we also believe that the initial transition to this new system needs to be as seamless and as undisruptive to clinical practice as possible. As such, we urge CMS to, at a minimum, maintain all of the current PQRS reporting mechanisms to ensure flexibility for physicians with different needs, keeping in mind that there is still a lot that needs to be improved, both in regards to the measures and reporting structure of PQRS. At the same time, we ask that CMS reconsider the 9

			measures, including a cross-cutting measure, across 3 domains requirement. We feel this is an arbitrary standard that more often than not results in reporting for the sake of reporting and subsequent data that is of little value. Although MIPS aims to streamline reporting, it also includes an additional layer of reporting that is not present today (i.e., CPIAs). When evaluating whether it is appropriate to maintain the 9 measure reporting requirement, CMS should take into account this added reporting burden, as well as the fact that some or all of the activities captured though it might be more meaningful and accurate representations of quality than the current set of PQRS quality metrics. While organized neurosurgery supports the goal of identifying national strategy domains, including the need to ensure a balanced scorecard for quality, it is sometimes challenging to fit measures into these discrete boxes. This has been evidenced by the multiple re-categorizations of measures each year. We also feel that by adding the new category of CPIAs, CMS will inherently target a wider array of quality interventions that satisfy the goals of multiple domains. As such, we recommend that CMS consider doing away with the domain requirement and instead use domains to simply guide measure selection. If this is not possible, CMS should, at the very least, allow certain measures that do not discretely fit into any one domain to be assigned to multiple domains to give physicians more flexibility to satisfy the 3 domain requirement. Also, CMS' process of assigning domains has historically occurred within a black box. We urge CMS to give relevant stakeholders an opportunity to provide input into these determinations before domains are presented in proposed rules.
MIPS	**Quality**: Reporting Mechanisms & Criteria	What policies should be in place for determining which data should be used to calculate a MIPS EP's quality score if data are received via multiple methods of submission? What considerations should be made	While we don't have a specific solution for how to tackle this problem, a physician should not be allowed to report the same measure for the same patient across

		to ensure a patient's data is not counted multiple times? (E.g., if the same measure is reported through different reporting mechanisms, the same patient could be reported multiple times).	multiple mechanisms. However, there may be a need for a physician to report independent measures through multiple mechanisms and for those measures, in total, to count toward satisfying the quality measure reporting requirement. For example, an EP might identify a handful of clinically relevant and e-specified measures that can be reported through an EHR, but also might identify a few other relevant measures that are not yet e-specified and can only be reported through a registry. CMS should recognize the reporting of measures across multiple reporting mechanisms in order to promote meaningful engagement and to encourage EPs to experiment with different options.
MIPS	**Quality**: Reporting Mechanisms & Criteria	Should CMS require that certain types of measures be reported? (E.g, should a minimum number of measures be outcomes-based? Should more weight be assigned to outcomes-based measures)?	While we very much support the value and importance of outcome measures, especially in regards to surgery, we also recognize that certain types of measures might be more appropriate for certain specialties and practice settings than others. Process measures that are evidenced based can be integral to improved outcomes and in some specialties, this foundational step must first be addressed before you can move on to outcomes. As such, CMS should maintain flexibility by not requiring the use of any specific type of measure. Doing so would assume that individual physicians can wield sufficient influence on which measures are developed and available to meet the needs of their patient population. It would not be appropriate to hold physicians accountable for something that is not necessarily within their direct control. There are also many infrastructure challenges that may prevent the development or incorporation of appropriate outcome measures into CMS programs, which must be accounted for. However, to promote the evolution of measurement, we do agree that at some point in the future it might be appropriate to consider assigning more weight to outcomes or other measures that require more complex methodologies and/or hold physicians

			accountable for more than simply a process of care. This should not be done until methodologies are more fine-tuned and widely accessible and applicable, including incorporation of risk adjustments and attribution methods. Fine-tuning these methodologies will require require technical and financial assistance from CMS. Infrastructure challenges may also prevent measure developers from developing outcome measures. These can involve problems with capturing patient reported or experience of care measures in the EHR as well as interoperability issues that interfere with the exchange of needed information, and the inability to do longitudinal tracking due to the lack of uniform patient identifiers. All of these factors must be accounted for and addressed before CMS should require the use of any particular measure.
MIPS	**Quality**: Reporting Mechanisms & Criteria	Should CMS require that reporting mechanisms include the ability to stratify the data by demographic characteristics such as race, ethnicity, and gender?	Stratifying data by these factors is important to ensure quality and access to care is balanced among diverse patient populations. Documentation of these factors will result in more accurate measurements and more precise accounting for risk and other factors that might influence performance. At the same time, CMS must keep in mind the additional burden this could pose to the physician in terms of reporting and to the entities collecting this data (e.g., QCDRs). Part of ensuring that entities, such as QCDRs, can easily gather this data might include CMS providing QCDRs with open access to its claims data.
MIPS	**Quality**: Reporting Mechanisms & Criteria	For the CAHPS for PQRS reporting option specifically, should this still be considered as part of the quality performance category or as part of the **clinical practice improvement activities** performance category?	We believe that patient experience and satisfaction should not be categorized as quality metrics given their subjective nature, the fact that they are often not directly under the control of the physician (e.g., physician wait times in a hospital setting), and not necessarily true indicators of quality (e.g., the spine

			surgeon who tells a patient to lose weight and stop smoking or who limits pain medications might be providing clinically indicated care, but might receive a low "performance" score from the patient). Even recommendations against a surgical intervention have been shown to negatively impact patient satisfaction scores in patients with spinal disorders. We fully recognize the need to evaluate and ensure high standards in regards to patient experience. However, we believe that holding physicians accountable for patient satisfaction measures can have the unintended consequence of incentivizing bad medicine and discouraging clinically- and cost-effective strategies. We would support CMS recognizing a wide range of patient satisfaction surveys and other tools under the Clinical Practice Improvement Activities category. Also, physicians should not be held accountable for the actual results of patient experience surveys due to their subjective nature. Instead, physicians should attest to administering a survey and receiving confidential feedback.
MIPS	**Quality**: Reporting Mechanisms & Criteria	What considerations should be made as CMS further implements CAHPS for all practice sizes? How can CMS leverage existing CAHPS reporting by physician groups?	No comment at this time.
MIPS	**Quality**: Reporting Mechanisms & Criteria	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?	In these cases, CMS should use its authority to re-adjust the weights of the other MIPS categories. However, we strongly caution against automatically adding weight to the Meaningful Use or Resource Use categories since these categories have been historically challenging for physicians in regards to relevancy. Since the CPIA category provides the most flexibility for physicians to receive recognition for QI activities that are most relevant to their practice, and because this category is already given the least amount of weight, we believe it would be most appropriate to recalibrate this category. Alternatively, CMS could allow specialties to select

			which other category(ies) they would like to count more for members of their specialty. We recommend that CMS customize the performance requirements for those EPs and work with the affected specialty and the related specialty society(ies) to set requirements that are appropriate for the unique nature of that particular specialty. Rather than taking a one-size-fits-all approach as it has with the current MU program, CMS must consider the varying practice patterns of specialties and sub-specialties, as well as the site-of-service in which a physician practices.
MIPS	**Quality**: Reporting Mechanisms & Criteria	Should CMS maintain a Measure-Applicability Verification (MAV) Process?	We support maintaining the MAV process so long as CMS maintains the process it employs today where triggers (i.e., clinical clusters) are clear and appropriately targeted. Broader, more cross-cutting measures (e.g, smoking cessation) must not trigger an audit since they could potentially be reported by any physician. It is also critical that the MAV cluster development process be more transparent. We urge CMS to create a mechanism whereby specialty societies may review and comment on the MAV algorithm to ensure that eligible professionals are not inappropriately targeted and unfairly penalized. Specialty societies are best equipped to determine which measures are most relevant to specialists. Currently, these decisions are made by CMS largely in a black box.
MIPS	**Quality**: Reporting Mechanisms & Criteria	If CMS customizes the performance requirements for certain types of MIPS EPs, how should CMS go about identifying the MIPS EPs to whom specific requirements apply?	No comment at this time other than what was already stated about working with specialty societies.
MIPS	**Quality**: Reporting Mechanisms & Criteria	What are the potential barriers to successfully meeting the MIPS quality performance category?	The biggest remaining barrier is an insufficient set of relevant measures to choose from. While QCDRs have allowed for the development of more diverse measures, this reporting mechanism is not yet accessible to everyone. CMS must continue to address measurement gaps and to improve the existing set of measures. We reiterate our concern that CMS has not yet allocated MACRA-authorized funding toward this effort. We also remind CMS of the importance of ensuring that measure

			development is evidence-based and clinician-led. We also reiterate our concern about arbitrarily high reporting thresholds (e.g. 9 measures across 3 NQS domains) that force physicians to report on measures that are marginally relevant to their practice simply for the sake of reporting.
MIPS	**Quality**: Data Accuracy	What should CMS require in terms of testing of the qualified registry, QCDR, or direct EHR product, or EHR data submission vendor product? How can testing be enhanced to improve data integrity?	See comments below.
MIPS	**Quality**: Data Accuracy	Should registries and qualified clinical data registries be required to submit data to CMS using certain standards, such as the Quality Reporting Document Architecture (QRDA) standard, which certified EHRs are required to support?	No comment at this time.
MIPS	**Quality**: Data Accuracy	Should CMS require that qualified registries, QCDRs, and HIT systems undergo review and qualification by CMS to ensure that CMS' form and manner are met? (E.g., CMS uses a specific file format for qualified registry reporting. The current version is available at: https://www.qualitynet.org/imageserver/pqrs/registry2015/index.htm. What should be involved in the testing to ensure CMS' form and manner requirements are met?	One problem with the current file format is that the standardized, one-form-fits-all does not always translate seamlessly for each QCDR. When developing forms for data submission it is critical that CMS work with registries to ensure that CMS can accept formats which allow registries to demonstrate unique features of their data, such as embedded risk adjustment. Since it require substantial effort by each QCDR to ensure its file transmissions meet the form and manner of CMS specifications, it would be beneficial for a QCDR to know at the start that its file format is accurate. To accomplish this, CMS could provide specifications and access to the testing portal to QCDRs for testing within a reasonable time period and prior to the CMS approval date (currently May). During that time, QCDRs should be able to test data for validity, as well as for data format.
MIPS	**Quality**: Data Accuracy	What feedback from CMS during testing would be beneficial to stakeholders?	It would be helpful for CMS to inform stakeholders of calculation errors and anything that does not comply with specifications, such as zero rates. In advance of, or concurrent with, updates to quality measures, CMS should clearly identify a timeline when testing tools will be available and at what point the

			version will be "static." Suggested milestones should be made available so that health IT vendors can incorporate measure testing into their product's timeline.
MIPS	**Quality**: Data Accuracy	What thresholds for data integrity should CMS have in place for accuracy, completeness, and reliability of the data? (E.g, if a QCDR's calculated performance rate does not equate to the distinct performance values, such as the numerator exceeding the value of the denominator, should CMS re-calculate the data based on the numerator and denominator values provided?)	The overall goal of CMS should be to collect as accurate data as possible and not be punitive to the EPs for inadequacies of the QCDR and EHR and/or CMS' process. Therefore, we recommend that these types of issues around accuracy, completeness, and reliability should be validated during testing. However, it may not always be possible to validate a calculation rate for things such as continuous variables. Asking for calculated rate and elements provides a second order check, so it is important to have both.
	Quality: Data Accuracy	Should CMS not require MIPS EPs to submit a calculated performance rate (and instead have CMS calculate all rates)?	
MIPS	**Quality**: Data Accuracy	If a QCDR omits data elements that make validation of the reported data infeasible, should the data be discarded? What threshold of errors in submitted data should be acceptable?	If a vendor is found incapable of submitting accurate data, then EPs who used that vendor should be held harmless from any penalties. CMS must also recognize that there may be instances where the problem may reside with CMS and not just the vendor, such as a vendor not submitting complete information because CMS failed to provide necessary and/or timely information. In these instances, CMS should also hold physicians harmless from any penalties. We also urge CMS to consider developing a fair process or methodology to deal with future situations where the physician makes the good faith effort to comply, but the data is deemed invalid and unreliable. For example, why should physicians who received high performance scores in the past, be labeled as "average" just because a CMS error prevented them from having a valid report in the current year?
MIPS	**Quality**: Data Accuracy	If CMS determines that the MIPS EP (individual EP or as part of a group practice or virtual group) has used a data reporting mechanism that does not meet CMS data integrity standards, how should CMS	Data integrity is critical and should be enforced. However, we believe there should be an initial probationary period where the entity is given the

		assess the MIPS EP when calculating their quality performance category score? Should there be any consequences for the qualified registry, QCDR or EHR vendor in order to correct future practices? Should the qualified registry, QCDR or EHR vendor be disqualified or unable to participate in future performance periods? What consequences should there be for MIPS EPs?	opportunity to correct identified issues. Immediate disqualification could adversely affect entities, such as a QCDR, that, because of lack of experience or an unintentional error, failed to meet data integrity standards. Immediate disqualification would also adversely impact the physicians who rely on these entities to satisfy federal quality reporting mandates. Again, these physicians should not be penalized for signing up with an entity that purported to offer reliable services.
MIPS	**Quality:** Use of CEHRT[1]	Under the MIPS, what should constitute use of CEHRT for purposes of reporting quality data?	We support the current policy of allowing physicians to report quality measures through certified EHR systems to fulfill the clinical quality measure component of Meaningful Use. **We also recommend that QCDR reporting count towards satisfying MU requirements**.
MIPS	**Quality:** Use of CEHRT	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?	Yes, especially since we have not yet resolved the many obstacles related to transmission of data across EHRs and between EHRs and registries.
MIPS	**Resource Use**[2]	Apart from the cost measures currently utilized as part of the Physician Value Based Payment Modifier,[3] are there additional cost or resource use measures (such as measures associated with services that are potentially harmful or over-used, including those identified by the Choosing Wisely initiative) that should be considered? If so, what data sources would be required to calculate the measures?	Neurosurgery has long voiced concern about the measures and methodologies currently used to calculate cost composite scores under the VM. It is absolutely critical that CMS stop using these meaningless measures and accelerate efforts to develop more specific episode-based cost measures. More focused measures would help to alleviate many of the challenges that currently plague resource use measurement, including how to accurately and meaningfully attribute a physician to their specific role in treating the beneficiary. Current measures hold physicians accountable for a range of decisions and related expenditures that are beyond an individual physician's control (e.g. when a hospitalist orders a CT scan). While we support efforts to encourage more team-based coordinated care, physicians must feel that they are engaged and capable of contributing. This cannot be accomplished by holding physicians accountable for things that they cannot directly impact. We urge CMS to invest more heavily in and speed up

the development of its existing work on episode-based cost measures. However, even with more focused episode-based cost measures, CMS must carefully develop, test and apply better risk adjustment mechanisms to account for the multiple factors that could affect the cost of care for a patient. These factors may include: number of comorbidities, social determinants of health, non-modifiable risk factors, detrimental health behaviors, and the intensity of services relative to the needs of the patient.

Surgeons should not be penalized for taking care of the sickest patients. Resource use measures also need to better account for less overt things that contribute to the overall value of care, such as return to work. Similarly, upfront investments in care (e.g., surgery, medical devices) might accrue long-term savings in regards to better outcomes and avoided costs elsewhere in the health system.

Finally, a major problem with the current VM program is its flawed definition of value. The cost measures that CMS uses to calculate value have absolutely nothing to do with what CMS is measuring on the quality side, which results in a flawed value equation. Ultimately, appropriateness of care (which accounts for both quality and spending) should be the goal, rather than measuring raw cost data in isolation.

Congress understood that the VM methodology is seriously flawed, which is why this category is worth only 10 points initially. We agree with that decision. We also agree with the MACRA's authors that improving the current episode-based measures and attribution process are critical to a fair and successful MIPS program and look forward to offering additional input as CMS complies with this mandate. CMS needs to devote significant data analysis and resources to this effort in order to ***replace,*** not ***expand,*** the current VM cost measures.

MIPS	**Resource Use**	How should CMS apply the resource use category to MIPS EPs for whom there may not be applicable resource use measures?	See earlier comments about re-calibrating the weights of the categories.
MIPS	**Resource Use**	What role should episode-based costs play in calculating resource use and/or providing feedback reports to MIPS EPs (under section 1848(q)(12) of the Act)?	See above. There is certainly an urgent need for episode-based cost measurement. Transparency and physician involvement in the development of these measures and the accompanying methodological decisions are critical. Furthermore, these measures should replace, not supplement, the current set of broad and flawed cost measures.
MIPS	**Resource Use**	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?	No comments at this time.
MIPS	**Resource Use**	How should we incorporate Part D drug costs into MIPS? How should this be measured and calculated?	No comments at this time.
MIPS	**Resource Use**	What peer groups or benchmarks should be used when assessing performance under the resource use performance category?	We support current adjustments that take into account the specialty mix of the group to ensure more accurate comparisons. However, more work is needed. Due to the diversity of physician practices even within the same specialty, making accurate comparisons of their performance will require far more detailed delineation—of specialty, sub-specialty, area(s) of expertise and/or site(s) of practice—than is currently conducted by either Medicare or private payers. Since resource use measurement is complicated by multiple factors and some providers are already at an advantage in regards to care efficiencies, we recommend giving providers the option of being benchmarked against themselves (i.e., self-improvement) or against their peers. This will allow those at various stages of readiness to demonstrate their commitment to value in a way that is most appropriate for their practice.
MIPS	**Resource Use**	CMS has received stakeholder feedback encouraging us to align resource use measures with clinical quality measures. How could the MIPS methodology, which includes domains for clinical quality and resource use, be designed to achieve such alignment?	The domains will not necessarily help to achieve this alignment. The underlying measures are what need improvement.
MIPS	**Clinical Practice Improvement Activities (CPIA)[4]:** Proposed Additional Subcategories	*Promoting Health Equity and Continuity*, including (a) serving Medicaid beneficiaries, including individuals dually eligible for Medicaid and Medicare, (b) accepting new Medicaid beneficiaries, (c) participating in the network of plans in the Federally-facilitated Marketplace or state	In general, organized neurosurgery believes that the CPIA category is a great opportunity for the MIPS program to encourage ongoing quality improvement and education efforts by all EPs.

	exchanges, and (d) maintaining adequate equipment and other accommodations (for example, wheelchair access, accessible exam tables, lifts, scales, etc.) to provide comprehensive care for patients with disabilities. *Social and Community Involvement*, such as measuring completed referrals to community and social services or evidence of partnerships and collaboration with the community and social services. *Achieving Health Equity* (as its own category or as a multiplier where the achievement of high quality in traditional areas is rewarded at a more favorable rate for EPs that achieve high quality for underserved populations, including persons with behavioral health conditions, racial and ethnic minorities, sexual and gender minorities, people with disabilities, and people living in rural areas, and people in HPSAs). *Emergency preparedness and response*, such as measuring EP participation in the Medical Reserve Corps, measuring registration in the Emergency System for Advance Registration of Volunteer Health Professionals, measuring relevant reserve and active duty military EP activities, and measuring EP volunteer participation in humanitarian medical relief work. *Integration of primary care and behavioral health*, such as measuring or evaluating such practices as: co-location of behavioral health and primary care services; shared/integrated behavioral health and primary care records; cross-training of EPs;	CMS should allow for the broadest interpretation of CPI activities possible. Physicians and other EPs should have the freedom to choose the CPI activities that are most beneficial and appropriate for their type of practice and patient population, regardless of subcategory domain. Subcategories should only serve as a guide for defining CPI activities. No category should be mandatory Physicians and other eligible professionals should be given credit for CPI activities in which they are currently engaged, including those that are mandated or encouraged by Medicare and other government programs. In general, CMS should give deference to specialty-specific CPI activities as proposed by national medical specialty societies and Boards. While these additional proposed categories may be appropriate for certain providers, they are largely relevant to primary care providers and those providing chronic care. Organized neurosurgery would like to see additional categories that are more relevant to acute care providers. We urge CMS to recognize a more diverse set of activities under the CPIA category. Some specific activities that neurosurgery would like to see recognized are: • Participation in a Qualified Clinical Data Registry and in registries run by other government agencies such as FDA or private entities such as a hospital, or medical specialty. • Serving on-call to the hospital emergency department. • Attending and participating as faculty in ACCME-accredited events (e.g., the AANS and/or CNS Annual Meetings, and other CME

			offerings). • Maintenance of certification (MOC) and other continuing medical education activities. • Fellowship or other advanced clinical training completed within a certain window of a performance year. • Physician practice accreditation, such as accreditation achieved by the National Committee on Quality Assurance (NQCA) or other recognized accreditation organizations. • Engagement in private quality improvement initiatives, such as those sponsored by health plans and health insurers. • Consulting evidence-based clinical practice guidelines or contributing to the development of such guidelines. • Use of patient experience surveys (not limited to CAHPS)
MIPS	**CPIAs:** Data Collection	Should EPs be required to attest directly to CMS through a registration system, web portal or other means that they have met the required activities and to specify which activities on the list they have met? Or alternatively, should qualified registries, QCDRs, EHRs, or other HIT systems be able to transmit results of the activities to CMS?	We strongly recommend that CMS adopt a clinical improvement activity attestation process that is as simple as possible and which occurs annually. This could be achieved through a web portal that is simple and easy to use. Transmission of CPI activity results also should be permitted but not required through EHRs and QCDRs, when and where the capabilities exist.
MIPS	**CPIAs:** Data Collection	What information should be reported and what quality checks and/or data validation should occur to ensure successful completion of these activities?	The physician or other eligible professional should be responsible for documenting CPI activities. Organizations and other entities that sponsor CPI activities should be required to maintain records for up to a certain period of time that can be used to verify physician or other eligible professional participation in a CPI activity.
MIPS	**CPIAs:** Data Collection	How often providers should report or attest that they have met the required activities?	Attestation should occur annually, however, some CPI activities (e.g., a certification) may be granted by the certifying organization for more than a one-year

			period. In such cases, EPs should be allowed to attest to that activity for each of the years until the certification's expiration. After the initial year, the physician or other eligible professional should not have to demonstrate anything additional in subsequent attestations until the certification expires unless additional actions are required by certifying organization
MIPS	**CPIAs:** Performance Assessment	What threshold or quantity of activities should be established under the clinical practice improvement activities performance category? • Should performance in this category be based on completion of a specific number of clinical practice improvement activities, or, for some categories, a specific number of hours? • If so, what is the minimum number of activities or hours that should be completed? • How many activities or hours would be needed to earn the maximum possible score for the clinical practice improvement activities in each performance subcategory? • Should the threshold or quantity of activities increase over time? • Should performance in this category be based on demonstrated availability of specific functions and capabilities?	CPI activity performance should be based on completion *or ongoing participation* in a specified number of clinical improvement activities rather than hours. Recognized CPI activities should include those in which an individual EP can participate or complete, as well as activities in which participation or completion occurs at the group practice level. At least initially, all CPI activities should weighted equally.
MIPS	**CPIAs:** Performance Assessment	How should the various subcategories be weighted? Should each subcategory have equal weight, or should certain subcategories be weighted more than others?	Again, all CPI activities, regardless of subcategories, should be weighted equally while experience with the program is gained. Providers also should not be required to attest to a CPIA in every subcategory and should be able to pick and choose from among categories.
MIPS	**CPIAs:** Performance Assessment	How should CMS define the subcategory of **participation in an APM**?	This must not be limited to "qualified" APMs, as defined under MACRA. Instead, it should allow for more flexibility and not have such stringent rules about levels of risk and revenue shares since this would only give EPs credit for a small portion of MIPS. Also, CMS should recognize both CMS and private payer models.
MIPS	**CPIAs:** Small Practices in Rural Areas and HPSAs	How should the clinical practice improvement activities performance category be applied to EPs practicing in these types of small practices or rural areas?	By allowing for the broadest definition of CPIs and maximum flexibility for EPs to select those that are most relevant to their practice type.
MIPS	**CPIAs:** Small Practices in Rural Areas and HPSAs	Should a lower performance threshold or different measures be established that will better allow those EPs to reach the payment	No comments at this time.

		threshold?	
MIPS	**CPIAs:** Small Practices in Rural Areas and HPSAs	What methods should be leveraged to appropriately identify these practices?	No comments at this time.
MIPS	**CPIAs:** Small Practices in Rural Areas and HPSAs	What best practices should be considered to develop flexible and adaptable clinical practice improvement activities based on the needs of the community and its population?	No comments at this time.
MIPS	**Meaningful Use**[5]	Should the performance score for this category be based solely on full achievement of meaningful use? (For example, an EP might receive full credit (e.g., 100 percent of the allotted 25 percentage points of the composite performance score) under this performance category for meeting or exceeding the thresholds of all meaningful use objectives and measures; however, failing to meet or exceed all objectives and measures would result in the EP receiving no credit (e.g., zero percent of the allotted 25 percentage points of the composite performance score) for this performance category).	The existing program's all-or-nothing scoring approach make it challenging for many physicians by assuming that every measure is absolutely appropriate and of equal value to every practice situation. Physicians have encountered substantial difficulty trying to comply with Stage 2, and it is expected that the vast majority will not achieve "full" compliance with Stage 3 either. Therefore, we strongly urge CMS to **NOT continue to rely on its all-or-nothing approach to compliance and instead give physicians <u>partial credit</u> that reflects their unique efforts and ability to satisfy the MU objectives**. This is increasingly important as CMS raises the bar on objectives and measures, but also consolidates the choice of objectives/measures. As noted earlier, the AANS/CNS also recommend that if MU continues with a structure similar to today that a physician who reports quality measures to a QCDR should automatically satisfy the clinical quality measures (CQM) portion of Meaningful Use. Given that there are significant interoperability issues in the current MU program, CMS also must ensure that EHR systems address these challenges and resolve basic cornerstones necessary for data exchange, such as patient matching, provider directories, standards, and privacy and security. Well-documented issues with certain measures, such as sharing summaries of care, must be resolved before physicians are held accountable for these actions. CMS also should focus on increasing the functional interoperability between vendors and among vendors and registries to ensure MU is a program that improves healthcare, and not another unnecessary regulatory

			burden on providers. Finally, meaningful Use should reduce data blocking to ensure that EHR vendors are sharing data with each other and are also sharing it with the registries.
MIPS	**Meaningful Use**	Should CMS use a tiered methodology for determining levels of achievement in this performance category that would allow EPs to receive a higher or lower score based on their performance relative to the thresholds established in the Medicare EHR Incentive program's meaningful use objectives and measures? (For example, an EP who scores significantly higher than the threshold and higher than their peer group might receive a higher score than the median performer.) How should such a methodology be developed? Should scoring in this category be based on an EP's under- or over performance relative to the required thresholds of the objectives and measures or should the scoring methodology of this category be based on an EP's performance relative to the performance of his or her peers?	As stated above, performance should account for the physician's ability to attest to and meet the reporting thresholds of each individual objective/measure, while also taking into account any exclusions and exemptions so that physicians are not penalized for measures that they inherently cannot satisfy. We do not believe that peer-to-peer performance comparisons are appropriate for the MU program. There is currently huge variation in the applicability of the objectives/measures to different providers and practice settings and it would be not only unfair, but methodologically challenging to conduct peer-to-peer comparisons.
MIPS	**Meaningful Use**	What alternate methodologies should CMS consider for this performance category?	CMS should collaborate with national specialty societies to develop health IT-enabled alternatives or pilots that could be optionally used to satisfy the MU component of the composite score. Physicians should be able to satisfy an alternative pathway that could be comprised of elements of MU, such as clinical data registry participation, data security/HIPAA checks and updates, and implementing clinical decision support functionality. In addition, those looking to move to alternative payment models could pilot alternatives to the MU program that assist in moving to new payment and delivery models. CMS could also implement additional health IT-enabled activities outside the scope of the current MU requirements such as imaging data-sharing, structured reporting, enabling electronic orders, etc. The ONC could readily establish health IT certification criteria for other IT functionality that supports these alternative actions. However, CMS and ONC would need to work closely with the national specialty societies to

			appropriately plan and implement these alternative pathways.
MIPS	**Meaningful Use**	How should hardship exemptions be treated?	We support maintaining the current hardship exemptions and request that CMS continue to add to the current list, as appropriate. CMS should also provide more targeted guidance on the specific circumstances that could apply under each exemption in order to give physicians more assurance about their ability to rely on such exemptions. **Overall, providers who are attempting to attest to Meaningful Use should not be penalized for actions they cannot control. CMS should ensure that each measure required for Meaningful Use is one that providers are able to attest to without relying on the actions of other individuals (patients, technology, or other providers).**
MIPS	"Other Measures": Measures from Other Medicare Payment Systems (**Quality** or **Resource Use**)	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?	Need a mix of all types of measures—even structure measures play a role in promoting quality on the local level.
MIPS	"Other Measures": Measures from Other Medicare Payment Systems (**Quality** or **Resource Use**)	How could CMS 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? How should CMS attribute the performance on the measures that are used under other quality reporting or value-based purchasing programs to the EP?	Where appropriate, CMS should give physicians the option to elect to be measured based on hospital or other facility-level performance as a surrogate for physician-level performance. It is critical that this decision remain in the control of the physician given the implications for payment and public reporting.
MIPS	"Other Measures": Measures from Other Medicare Payment Systems (**Quality** or **Resource Use**)	To which types of EPs should these be applied? Should this option be available to all EPs or only to those EPs who have limited measure options under the quality and resource use performance categories?	No comments at this time.
MIPS	"Other Measures": Measures from Other Medicare Payment Systems (**Quality** or **Resource Use**)	How should CMS link an EP to a facility in order to use measures from other payment systems? (For example, should the EP be allowed to elect to be analyzed based on the performance on measures for the facility of his or her choosing? If not, what criteria should CMS use to attribute a facility's performance on a given measure to the EP or group practice?)	No comments at this time.
MIPS	"Other Measures": Global Population-based Measures	What types of global and population-based measures should be included under MIPS? How should CMS define these types of	No comments at this time.

	(**Quality**)	measures?	
MIPS	"Other Measures": Global Population-based Measures (**Quality**)	What data sources are available, and what mechanisms exist to collect data on these types of measures?	No comments at this time.
MIPS	EPs: Non-Face to Face Practices[6]	How should CMS define the professional types that typically do not have face-to-face interactions with patients?	No comments at this time.
MIPS	EPs: Non-Face to Face Practices	What criteria should CMS use to identify these types of EPs?	No comments at this time.
MIPS	EPs: Non-Face to Face Practices	Should CMS base this designation on their specialty codes in PECOS, use encounter codes that are billed to Medicare, or use an alternate criterion?	No comments at this time.
MIPS	EPs: Non-Face to Face Practices	How should CMS apply the four MIPS performance categories to non-patient-facing EPs?	No comments at this time.
MIPS	EPs: Non-Face to Face Practices	What types of measures and/or clinical practice improvement activities (new or from other payments systems) would be appropriate for these EPs?	No comments at this time.
MIPS	**Performance Standards**[7]: Historical Performance	Which specific historical performance standards should be used? • For example, for the quality and resource use performance categories, how should CMS select quality and cost benchmarks? • Should CMS use providers' historical quality and cost performance benchmarks and/or thresholds from the most recent year feasible prior to the commencement of MIPS? • Should performance standards be stratified by group size or other criteria? • Should CMS use a model similar to the performance standards established under the VM?	We take issue with the apparent assumption that CMS will continue to base payment adjustments upon a performance period that occurred two years earlier. This forces the agency to truncate development of policies and hinders timely modifications in the program. It also means that physicians have little or no idea of what Medicare is judging them on. We strongly urge CMS to make every effort to reduce the gap between the performance period and the payment year. Physicians and groups need to know who they are being compared to, what their thresholds are, and what precisely they are working toward. We urge CMS to prioritize outreach and education to empower providers and groups to operate with clarity in MIPS. Performance standards should not change periodically, as CMS suggests in the RFI. Rather, the standards for one performance year should remain the standards throughout the entire performance year. It is difficult, if not impossible, to identify the most

appropriate performance standard without knowing what measures will be used and what other mechanisms will be adopted to ensure fair comparisons. What we do know is that there are pros and cons of different types of benchmarks, as summarized below. As such, CMS might have to rely on a combination of strategies.

- Absolute benchmarks (fixed threshold or percentile ranking-- e.g, the physician must have at least 90% performance on a process measure): Absolute attainment is the most straightforward and predictable for physicians. However, it could remove the motivation for ongoing improvement once a threshold has been attained. Also, in the case of a budget neutral program, such as MIPS, the more physicians who succeed, the smaller the incentive payment available per provider since the pool of penalties from which to finance incentives will be small.
- Relative benchmarks (e.g., physician's performance must be in the top 20th percentile of performance): Relative benchmarks may be based on the performance of comparative peers in a local market, the state, nationally, or even non-geographic peer groups. Typically, points are assigned on a sliding scale based on performance and the absolute score required to reach the percentile cut point changes over time. Relative thresholds are problematic for many reasons. For one, physicians do not know ahead of time what level of performance is needed to succeed, which creates uncertainty as to whether their performance is "good enough." Also, when topped out measures are maintained, physicians may have very high performance that does not meet the threshold for "high" performance," but yet is not meaningfully different from the performance of those who

do qualify for a performance based payment incentive. Relative benchmarks might also promote a "race to the top" and create perverse incentives to allocate resources to improvement on a measure that might not yield the greatest clinical benefit (or even lead to overtreatment).

In addition, rewards can be based on:

- Attaining specific benchmarks, which might favor providers who have more resources to devote to QI activities;
- Improving over time, which could disproportionately reward historically poor performers who have more room for improvement; or
- A combination of attainment and improvement.

Taking all of these strategies into consideration, we support a flexible, multi-pronged approach that adheres to the following overarching principles:

- Start out simple. Using historical data as a baseline is the simplest option, especially when working with administrative data. However, the MIPS process adds additional reporting and compliance options where historical data might not be available. Furthermore, the expanded variety of metrics and reporting options available to physicians under MIPS will make it rare that any two physicians report on the same exact set of measures. This will make it virtually impossible to conduct evaluations based on relative performance. Given these challenges, the least complex methodology to adopt in the initial stages of MIPS would be one that relies on multiple absolute targets along a continuum to motivate improvement at all levels of performance and to continue to motivate improvement at the top end of the

performance distribution. It is also preferable to use some future year as the basis for determining historical performance.

- Phased approach: As we gain experience and build a stronger foundation of data, benchmarks that evaluate self-improvement based on historical baselines may be appropriate, as could a strategy that accounts for both improvement and attainment. For instance, even when improvement is evaluated, there might still be a role for recognizing the attainment and maintenance of performance (e.g., is a pilot only average if they land all their planes safely?). The last step would be to transition to national, regional, or other peer-to-peer relative comparisons. The overall goal should be to encourage gradual, continual improvements over time rather than the greatest amount of compliance.
- Recognize appropriate ceilings. While there might be a need to adjust benchmarks and performance standards over time, these periodic updates should not result in a "moving target" that inappropriately penalizes high value physicians by holding them to an endlessly higher standard.
- Performance measure benchmarks should rarely ever be set at 100%. It's impossible to account for every exclusion from the denominator, no matter how well a measure is constructed, and setting the bar this high could perversely incentivize overtreatment or even gaming.
- Target outliers only: Payment adjustments should target only the outliers rather than those whose performance is clustered around the mean. Payment adjustments should be based only on significant differences in performance.
- Adjustments over time. Strategies and methodologies will almost certainly need to

			be adjusted over time. • Risk adjustments are critical. Risk adjustments—for factors related to health status, stage of disease, genetic factors, local demographics and socioeconomic status--must be reflected in performance assessments to accommodate variations in patient need and the costs of care and to ensure continued access to care for more vulnerable populations. Adjustments also should be made to account for the acuity of certain settings (e.g., academic settings) and the variable resources available to physicians. We strongly urge CMS to NOT rely on the VM as the foundation of performance under MIPS since a very large percentage of physicians already (and will) have VM scores that are not based on actual data and that bear little relevance to their own performance. Finally, we urge CMS to invest in the potential development of standards that differ according to size and other practice features. As part of this process, CMS should refine the VM specialty mix adjustments to ensure that performance comparisons are applied to groups of similar characteristics. These calculations should be very clear and highly transparent, so that physicians can understand them and be successful in MIPS.
MIPS	**Performance Standards**: Historical Performance	For the **clinical practice improvement activities** performance category, what, if any, historical data sources should be leveraged?	Based upon the legislative language describing the new CPI category, we do not believe that Congress intended for CMS to somehow measure whether or not a particular activity "improved" care. The logistics of measuring how many patients took advantage of after-hours care, e-mailed a doctor, or utilized other services visualized in the law, are mind-boggling.
MIPS	**Performance Standards:** Improvement	How should CMS define improvement and the opportunity for continued improvement? For example, section 1848(q)(5)(D) of the Act requires the Secretary, beginning in the second year of the MIPS, if	A goal of ongoing quality improvement is to show consistent improvement over time. However, the opportunity for improvement may differ among

		there are available data sufficient to measure improvement, to take into account improvement of the MIPS EP in calculating the performance score for the **quality** and **resource use** performance categories.	different measures and physicians practicing in different settings. We resist the notion that certain measures that have reached a point of saturation should not be included. The MIPS is also not designed to be a tournament-style program, as CMS is required to disclose what benchmarks are prior to the start of a performance period. As such, generous education and outreach must be used in concert with performance standards development so that groups and providers know exactly who their peers are and what their goals will be.
MIPS	**Performance Standards:** Improvement	How should CMS incorporate improvement into the scoring system or design an improvement formula?	See below.
MIPS	**Performance Standards:** Improvement	What should be the threshold(s) for measuring improvement?	Thresholds will need to be considered for the individual metrics utilized by a provider and the unique practice environments in quality reporting. There are metrics where incidence of an adverse event are extremely low (DVT/PE after elective lumbar discectomy) and where showing improvement may require excessively high sample sizes, sizes that an individual practitioner may never achieve. Other practice environments may have higher rates of similar adverse events due to patient population (DVT/PE in a population of cervical spinal cord injury patients). "Improvement" will need to be considered based upon the quality element and practice, with appropriate risk adjustment employed.
MIPS	**Performance Standards:** Improvement	How would different approaches to defining the baseline period for measuring improvement affect EPs' incentives to increase quality performance? • Would periodically updating the baseline period penalize EPs who increase performance by holding them to a higher standard in future performance periods, thereby undermining the incentive to improve? • Could assessing improvement relative to a fixed baseline period avoid this problem? • If so, would this approach have other consequences CMS should consider?	See earlier comments. Yes, periodically updating the baseline could unfairly penalize those with historically high performance and eventually reach a point where it poses an insurmountable challenge for all. At the same time, a fixed benchmark could also disproportionately reward historically poor performers.

MIPS	**Performance Standards:** Improvement	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?	Under the Hospital Value-Based Purchasing Program, participants can win points for improvement as compared to the baseline, and additional points for achievement as compared to performance from the prior year. While we support this concept and urge CMS to investigate the feasibility of applying a similar approach under MIPS, there are a few factors that might impede this application of this strategy. For one, we question how this could work in the physician world where thousands of group practices operate in a fluid environment of recruitment, acquisition, expansion, and reduction. If a particular group improves one year but the payment adjustment is applied two years later, the providers or groups responsible for positive results may no longer be part of the group and may never see any reward for their achievements. Conversely, those who achieved success somewhere else and then moved to a group with low performance two years earlier will be penalized instead of rewarded for their efforts. Other aspects of the Hospital VBP's methodology would be very problematic for individual assessments, as well. The hospital program relies upon DRG and ICD-9-CM procedure coding; these coarse measures are not reliable for large assessments, and will become even more inaccurate when applied to individual physician practices. The system-based approach that is used by the Hospital VBP Program likely will not be effective when applied to individual physicians or physician groups. Nevertheless, we encourage CMS to further evaluate ways to employ this strategy in MIPS in consultation with relevant clinical stakeholders.
MIPS	**Performance Standards:** Improvement	Should CMS consider improvement at the measure level, performance category level (i.e., quality, clinical practice improvement activity, resource use, and meaningful use of certified EHR technology), or at the composite performance score level?	We caution CMS against using a composite measure of improvement. Success in one category does not mean success in another. Likewise, failure in one category does not indicate failure in another category.
MIPS	**Performance Standards:**	Should improvements in health equity and the reductions of health	While we share the goal of providing high quality care

	Improvement	disparities be considered in the definition of improvement? If so, how should CMS incorporate health equity into the formula?	to all patients and the goal of reducing socioeconomic disparities in care, making the elimination of health disparities the responsibility of individual reporting physicians is not realistic. These systems-based goals must be assessed with systems-based measures, not measures that are reported at the level of the individual practitioner. The ability of surgical subspecialists to remedy disparities in access to treatment for diabetes mellitus or chronic cardiac conditions based upon socioeconomic disparities will be limited.
MIPS	**Performance Standards:** Methodology	In the CY 2016 PFS proposed rule, CMS proposed to publicly report on Physician Compare an item-level benchmark derived using the Achievable Benchmark of Care (ABC™) methodology. CMS seeks comment on using this methodology for determining the MIPS performance standards for one or more performance categories.	We continue to voice concerns over the quality of physician data on the Physician Compare website. These concerns highlight many issues with present quality reporting, including concerns over patient attribution, risk assessment, and the accuracy of reported elements. Using a "star" system is of even greater potential ill effect, and will not aid in patient assessment and decision making. There are a number of methodological concerns with reporting through Physician Compare: • The fact that individual physicians often do not have control over institutional decisions regarding the reporting/selection of measures; • The value of weighted averages that wash out outliers; • The potential need for specialty benchmarking or regional vs. national benchmarking; • The need to employ consistent methodologies across federal programs; • Concerns about the limitations of purely administrative data; and • Concerns about setting standards of care or other legal implications that may result from publicly reported benchmarked data.
MIPS	Weighting Performance Categories[8]	Are there situations where certain EPs could not be assessed at all for purposes of a particular performance category? If so, how should CMS account for the percentage weight that is otherwise applicable for that category? Should it be evenly distributed across the remaining	There are instances where providers may not have adequate metrics to fulfill given performance categories. The most basic would be the lack of PQRS quality metrics available for some specialties, where

		performance categories? Or should the weights be increased for one or more specific performance categories, such as the **quality** performance category?	there are simply not an appropriate number and distribution of quality metrics to allow for reporting. As mentioned earlier, to account for the percentage weight that would have been applicable to the quality where performance measures are lacking, CMS should work with affected medical societies to determine how the percentage weight should be re-distributed and whether CPI activities could have their weight increased to make up for the lack of quality measures. Similarly, we would also request that CMS allow for more expedited assessment of individual quality metrics and measures groups. Interested specialty societies that develop quality metrics and measures groups should have a mechanism for expedited review so that they know well in advance whether their measures would be counted under MIPS. Also, CMS should also set up an appeals and communication process with EPs after they receive their quarterly feedback forms to ensure their progress towards 100 percent.
MIPS	Weighting Performance Categories	Generally, what methodologies should be used as we determine whether there are not sufficient measures and activities applicable and available to types of EPs such that the weight for a given performance category should be modified or should not apply to an EP? Should this be based on an EP's specialty? Should this determination occur at the measure or activity level, or separately at the specialty level?	We believe EP specialty is the easiest measure to use for this assessment. We also believe that these decisions should be considered at a specialty level, and not at the level of a measure or a given activity. The consideration must also account for different means of reporting. Physicians in large multi-specialty groups may have options for successful reporting that are not available to small single-specialty practices. The MIPS program should not penalize small groups of practitioners simply due to lack of quality reporting options. As noted earlier, we also believe that the hardship exemptions utilized in the present system for Meaningful Use Reporting should be considered for continued use.

MIPS	Weighting Performance Categories	What case minimum threshold should CMS consider for the different performance categories?	No comments at this time.
MIPS	Weighting Performance Categories	What safeguards should CMS have in place to ensure statistical significance when establishing performance thresholds? For example, under the VM one standard deviation is used. Should CMS apply a similar threshold under MIPS?	No comments at this time.
MIPS	Composite Performance Score and Performance Threshold	How should CMS assess performance on each of the 4 performance categories and combine the assessments to determine a composite performance score?	We believe the elements of the MIPS system should be addressed individually. Where there are not adequate tools for reporting, such as in quality metrics for some subspecialties, the individual EPs should be held harmless for that element, and the weight of that portion of the score distributed over the other elements of the MIPS score, in consultation with specialty societies.
MIPS	Composite Performance Score and Performance Threshold	For the **quality** and **resource use** performance categories, should CMS use a methodology (for example, equal weighting of quality and resource use measures across National Quality Strategy domains) similar to what is currently used for the VM?	No comments at this time, other than the recommendation made earlier about the VM being an ill-conceived foundation of performance under MIPS. We also reiterate our support for moving away from mandatory compliance with a specific number of NQS domains.
MIPS	Composite Performance Score and Performance Threshold	How should CMS use the existing data on quality measures and resource use measures to translate the data into a performance threshold for the first two years of the program?	It may prove impossible to establish accurate thresholds a priori of EP use of the new system. Present reporting is fraught with concern, from unavailability of reporting options for some physicians, inadequate risk adjustment, difficulties in attribution of expenditures, etc. We would proffer that, should such thresholds be established, that they respect the challenges of the present system and that they do not carry forward limitations of present reporting and attribution that may decrease compliance with MIPS. Given the imperfect and still changing nature of the current incentive programs, it is preferable to use some future year as the basis for determining historical performance.
MIPS	Composite Performance Score and Performance Threshold	What minimum case size thresholds should be utilized? For example, should CMS leverage all data that is reported even if the denominators are small? Or should CMS employ a minimum patient threshold, such as a minimum of 20 patients, for each measure?	No comment at this time.
MIPS	Composite Performance Score	How can CMS establish a base threshold for the **clinical practice**	Due to the broad and variable nature of these

	and Performance Threshold	**improvement activities**? How should this be incorporated into the overall performance threshold?	activities, this task will not be simple. For example, while we believe that MOC programs should be respected and acknowledged by the MIPS system, a standardized system of MOC is not appropriate. Different specialties will have different needs for MOC reporting and the MIPS system should allow this to remain the responsibility of individual specialty societies. As noted earlier, EPs should simply be judged by their ability to attest to a minimum number of activities. The intent of this category was not to evaluate performance in the same manner as quality or ever resource use.
MIPS	Composite Performance Score and Performance Threshold	What other considerations should be made as CMS determines the performance threshold for the total composite performance score? For example, should CMS link performance under one category to another?	No comment at this time.
MIPS	Public Reporting	What should be the minimum threshold used for publicly reporting MIPS measures and activities for all of the MIPS performance categories on the Physician Compare website? (For example, CMS is currently using a minimum 20 patient threshold for public reporting through Physician Compare of quality measures (in addition to assessing the reliability, validity and accuracy of the measures). An alternative to a minimum patient threshold for public reporting would be to use a minimum reliability threshold).	Ongoing and largely unresolved problems with risk stratification in quality reporting and attribution of expenses in resource use make public reporting of these results premature. Since this is an opportunity to press the reset button on what has become a runaway train, we would suggest that CMS first devote time and resources to smartly developing the MIPS system, accrue at least 2 years of data using the new system, confidentially share that data with practicing physicians via clear, easy to understand reporting, and then consider sharing it with the public via Physician Compare or a similar site. Similar to current programs, such as the PQRS, the early years of MIPS could include public reporting of data that indicates whether an EP satisfied the reporting requirements for the multiple components of MIPS, but attempting to accurately calculate and showcase performance data for public consumption is an unrealistic goal for the initial years of this new program. There are currently too many unresolved

			problems related to risk adjustment, attribution, appropriate sample sizes and even the ongoing lack of relevant measures for certain specialties, which makes public reporting of performance data, in many instances, premature. When making decisions about whether a measure is ready for public reporting, CMS should continue to adhere to its current policy of selecting only measures that prove to be valid, reliable, and accurate upon analysis; deemed statistically comparable; meet a minimum sample size of patients; are not first year measures; and have proven, through concept testing, to be of value to consumers. In regards to appropriate minimum patient thresholds, CMS should keep in mind that these thresholds might vary across measures and even specialties. The process of determining whether measures are ready for public reporting should occur in as transparent of a manner as possible and should rely heavily on relevant clinical expert input. We also continue to caution against using raw file downloadable databases to present data to the public that is not quite ready for posting on physician profile pages. We are concerned that such data could be misleading, misinterpreted or misused by the public.
MIPS	Public Reporting	Should CMS include individual EP and group practice-level quality measure data stratified by race, ethnicity and gender in public reporting (if statistically appropriate)?	While all patients deserve equal access to high quality care and stratifying data might help to identify and reduce disparities in care, CMS first needs to address more foundational challenges related to public reporting (e.g., appropriate sample sizes, accurate attribution, and meaningful formats). Attempting to stratify data before these foundational issues are addressed would only further complicate the endeavor and produce potentially more confusing and less actionable data for physicians and the public. Furthermore, targeting health disparities at the individual physician level might not be practical due to

			small sample sizes and other methodological issues that might result in misleading and confusing information for the public. Targeting disparities is a larger system goal that might need to be addressed with systems-level measures, not measures that are reported at the level of the individual practitioner.
MIPS	Feedback Reports	What types of information should CMS provide to EPs about their practice's performance within the feedback report? For example, what level of detail on performance within the performance categories will be beneficial to practices?	In general, we feel that the more data that is shared with EPs the better so long as it is presented in an easy to understand format. The previous QRUR reports offered summary data, but little in depth for individual EPs. The more recent Supplemental QRURs completed on a procedure-based level featured tremendous amounts of information about individual episodes, but offered limited aggregation of data into a usable format. Perhaps most importantly, it was not clear from reviewing the Supplemental QRURs where a given EP could intervene to decrease costs. Simply sharing large amounts of data with individual EPs who do not have database personnel to parse the information into a useful format is of limited efficacy. We would also like to remind CMS of ongoing challenges that EPs and practices continue to face when trying to access these reports. While we appreciate CMS' efforts to keep these reports secure and confidential, this process should not result in the diversion of valuable time away from the patient. Finally, we thank CMS for recent efforts to improve the readability of these reports, including additional drill down tables, but remind the agency that all the fixes in the world will not make inherently flawed measures more comprehensible or meaningful. A large part of improving these reports will be improving the underlying measures and performance calculation methodologies.
MIPS	Feedback Reports	Would it be beneficial for EPs to receive feedback information related to the **clinical practice improvement activities** and **meaningful use of certified EHR technology** performance categories? If so, what types of	Yes, but since the CPIA category could span a variety of activities, CMS will likely have to consult with professional societies and other entities to gather this

		feedback?	data and verify this data and to ensure it is being presented accurately.
MIPS	Feedback Reports	What other mechanisms should be leveraged to make feedback reports available? • Should CMS continue to make feedback available through the web-based portal currently used for PQRS, VM, and the Physician Feedback program? • What other entities and vehicles could CMS partner with to make feedback reports available? • How should CMS work with partners to enable feedback reporting to incorporate information from other payers, and what types of information should be incorporated?	CMS should work toward all-payer composite feedback reports since this would give physicians a more comprehensive view of their performance. However, this should be a longer term goal. For the immediate future, CMS should focus on making the current reports more user-friendly. At the same time, we do believe that QCDRs should maintain control over providing quality data feedback to its participants. CMS should not attempt to reinterpret this data or otherwise re-purpose it to fit within its own QRUR format since this might affect the soundness of the data. Web-based reports as well as dashboards and paper reports should be made available and the process for accessing these sites should be as simple as possible, while respecting the confidentiality of the data.
MIPS	Feedback Reports	Who within the EP's practice should be able to access the reports? (For example, currently under the VM, only the authorized group practice representative and/or their designees can access the feedback reports.) Should other entities be able to access the feedback reports, such as an organization providing MIPS-focused technical assistance, another provider participating in the same virtual group, or a third party data intermediary who is submits data to CMS on behalf of the EP, group practice, or virtual group?	The current requirement that only allows an "authorized group practice representative" to access these reports often restricts an individual EP's ability to directly access his/her own report. While we very much value the need to ensure secured access to these reports, the EPs who are being evaluated in the report should each have independent access to the reports.
MIPS	Feedback Reports	With what frequency is it beneficial for an EP to receive feedback? (Currently, CMS provides Annual Quality and Resource Use Reports (QRUR), mid-year QRURs and supplemental QRURs.) • Should CMS continue to provide feedback to MIPS EPs on this cycle? • Would there be value in receiving interim reports based on rolling performance periods to make illustrative calculations about the EP's performance? • Are there certain performance categories on which it would be more important to receive interim feedback than others? • What information that is currently contained within the QRURs should be included? (More information on what is available	Reports should evolve into "dashboards" that are made available to EPs in as real-time as possible, but at the very least, on a quarterly basis. The current annual distribution strategy, and the two year gap between performance and payment, greatly reduce the utility and value of these reports. Feedback reports should meaningfully guide improvements in practice.

		within the QRURs is at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2014-QRUR.html.)	
MIPS	Feedback Reports	Should the reports include data that is stratified by race, ethnicity and gender to monitor trends and address gaps towards health equity?	As noted earlier, the task of addressing gaps in health equity might not best be solved through individual measurement. Efforts to stratify based on these factors at this early stage would only serve to further complicate an already complex endeavor
MIPS	Feedback Reports	What types of information about items and services furnished to the EP's patients by other providers would be useful? In what format and with what frequency?	The feedback reports need to do a better job at parsing out resource use that is in the direct control of the EP and that which is not. Resource use data should also focus on more discrete clinical bundles or episodes so that all services included, whether by the EP or other providers, are related to a common goal (versus the current MSPB and Total Per Capita Cost measure, which are much too imprecise in their focus).

APMs	"**Qualifying APM Participant**": Revenue Approach	Under MACRA, CMS may rely either on a revenue approach or a patient approach to determine whether an EP is a qualifying APM participant. If CMS used a revenue approach, how should CMS define "services furnished under this part through an [eligible alternative payment] EAPM entity"?	In general, the process of qualifying APMs that are relevant across medicine will be challenging. The eventual threshold of at least 75% of Medicare payments coming from a qualifying APM will make it very challenging for each subspecialty to identify a relevant payment model. CMS might want to consider qualifying procedure-specific APMs, condition-specific APMs, and population-based APMs. It is also critical that there is alignment between the physician compensation system and the incentives. While we support incentivizing more team-based approaches to care, attribution of resource use remains an issue. Physicians should only be held accountable for things they have control over, since we have not yet perfected appropriate methodologies to adjust for risk and ensure accurate attribution across providers and settings of care. We also support better transparency and better access to data, which will help specialties develop better models and better understand their care processes and spending. When it comes to administering the 5% annual base Medicare payment update for participating in a qualified APM, CMS should base the update on the physician services provided under that model to ensure it goes directly to them. This will help to minimize problems with hospitals maintaining control or otherwise being the gatekeeper of all the potential shared savings of a model. This program must also account for the fact that some groups are already efficient. CMS should think about how to continuously incentivize improvements, while

			also recognizing that ceilings will be reached and high performance should continue to be rewarded.
APMs	"**Qualifying APM Participant**": Revenue Approach	What policies should the Secretary consider for calculating incentive payments for APM participation when the prior period payments were made to an EAPM entity rather than directly to a QP (For example, if payments were made to a physician group practice or an ACO?) • What are the advantages and disadvantages of those policies? What are the effects of those policies on different types of EPs (that is, those in physician-focused APMs versus hospital-focused APMs, etc.)? • How should CMS consider payments made to EPs who participate in more than one APM?	Bonuses for successful contribution to an APM should incentivize the provider. Adjustment between years of being paid by provider focused models or hospital-focused models may be imperfect. Continued incentive and bonus payments should encourage the movement to effective APMs if CMS ensures bonuses for APMs that are shifting away from FFS and those that are producing higher quality care. EPs should be able to participate in more than one APM. There will likely need to be multiple types of APMs in order for physicians in all specialties to participate, and in order to all patients of these physicians to benefit. Beneficiary-allocation formulas may also need to be applied.
APMs	"**Qualifying APM Participant**": Revenue Approach	What policies should the Secretary consider related to estimating the aggregate payment amounts when payments are made on a basis other than fee-for-service (that is, if payments were made on a capitated basis)? • What are the advantages and disadvantages of those policies? • What are their effects on different types of EPs (that is, those in physician- focused APMs versus hospital-focused APMs, etc.)?	It is important that CMS is prepared to adjust estimates of aggregate payment amounts over time. Initial discrepancies in payments between hospital-focused APMs versus physician-focused APMs are difficult to predict, but will hopefully converge over time.
APMs	"**Qualifying APM Participant**": Revenue Approach	What types of data and information can EPs submit to CMS for purposes of determining whether they meet the non-Medicare share of the Combination All-Payer and Medicare Payment Threshold, and how can they be securely shared with the federal government?	EPs should be able to submit information on payments and patient numbers from Medicare and other payers (and percentages thereof) from the prior year. A secure, interactive submission platform would ideally exist.
APMs	"**Qualifying APM Participant**": Patient Approach[9]	What are examples of methodologies for attributing and counting patients in lieu of using payments to determine whether an EP is a qualifying APM participant (QP) or partial QP?	Ideally the attribution is based on number of patients, and not a multiplier of fees.
APMs	"**Qualifying APM Participant**": Patient Approach	Should this option be used in all or only some circumstances? If only in some circumstances, which ones and why?	No comment at this time.
APMs	**Eligible APMs**: "Nominal Financial Risk"	What is the appropriate type or types of "financial risk" under section . . . to be considered an EAPM entity?	Any amount deemed acceptable to the proposing group in variable formats, such as sharing downside risk in global budget models, bundled episode payment, or

			partial capitation.
APMs	**Eligible APMs**: "Nominal Financial Risk"	What is the appropriate level of financial risk "in excess of a nominal amount" . . . to be considered an EAPM entity?	An amount deemed acceptable to the proposing group.
APMs	**Eligible APMs**: "Nominal Financial Risk"	What is the appropriate level of "more than nominal financial risk if actual aggregate expenditures exceed expected aggregate expenditures" that should be required by a non-Medicare payer for purposes of the Combination All-Payer and Medicare Payment Threshold?	There is no single APM that will apply to all physicians, health problems, and patients. The opportunities to improve quality and reduce costs will differ for each specialty and population. There does not necessarily have to be a "number" placed on the nominal financial risk as long as it is demonstrated that there is expected improvement in quality of care or expected reduction in total costs.
APMs	**Eligible APMs**: "Nominal Financial Risk"	What are some points of reference that should be considered when establishing criteria for the appropriate type or level of financial risk, e.g., the MIPS or private-payer models?	No comment at this time, although the AMA resource detailing the variety of potential APMs that could be developed offers many attractive ideas.
APMs	**Eligible APMs:** Medicaid Medical Homes & other State Medicaid Program APMs	What criteria could the Secretary consider for determining comparability of state Medicaid medical home models to medical home models expanded under section 1115A(c) of the Act?	No comment at this time.
APMs	**Eligible APMs:** Medicaid Medical Homes & other State Medicaid Program APMs	Which states' Medicaid medical home models might meet criteria comparable to medical homes expanded under section 1115A(c) of the Act?	No comment at this time.
APMs	**Eligible APMs:** Medicaid Medical Homes & other State Medicaid Program APMs	Which current Medicaid alternative payment models – besides Medicaid medical homes are likely to meet the criteria for comparability of state Medicaid medical homes to medical homes expanded under section 1115A(c) of the Act and should be considered when determining the all-payer portion of the Combination All-Payer and Medicare Payment Threshold Option?	No comment at this time.
APMs	**EAPM Entity Requirements:** Definition	What entities should be considered EAPM entities?	Examples could include HMO systems and VA systems.
APMs	**EAPM Entity Requirements:** Quality Measures	What criteria could be considered when determining "comparability" to MIPS of quality measures used to identify an EAPM entity? (Please provide specific examples for measures, measure types (for example, structure, process, outcome, and other types), data source for measures (for example, patients/caregivers, medical records, billing claims, etc.), measure domains, standards, and comparable methodology.)	These criteria need to be specialty-specific and disease-specific. The measures should reflect the types of patient conditions treated rather than having universal measures. Metrics can mirror specialty-specific MIPS measures, with additional specifics for each APM proposal such as specialty-specific, disease-specific, or population-specific measures.
APMs	**EAPM Entity Requirements:** Quality Measures	What criteria could be considered when determining "comparability" to MIPS of quality measures required by a non-Medicare payer to qualify for the Combination All-Payer and Medicare Payment Threshold?	These criteria need to be specialty-specific and disease-specific. The measures should reflect the types of patient conditions treated rather than having universal

		(Please provide specific examples for measures, measure types, (for example, structure, process, outcome, and other types), recommended data sources for measures (for example, patients/caregivers, medical records, billing claims, etc.), measure domains, and comparable methodology.)	measures.
APMs	**EAPM Entity Requirements:** Use of CEHRT	What components of certified EHR technology (as defined in section 1848(o)(4) of the Act) should APM participants be required to use? Should APM participants be required to use the same certified EHR technology currently required for the Medicare and Medicaid EHR Incentive Programs or should CMS other consider requirements around certified health IT capabilities?	Full compliance with Meaningful Use requirements have been a struggle for some physician groups to achieve. Rather than impose the same requirements as Medicare and Medicaid EHR Incentive Programs, CMS should consider the presence of any certified EHR technology as enough to fulfill requirements. EAPM entities should include in the proposal minimum EHR needs and criteria for defining success in the APM plan, without an all-or-none approach to EHR requirements. Partial credit should be allowed. This inclusiveness may incentivize innovation in responsible health care delivery rather than commit large budgets to EHR compliance without necessarily increasing value.
APMs	**EAPM Entity Requirements:** Use of CEHRT	What are the core HIT functions that providers need to manage patient populations, coordinate care, engage patients, and monitor and report quality? Would certification of additional functions or interoperability requirements in HIT products (e.g., referral management or population health management functions) help providers succeed within APMs?	Currently, HIT is heterogeneous and without specific standards. Requiring some documented use of HIT, i.e., any use of HIT (but without imposing additional HIT certifications) would afford maximal opportunity for providers to succeed in their frameworks and proposed APMs. Asking for specific interoperability or specific HIT functions may pose undue burden on providers who otherwise would succeed and otherwise has the potential to effect cost control and population health in the APM. While those who do not have advanced EHR or HIT should not be penalized, those with core activities amenable to real-time measurement and reporting on patient outcomes and experience can be rewarded.
APMs	**EAPM Entity Requirements:** Use of CEHRT	How should CMS define "use" of certified EHR technology (as defined in section 1848(o)(4) of the Act) by participants in an APM? (For example, should the APM require participants to report quality measures to all	All professionals in the APM should not be required to use certified EHR technology. A particular subset can be defined, on a voluntary basis only, not a requirement

		payers using certified EHR technology or only payers who require EHR reported measures? Should all professionals in the APM in which an eligible alternative payment entity participates be required to use certified EHR technology or a particular subset?)	basis. Any use of EHR while participating in a qualifying APM constitutes use. Reporting by EHR technology should only be to payers who require such reported measures, not to all payers. While those who do not have advanced EHR should not be penalized, those with core activities amenable to real-time measurement and reporting can be rewarded.
APMs	**Physician-Focused Payment Models[10]:** Definition	How should "physician- focused payment model" (PFPM) be defined?	Under MACRA, there is no guarantee that a PFPM will qualify as an APM. PFPMs should qualify as APMs
APMs	**Physician-Focused Payment Models:** Criteria	What criteria should be used by the Physician-focused Payment Model Technical Advisory Committee ("the Committee") for assessing PFPM proposals submitted by stakeholders? (CMS is interested in hearing suggestions related to the criteria discussed in this RFI as well as other criteria.)	PFPM or APM proposals can include any reasonable plan to make meaningful shift in payment architecture. Proposals can include a variety of strategies, and should not be limited to one criterion. Global budget models, episode payments, partial capitations, and others should all be considered. There will need to be multiple types of APMs in order for physicians in all specialties to participate, and in order for all types of patients to benefit. For instance, these are possible frameworks for physicians and PFPMs to address common barriers and opportunities for improvement in care delivery and outcomes: 1) Payment for High-Value Service. 2) Condition-Based Payment of Physician Services. 3) Multi-Physician Bundled Payment. 4) Physician-Facility Procedure Bundle 5) Warrantied Payment for Physician Services 6) Episode Payment for a Procedure 7) Condition Based Payment Each of these APM frameworks addresses different opportunities for savings and different barriers in the current payment system. Each APM design will be adapted to unique service and outcomes for specialty-specific health problems or treatments.
APMs	**Physician-Focused Payment**	Are there additional or different criteria that the Committee should use	Specialists are likely to propose innovative models

	Models: Criteria	for assessing PFPMs that are specialist models? What criteria would promote development of new specialist models?	reflecting the unique and specialized nature of their care. Best practices will be incorporated. Pilots should be considered. Those with more advanced performance measures may be considered for receiving additional bonus incentives, such as those reflecting outcome and patient experience.
APMs	**Physician-Focused Payment Models:** Criteria	What existing criteria, procedures, or standards are currently used by private or public insurance plans in testing or establishing new payment models? Should any of these criteria be used by the Committee for assessing PFPM proposals? Why or why not?	Specialty societies are working with consultant groups and other stakeholders to develop a possible menu of APMs. These can serve as a framework for physicians and PFPMs to address common barriers and opportunities for improvement in care delivery and outcomes: 1) Payment for High-Value Service. 2) Condition-Based Payment of Physician Services. 3) Multi-Physician Bundled Payment. 4) Physician-Facility Procedure Bundle 5) Warrantied Payment for Physician Services 6) Episode Payment for a Procedure 7) Condition Based Payment Each of these APM frameworks addresses different opportunities for savings and different barriers in the current payment system. Each APM design will be adapted to unique service and outcomes for specialty-specific health problems or treatments. Some of these APMs will be require fewer additional resources for implementation versus other APMs that will likely only be feasible for larger multi-specialty platforms. More complex APM structures may require an Alternate Payment Entity to for payment distribution.
APMs	**Physician-Focused Payment Models:** Delivery Reform Requirements	Should CMS propose that PFPMs should primarily be focused on the inclusion of participants in their design who have not had the opportunity to participate in another PFPM with CMS because such a model has not been designed to include their specialty?	Specialty-specific and procedure-specific designs are needed. Even if participants overlap with other general providers or other specialties, there stakeholders should be able to propose PFPM's that are specialty-specific, diagnosis-specific, and procedure-specific.

			Each of these 7 APM frameworks mentioned above addresses different opportunities for savings and different barriers in the current payment system. Each APM design will be adapted to unique service and outcomes for specialty-specific health problems or treatments.
APMs	**Physician-Focused Payment Models:** Delivery Reform Requirements	Should proposals be required to state why the proposed model should be given priority, and why a model is needed to test the approach?	Yes, proposed models should be accompanied by relevant available context for priority, clinical relevance, and impact on patient outcome and/or population health. If available, established specialty proposals for APMs may provide a framework for new, similar proposals.
APMs	**Physician-Focused Payment Models:** Delivery Reform Requirements	Should proposals be required to include a framework for the proposed payment methodology, how it differs from the current Medicare payment methodology, and how it promotes delivery system reforms?	Yes.
APMs	**Physician-Focused Payment Models:** Delivery Reform Requirements	If a similar model has been tested or researched previously, either by CMS or in the private sector, should the stakeholder be required to include background information and assessments on the performance of the similar model?	CMS should provide multiple accepted APMs. If a stakeholder proposes to follow a published, accepted model, additional information is not mandatory. If a stakeholder proposes to modify a published, accepted model or proposes a novel model, background information and, where available, assessment on performance should be included.
APMs	**Physician-Focused Payment Models:** Delivery Reform Requirements	Should Proposed models be required to aim to directly solve a current issue in payment policy that CMS is not already addressing in another model or program?	No. This should not be a requirement. This notion may dis-incentivize sources of innovation toward improved health care delivery. Proposed models should not be required to aim to directly solve a current issue in payment policy not already addressed by CMS in another model or program. Proposed models may find other, even more efficient ways to address existing issues. The proposed models should aim (a) to solve a health care delivery problem, (b) to deliver patient outcomes-focused care with appropriate use, or (c) to deliver care

			with an eye toward maximizing population health.
APMs	**Physician-Focused Payment Models:** Model Design	Should CMS require that proposals include the same information that would be required for any model tested through CMMI? (http://innovation.cms.gov/Files/x/rfi-websitepreamble.pdf). CMS seeks input on: • The usefulness of this information • Which of the suggested information is appropriate to consider as criteria, and • Whether other criteria should be considered. (The provision of information would not require particular answers in order for a PFPM to meet the criteria. Instead, a proposal would be incomplete if it did not include this information).	CMS can use CMMI as a framework, but should not require exactly the same information as the CMMI model. Proposals should not be considered incomplete without all CMMI information. Proposals with advanced evidence and measures can be scored more highly, but those that demonstrate potential at pilot stage should not be penalized or labeled "incomplete."
APMs	**Physician-Focused Payment Models:** Model Design	Should CMS require submission of information in the following areas: • Definition of the target population, how the target population differs from the non-target population and the number of Medicare beneficiaries that would be affected by the model. • Ways in which the model would impact the quality and efficiency of care for Medicare beneficiaries. • Whether the model would provide for payment for covered professional services based on quality measures, and if so, whether the measures are comparable to quality measures under the MIPS quality performance category. • Specific proposed quality measures in the model, their prior validation, and how they would further the model's goals, including measures of beneficiary experience of care, quality of life, and functional status that could be used. • How the model would affect access to care for Medicare and Medicaid beneficiaries. • How the model will affect disparities among beneficiaries by race, and ethnicity, gender, and beneficiaries with disabilities, and how the applicant intends to monitor changes in disparities during the model implementation. • Proposed geographical location(s) of the model. • Scope of EP participants for the model, including information about what specialty or specialties EP participants would fall under the model. • The number of EPs expected to participate in the model,	Quality measures should be defined only with represented specialty input. These can be similar to MIPS or may be defined in another way under a specialty-specific or disease-specific APM agreement. Measures should be disease-specific, specialty-specific, or population-specific, and should be defined specific to each APM proposal. Scope, number and interest of EP participants is appropriate to define. Relevant stakeholder support is also appropriate to list. Anticipated CEHR use is appropriate to document. Method for attributing beneficiaries to participants is an absolute necessity. Business cases for participation should be encouraged. Payment mechanisms and financial risk models proposed for the model may be included. We again caution against one fixed set of rules, and recommend disease-specific, specialty-specific, or population-specific targets defined in each APM proposal. The targets should be simple to measure, and should avoid all-or-nothing scenarios. Partial credit

information about whether or not EP participants for the model have expressed interest in participating and relevant stakeholder support for the model.

- To what extent participants in the model would be required to use certified EHR technology.
- An assessment of financial opportunities for model participants including a business case for their participation.
- Mechanisms for how the model fits into existing Medicare payment systems, or replaces them in part or in whole and would interact with or complement existing alternative payment models.
- What payment mechanisms would be used in the model, such as incentive payments, performance-based payments, shared savings, or other forms of payment.
- Whether the model would include financial risk for monetary losses for participants in excess of a minimal amount and the type and amount of financial performance risk assumed by model participants.
- Method for attributing beneficiaries to participants.
- Estimated percentage of Medicare spending impacted by the model and expected amount of any new Medicare/Medicaid payments to model participants.
- Mechanism and amount of anticipated savings to Medicare and Medicaid from the model, and any incentive payments, performance-based payments, shared savings, or other payments made from Medicare to model participants.
- Information about any similar models used by private payers, and how the current proposal is similar to or different from private models and whether and how the model could include additional payers other than Medicare, including Medicaid.
- Whether the model engages payers other than Medicare, including Medicaid and/or private payers. If not, why not? If so, what proportion of the model's beneficiaries is covered by Medicare as compared to other payers?
- Potential approaches for CMS to evaluate the proposed model (study design, comparison groups, and key outcome measures).
- Opportunities for potential model expansion if successful.

should be available. As such, a choice of potential approaches for CMS evaluation should be included. APM choices should be varied, as no single APM will work for all physicians, all diseases, all care processes, or all patients.

Proposals should be open to the possibility for scalability and expansion in the future. Pilots should be considered, with innovation and expansion in the future.

Organizations that use APMs with more advanced measures can qualify for additional bonus payments, but those with less advanced achievements should not be at additional financial risk in excess of a set amount agreed upon by model participants.

The models should continuously incentivize improvements, while also recognizing that ceilings will be reached and performance should continue to be rewarded. Provisions should include:

- Adjustments over time: Strategies and methodologies will need to be adjusted over time.
- Risk adjustment: for factors related to health status, stage of disease, genetic factors, local demographics and socioeconomic status. Adjustments also should be made to account for the acuity of certain settings (e.g., academic settings) and the variable resources available to physicians.

MIPS/ APMs		What should CMS consider when organizing a program of technical assistance to support clinical practices as they prepare for effective participation in the MIPS and APMs?	CMS should provide support for developing and implementing better performance measures in APMs. This should be done with specialty-specific input. CMS should provide improved and timely Medicare data sharing with physicians to enable providers to take action to improve care.
MIPS/ APMs		What existing educational and assistance efforts might be examples of "best in class" performance in spreading the tools and resources needed for small practices and practices in HPSAs? What evidence and evaluation results support these efforts?	No comment at this time.
MIPS/ APMs		What are the most significant clinician challenges and lessons learned related to spreading quality measurement, leveraging CEHRT to make practice improvements, value based payment and APMs in small practices and practices in health shortage areas, and what solutions have been successful in addressing these issues?	No comment at this time.
MIPS/ APMs		What kind of support should CMS offer in helping providers understand the requirements of MIPS?	No comment at this time.
MIPS/ APMs		Should such assistance require multi-year provider technical assistance commitment, or should it be provided on a one-time basis?	No comment at this time.
MIPS/ APMs		Should there be conditions of participation and/or exclusions in the providers eligible to receive such assistance, such as providers participating in delivery system reform initiatives such as the Transforming Clinical Practice Initiative (TCPI; http://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/), or having a certain level of need identified?	No comment at this time.

ENDNOTES

[1] "Currently under the PQRS, the reporting mechanisms that use CEHRT require that the quality measures be derived from CEHRT and must be transmitted in specific file formats. For example, EHR technology that meets the CEHRT definition must be able to record, calculate, report, import, and export clinical quality measure (CQM) data using the standards that the Office of the National Coordinator for Health Information Technology (ONC) has specified, including use of the Quality Reporting Data Architecture (QRDA) Category I and III standards."

[2] CMS notes that there will be forthcoming opportunities to comment on the development of care episodes and patient condition groups and classication codes, and patient relationship categories and groups as required under MACRA.

[3] Physician Value-Based Payment Modifier Cost Measures: (1) Total Per Capita Costs for All Attributed Beneficiaries measure; (2) Total Per Capita Costs for Beneficiaries with Specific Conditions (Diabetes, Coronary artery disease, Chronic obstructive pulmonary disease, and Heart failure); and (3) Medicare Spending per Beneficiary (MSPB) measure.

[4] MACRA requires that the clinical practice improvement categories performance category must at least include: expanded practice access, population management, care coordination, beneficiary engagement, patient safety and practice assessment, and participation in an APM. Discretion was given to the Secretary to add other subcategories of activities.

[5] CMS notes that it only seeks comments on the meaningful use performance category under the MIPS; we are not seeking comments on the Medicare and Medicaid EHR Incentive Programs.

[6] MACRA requires the Secretary to give consideration to the circumstances of professional types (or subcategories of those types based on practice characteristics) who typically furnish services that do not involve face-to-face interaction with patients when defining MIPS performance categories.

[7] MACRA requires the Secretary, in establishing performance standards with respect to measures and activities for the MIPS performance categories, to consider: historical performance standards, improvement, and the opportunity for continued improvement.

[8] MACRA requires the Secretary to assign different scoring weights (including a weight of zero) from those that apply generally under the MIPS if there are not sufficient measures and activities applicable and available to each type of EP.

[9] MACRA provides that the Secretary can use percentages of patient counts in lieu of percentages of payments to determine whether an EP is a qualifying APM participant (or partial qualifying APM participant).

[10] MACRA, establishes an independent "Physician-focused Payment Model Technical Advisory Committee" (the Committee). The Committee is to review and provide comments and recommendations to the Secretary on physician focused payment models (PFPMs) submitted by stakeholders. The law also requires the Secretary to establish, through notice and comment rulemaking following an RFI, criteria for PFPMs, including models for specialist physicians, that could be used by the Committee for making its comments and recommendations. This RFI is intended to fulfill that requirement and seeks input on potential criteria that the Committee could use for making comments and recommendations to the Secretary on PFPMs proposed by stakeholders.

[11] MACRA requires the Secretary to enter into contracts or agreements with entities (such as quality improvement organizations (QIOs),

regional extension centers (RECs), and regional health collaboratives beginning in FY 2016 to offer guidance and assistance to MIPS EPs in practices of 15 or fewer professionals. Priority is to be given to small practices located in rural areas, HPSAs, and medically underserved areas, and practices with low composite scores. The technical assistance is to focus on the performance categories under MIPS, or how to transition to implementation of and participation in an APM.