November 9, 2015

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Ave., SW
Washington, DC 20201

Dear Administrator Slavitt,

On behalf of the American Academy of Family Physicians (AAFP), which represents 120,900 family physicians and medical students across the country, I am responding to CMS's request for information regarding implementation of the Merit-Based Incentive Payment System (MIPS), promotion of Alternative Payment Models (APM), and incentive payments for participation in eligible APMs as published in the October 1, 2015 *Federal Register*.

Before the AAFP responds to the questions posed by CMS, we must reiterate our full support for the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). This law not only repealed the faulty sustainable growth rate formula, but it also set our health care system on a path away from episodic, fee-for-service payments toward more comprehensive and value-based payment. Furthermore, *MACRA* enables us to rebalance US care delivery systems to place greater emphasis on the value of comprehensive, continuous, coordinated, and connected primary care to both patients and payers.

Despite our strong support for MACRA, the AAFP remains very concerned that the MIPS and APM programs will be built upon the biased and inaccurate relative value data currently used in the fee-for-service system. We strongly recommend that more be done to ensure Medicare pays appropriately for primary care physician services in these new payment models rather than paying based on this biased actuarial data that further exacerbates the undervaluation of primary care services. To achieve this goal, we urge CMS to use its authority and take administrative actions to increase the values of primary care services in the Medicare program.

The AAFP looks forward to working with your agency. We remain an available resource as CMS further develops MIPS and APM options that will influence Medicare payments to physicians beginning in 2019. Our comments respond to your full set of questions, focusing on a subset of specific themes. The following is a summary of those themes:

- **Measure Harmonization**
  The AAFP supports reasonable and achievable quality improvement programs that promote continuous quality improvement and measure patient experiences. However, the AAFP opposes an approach that requires physicians to report on a complex set of measures that do not impact or

influence the quality of care provided to patients. Unfortunately, the current PQRS program does not support true quality improvement. Instead, it focuses on making physicians comply with burdensome reporting criteria, using resources that could otherwise be spent on continuous and meaningful quality improvement activities. By placing an emphasis on satisfying reporting requirements to avoid penalties, current programs distract attention from the real goal—providing high quality health care to patients. The AAFP strongly urges CMS to streamline, harmonize, and reduce the complexity of quality reporting in the MIPS and APM programs. All measures used must be clinically relevant, harmonized among all public and private payers, and minimally burdensome to report. To accomplish this, the AAFP recommends in numerous places that **CMS use the core measure sets developed by the multi-stakeholder Core Quality Measures Collaborative to ensure alignment, harmonization, and the avoidance of competing quality measures among payers. These sets contain a variety of measure types**.

- **Definition of the Patient Centered Medical Home**
  The AAFP strongly supported the inclusion of the Patient-Centered Medical Home (PCMH) in *MACRA*. We continue to believe this advanced primary care delivery model, when aligned with an appropriate payment model, represents the best path for empowering primary care to deliver on the Triple Aim. We will state explicitly that we do not consider the PCMH tantamount to third-party recognition as a PCMH. The PCMH is a set of functions within a practice, not something granted by a third party. The AAFP encourages CMS to consider the *Joint Principles of the Patient-Centered Medical Home* and the key functions of the Comprehensive Primary Care (CPC) initiative as criteria for determining what constitutes a PCMH. The Joint Principles, when aligned with the five key functions of the CPC initiative, capture the true definition of a PCMH and its performance thresholds.

  Furthermore, we do not believe a physician should be required to pay a third party to secure the recognition necessary to participate in a Medicare program.

- **Comprehensive Primary Care Payment Reform**
  The AAFP strongly supports moving a larger percentage of payments from the traditional fee-for-service model toward APMs, a position also supported by Family Medicine for America's Health, a collaboration of leading family medicine organizations in the United States. We believe payment models should be designed to promote quality over volume. With respect to primary care, CMS should establish an APM that is a PCMH model based on the *Joint Principles of the Patient-Centered Medical Home* and the key functions of the CPC initiative.

  Furthermore, the AAFP proposes that payments for primary care services under this advanced primary care delivery model be made on a per-patient basis through the combination of a global payment for direct patient care services and a global care management fee. The global payment for primary care services would capture the "core primary care" services, a majority of which are provided by family physicians. AAFP records indicate these services number approximately 80. Any services provided by the family physician that fall outside the core primary care suite would be paid on a fee-for-service basis, through an appropriate bundle, or via a global payment structure. The second element of this blended payment model — a global care management fee—would capture those services performed by the physician or practice that contribute to the continuity and coordination of care, promote compliance and adherence, and facilitate appropriate use of health care resources.

  The AAFP further proposes both the global payment for core primary care services and the global payment for care management be risk-adjusted based upon patient health status, as well as demographic, socioeconomic, and geographic factors. We believe both the global payments for both

core primary care services and care management payments should be eligible for the five percent bonus payment under the APM program.

- **Virtual Groups**
  The AAFP sees great value and promise in the use of virtual groups as a means of allowing solo and small practices to aggregate patient populations, align resources, and form a structure to help them them to improve their performance while maintaining their independence.

  We believe virtual groups should be limited to physicians in the same discipline—or closely aligned disciplines—and connected by a reasonable geographic boundary. Considering that virtual group programs have already been established and have demonstrated favorable quality and cost performance before the implementation of MACRA, the AAFP believes there should be no limit on the number of virtual groups in the first year. To encourage the creation and growth of virtual groups, the AAFP calls on CMS to allow virtual groups to consist of multiple Taxpayer Identification Numbers (TINs) or to classify multiple TINs to be classified under a new TIN specific to the new virtual group. At least in the early years of the program, the AAFP encourages CMS not to allow TINs to split for the sake of administrative simplicity.

  In addition, the AAFP believes CMS should establish thresholds based on the eligible number of patient lives attributed to a virtual group, and not arbitrarily dictate and restrict the number of providers participating in a virtual group. To secure a statistically valid patient sample size, which we believe will also facilitate the production of desired outcomes, we recommend that the patient sample be more than 5,000 to assure statistical validity. However, we fully recognize that CMS needs to solve how this number will impact this creates an issue that CMS needs to solve in order to effectively engage those practices in rural, sparsely populated areas.

- **Patient Attribution**
  The AAFP encourages CMS to use the attribution methodology used in the Comprehensive Primary Care (CPC) initiative since that program uses a prospective attribution model. Prospective attribution dramatically increases patient engagement with a usual source of primary care and does not have to limit patient choice in any way. In addition, providing physicians with a prospective list of patients for which they are responsible facilitates proactive population management, which leads to improved outcomes. In contrast, retrospective attribution methodologies are particularly burdensome to physicians, because it is challenging for physicians to engage in effective population health management if they do not know which patients need to be targeted for delivery, management, and/or coordination of care. The AAFP also urges CMS to include a reconciliation process in whatever methodology it adopts. Under such a reconciliation process, a family physician should be able to review, add, or remove patients from the list received from CMS. This element is currently lacking in the CPC's attribution methodology.

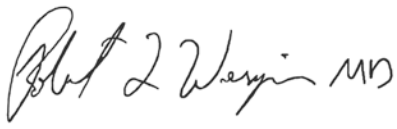
- **Meaningful Use**
  The AAFP believes several barriers exist to successfully meeting the MIPS quality performance category. The first and most significant barrier is the poorly designed meaningful use program and its lack of interoperability standards, which prohibit the sharing of patient information in a useful form. Physicians face significant challenges with their EHRs and meeting current meaningful use standards. Until the meaningful use program is improved and the EHR issues are resolved, it is difficult to foresee a large percentage of physicians—particularly physicians in small and independent practices—being successful in MACRA programs. EHRs should be a tool for success in a physician's practice, not an obstacle to overcome.

- **Clinical Practice Improvement Activities**
  The AAFP encourages CMS to offer physicians multiple options for completing clinical practice improvement activities. If a practice is a recognized PCMH, then CMS should immediately provide this practice with the maximum score and not require further verification from the practice. If an Eligible Provider (EP) completes an accredited Performance Improvement Continuing Medical Education (PI-CME) activity, as defined by the AAFP, AMA, AOA, AAPA or other nationally recognized credit systems with a formally defined PI-CME activity category, then CMS should immediately provide this practice with substantial points toward the score for the Clinical Practice Improvement Activities Performance Category, and need not require further verification from the practice. However, if the practice is not a recognized PCMH, and the EP has not completed an accredited PI-CME activity during the time frame under evaluation, then other options could be considered for completion of clinical practice improvement activities. Such options could include participation in clinical practice improvement activities required by hospitals and health systems, specialty certifying boards or societies, state Medicaid or payers.

- **Health Disparities**
  The AAFP supports reducing health disparities as a part of care delivery and urges CMS to move forward with expanding its risk-adjustment methodology in quality measures to incorporate social and economic factors such as race, income, education, and region. Risk-adjusting for socioeconomic status ensures the measures are fair and sets the standard for comparison of physician performance by adjusting for factors outside of the physician's control. Not adjusting could lead to misleading conclusions about physician performance. As a result, further disparities in care could be magnified. Through HealthLandscape, the AAFP has developed the Community Vital Signs tool that could assist practices of all sizes understand the social and economic status of their patient population.

We thank you for the opportunity to provide these comments and suggestions regarding *MACRA*. We look forward to working with you and your colleagues during the upcoming year to establish a regulatory framework that will transform our health care system, improve patient outcomes and experiences, and appropriately utilize our nation's limited financial resources. Please do not hesitate to call upon the AAFP for assistance. For additional information, please contact Shawn Martin, Senior Vice President for Advocacy, Practice Advancement and Policy at smartin@aafp.org or 888-794-7481 ext. 2500.

Sincerely,



Robert L. Wergin, MD, FAAFP
Board Chair

Enclosed:
-AAFP response to the 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

AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

Response to the 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

A. The Merit-Based Incentive Payment System (MIPS)

1. MIPS EP Identifier and Exclusions

CMS solicits input to the planning and implementation of the MIPS and requests comments on what specific identifier(s) should be used to appropriately identify MIPS eligible professionals (EPs) for purposes of determining eligibility, participation, and performance under the MIPS performance categories. In the request for information (RFI), CMS seeks comments on the use of Tax Identification Numbers (TINs) and National Provider Identifiers (NPs), or a combination thereof, whether the agency should create a distinct MIPS Identifier, and the advantages and disadvantages associated with these alternatives.

The AAFP recommends CMS use a combination of the MIPS EP's TIN and NPI, as the agency does in the PQRS and other programs. We oppose the establishment of a new identifier—it is not needed and would only add to the daily administrative complexity physicians currently face. A combination of these existing identifiers is that it will enable easier identification of MIPS EPs for research purposes, as well as allow easier linkage of the MIPS program data with other data sets for research purposes. Additionally, most physician practices are accustomed to using the existing NPI and TIN identifier system. One disadvantage of creating a new distinct MIPS identifier would be the requirement to use a crosswalk to link MIPS data to other data sets. The TIN and NPI combination also allows for the identification of group practices. Performance for MIPS EPs that practice under multiple TINs should be calculated based on the unique TIN-NPI combination. The EP, group practice, and virtual group should be required to update their information in the Provider Enrollment, Chain and Ownership System (PECOS) when, and only when, there is a change in the information.

If the MIPS EP identifier is a combination of NPI and TIN, individuals should be able to change identifiers only if they enter or leave a virtual group. CMS should carefully construct the rules for entering and leaving a virtual group to restrict opportunities for individuals who are "poor-performing" to switch identifiers.

2. Virtual Groups

HHS is authorized under MACRA to establish a process to allow an individual MIPS EP or a group practice of not more than 10 MIPS EPs to elect for a performance period to be a virtual group with other such MIPS EPs or group practices. CMS seeks comment on the following questions:

How should eligibility, participation, and performance be assessed under the MIPS for voluntary virtual groups?

For virtual groups, eligibility, participation, and performance should be assessed no differently than any other groups under MIPS. The AAFP believes voluntary virtual groups should be able to collaborate as a team in order to transform health care delivery. Virtual groups can demonstrate this by signing an agreement with a payer, outlining performance expectations, as well as risk and reward parameters. The program should be balanced such that quality and cost performance are rewarded.

Virtual groups should have a unique, newly created identifier to enable effective identification of the group. If a virtual group consists of a subset of EPs for one TIN, CMS needs to be able to identify the subset that is part of the virtual group separate from the entire TIN. However, at least in the early years of the program, the AAFP encourages CMS to not allow TINS to split for the sake of administrative simplicity.

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To encourage the creation and growth of virtual groups, the AAFP calls on CMS to allow virtual groups to consist of multiple TINs or for multiple TINs to be classified under a new TIN specific to the new virtual group. The AAFP foresees virtual groups forming in a variety of settings and circumstances, and we encourage CMS to not be overly prescriptive on the administrative structure of these 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 we allow TINs to split?
At least in the early years of the program, the AAFP encourages CMS to not allow TINs to split for the sake of administrative simplicity. If CMS allows TINs to split and individual members of a TIN have decided not to join the virtual group, they should be considered as individual EPs, unless CMS has some means to collectively consider them apart from the individuals in the TIN who joined the virtual group.

Should there be a maximum or a minimum size for virtual groups? For example, should there be limitations on the size of a virtual group, such as a minimum of 10 MIPS EPs, or no more than 100 MIPS EPs that can elect to be in a given virtual group?
The AAFP believes CMS should establish thresholds based on the eligible number of patient lives attributed to the virtual group and not arbitrarily dictate and restrict the number of providers participating in a virtual group. However, to be statistically valid, we recommend patient sample size be more than 5,000. We fully recognize CMS needs to solve how this number will impact this creates an issue that CMS needs to solve for on how to effectively engage those practices in rural, sparsely populated areas.

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? We are 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 we should consider? Should we limit for virtual groups the mechanisms by which data can be reported under the quality performance category to specific methods such as QCDRs or utilizing the Web interface?
As virtual group programs have already been established and have demonstrated favorable quality and cost performance before the implementation of MACRA, the AAFP believes there should not be a limit on the number of virtual groups in the first year. Furthermore, the AAFP sees virtual groups as an opportunity for small group practices to be successful under MACRA. Limiting the availability of this pathway would restrict opportunities for small and independent practices.

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? Should limits be placed on the size of virtual groups or the number of groups?
For reasons already stated, the AAFP does not believe CMS should arbitrarily restrict the number of virtual groups.

Under the voluntary virtual group election process, 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?
The AAFP recommends CMS allow prospective virtual groups to demonstrate through an application process, and that they have reliable mechanisms in place for establishing patient attribution, as well as reporting under MIPS throughout the performance period. These mechanisms could include the virtual group prospectively receiving patient consent in a manner similar to the requirements of the chronic care management services. Alternatively, it could include the option for virtual groups to demonstrate patient attribution through previous claims submitted by providers within the virtual group. Either method enables practices in the virtual group to know which patients are attributed to the group and how the virtual group is performing in real time, allowing—if needed—practices to modify their actions during the performance period and make improvements, if needed. We encourage CMS to not

be restrictive in how virtual groups demonstrate this and instead allow flexibility for innovative proposals from virtual groups as part of the anticipated application process.

Section 1848(q)(5)(I)(ii) of the Act provides that a virtual group may be based on appropriate classifications of providers, such as by specialty designations or by geographic areas. 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?
Since CMS and physician practices already offer a way for multi-specialty groups to come together through the Medicare Shared Savings Program and other accountable care organization options, the AAFP urges CMS to limit virtual groups to practices of the same or similar specialties. We view the design of virtual groups as intending to increase the number of patients for quality evaluation, which is best done by single or similar disciplines to facilitate comparison. The AAFP believes any limitations should be based on the chosen population, its size, and where they reside and not by an arbitrary mileage restriction or state boundary. Since patient populations can be widely dispersed or closely compacted depending on the geographic area, CMS should not impose an arbitrary mileage limitation. Instead, CMS should consider population density or other geographic limitation based on the location of the virtual group.

3. Quality Performance Category
a. Reporting Mechanisms Available for Quality Performance Category
In the RFI, CMS seeks comment on the following questions:

Should we maintain all PQRS reporting mechanisms noted above under MIPS?
While PQRS participation is increasing, only 51 percent of eligible providers participated in 2013. The lack of participation is multifactorial, but the complexity of reporting requirements contributes to poor participation. There is a general belief among physicians that reporting of claims data does little to improve patient care. In a recent AAFP member survey assessing members' readiness and perceptions of value-based payment, more than 80 percent of AAFP members believe the lack of resources to report, validate, and use data is a barrier to value-based payment success.

Current PQRS reporting mechanisms are very confusing to practices due to the amount of options, the complexity, and onerous criteria. However, given that physicians function in practices of various sizes with differing available resources to spend on reporting, CMS should continue to provide several methods and options—Group Practice Reporting Option (GPRO) web-interface, Qualified Clinical Data Registry Reporting (QCDR), electronic health record (EHR), registry, claims—to report on quality measures for the MIPS program. The AAFP does not yet see a single perfect reporting solution for all practices, and our members vary in their reporting capabilities and practice sophistication. Though it continues to yield a relatively high failure rate, claims-based reporting is the only feasible option for some practices while other practices are able to take advantage of other means.

We encourage CMS to choose reporting options that require the least amount of burden. Instead of overly focusing on the reporting of quality measures, CMS should keep the focus on a continuous process for clinical improvement. Ultimately, QCDR-based reporting may be the least burdensome as work is done "behind the scenes." However, the set-up for QCDR is time consuming and a costly investment for the practice. Though the EHR reporting option in theory should be less burdensome, practices continue to find it difficult to work with EHR vendors. Members report many concerns with this reporting option. While claims data may be all that is available at the present time, CMS should pursue pathways that allow for the reporting of clinical data. Despite the lack of a perfect reporting option, CMS should encourage quality reporting by physicians to focus on care delivery and quality measures, not on the technology used for reporting.

If so, 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?

The data selected for use should be valid and reliable, and discrepancies should be analyzed carefully to ensure the physician is receiving an appropriate quality score based on the physician's true performance. If data is submitted via multiple methods, CMS must establish a review process that includes the physician or practice to help determine the accuracy of the data submitted and choose the reporting method that contains the most valid and reliable data reflecting the EP's true performance. The time for this review must be adequate and realistic (e.g., 90 days). There is widespread concern that the current PQRS reporting mechanisms are inadequate, as data submitted via electronic health record (EHR) and qualified clinical data registries (QCDR) could not be validated and subsequently left out from the 2016 value-based payment modifier program. CMS must resolve these issues prior to moving forward.

Many of the challenges outlined in this question further demonstrate the need for applicable and accepted interoperability standards. The lack of such standards makes the reporting and collection of data from multiple sources overly complex and challenging for physicians.

What considerations should be made to ensure a patient's data is not counted multiple times? For example, if the same measure is reported through different reporting mechanisms, the same patient could be reported multiple times.

We believe CMS can ensure a patient's data is not counted multiple times by examining the TIN and NPI combination submitted with the measure. This would allow for the proper identification of the physician and practice. If multiple physicians and practices report on a single patient more than once, that likely means that the patient was assessed multiple times, and therefore, each reporting physician and practice should receive points for purposes of CMS calculating the MIPS score. If data is submitted via multiple methods, CMS should include a review process that includes the physician or practice to help determine the accuracy of the data submitted and to choose the reporting method that contains the most valid and reliable data reflecting the true performance. If this is to take place, the review time needs to be adequate and realistic (e.g., 90 days). The AAFP reminds CMS that often there is shared responsibility for a patient, as demonstrated with the All Cause Readmission and the Medicare Spending per Beneficiary Measures. However, coordination of care is not emphasized in the implementation of these measures, and the AAFP encourages CMS to address this shortfall. CMS should explore requiring virtual groups to designate a primary care physician as the coordinator of care in order to avoid duplication in counting a patient's data.

Should we 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?

The AAFP supports reasonable and achievable quality improvement programs that promote physician involvement. **The AAFP strongly recommends CMS use the core measure sets developed by the multi-stakeholder Core Measure Collaborative to ensure alignment, harmonization, and the avoidance of competing quality measures among payers. These sets contain a variety of measure types**. Unfortunately, the PQRS has not been a program that supports true quality improvement. Instead, its focus is on physicians complying with burdensome reporting criteria that use resources that could otherwise be spent on meaningful quality improvement. The PQRS places an emphasis on satisfying reporting requirements in order to avoid penalties rather than improving the quality of patient care. We strongly encourage CMS to streamline and reduce the complexity of the PQRS criteria under MIPS. Measures need to be clinically relevant, harmonized among all public and private payers, and minimally burdensome to report.

Should we maintain the policy that measures cover a specified number of National Quality Strategy (NQS) domains?

While good in theory, the NQS adds complexity for a physician when choosing which measures to report. Additionally, there is little supporting evidence that the NQS domains themselves lead to improved care. This added layer of complexity requires a physician to navigate the domains and subset of available measures within that domain, diverting attention away from measures that may have a greater impact on the physician's patient panel. **The AAFP strongly recommends CMS use the core measure sets developed by the multi-**

stakeholder Core Measure Collaborative to ensure alignment, harmonization, and the avoidance of competing quality measures among payers. These sets contain a variety of measure types targeting different clinical areas.

Should we require that certain types of measures be reported? For example, should a minimum number of measures be outcomes-based? Should more weight be assigned to outcomes-based measures?

The AAFP strongly recommends CMS use the core measure sets developed by the multi-stakeholder Core Measure Collaborative to ensure alignment, harmonization and the avoidance of competing quality measures among payers. An outcome measure is not a starting point but an ending point. Establishing strong and meaningful process measures that are tied to evidence-based outcomes can help lead a practice toward improvement. Disjointed process and outcome measures lead to an increased administrative burden. The PCMH/ACO core measure set contains a variety of measure types including process, outcome, and patient reported outcome measures. Before assigning weight to measures, CMS needs to assure that the data is valid and reliable. Therefore, the AAFP recommends CMS consider phasing in measure weighting and not include it from the beginning of MIPS.

The PCMH model empowers patients to participate fully in their care—and places the patient at the center of the care team. In this role, patients play an active part in setting goals, participating in treatment decisions, engaging in self-care, and monitoring and assessing outcomes. Health care is a true partnership in which the physician and the patient both have responsibilities. However, this shared responsibility is currently not demonstrated in performance measurement; rather it rests with the physician. The goal of performance measurement is to improve patient outcomes, including improving the patient's health status, as well as reducing their morbidity and mortality. Therefore, it is important to engage all stakeholders that have an impact on these goals, including patients, family members or caregivers, clinicians, and the health care system. Current quality measures only take into account the physician's performance and do not explicitly acknowledge these interdependencies so that everyone can work together towards the improved health of the patient. Family physicians work in collaboration with patients through shared decision making, motivational interviewing, and relationship building to create an environment of trust, engagement, and activation. Regardless of these efforts, there are patients who are unwilling to engage or participate in the treatment plan co-created by themselves and the physician. Sometimes this is due to socioeconomic determinants of health factors. In these cases, the AAFP is supportive of risk adjustment.

However, there are patients who actively choose not to participate in their health care and do not actively engage in the process. For these patients, the AAFP seeks to encourage CMS to consider measures of patient compliance that take into account the patient's active role in their health care. This measure would allow a physician and evaluators of performance to see the total picture of performance, while taking into account the shared responsibility of the partnership, not just a partial view. Measures could include adherence to prescribed medications, refusal of appropriate treatment, and active participation in and adherence to longitudinal treatment. Enabling this type of measurement allows physicians to account for those patients who lack engagement thereby reducing the potential issue of adverse patient selection.

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

CMS should consider reporting mechanisms that include the ability to stratify the data by demographic factors. This approach, however, should be carefully phased in. It is AAFP's policy on health literacy—the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health care decisions—that the AAFP champions the promotion of health literacy throughout all aspects of the health care system. To truly capture and improve health disparities, an EHR must capture or incorporate data such as income, health literacy levels and other socio-demographic factors. We support the collection of this data and its use in performance measures; however, EHRs must first integrate this capability into their systems. The AAFP is supportive of the collection of this data, but we are also concerned with the undue

burden that this may place on practices if EHRs are unable to capture this information easily or at an increased cost.

The AAFP has extensive experience in this area through our HealthLandscape products and services. Through HealthLandscape, the AAFP-developed a tool—Community Vital Signs API—allows a physician or practice to incorporate community-level demographic and economic data into their EMR to provide a more comprehensive analysis of the individual patient and the population of their patient panel.

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? What considerations should be made as we further implement CAHPS for all practice sizes? How can we leverage existing CAHPS reporting by physician groups?

The AAFP strongly recommends CMS use the core measure sets developed by the multi-stakeholder Core Measure Collaborative to ensure alignment, harmonization, and the avoidance of competing quality measures among payers. These sets contain a variety of measure types, including patient-reported outcome measures, such as CAHPS.

As the patient-physician relationship is the foundation of primary care, the AAFP is appreciative that CMS continues to value the patient's experience. Additionally, the quality and safety principle, as outlined in the *Joint Principles of the Patient-Centered Medical Home*, indicates the importance and value of patients being active participants in their care through feedback. Therefore, the AAFP is supportive of measuring patient experience through surveys such as the CAHPS and others.

However, we are concerned about the resources needed for small practices to participate in CAHPS using a certified vendor. The AAFP believes that measures should not impose an inappropriate financial burden on practices collecting data, as outlined in our policy on Performance Measurement Criteria. Requiring a practice to pay for the administration of CAHPS is requiring them to pay to participate in Medicare, which the AAFP adamantly opposes. The mandate to use a CAHPS-certified vendor comes with great expense and is resource intensive, especially for smaller practices. If using CAHPS continues to cost practices, small practices will likely not be able to afford to implement it, and thus, these practices could receive a reduction in points. Furthermore, practices should not be penalized for factors outside of their control, such as lack of patient engagement in completing the survey. **The AAFP notes that CMS, as part of the Core Quality Measures Collaborative effort with the AHIP and others, has suggested that the CAHPS survey be provided free to physician offices and their patients through an online process. The AAFP is very supportive of this effort for all practices and especially physicians in small practices.**

What are the potential barriers to successfully meeting the MIPS quality performance category?

The AAFP believes several barriers exist for successfully meeting the MIPS quality performance category. The first and most significant barrier is the poorly designed meaningful use program and the lack of interoperability standards that prohibit the sharing of patient information in a useful form. Physicians face significant challenges with their EMRs and meeting current meaningful use standards. Until the meaningful use program is improved, it is difficult to foresee a large percentage of physicians, specifically small and independent practices, being successful in the MIPS or APM program. There are other challenges, which include:

- Overly complex program requirements;
- Burdensome and difficult reporting requirements;
- Lack of measure alignment among payers;
- Lack of timely and actionable feedback for improvement;
- Perception that MIPS is yet another reporting program and not a program to improve quality and reduce costs;
- Patient non-compliance with treatment plans and medication;
- Inaccurate patient attribution;

- Lack of risk-adjustment for socioeconomic factors;
- Lack of interoperability to accurately transmit and receive data across the medical neighborhood;
- Lack of practice infrastructure to help them effectively carry out quality improvement efforts and target high-risk, high cost patients (e.g. care coordinators); and
- Lack of resources to report, validate, and use data.

What are the potential barriers to successfully meeting the MIPS quality performance category?
The AAFP believes several barriers exist for successfully meeting the MIPS quality performance category. The first and most significant barrier is the poorly designed meaningful use program and the lack of interoperability standards that prohibit the sharing of patient information in a useful form. Physicians face significant challenges with their EMRs and meeting current meaningful use standards. Until the meaningful use program is improved, it is difficult to foresee a large percentage of physicians, specifically small and independent practices, being successful in the MIPS or APM program. There are other challenges, which include:

- Overly complex program requirements;
- Burdensome and difficult reporting requirements;
- Lack of measure alignment among payers;
- Lack of timely and actionable feedback for improvement;
- Perception that MIPS is yet another reporting program and not a program to improve quality and reduce costs;
- Patient non-compliance with treatment plans and medication;
- Inaccurate patient attribution;
- Lack of risk-adjustment for socioeconomic factors;
- Lack of interoperability to accurately transmit and receive data across the medical neighborhood;
- Lack of practice infrastructure to help them effectively carry out quality improvement efforts and target high-risk, high cost patients (e.g. care coordinators); and
- Lack of resources to report, validate, and use data.

b. Data Accuracy
Since accuracy of data is critical to the proper calculation of a MIPS composite score, CMS seeks comment on what additional data integrity requirements should be in place for the reporting mechanisms in the MIPS program. Specifically, CMS seeks comment on the following questions:

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?
CMS should define quality measurement reporting lifecycles to range from the initial data collection to the submission of validated measures. For each stage in the life cycle, there needs to be standards for both input into the lifecycle stage as well as standards for the output stage. CMS, the Office of the National Coordinator for Health Information Technology, and the National Institute of Standards and Technology can then work on certification requirements for each lifecycle stage. This allows for flexibility in product development and implementation, while assuring measure fidelity across the entire lifecycle.

The AAFP identifies the following lifecycle stages:

1. Data collection
2. Patient-level aggregation
3. Measure calculation
4. Measure result validation
5. Provider/practice measure review
6. Submission package creation
7. Measure package submission

One of the limitations of the current certification process for certified EHR technology is that certification is at only one level. The AAFP believes this limitation holds certification at a low bar. To further drive the market, the AAFP believes that at least a two-tier certification would be more helpful. This would allow the lower tier to represent the minimally required certification to support each lifecycle stage whereas the higher tier can be reserved for more exceptional implementations of the lifecycle stage.

The AAFP calls for CMS to provide a full suite of testing tools to support vendors in developing products to pass certification. In the best case, these tools would be open source, so vendors could integrate them into their development and building processes. We believe CMS should produce a robust set of test data for vendors and certifiers to use for testing their products. Furthermore, CMS should establish a process for rapid evaluation and improvement of certifying and tooling, since the AAFP believes testing needs to be agile as new knowledge is gained. We also believe aftermarket surveillance is important if we are to be sure the certification process is ensuring products work as intended in full-scale production.

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?
Yes, there should be a default standard that all products use for submitting quality measures and all products use for receiving quality measures support and use. Given the lack of interoperability standards, this would ensure a minimum level of interoperability across the quality measurement ecosystem. Beyond this default standard, the market should be allowed to use other standards that achieve the desired functionality of sharing quality measurement data, but we reiterate that all involved must support the default standard.

Should CMS require that qualified registries, QCDRs, and health IT systems undergo review and qualification by CMS to ensure that CMS' form and manner are met? For example, CMS uses a specific file format for qualified registry reporting. What should be involved in the testing to ensure CMS' form and manner requirements are met?
Using the lifecycle model the AAFP discussed in response to the first question within the Data Accuracy section, CMS should focus on the inputs and outputs regarding qualification. The QCDR or health IT system under review should be given a set of inputs for the appropriate lifecycle stage(s), and CMS should verify the achieving of appropriate output(s). The only exception would be to verify that health information is being protected. QCDR providers and health IT vendors should be required to attest to policies and procedures that ensure confidentiality of patients and providers.

What feedback from CMS during testing would be beneficial to these stakeholders?
The AAFP believes CMS must ensure that the testing and certification process is completely transparent. CMS should provide reporting feedback to practices, including which requirements were passed and which were not. For key requirements that require interaction with the end-user, CMS should strongly consider recording the process during certification and make the recordings available in the final report. This would give clarity on how a specific requirement is intended to be completed by the end-user. End-users could the use these videos during their purchase and/or upgrade deliberations.

What thresholds for data integrity should CMS have in place for accuracy, completeness, and reliability of the data? For example, 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? Should CMS not require MIPS EPs to submit a calculated performance rate (and instead have CMS calculate all rates)? Alternatively, for example, 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 the data represents demonstrably wrong data, the submission should be immediately rejected with specific error reporting for the submitter to know why the data was demonstrably wrong, such as the numerator is larger than the denominator. All such submissions should be logged by CMS. Periodic reviews or automatic thresholds that

trigger a review should be put in place. On review, a post-market audit of the QCDR or health IT system may be warranted. The further downstream the patient data travels from the point of care, the greater the likelihood of a data breach. CMS should allow for the submission of calculated quality measures to mitigate the data-breach risk.

The AAFP believes blatant errors, such as a numerator being bigger than a denominator, should automatically be rejected as well as submissions that fail other validation routines CMS should utilize. Most errors will be undetectable by validation routines as they are typically related to underlying data collection or organization errors. These latter errors will be present in many novel reporting attempts and organizations should be pressed to improve their underlying data structures but have a grace period to do so. For example, if a practice has multiple empty fields for quality measures, this is more likely to be related to either recording or pulling data incorrectly. This is not an "error" that a validation routine would capture but it is deserving of reaction to the practice via the QCDR to audit or otherwise certify that these are not missing data but actually related to care gaps. There will likely be large changes in reported measures for practices migrating to a new EHR. This occurs frequently in the current health care environment. A practice might have radical changes in its reported measures between two years. In these types of cases, because preventive service data is not migrated, practices often must manually refill the critical data gaps that remain. These are also not "errors," but should trigger a query, audit, or requirement of a flag from the QCDR that explains the variance. In such cases, CMS should consider holding a practice harmless regarding MIPS payments for a year. There should be a process for recognizing blatant gaps or radical changes from past reporting that trigger queries about their cause or be referred back to the QCDR for a review, audit, or flag. While nearly 90 percent of family physicians have an EHR, less than 15 percent can produce registries essential to measuring production and reporting. There will be three- to five-year rolling period where errors will occur with great frequency, and the ability of QCDRs and practices to mitigate them will be difficult. The AAFP recommends a short-term tolerance approach that includes a mid-term option for practices to correct error-related audits or queries. Finally, CMS should include a long-term goal to reduce errors, while respecting EHR migrations and other factors will always cause periods of high-error generation for some practices and systems.

If CMS determines that the MIPS EP (participating as an individual EP or as part of a group practice or virtual group) has used a data reporting mechanism that does not meet our data integrity standards, how should CMS 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?

The AAFP calls on CMS to make it clear and transparent to the provider if a specific QCDR or health IT system has passed certification for data integrity standards. If a product has passed certification, and then was found to have data integrity issues, the provider should be held harmless. CMS should notify the QCDR or health IT system immediately upon determination that data integrity standards are not being met. The organization should be given enough information to understand what is not being met. Additionally, it should be given a small grace period, 90 days for example, to fix the issue. If the provider has not rectified the problem within that time, it should be penalized financially. If the issues have not rectified, within 120 days, certification should be removed. CMS should maintain an online list of all QCDR and health IT systems that are having data integrity issues within that 120-day window.

c. Use of Certified EHR Technology (CEHRT) under the Quality Performance Category

In the RFI, CMS seeks comment on the following questions:

Under the MIPS, what should constitute use of CEHRT for purposes of reporting quality data?

The AAFP considers whether the only relevant and important action is the successful submission of quality measurement data and not whether a provider used a specific piece of technology. Providers should be able to use the best technology available to them. If that technology is not certified, then additional requirements on the provider may be made to demonstrate valid calculation of quality measures.

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. Per the AAFP's response to the Data Accuracy section, we outline a process to certify health IT components that perform the different stages of the quality measure reporting lifecycle.

4. Resource Use Performance Category

In the RFI, CMS seeks comment on the following questions:

Apart from the cost measures, 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?
The AAFP supports the Choosing Wisely campaign and has endorsed a list of 15 recommendations highlighting potentially unnecessary tests and overutilization. Since the Choosing Wisely website states, "each patient situation is unique, providers and patients should use the recommendations as guidelines to determine an appropriate treatment plan together," it is imperative that physicians and patients use shared decision making to determine the right approach for that specific patient. Additionally, it is imperative physicians not be penalized by cost or resource use measures when choosing the right approach for a specific patient.

The AAFP strongly recommends CMS use the core measure sets developed by the multi-stakeholder Core Measurement Collaborative to ensure alignment, harmonization, and the avoidance of competing quality and resource use measures among payers. These sets contain a variety of measure types including resource use and overutilization measures as targeted by Choosing Wisely. It is important to consider that while family physicians will have frank and engaged discussions with their patients about "choosing wisely," patients may still choose more expensive care or unnecessary tests that contribute to the total cost of care.

Family physicians and other primary care providers can be responsible for the management of the total cost of care as long as they have access to real-time quality and cost information and resources needed to monitor cost. Cost for surgeries, procedures, labs, and diagnostic tests should be available to physicians, so they and their patients can make informed decisions when referring patients to specialists and ordering diagnostic tests and labs. This is especially true for attributed patients. Necessary resources include easy-to-use tools to view and share cost and resource use information with their patients, increased global payment for primary care services, and an appropriate care management fee (similar to that of the Comprehensive Primary Care initiative or Chronic Care Management code).

As primary care physicians take on more responsibility for total cost of care and as payment for primary care becomes more global and comprehensive, prior authorizations, paperwork associated with justification of clinical decisions, and other hassles intended to control utilization need to be discontinued as they add administrative burden without improving patient care.

What role should episode-based costs play in calculating resource use and/or providing feedback reports to MIPS eligible professionals under section 1848(q)(12) of the Act?
Episode-based information, such as services provided and associated costs, could be helpful to a physician when making treatment and care coordination decisions with patients and for effectively managing their population of patients. However, in order for physicians to be responsible for resource use, including episode-based costs, they need access to timely and actionable information regarding these costs. Cost for surgeries, procedures, labs, and diagnostic tests should be available to EPs, so they can make informed decisions when referring patients to specialists and ordering diagnostic tests and labs. Current bundled services that roll into episode-based costs should be included in feedback reports to MIPS EPs. Additionally, physicians also need access to specialists' quality performance outcomes to make informed decisions when referring patients. Having both cost and quality information related to services furnished to their patients by other providers will enable family physicians to make

informed decisions taking into account both cost and quality. It's crucial for a family physician to have this information if they will be responsible for a patient's total cost of care or episode-based costs.

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?

The AAFP strongly recommends that CMS implement across Medicare programs the Core Measurement Collaborative's PCMH/ACO core measure set that includes resource use measures for larger MIPS entities and potentially the PCMH measures across individual and small groups.

Currently, the Value-Based Payment Modifier (VM) and the Hospital Value-Based Purchasing Program currently contain some aligned quality and resource use measures. Wherever possible, alignment should be implemented wherever possible across all parts of the Medicare program and with private payers. This alignment needs to include payment across all care settings to ensure all entities, including MIPS and EAPMs, work together to meet the triple aim. Any misalignment should be fully intentional and explained.

How should we incorporate Part D drug costs into MIPS? How should this be measured and calculated?

The AAFP agrees that Medicare Part D drug costs should be incorporated into MIPS. However, the caveat is if physicians are held accountable for the cost management of the medications they prescribe, then current issues must be mitigated or resolved. Under current conditions, it is impossible for primary care physicians to be fully responsible for Part D drug costs.

The Congressional Budget Office (CBO) estimates Part D spending will total $76 billion this year, representing 14 percent of total Medicare spending in 2015. Currently, Medicare Part D formularies are ever changing, and the costs of generics are rapidly increasing. Pharmaceutical manufacturing companies have consolidated, creating less competition, while single manufacturers have significantly raised generic medication prices. For example, the cost of Albuterol has increased from $4 to $40.

Any value-based payment arrangement, including MIPS, should not penalize physicians for providing the drugs their patients need. Part D spending depends on several factors: the number of Part D enrollees, their health status and drug use, the number of low-income subsidy recipients, and plans' ability to negotiate discounts and rebates with drug companies and manage use (e.g., promoting use of generic drugs, prior authorization, step therapy, quantity limits, and mail order). Since physicians are not responsible for many of these pharmaceutical pricing and formulary factors, the AAFP encourages CMS to make adjustment for such factors outside the physician's control.

The negative impact of these circumstances is compounded by the fact that patients are discovering formulary and drug cost changes at the point of picking up prescriptions, which has decreased medication adherence and forced physicians to change medication protocols that were otherwise effective. Medicare patients are often on fixed incomes and very sensitive to increases in co-payments.

Exposing these frequent price and formulary fluctuations to the prescriber at the time of ordering is a large burden for providers today. The electronic drug formulary availability is not as widely available as it should and the implementation within the EHRs is very sub-optimal. These can be improved but it needs to be a priority of CMS, ONC, and the health IT industry.

Besides the instability of drug prices and formulary changes, timeliness of Part D claims information is also an issue. During the CMMI Medical Neighborhood project, Medicare Part D claims had a lag time of up to two years.

If CMS is going to incorporate Part D drug costs into MIPS, then information on cost and formularies must be available to physicians in real-time. This information allows physicians to work with patients on providing the best treatment while taking cost factors into account.

The AAFP would suggest CMS integrate Part D drug costs into MIPS using a phased-in approach. In phase one, primary care physicians should only be held responsible for the cost of the medications that they prescribe when real-time drug costs are available from the 20-22 Part D plans/region. When measuring and calculating Part D drug costs, it will be important for CMS to use medical diagnosis, socioeconomic characteristics, and other risk adjusters for comparison and benchmark purposes. These factors would help account for appropriate increased Part D medication costs associated with specific illnesses and several chronic illnesses. As prescribers of these medications, physicians will be accountable for them in terms of resource use and impact on quality, with the aforementioned reforms in place.

What peer groups or benchmarks should be used when assessing performance under the resource use performance category?
The AAFP believes peer groups and associated thresholds and benchmarks need to be as comparable as possible. To do that, there need to be adjustments or restructuring of the peer groups, as well as associated threshold and benchmarks on two levels.

One level is the patient population served by the physician/practice. Comparability at this level is attained through risk adjustment, which relates to medical risk, severity of illness/condition, socioeconomic factors, etc.

The other level concerns the demographics of the physician/practice itself. That speaks to specialty, practice size, geography, number of attributed patients, etc. The AAFP suggests the following peer groups accounting for statistical significance and mean variation of TINs with:

- One provider
- Two to five providers
- Six to 12 providers
- 13 to 25 providers
- 26 to 50 providers
- 51 to 75 providers
- 76 or more providers

Comparability is especially critical to physicians who practice in solo, small, or independent practice environments, rural settings, and in health professional shortage areas, since they may not have access to supporting services available to physicians who do not practice in other practice settings. Supporting services may include practice transformation, care coordination, access to needed specialists, behavioral health, adequate nursing, and pharmacy support. Additionally, those in smaller entities may not have IT/data sophistication, creating a disadvantage for monitoring quality and resource use.

If CMS can structure its peer comparison methodology in such a way that comparability is attained at both levels, then true peer comparisons can be made.

The AAFP is also calling on CMS to assess performance by including risk stratification based only on patient, demographic, and socioeconomic factors. We do not believe CMS should consider group size when assessing performance. Since a physician's performance will be assessed at the NPI level, CMS need not factor in a group's size. If CMS did so, the AAFP is concerned it would significantly discourage small or solo practices from achieving success in the MIPS.

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?
Quality and resource use measures need to be aligned with each other and across all specialties and care environments. Any misalignment should be fully intentional and explained. Alignment of measures would

encourage all physicians to work towards the same goal of better health and improved care at a lower cost. **The AAFP strongly recommends CMS use the core measure sets developed by the multi-stakeholder Core Measurement Collaborative to ensure alignment, harmonization, and the avoidance of competing quality measures among payers.** The PCMH/ACO core measure set contains a variety of measure types, using a variety of data sources that are appropriate for each measure. This includes both resource use and clinical quality measures.

If issues related to EHR interoperability across all care settings/physicians could be solved, care continuity and care management could be significantly improved. With shared accountability of physicians and care settings, care gaps and high-cost utilization could be corrected earlier in the process. At that point, all NPIs and TINs involved in the care could be held accountable for improving care and reducing cost.

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?
The AAFP strongly encourages CMS to align and harmonize every measure under all relevant federal programs, regardless whether or not those measures are used for the MIPS program or efforts. Measures must be evidence-based and harmonized in order that family physicians both understand and trust how CMS is measuring their performance. Family physicians participating in the MIPS should be able to focus their efforts on providing high-quality clinical care to their patients.

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?
While alignment is ideal in this program, the AAFP does not believe merging the two performance categories would be beneficial, instead we believe that the measures must be kept distinct. However, performance measures should be evidence-based and harmonized among CMS and private payers in order for physicians to understand how their performance is being measured. More than 60 percent of family physicians have contractual relationships with seven or more private payers. Measure alignment and harmonization among public and private payers should make quality and cost reporting simpler, lead to a reduction in administrative burdens, and create more time for actual patient care. In addition, aligning measures among private and public payers should increase the patient population for a more comprehensive and thorough analysis.

5. Clinical Practice Improvement Activities Performance Category

CMS seeks comment on other potential clinical practice improvement activities and on the criteria that should be applicable for all clinical practice improvement activities.
Since the MIPS is new and will be complicated for many physicians, we believe CMS must offer physicians multiple options for completing clinical practice improvement activities. When a practice is a recognized Patient Centered Medical Home, then CMS should immediately provide this practice with the maximum score and need not require further verification from it. If an Eligible Provider (EP) completes an accredited Performance Improvement Continuing Medical Education (PI-CME) activity, as defined by the AAFP, AMA, AOA, AAPA or other nationally recognized credit system with a formally defined PI-CME activity category, then CMS should immediately provide this practice with substantial points toward the score for the Clinical Practice Improvement Activities Performance Category, and need not require further verification from the practice.

However, if the practice is not a recognized PCMH, and the EP has not completed an accredited PI-CME activity during the time frame under evaluation, then other options could be considered for completion of clinical practice improvement activities. Such options could include participation in clinical practice improvement activities as required by hospitals and health systems, specialty certifying boards or societies, state Medicaid, or payers.

In the RFI, CMS seeks input on the following categories:

A subcategory of 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 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.
Due in part to poor payment levels in the current fee for service payment model, access for patients with Medicaid and dual eligible individuals is limited. These individuals often have the greatest need for health care services, so adequately paying for services delivered is necessary to ensure adequate access. Verifying that a practice cares for these patients could be based on claims data and having this as a subcategory could improve access to care for these patients. **The AAFP would strongly object to and oppose any requirement that physicians and/or practices must accept Medicaid patients. However, the AAFP encourages CMS to measure and recognize those practices that do.**

A subcategory of 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.
Practices should have a standardized process to screen for social determinants of health such as food security, employment and housing. As noted previously, the AAFP has a tool—Community Vital Signs—that can be incorporated into an EHR. Community Vital Signs allows physicians to account for social determinants as part of their individual or population health activities. Patient screenings should be followed by appropriately linking the patient with community partners, including the public health department and appropriate social services. Currently, there is no evidence-based measure for use in the practice setting to quantify the rates of completed referrals. Comprehensive Primary Care (CPC) practices have worked on referral continuity, and CMS should take lessons and best practices from the CPC initiative to identify proven means for practices to track and report referral completion.

We believe CMS should make considerations that must include the availability of community resources and a definition or model of what is considered “evidence” of partnerships/collaboration. There needs to be some bi-directional method for these considerations and measures. The social determinants of health include poverty and its effect on health and we encourage CMS to consult our related AAFP policy as the agency develops these programs.

A subcategory of 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.
Achieving health equity is important and incredibly difficult for many physicians who care for underserved populations. These patients often face several life challenges that affect their health care, and thus, it is often harder to achieve “high quality” in these areas. Providers who serve these populations should not be penalized for these challenges. In fact, they should be rewarded for their willingness to work with their patients to address these challenges. While demographic information could be collected through the EHR and could verify to whom providers were providing care, adequate measures do not yet exist to properly evaluate the quality of care delivered to these patients. “Achieving Health Equity” should not be a sub-category under Clinical Performance Improvement, but “Reducing Health Disparities” could be considered a replacement. This would encourage providers to participate in the care of more challenging patient populations and would hopefully improve access for all.

In the AAFP’s comment letter—sent in response to the 2016 proposed Medicare physician fee schedule—the Academy urged CMS to move forward with expanding its risk-adjustment methodology in quality measures to incorporate social and economic determinates such as race, income, education, and region. Risk-adjusting for socioeconomic status ensures the measures are fair and sets the standard for comparison of physician performance by adjusting for factors outside of the physician’s control. Not adjusting could lead to misleading

conclusions about physician performance. As a result, further disparities in care could be magnified. However, given that performance measures currently do not take into account social determinates of health and socioeconomic factors we believe a physician's performance cannot be accurately measured at the current time. The NQF's trial period for Risk-Adjustment for Sociodemographic Factors is targeting this and will hopefully develop measures that will better capture reductions in health disparities. Until then, this should not be included as a subcategory of Achieving Health Equity.

A subcategory of 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.

The AAFP encourages CMS to also consider a physician's participation in:

- Disaster Medical Assistance Teams;
- Community Emergency Response Teams;
- US Public Health Service Commissioned Corps;
- Indian Health Service;
- Federally Qualified Health Centers;
- Rural Health Centers;
- Public Health Departments;
- Local Free Clinics; and
- a medical examiner capacity.

In addition, there are other things that can be done at the practice level to ensure that the practice remains open and available during an emergency. The AAFP has Disaster Relief and Preparedness information that addresses personal, practice, and community preparedness.

A subcategory of 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;

The AAFP advocates for the integration of behavioral health with primary care. We encourage CMS to create incentives and assistance to help practices achieve *the Joint Principles: Integrating Behavioral Health Care into the Patient-Centered Medical Home*. Measures and evaluation of behavioral health integration should be consistent with these principles.

The AAFP strongly encourages CMS to consider the role of primary care and behavioral health as a MIPS clinical improvement activity. While psychiatric professionals are an essential element of the total health care continuum, patients with mental health issues continue to access the health care system through primary care physicians. The desire of patients to receive treatment from their primary care physicians, or at least to have their primary care physicians more involved in their care, has been repeatedly documented with statistics showing 50 percent of all behavioral health disorders being treated by primary care. Improving mental health treatment requires enhancing the ability of the primary care physician to screen, treat and appropriately manage the psychiatric care given to patients. Since family physicians traditionally focus on treating the whole patient, they recognize the mind, body and spirit connection. Promotion of mental health, diagnosis and treatment of mental illness and substance abuse disorders in the individual and family context are integral components of family medicine. Family physicians are uniquely positioned to recognize and treat problems in the continuum from mental health to mental illness in a way that is systemic, integrated, and cost effective.

Behavioral Health integration with primary care is already being implemented in numerous locations throughout the country. CMS should look to model integration efforts to learn what factors help create successful integration, identify barriers that will keep integration from being successful, and verify mechanisms can best be used within practices to validate and measure integration. There are three primary models emerging for integration:

Consultative; Co-located; and Collaborative. Measurement and validation needs to be appropriate to each model and the degree of coordination (referral to separate location with separate funding), co-location (referral to resource located in the same office, typically with separate funding), or integration (part of same team and face-to-face coordination in same location or telemetry with same funding source). AAFP encourages CMS to look to the work on Behavioral Health integration published by the PCPCC's Behavioral Health Special Interest group. This group identified a number of best practices and model programs that could be evaluated to bring forward effective ways to validate and measure behavioral health integration in a variety of primary care settings.

Furthermore behavioral health resources are scarce in most parts of the country, with 55 percent of US counties not having a practicing behavioral health worker and 77 percent reporting unmet behavioral health needs. For those that do have access to care, if they are referred outside of their family physician's care, 30-50 percent will not make their first appointment with the behavioral health specialist. Family physicians can draw the clinical practices of medical care and behavioral health closer together by co-locating a behavioral health specialist within the primary care team, and likewise, supporting behavioral health practices that include family physicians. This "bi-directional" care coordinates medical and behavioral health services for the benefit of patients. A measure of a behavioral health specialist co-locating with a primary care physician would prove activity is taking place but would exclude most providers from this measure due to the shortage of behavior health providers available to join primary care in many communities. We encourage CMS to measure the use of the PHQ-9 in practice as a tool to validate behavioral health integration in primary care. In addition, practices should have the ability to validate their behavioral health integration by proving their efforts to refer, either locally or virtually, to a behavioral health specialist. There is currently no validated measurement for referral to behavioral health and the AAFP encourages CMS to look at referral continuity efforts and reporting in the CPC to identify effective and efficient ways to validate participation.

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?

Since the MIPS is new and will be complicated for many physicians, we believe CMS must offer physicians multiple options to attest their completed clinical practice improvement activities. When the practice is a recognized PCMH, then CMS should immediately provide this practice with the maximum score and need not require further verification from the practice. We view the PCMH as a delivery and payment model that promotes quality and value over volume. Practices and physicians that adhere to *the Joint Principles of the Patient-Centered Medical Home* and essential functions of the Comprehensive Primary Care (CPC) initiative should be considered by CMS as having satisfactorily met all MIPS clinical practice improvement activities.

If the EP has completed a certified/accredited Performance Improvement Continuing Medical Education (PI-CME) activity, as recognized by the AAFP, AMA, AOA, AAPA or other nationally recognized credit systems with a formally defined PI-CME activity category, then CMS should accept the EP's attestation of such PI-CME activity completion, provide the eligible professional with substantial points toward the score for the Clinical Practice Improvement Activities Performance Category, and need not require further verification from the practice. If further verification is needed, CMS could request data transmission from the credit system.

However, if the practice is not a recognized PCMH, and the EP has not completed a certified/accredited PI-CME activity during the time frame under evaluation, then CMS could require the EP to attest to participation in clinical practice improvement activities through their hospital, health system, specialty certifying board or societies, state Medicaid or payer network. If those organizations do not have qualified registries, QCDRs, or EHRs with direct extraction tools that enable the transmission of data to verify the EP's completion of such clinical practice improvement activities, then CMS should offer physicians the ability to attest to completion of such activities and the agency could then, if needed as part of a fraud, waste, and abuse detection efforts, verify the physician's completion of the attested activities.

What information should be reported and what quality checks and/or data validation should occur to ensure successful completion of these activities?
Again, the AAFP calls on CMS to offer an attestation method for physicians and then the agency can verify afterwards as needed.

How often providers should report or attest that they have met the required activities?
The AAFP does not believe the reporting period should be any more frequent than once yearly. CMS should align the reporting period to the performance period rather than continue utilizing the disconnected and clinically useless two-year delay between a performance year and a payment year.

What threshold or quantity of activities should be established under the clinical practice improvement activities performance category? Based on completion of a specific number of clinical practice improvement activities or specific number of hours?
Physicians and practices must have multiple options and should be able to choose from a menu of clinical practice improvement activities. When the practice is a certified, recognized PCMH, then the threshold will have been met and no additional activities should be required. If not, the EP should receive substantial points by completing three clinical practice improvement activities through their hospital, health system, specialty certifying board or society, state Medicaid or payer network. The EP would need to complete three such activities to secure all 15 points attributable to this category under the composite score; i.e., 15 percent (which is the weight of this category) of the maximum 100 point composite score. Participation in one activity would net 5 points; two activities would net 10 points. Participation in a recognized PCMH or an APM should net the practice all 15 points. The EP's completion of a certified/accredited PI-CME activity, as recognized by the AAFP, AMA, AOA, AAPA or other nationally recognized credit systems with a formally defined PI-CME activity category should net that EP substantial points.

If so, what is minimum number of activities or hours?
Scores should be based on the number of clinical practice improvement activities as above.

Should the threshold increase over time?
Possibly, but this should not occur until the program has more than 5 years of experience.

Should performance in this category be based on demonstrated availability of specific functions and capabilities?
Having functions available is important, as it is hard to track how patients actually participate. Otherwise, determining how to score this category would be burdensome for practitioners as well as CMS. However when CMS recognizes practices that are recognized PCMHs or APMs, then no other specific functions or capabilities are needed. If the EP's has completed a certified/accredited PI-CME activity during the evaluation time frame CMS should provide substantial points toward fulfilling the requirement to demonstrate participation in clinical practice improvement activities, and recognizes EP's that have completed one, two or three other types of clinical practice improvement activities as having substantially completing the requirement. For those EP's who complete a clinical practice improvement activity through their hospital, health system, specialty certifying board or society, state Medicaid or payer network, CMS may need to rely upon the EP's attestation to having completed such activities, as those organizations' qualified registry, QCDR, or EHR may not have the functional capability of transmitting such data automatically.

How should various subcategories be weighted? Should each have equal weight?
Since every community is different, it is important for each subcategory to be based on the specific community. With the ability for practices to choose their own clinical practice improvement activities from a menu of services, each practitioner could choose what is most important to their community. While the AAFP believes that the incentives in MACRA should be aligned to incentivize providing care to Medicaid beneficiaries, the weight of these subcategories should not be structured so that serving Medicaid beneficiaries is mandatory.

How should we define the subcategory of participation in an APM?
Participation in any APM defined in the law and those that will be proposed by the Physician-Focused Technical Advisory Committee for the purposes of clinical practice improvement activities should reward practices that have been participating and undergoing practice transformation. Any PCMH recognition from any entity, including commercial insurers, participation in state medical home programs, or medical home as defined under MACRA should qualify a practice for all the points in the clinical practice improvement category. The EP's completion of a certified/accredited PI-CME activity should qualify that PE for substantial points in the clinical practice improvement category. We would also encourage harmonization of the APM definition between MIPS and APM, focusing on functionally and practice transformation.

How should clinical practice improvement activities be applied to EPs in small practices or rural areas?
If clinical practice improvement activity points are based on availability of such clinical practice improvement activities, this helps apply the program to small and rural practices. If small or rural practices are allowed to choose their clinical practice improvement activities, and they only need three out of the total subcategories, it will allow them to select those activities that are most relevant to their clinic and community. However, practices should be allowed to continue with these same without being required to change or move on to something new. This on-going approach would allow small and rural practices time needed to sustain change, implement on-going improvement, and integrate new processes into workflows. Small and rural practices have access to technical assistance through MACRA and this money will be needed to assist those who are thinly staffed to achieve their clinical practice improvement goals. Most importantly, if a practice is a certified PCMH, it will receive all available clinical practice improvement points and will be better positioned to enter the APM track when an entry ramp becomes available. The technical assistance money should focus first on the core functions of medical home, which are: access, care coordination, patient engagement, risk stratified care management, and planned care. In addition practices need training and technical support for how to lead and sustain change and quality improvement at the practice level.

Should a lower performance threshold or different measure be established that will better allow those EPs to reach the payment threshold?
If points are not allocated as the AAFP recommends, barriers could exist for these EPs and in those circumstances the AAFP believes CMS should consider allowing clinical practice improvement points at a virtual group level.

What methods should be leveraged to appropriately identify these practices?
CMS should begin with the TIN of the practice to determine the number of providers attributed to that TIN based on the NPIs. CMS does not appear to currently have a clearly defined and published single definition for what qualifies an area to be considered rural. Various definitions available through federal agencies and policy organizations, if applied would have very different results for which providers would be identified as rural. CMS needs to clearly define the definition that will be used in this program and identify the impact of such definition by the number of providers that would benefit from this support. We encourage CMS to establish a broad and flexible approach that includes as many regions as possible, rather than a restrictive definition, which would limit the number of practices that qualify for consideration under the rural definition.

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?
If practices are given the option to choose from a menu of options, ranging from PCMH to certified/accredited PI-CME, to other types of clinical practice improvement activities, this would allow them to focus on what fits the needs of their population and community. As needs of clinics, communities, and populations vary, so do specific needed areas of improvement.

What types of global and population-based measures should be included under MIPS? How should we define these types of measures? What data sources are available, and what mechanisms exist to collect data on these types of measures?

The AAFP strongly recommends CMS use the core measure sets developed by the multi-stakeholder Core Measurement Collaborative to ensure alignment, harmonization, and the avoidance of competing quality measures among payers. This group has been meeting for over a year to identify the most pertinent measures for PCMH/ACO and other specialty specific providers. Global and population-based measures should only apply to an ACO, larger health system, or public health agency that is responsible for a larger population of patients. These measures are not appropriate for the individual physician or small group practice. Physicians and groups should only be responsible for the patients that are attributed to their practice, since they will have the most impact on their health.

While we believe family physicians should not be responsible for the total cost of care under the current payment system, the AAFP continues to believe that family physicians are the best stewards of health care dollars yet they only account for a small percentage of the overall health care spend. A recent study shows that few providers receive cost data on specialist, lab, hospital/ED, and pharmacy. We believe providers need more cost transparency from payers before primary care physicians can be completely responsible for the total cost of care, but we still firmly believe that primary care is best situated to control the overall health care costs.

6. Meaningful Use of Certified EHR Technology Performance Category

In the RFI, CMS seeks comment on the following questions:

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

The AAFP does not believe the performance score under this category should be based solely on the full achievement of meaningful use. This approach encourages the "check-box" tendencies of the existing meaningful use program, which only adds administrative burden to providers to meet requirements. Providers should be rewarded and supported in their efforts to meet the guidelines set forth in the MIPS program, rather than penalized for falling short. CMS should allow—and provide partial points—for what has been achieved, rather than punishing for what has not been achieved in order to develop an environment that is conducive to improvement. The AAFP advocates that performance scoring be based on linear scoring, which helps maintain even weighting among the criteria. Missing the mark on a single, heavily weighted measure could severely affect a provider's overall performance score and cause that provider to fail the category completely. Evenly weighting the measures, and giving points for what has been achieved, gives providers a better opportunity to achieve success.

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?

The AAFP does not believe a tiered methodology should be used to determine levels of achievement within this category. A tiered methodology could ultimately punish providers who are demonstrating improvement and success. **There currently is a lack of evidence to support the link between higher achievement of thresholds in the EHR Incentive program and achievement of the Triple Aim.** Additionally, the percentage of patients that meets a specific measure's criterion will vary based on the composition of the EP's patient panel. The AAFP believes there should be a threshold fairness that addresses the differences in panel composition, available resources, etc., among small and large practices. A one-size-fits-all approach will not lead to equally distributed success among providers. We ask that CMS consider stratification of benchmarking when scoring providers. Comparing group practices to similar group practices and solo practitioners to similar solo practitioners would provide more accurate data related to each provider's efforts to improve patient care.

How should such a methodology be developed?

The AAFP does not support a tiered methodology. Therefore, it should not be developed.

How should exemptions be treated?
CMS should retain existing exclusions developed under the EHR Incentive program. Providers should only be asked to report on measures for which there is relevant Medicare data. If a provider qualifies for an exclusion or exemption, weighting should be evenly distributed among the remaining measures.

8. Development of Performance Standards

In the RFI, CMS seeks comment on the following questions:

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?
Historical performance should be based on valid and reliable performance data previously submitted by the physician. Given that PQRS uptake is far from 100 percent, it may be difficult to use historical quality performance from the most recent year for all providers. EPs that did not participate in the previous historical performance period should not be penalized for the lack of data to develop a threshold or benchmark. Benchmarks need to be meaningful and achievable and not arbitrarily set. In order for physicians to truly understand how their performance is being measured and the performance that is expected of them, the benchmarks for both quality and resource-use measures need to be published in advance of the performance year. Additionally, the AAFP urges CMS to hold the benchmarks steady for at least two years, as is done in the ACO MSSP, instead of reassessing after each performance year. Frequent updating of these benchmarks undermines the business case for investments by providers to improve the effectiveness of care delivery.

Considering that current CMS payment systems relay on a two-year lag between the performance year (when data is collected and reported) and the payment year, the AAFP continues to believe that two-year old data is not actionable or meaningful in any way, and we implore CMS to explore ways to realistically provide actionable feedback.

Should performance standards be stratified by group size or other criteria? Should we use a model similar to the performance standards established under the VM?
Performance standards should continue to be stratified by group size as there are often different resources available depending on group size and ownership type. Additionally, the statistical variability differs by group size, so it would be unfair to compare a solo EP to a group of EPs. Furthermore, available resources should also be taken into account as physician owners may not have the available resources of time and money to solely dedicate to reporting and quality efforts compared to those of a larger, system owned practice. Additionally, only 28 percent of practices have the ancillary staff, such as care coordinators and managers, who can significantly help with the provision of services that support the prevention of readmissions, population health management, and registry support. The AAFP believes there should be a fairness of thresholds that addresses the differences in panel composition, available resources, etc., among small and large practices. A one-size-fits-all approach will not lead to equally distributed success among providers. We would ask that CMS consider stratification of benchmarking when scoring providers. Comparing group practices to similar group practices and solo practitioners to similar solo practitioners could provide more accurate data related to a provider's efforts to improve patient care. The AAFP suggests the following peer groups accounting for statistical significance and mean variation of TINs with:

- One provider
- Two to five providers
- Six to 12 providers
- 13 to 25 providers
- 26 to 50 providers
- 51 to 75 providers
- 76 or more providers

For the clinical practice improvement activities performance category, what, if any, historical data sources should be leveraged?
If the practice fulfills its requirement to engage in clinical practice improvement activities by being a recognized PCMH, then that practice is continually assessing and improvement of its historical and current performance. If the EP fulfills its clinical practice improvement requirement by completing a certified/accredited PI-CME activity, then that EP has compared his or her baseline (historical) practice performance or patient outcomes against nationally recognized evidence-based benchmarks, and then subsequently re-measured his or her performance or outcomes. Thus in either of those two instances, no additional historical data is needed.

However, when the practice is not a recognized PCMH, and the EP has not completed a certified/accredited PI-CME activity during the time frame under evaluation, but instead, the EP completes one or more clinical practice improvement activities through their hospital, health system, specialty certifying board or society, state Medicaid or payer network, and such activity(s) do not require baseline measurement and subsequent re-measurement, then yes, CMS may choose to require the EP to attest to review of historical data prior to completion of the clinical practice improvement activity(s).

How should we 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 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.
The AAFP strongly urges CMS to avoid evaluations that result in pass/fail determinations. Instead, all improvement should be taken into account when calculating the performance score of the quality and resource use performance categories. The purpose of a quality improvement program, such as MIPS, is to encourage, not hinder, better care and improvement in areas that may be lagging. Not recognizing improvement will discourage physicians from making lasting changes in their practices that will benefit the MIPS program. The goal is to create a process that facilitates continuous quality and performance improvement. You cannot achieve continuity if there are arbitrary thresholds that discourage physicians.

How should CMS incorporate improvement into the scoring system or design an improvement formula? What should be the threshold(s) for measuring improvement?
Points should be applied for practices that have demonstrated improvement at the measure level. The physician's or group's previous performance on each individual measure should be the threshold for measuring improvement. For those who have improved over their baseline, they should receive recognition in the form of points towards their quality performance score. For those who have improved over the set threshold, they should receive more points. For those who have reached and exceeded the benchmark, they should have a fixed benchmark to not deter or penalize those who are high achievers. Additionally, those who have reached the fixed benchmark and improve over the previous year's performance should be recognized for their increased performance. For a physician to truly understand how the physician's performance is being measured, and to better understand the performance that is expected, the benchmarks for both quality and resource-use measures need to be published in advance of the performance year. Additionally, the AAFP urges CMS to hold the benchmarks steady for two years, as is done in the ACO MSSP, instead of reassessing after each performance year. Frequent updating of these benchmarks undermines the business case for investments by providers to improve the effectiveness of care delivery.

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?

The AAFP recommends a fixed baseline to assess improvement, so the incentive to improve is not undermined. EPs should be recognized for their continued success compared to their fixed baseline. Updating the baseline would weaken movement towards improvement. Additionally, the AAFP urges CMS to hold the benchmark steady for at least two years if not longer, as is done in the ACO MSSP, instead of reassessing after each performance year. Frequent updating of these benchmarks undermines the business case for investments by providers to improve the effectiveness of care delivery.

Should CMS use the same approach for assessing improvement as is used for the Hospital Value-Based Purchasing Program? What are the advantages and disadvantages of this approach?
The AAFP is very supportive of assessing and recognizing improvement in quality performance. As previously noted, the AAFP opposes a pass/fail approach. Recognizing both achievement and improvement, as in the hospital VBP, gives lower performers encouragement for continual improvement. The hospital VBP program has done the equivalent for hospitals. Given that improvement will be assessed at the individual EP and group level, not the health system, recognizing improvement is more important than ever.

Should CMS consider improvement at the measure level, performance category level (that is, quality, clinical practice improvement activity, resource use, and meaningful use of certified EHR technology), or at the composite performance score level?
Yes. The AAFP believes physicians and practices should get recognition for making improvements at any and all levels, including the measure level, performance category level and composite score level. Improvement at any level should be considered for points towards improvement.

Should improvements in health equity and the reductions of health disparities be considered in the definition of improvement? If so, how should CMS incorporate health equity into the formula?
The AAFP supports reducing health disparities as a part of care delivery and urges CMS to move forward with expanding its risk-adjustment methodology in quality measures to incorporate social and economic determinates such as race, income, education, and region. Risk adjusting for socioeconomic status ensures the measures are fair and sets the standard for comparison of physician performance by adjusting for factors outside of the physician's control. Not adjusting could lead to misleading conclusions about physician performance. As a result, further disparities in care could be magnified.

The AAFP through HealthLandscape has developed a tool—Community Vital Signs API—that could assist practices of all sizes understand the social and economic status of their patient population. However, given that performance measures currently do not take into account social determinates of health and socioeconomic factors, physician performance cannot be accurately measured at the current time. The NQF's trial period for Risk-Adjustment for Sociodemographic Factors is targeting this problem and will hopefully develop measures that will better capture reductions in health disparities. Until risk adjustment for these factors is in place, health equity should not be included in the definition of improvement.

Regarding incorporating health equity into the formula, the AAFP believes CMS should look at emerging research in primary care practice-based research networks (PBRNs) and other primary care literature to determine best ways to measure health equity outcomes. Furthermore we believe proper funding for this research is critical.

In the CY 2016 PFS proposed rule (80 FR 41812), the Secretary proposed to publicly report on Physician Compare an item-level benchmark derived using the Achievable Benchmark of Care (ABC™) methodology. We seek comment on using this methodology for determining the MIPS performance standards for one or more performance categories.
Though the ABC method has potential, it has not been proven by current research to be successful for this magnitude of a program. Further research is needed to know if the ABC is the appropriate methodology for benchmarking physician performance. This research should take into account a diverse set of measure types, specialties, and regions to ensure this is the best methodology. Additionally, the ABC benchmark is based on a

“pared mean” of the best performers, while the performance threshold for the MIPS program is defined by statute as reflecting the mean or median performance of all EPs for a prior period. These are two conflicting methodologies.

9. Flexibility in Weighting Performance Categories

In the RFI, CMS seeks comment on the following questions:

Are there situations where certain EPs could not be assessed at all for purposes of a particular performance category? If so, how should we account for the percentage weight that is otherwise applicable for that category? Should it be evenly distributed across the remaining performance categories? Or should the weights be increased for one or more specific performance categories, such as the quality performance category?

Physicians practicing part-time may not have enough quality and resource-use data to ensure their performance is valid and reliable enough to base penalties and bonuses upon. The low-volume threshold should take this issue into account. If this is the case, they should not be held responsible for quality and resource-use performance and should, perhaps, have modified requirements for clinical and practice improvement.

In addition, the AAFP urges CMS to consider including flexibility for residency programs. Residency programs can employ physicians that do not necessarily bill Medicare claims frequently to generate sufficient data that can be calculated by CMS to assess their performance.

Furthermore the AAFP urges CMS to produce education targeted specifically for residency programs since these institutions are creating the next generation of physicians. It will be especially important for these future physicians to participate and learn about the MIPS and APM programs.

Finally, CMS should also take into account physician researchers and physicians serving in faculty, research, and/or administrative positions that also might not bill Medicare frequently enough to generate adequate performance data.

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?

A lack of applicable measures is not an issue for family medicine. This is why we continue to encourage CMS to adopt and implement the core measure set for primary care. Looking beyond family medicine and primary care, we suggest that the methodology should take into account both the measure/activity level and the specialty. There are various factors that may preclude an EP from fully participating, including a lack of measures that apply and low-volume patient activity, which should be taken into account for the modification of a performance category.

What case minimum threshold should CMS consider for the different performance categories?

In terms of a minimum threshold for the different MIPS performance categories, the AAFP prefers the use of a minimum reliability threshold instead of a minimum patient threshold. As highlighted in our Guiding Principles on Physician Profiling, we believe that the validity, accuracy, reliability, and limitations of data used are important when reporting on performance and profiling results. Case minimum thresholds should be different for each measure, so using a minimum reliability threshold can help mitigate the variation between measure types. Additionally, individual EPs and group practices differ in variation, so the use of a minimum reliability threshold approach will acknowledge and take this issue in to account.

What safeguards should we have in place to ensure statistical significance when establishing performance thresholds? For example, under the VM one standard deviation is used. Should we apply a similar threshold under MIPS?

In order for performance thresholds to be used, statistical significance must be insured, which starts with verifiable, reliable, and valid data. From a statistical standpoint, groups and individuals may need benchmarks and adjustments to benchmarks based on different standard deviation levels due to variation. When establishing statistically significant thresholds, CMS should use methods that account for variation differences in individuals and groups of different sizes, as well as geographic and socioeconomic status of the patient population.

10. MIPS Composite Performance Score and Performance Threshold

In the RFI, CMS seeks comment on the following questions:

How should we assess performance on each of the 4 performance categories and combine the assessments to determine a composite performance score?

The MACRA details how the composite performance score is determined by each category to combine for a composite performance score. The performance categories will be weighted with quality at 50 percent, resource use at 10 percent, clinical practice activities at 15 percent, and EHR at 25 percent contributing to a composite score ranging from 0-100. At this point, there is no methodology that will clearly lead to achievement of the Triple Aim; however, the AAFP suggests the following:

- In the quality performance category, the AAFP proposes that the use of the core measure sets as outlined by the Core Measurement Collaborative, would result in a net of all quality points available in the category. This would give physicians an opportunity to acclimate themselves to the reporting system and measures before they are subject to penalties for low performance. Additionally, it will further promote quality measure alignment across the health care system.
- In the resource-use performance category, the same methodology should be used.
- In the clinical practice improvement category, practices and physicians should be able to choose from a menu of options. Participation in a recognized PCMH or any other APM would net all 15 points for the practice. Likewise, completion of a certified/accredited PI-CME activity would net substantial points for the EP. For all other EP's, participation in 1 activity would net 5 points, 2 activities would net 10 points, and 3 activities would net all 15 points.
- In the EHR performance category, the AAFP advocates that performance scoring should be based on linear scoring, which helps maintain even weighting among the criteria. Missing the mark on a single, heavily-weighted measure could severely affect a provider's overall performance score and cause a provider to fail the category completely. Evenly weighting the measures and giving points for what has been achieved gives providers a better opportunity to achieve success. The AAFP does not believe a tiered methodology should be used to determine levels of achievement within this category. A tiered methodology could ultimately punish providers who are demonstrating improvement and success. There is currently not enough evidence to support the link between higher achievement of thresholds in the EHR Incentive program and achievement of the Triple Aim.

Last, the AAFP believes there should be a fairness of thresholds that addresses the differences in panel composition, available resources, etc., among small and large practices. A one-size-fits-all approach will not lead to equally distributed success among providers. We would ask that CMS consider stratification of benchmarking when scoring providers. To do that, there need to be adjustments or structuring on two levels.

One level is the patient population served by the physician and practice. Comparability at this level is attained through risk adjustment, which relates to severity of illness and condition, and whether or not the patient population is underserved (socioeconomic characteristics). The second level—demographics of the physician/practice itself—speaks to specialty, practice size, and geographic location. If peer comparison methodology can be structure such that comparability is attained at both levels, then true peer comparisons can be made.

For the quality and resource use performance categories, should we 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?

The AAFP discourages the mandatory weighting across the NQS and proposes equal weighting of measures at the start of MIPS. Eventually, CMS should consider giving the EPs the ability to choose how they would like their measures (both quality and resources use) weighted (with caps and minimum weighting thresholds for some measures), so it can align with their current performance priorities. This would give them more input and stake into their performance, while also selecting a weighting structure that works for their particular practice environment.

How should we 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?

First, if CMS wants to use existing data on quality measures and resource use for a baseline, threshold, or benchmark, that data must align with the measures that will be included in MIPS in 2019. Where it does, CMS can use it to calculate composite scores in much the same way that it will do so under MIPS when implemented and use the mean or median of those composite scores to create performance thresholds for the first two years of the program. **Where the data does not align exactly, CMS should not use it for this purpose.**

While MACRA states a prior year will set the performance baseline for a practice, the AAFP strongly encourages CMS to consider the issues of having performance data from a different program used as the baseline performance data for the MIPS. For a physician to truly understand how the physician's performance is being measured, and to better understand the performance that is expected, the benchmarks for both quality and resource-use measures need to be published in advance of the performance year. Additionally, the AAFP urges CMS to hold the benchmark steady for at least two years if not longer, as is done in the ACO MSSP, instead of reassessing after each performance year. Frequent updating of these benchmarks undermines the business case for investments by providers to improve the effectiveness of care delivery.

The AAFP believes there should be a fairness of thresholds that addresses the differences in panel composition, available resources, etc., among small and large practices. A one-size-fits-all approach will not lead to equally distributed success among providers. We would ask that CMS consider stratification of benchmarking when scoring providers. Comparing group practices to similar group practices and solo practitioners to similar solo practitioners could provide more accurate data related to a provider's efforts to improve patient care.

What minimum case size thresholds should be utilized? For example, should we leverage all data that is reported even if the denominators are small? Or should we employ a minimum patient threshold, such as a minimum of 20 patients, for each measure?

In terms of a minimum threshold for the different MIPS performance categories, the AAFP prefers the use of a minimum reliability threshold instead of a minimum patient threshold. As highlighted in our Guiding Principles on Physician Profiling, we believe that the validity, accuracy, reliability, and limitations of data used are important when reporting on performance and profiling results. Case minimum thresholds should be different for each measure, so using a minimum reliability threshold can help mitigate the variation between measure types. Measures that may meet a different minimum threshold should be identified by CMS and open for public comment. The AAFP suggests the following peer groups accounting for statistical significance and mean variation of TINs with:

- One provider
- Two to five providers
- Six to 12 providers
- 13 to 25 providers
- 26 to 50 providers
- 51 to 75 providers
- 76 or more providers

Additionally, individual EPs and group practices differ in variation, so the use of a minimum reliability threshold approach will acknowledge and take this issue in to account. The AAFP believes there should be a fairness of thresholds that addresses the differences in panel composition, available resources, etc., among small and large practices. A one-size-fits-all approach will not lead to equally distributed success among providers. We would ask that CMS consider stratification of benchmarking when scoring providers. As noted earlier, we ask that CMS consider stratification of benchmarking when scoring providers and to do so on two levels. One level is the patient population served by the physician and practice. Comparability at this level is attained through risk adjustment, which relates to severity of illness and condition, and whether or not the patient population is underserved (socioeconomic characteristics). The second level—the demographics of the physician/practice itself—speaks to specialty, practice size, and geographic location. If peer comparison methodology can be structure such that comparability is attained at both levels, then true peer comparisons can be made.

How can we establish a base threshold for the clinical practice improvement activities? How should this be incorporated into the overall performance threshold?

Given that there is not a previous performance year for clinical practice improvement from which to pull data, 2019 should be used as the baseline year. A performance threshold should not be set, since there is no historical data to determine performance. Practices that are participating in a PCMH recognition program through an accreditation body, health insurance plan, or local or regional effort should be able to utilize their activities for the baseline threshold. Given that practice transformation is a time-intensive process that touches all aspects of a practice, including quality, safety, patient engagement, and population health management, we recommend that these efforts be recognized when establishing a baseline. When the practice fulfills its requirement to engage in clinical practice improvement activities by being a recognized PCMH, then that practice is continually assessing and improving its performance. Likewise, if the EP fulfills its clinical practice improvement requirement by completing a certified/accredited PI-CME activity, then that EP has, as part of the activity compared his or her baseline practice performance or patient outcomes against nationally recognized evidence-based benchmarks, and then subsequently re-measured his or her performance or outcomes. Thus in either of those two instances, establishment of a base threshold and incorporation into the overall performance threshold is not applicable.

If the practice is not a recognized PCMH, however, and the EP has not completed a certified/accredited PI-CME activity during the time frame under evaluation, but instead completes one or more clinical practice improvement activities through their hospital, health system, specialty certifying board or society, state Medicaid, or payer network, and such activity(s) may not require baseline measurement and subsequent re-measurement; then yes, CMS may choose to require the EP to attest to review of his or her base threshold and subsequent performance following completion of the clinical practice improvement activity(s).

What other considerations should be made as we determine the performance threshold for the total composite performance score? For example, should we link performance under one category to another?

Generally speaking, performance under one category should not be linked to another. However, the AAFP is supportive of a process that may reduce the reporting burden on physicians. If linking a performance measure from one category to satisfy another requirement in another category, thereby reducing the reporting burden, the AAFP would be supportive of this. The AAFP believes there should be a fairness of thresholds that addresses the differences in panel composition, available resources, etc., among small and large practices. A one-size-fits-all approach will not lead to equally distributed success among providers. We would ask that CMS consider stratification of benchmarking when scoring providers on two levels. One level is the patient population served by the physician and practice. Comparability at this level is attained through risk adjustment, which relates to severity of illness and condition, and whether or not the patient population is underserved (socioeconomic characteristics). The second level—the demographics of the physician/practice itself—speaks to specialty, practice size, and geographic location. If peer comparison methodology can be structured such that comparability is attained at both levels, then true peer comparisons can be made.

11. Public Reporting

In the RFI, CMS seeks comment on 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. CMS notes that in the 2016 PFS proposed rule, the agency will continue 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). CMS also notes that an alternative to a minimum patient threshold for public reporting would be to use a minimum reliability threshold and seek comment on this concept too. Finally, CMS seeks comment on whether CMS should include individual EP and group practice-level quality measure data stratified by race, ethnicity, and gender in public reporting, if statistically appropriate.

In terms of a minimum threshold for publicly reporting MIPS measures and activities for all of the MIPS performance categories on the Physician Compare website, the AAFP prefers the use of a minimum reliability threshold instead of a minimum patient threshold. As highlighted in our Guiding Principles on Physician Profiling, we believe that the validity, accuracy, reliability, and limitations of data used are important when reporting profiling results and providing physician feedback. Consistent with our Guiding Principles on Physician Performance Reporting, we also believe that it is important to be transparent in the number of cases assessed per measure. However, as far as a threshold for reporting is concerned, we believe that reliability is superior to a simple, arbitrary number of patients. We would also refer CMS to our policy on Performance Measures Criteria for perspective on this issue.

As noted in our comments on the proposed 2016 Medicare physician fee schedule, the AAFP is supportive of the Physician Compare concept but has several concerns regarding the complexity and accuracy of the information and its usefulness to consumers. It is increasingly important for CMS to address these concerns, given that MACRA expands the use of the Physician Compare website.

For instance, while CMS has mechanisms in place to ensure the data is valid, reliable, and correctly attributed, errors still persist. Because of this, the AAFP urges CMS to extend the current preview period from 30 to 90 days at a minimum. This will give the physician sufficient time to review, validate, and appeal, if needed, before public reporting of the physician's data. If information is under review, it should not be publicly reported on the website until the issues are resolved. Additionally, we suggest that only group-level data be reported on Physician Compare until this issue is resolved completely. When making decisions regarding their health care, consumers should be able to view accurate performance data.

The AAFP also is concerned about the timeliness of the feedback reports given to physicians and group practices. These reports are not available until approximately six to nine months after the close of the reporting period, giving no opportunity for a practice to improve performance until well into the next reporting period. The AAFP urges CMS to provide feedback to physicians quarterly.

Finally, we note that the information on Physician Compare needs to be relatively simple in order for consumers to make informed medical decisions. Thus, we would argue against including individual EP and group practice-level quality measure data stratified by race, ethnicity, and gender in public reporting at this time, even if statistically appropriate. We do not believe that such level of detail is needed or wanted by Medicare consumers, and we fear it would more likely confuse than inform Medicare beneficiaries.

12. Feedback Reports

In the RFI, CMS seeks comment on the following questions:

What types of information should we 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?
The feedback report should contain quality and resource use at the measure level; EHR attestation information; and recognition of fulfillment of the clinical improvement activity requirement. We encourage CMS to provide

feedback on a practice's performance monthly if possible or at least quarterly. Further, each report should show performance for not only the present month or quarter but also prior months or quarters so physicians can see the change in performance over time to drive quality improvement efforts. Ideally, this trend data should be presented in graphic form. Finally, the level of detail should be sufficient that the information contained in the feedback report is actionable.

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 feedback?
EPs receive feedback on clinical practice improvement activities via their practice's PCMH or other activities such as their completion of a certified/accredited PI-CME activity. Thus, for clinical practice improvement activities, the report from CMS should confirm that they have met the requirement by being a PCMH, or by having completed a certified/accredited PI-CME in the previous reporting years. For meaningful use of an EHR, a practice should be able to view the objectives in which the practice attested for the previous reporting periods and the points attributed to those objectives for purposes of calculating the composite score. Additionally, it would be beneficial to provide some historical data on these activities to give context and information for improvement purposes.

What other mechanisms should be leveraged to make feedback reports available? Currently, CMS provides feedback reports for the PQRS, VM, and the Physician Feedback Program through a web-based portal. Should CMS continue to make feedback available through this portal? 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?
At the current time, the quality resource use reports (QRURs) are very difficult to access and obtain through the web-based portal. The AAFP knows that physicians and group practices are unaware of these reports, in part because they are so difficult to access. CMS should explore other entities and vehicles for distribution and how to increase awareness of the reports. For instance, CMS could partner with Quality Improvement Networks, which are already involved in transformation and quality improvement support at the physician level. Other options that align with current quality initiatives and reporting entities include Transforming Clinical Practice Initiative Support and Alignment Networks and Practice Transformation Networks, specialty societies, and EHR and registry vendors.

Given that more than 60 percent of the AAFP's membership works with seven or more payers, feedback reports from all payers need to be aligned and, ideally, combined to enable meaningful quality improvement efforts. More than 75 percent of AAFP members believe that the lack of uniform payer reports on performance is a barrier to implementing value-based care models in their practice. **CMS should continue working with the Core Measure Collaborative's efforts to align and harmonize quality measures across payers.** CMS should push the collaborative to harmonize feedback reporting across payers, too. The AAFP is very supportive of the data aggregation efforts of the Comprehensive Primary Care (CPC) initiative. The AAFP urges CMS to closely watch the common data approach developed by the regions, and monitor how the aggregate reports reduce physician burden and support primary care. CMS should model best practices of the CPC's data aggregation efforts nationwide.

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?
Whomever the group or physician authorizes to access the reports should be able to do so. Perhaps there should be a "practice or TIN administrator" that could grant report access to more staff. Currently, the limits on who can actually access the report are confusing, and gaining access to the portal has proven to be difficult for many AAFP members. If a group or EP is participating in a practice transformation collaborative for quality improvement

support, it may be appropriate for them to have access to the feedback report, as long as consent is given by the practice.

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 we 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?
Feedback reports should be provided on a quarterly basis in order to ensure ongoing opportunities exist to facilitate timely, enduring quality improvement. While some information will not be new or updated (e.g. quality measures based on reporting), at minimum, claims-based measures that have new and updated performance information should be provided at quarterly intervals.

Should the reports include data that is stratified by race, ethnicity and gender to monitor trends and address gaps towards health equity?
While these categories are important in monitoring health equity, other sociodemographic factors—income, education level, and health literacy—are equally crucial in terms of addressing gaps in health equity. If CMS can provide this information by placing no further burden on practices, including it would be beneficial. However, some EHRs, even though it is a requirement to be a CEHRT, do not currently capture this information accurately.

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?
To truly realize the potential of primary care data, family physicians and other primary care providers need to be given access to cost and quality data on all physician specialists, hospitals, and other health care providers; including laboratories, imaging centers, dialysis providers, etc. Access to cost and quality data will assist family physicians in making informed decisions when referring patients. Having both cost and quality information—related to services furnished to their patients by other providers—will enable family physicians to make better, informed decisions that take into account both cost and quality. In order for family physicians to take responsibility for their patients' total cost of care, it is crucial for them to have this information. In sum, for an EP to be responsible for total cost, he or she should know the cost of other providers' services and the quality of those services, as well as the actual services that others provide to the EP's' attributed patients. This should be provided in a quarterly report that is written in an easy-to-read, accessible format.

B. Alternative Payment Models (APMs)

In the RFI, CMS seeks comment on the following questions:

How should CMS define ''services furnished under this part through an eligible alternative payment entity (EAPM) entity''?
In the law, the full phrase is "such services furnished under this part through an eligible alternative payment [EAPM] entity." There are two key elements to this phrase.

The first element is "such services furnished under this part." That element alludes to a phrase earlier in the same portion of the law, which reads "covered professional services furnished by such professional during the most recent period for which data are available." As noted in section 1848(z)(3)(A), "covered professional services" has the meaning given that term in section 1848(k)(3)(A), which is "services for which payment is made under, or is based on, the fee schedule established under this section and which are furnished by an eligible professional" (i.e. services paid under or based on the Medicare physician fee schedule). Consequently, "such services furnished under this part" means services paid under or based on the Medicare physician fee schedule furnished by the professional in question during the most recent period for which data are available, which is a function of CMS data capabilities and limitations. As noted in our response to the MIPS questions, the **AAFP remains concerned**

that the MIPS and APMs will be built upon the current biased and inaccurate relative value utilization data currently used in the fee-for-service system. We feel more must be done to ensure that Medicare is paying appropriately for primary care physician services in these new payment models rather than paying based on this biased actuarial data that further exacerbates the undervaluation of primary care services.

The second element is "through an EAPM entity." This element means that the services in question are those that the professional provides through his or her affiliation (e.g. as an owner, employee, independent contractor) with an EAPM entity as defined in section 1848(z)(3)(D).

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?

The language in section 1848(z)(1)(A) reads, in part, "there shall also be paid **to such professional** an amount equal to five percent of the estimated aggregate payment amounts for such covered professional services under this part of the preceding year" (emphasis added). To the extent that Medicare can associate prior performance period payments with a qualifying APM participant (e.g., through the rendering National Provider Identifier on a claim), calculation and payment of the incentive payment should be at the level of the qualifying professional (QP), even in situations in which the prior period payments were made to an EAPM rather than directly to the QP. The statute indicates that payment should flow to the QP.

We recognize that there may be some situations in which CMS cannot trace prior period payments to an individual QP. In those cases, payment to the EAPM entity would be acceptable. However, those cases should be the exception rather than the norm.

The advantage of directing these incentive payments to individual QPs wherever possible is that it does, in fact, incentivize them to participate in EAPM entities, because they know that the five percent bonus will come back to them as individuals. It also has the advantage of being agnostic to the type of EAPM entity in which the QP participates. Whether the EAPM entity is physician-focused or hospital-focused, the QP will know that the APM bonus will flow back to him or her, not the entity, so the incentive payment will not bias the QP in his or her choice of EAPM entity. Finally, this policy has the advantage of simplifying APM bonus payments for QPs participating in multiple APMs, because CMS will be issuing one incentive payment for the QP, without regard to the EAPM entity or entities in which he or she participates.

The one disadvantage to this approach is that it does not reward the EAPM entity for the value it adds to the health care system. However, we do not believe that is the intent of these incentive payments in the first place. To the extent that an EAPM entity brings value to the health care system, that value should be recognized and rewarded through the primary payments to the EAPM for its services and through other pay-for-performance mechanisms apart from the incentive to participate in an EAPM entity. Please see the AAFP policy on appropriate pay-for-performance for additional clarification.

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.)?

The AAFP strongly supports the goal of moving a larger percentage of payments from the traditional fee-for-service towards alternative payment models. We believe that payment models should support delivery models that promote quality over volume. With respect to primary care, CMS should consider the *Joint Principles of the Patient-Centered Medical Home* and the key functions of the Comprehensive Primary

Care (CPC) initiative as criteria for determining comparability of state Medicaid medical home models to medical homes expanded under Section 115A(c) of Title XIX. The Joint Principles, as defined by the AAFP, American Academy of Pediatrics, American College of Physicians, and the American Osteopathic Association, include the following characteristics as essential to the Medical Home:

- Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- Physician directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- Whole person orientation – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care, chronic care, preventive services, and end of life care.
- Care is coordinated and/or integrated across all elements of the complex health care system and the patient's community.
- Quality and safety are hallmarks of the medical home.
- Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.
- Payment appropriately recognizes the added value provided to patients who have a PCMH.

The key functions of the Comprehensive Primary Care initiative, listed below, align with one or more of the Joint Principles and include:

- Risk-stratified care management
- Access and continuity
- Planned care for chronic conditions and preventive care
- Patient and caregiver engagement
- Coordination of care across the medical neighborhood

These functions along with the milestones established for each of the four years of the CPC provide guidance to primary care practices regarding how to implement each of the functions for a medical home within or outside of Medicaid.

The AAFP proposes that payments for primary care services under this advanced primary care delivery model, as outlined above, be made on a per patient basis through the combination of a global payment for direct patient care services and a global care management fee. The global payment for primary care services would capture the "core primary care" services, which are provided a majority of time by a majority of family physicians. The AAFP has documented these services to number approximately 80. Any services provided by the family physician that fall outside the core primary care suite of services would be paid on a fee-for-service basis or through an appropriate bundle or global payment structure for such services. The second element of this blended payment model would be a global care management fee that would capture those services performed by the physician or practice that contribute to continuity and coordination of care, promote compliance and adherence, and facilitate appropriate use of health care resources. We further propose that both the global payment for core primary care services and the global payment for care management would be risk adjusted based upon the health status of the patient, as well as demographic, socioeconomic, and geographic factors. We believe both the core primary care and care management payments should be eligible for the five percent bonus payment under the APM program.

We would further suggest that, at some point in the future, the two global payments could be combined into a single comprehensive primary care payment. However, we feel that both physicians and payers are not yet in the appropriate position to consider such a policy.

Similar to the payment model outlined earlier in this section, a comprehensive primary care payment model would represent a new and increased investment in primary. It is our general opinion that there should be a substantial increase in payments for primary care services over current levels if we want to accomplish our shared goals. Pursuant to this belief, we do not believe a comprehensive primary care payment would be built on the foundation

of the episodic-based RBRVS system. Instead, the comprehensive payment would be established based on the core primary care services described earlier in this section. A comprehensive payment would be allocated to physicians or practices for a comprehensive set of core primary are services and would include such resources necessary to establish and maintain the systems and teams necessary to deliver comprehensive, continuous, coordinated, and connected primary care. The comprehensive payment would be commensurate with the level of accountability for performance and outcomes.

A comprehensive primary care payment would be appropriately risk-adjusted, enable the management of populations of patients, and incorporate evaluation of performance based on the triple-aim. The comprehensive payment would allow primary care practices to adapt to the needs of their local communities and promote innovative in care delivery. A primary care comprehensive payment, while independent of the RBRVS system, would not be incompatible with fee-for-service payments and would allow for such payments for services that fall outside the core primary care services included.

If prior period payments were made on a capitated basis, CMS should feel free to make the corresponding APM incentive payment to the individual or entity receiving the capitation. In any case, the full amount of the capitated payment should be used to calculate the APM participation incentive payment, since the capitated payment otherwise represents the payment amount for the covered professional services.

The primary advantage of this approach is its relative simplicity, both for CMS and the QPs and EAPM entities. One disadvantage is that such an approach may direct more incentive payments to EAPM entities than would otherwise be the case if CMS provided capitated payments to the individual QP level, even though the law's intent is to incentivize individual QP participation in EAPM entities. This approach may also have the disadvantage of encouraging individual QPs to choose EAPM entities that do not take capitation (or take capitation to a lesser degree). Whether such EAPM entities are more likely to be physician-focused or hospital-focused is unknown.

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?

We recognize that CMS will not have the necessary information on its own to calculate the Combination All-Payer and Medicare Payment Threshold and that it will need to rely on information voluntarily submitted by QPs. As we read the statute, CMS will need two pieces of information from QPs, along with the Medicare payment data that it already has, to calculate the Combination All-Payer and Medicare Payment Threshold:

1. The sum of all other (non-Medicare) payments, regardless of payer (other than payments made by the Secretary of Defense (e.g., Tricare) and the Secretary of Veterans Affairs and Medicaid payments in states in which no medical home or APM is available under Medicaid in those states)
2. The portion of that sum that is made under arrangements in which:
    a. Designated quality measures apply;
    b. Certified EHR technology is used; and
    c. The EP participates in an entity that:
        i. Bears more than nominal financial risk or
        ii. With respect to Medicaid, is a medical home that meets criteria comparable to medical homes expanded under the Center for Medicare and Medicaid Innovation

In an ideal world, this information would be captured by a clinical data repository and reported on the physician's behalf by the CDR entity. To accomplish this, the CDR entity needs access to Medicare claims to link payment data with clinical data from the EHR support this type of report on behalf of the provider. A CDR entity must also be recognized by CMS as a qualified entity to perform this reporting. However, we currently know of no existing source for this information external to the QP's practice. However, we believe that most QPs should be able to identify the sum of all other (non-Medicare) payments, regardless of payer from their practice management or

billing systems. Therefore, QPs wanting to take advantage of this option will need to voluntarily attest to it or submit it on a form prescribed by CMS. We trust that CMS can securely receive such information through existing electronic platforms such as the CMS Enterprise Identity Management (EIDM) system. CMS, in turn, will need to audit or verify such information on a targeted, as needed basis.

c. Patient Approach

In the RFI, CMS seeks comment on the following questions:

What are examples of methodologies for attributing and counting patients in lieu of using payments to determine whether an EP is a QP or partial QP?

We understand that, solely for purposes of determining whether an EP is a QP or partial QP, MACRA (through the addition of section 1833(z)(2)(D) to the Social Security Act) provides the Secretary (i.e. CMS) the option to use counts of patients in lieu of payments. The determination that an EP is a QP, in turn, determines the EP's eligibility for the 5 percent bonus under the APM track.

We further understand that whatever methodology for attributing and counting patients CMS may use for this purpose will not necessarily impact attribution of patients to the EP under the EAPM or EP compensation under a given EAPM. How an EAPM attributes patients to participating EPs (if it does so at all) and how an EAPM compensates EPs are matters internal to the EAPM and not the subject of this question.

The attribution methodology used in the Comprehensive Primary Care Initiative (CPCI) is an example of an approach AAFP encourages CMS to follow for purposes of section 1833(z)(20(D), because there are aspects of the CPCI methodology to which we think CMS should adhere regardless of what methodology it adopts for this purpose. For instance, CPCI uses prospective attribution. Prospective attribution dramatically increases patient engagement with a usual source of primary care and does not have to limit patient choice in any way. Also, providing physicians with a prospective list of patients for which they are responsible facilitates proactive population management, which leads to improved outcomes. In contrast, retrospective attribution methodologies are particularly burdensome to physicians, because it is challenging to engage in effective population health management if you do not know which patients you need to target for delivering, managing, and/or coordinating care.

Another aspect of the CPCI methodology that we think is worth emulating in the context of section 1833(z)(2)(D) is the use of chronic care management as a driver of attribution. The AAFP notes that provision of the new chronic care management (CCM) code requires prospective patient consent. It provides a clear, transparent indication of whom patients consider their primary physician to be and honors patient choice. We think clarity, transparency, and patient choice are important elements to include in any methodology used to implement section 1833(z)(2)(D). That said, CCM services should be a factor in the attribution of patients under this part of the law, but it should not be the overriding factor. The AAFP believes there are significant advantages to requiring individuals to select a primary care physician or primary care team and recognizes that this would be a fundamental shift in the administration of the Medicare program. However, independent of such selection, it is difficult to design new, alternative payment models to reward efficient, well-coordinated care, which depends on connecting a patient to a primary care physician based on the patient's choices. To the extent patient choice is important within EAPMs, it is also important in determining who is a QP when patient counts, rather than payments, are used for that purpose.

If CMS decides to use a methodology under section 1833(z)(2)(D) that attributes patients based on prior services and claims, then, similar to the CPCI methodology, we would advocate for a 24-month look back period and attributing a patient to where the plurality of primary care services occur for this purpose. In this context, the AAFP recognizes that there are providers of health care other than physicians who render some primary care services. Such providers may include nurse practitioners, physician assistants, and, for some high-risk, high complexity patients, other sub-specialized physicians. We also recognize that these providers of primary care services may meet the needs of specific patients. In doing so, they should provide these services in collaborative teams in which

the ultimate responsibility for the patient resides with the primary care physician. Thus, If CMS decides to use a methodology under section 1833(z)(2)(D) that attributes patients based on prior services and claims, the AAFP encourages CMS to consider the 2-step attribution process used in the MSSP program, to ensure patients are first attributed to a primary care physician, where possible.

Finally, the AAFP urges CMS to include a reconciliation process in whatever methodology it adopts for purposes of section 1833(z)(2)(D). Under such a reconciliation process, a family physician can review, add, or remove patients from the list received by CMS. This element is lacking in the CPCI methodology, and the AAFP has heard from many members that there is little recourse or opportunity to make corrections to their list of attributed patients. The AAFP feels that inclusion of a reconciliation process would help alleviate this problem

Should this option be used in all or only some circumstances? If only in some circumstances, which ones and why?
It is unclear at this point that there are any obvious circumstances in which patients rather than payment would be the best approach. Absent a clear and compelling justification for using patient counts as provided in section 1833(z)(2)(D), we would encourage CMS to focus on the primary methodology (i.e. payments) for purposes of determining whether an EP is a QP or partial QP.

d. Nominal Financial Risk
In the RFI, CMS seeks comment on the following questions:

What is the appropriate type or types of "financial risk" under section 1833(z)(3)(D)(ii)(I) of the Act to be considered an Eligible Alternative Payment Model (EAPM) entity?
Family physicians already have risk associated with their own operating expenses. Any formula for establishing risk must account for provider overhead, including the additional cost of technology and personnel required to satisfy the data collection and reporting requirements associated with being part of an EAPM entity. Other expenditures incurred by the primary care physician include costs associated with transforming their practices and implementing advance primary care functions, as noted in the CPC initiative.

Regarding types of financial risk, the ability of primary care to manage total costs of care relies heavily on the availability of timely, accurate, and actionable quality and costs data on all physicians and providers of health care services. Only then could they accept performance and management of the total cost of care risk and not insurance risk. Insurance risk is the actuarial differential related to the inherent risk of the insured population. The AAFP does not believe that "insurance" or "actuarial" risk is an appropriate type of "financial risk" for purposes of implementing this section of the law.

What is the appropriate level of financial risk "in excess of a nominal amount" under section 1833(z)(3)(D)(ii)(I) of the Act to be considered an EAPM entity?
The appropriate level of financial risk will vary depending on the size and financial structure of the EAPM entity and whether that entity is at risk for paying for services that they do not render directly, i.e. total cost of care. Useful frameworks for determining the level of financial risk in question (i.e., the risk corridors) could be the percent of total revenue or the percent of premium equivalent for which the EAPM entity is at risk.

EAPM entities with primary, specialty, hospital, and post-acute care could have a wider risk corridor (i.e. a higher level of financial risk in excess of a nominal amount). To the extent that an entity is directly providing the services, the entity should be allowed to assume a greater portion of the risk. Primary care only entities should have a lower downside risk than hospital-based entities. As noted in other sections of our comments, the ability of primary care to manage total costs of care relies heavily on the availability of timely, accurate, and actionable quality and costs data on all physicians and providers of health care services. If CMS feels such comprehensive data can be provided in a timely manner, then there could be an expectation that primary care EAPM's should manage higher levels of financial risk, but we believe that upside risk is more appropriate.

From a practical standpoint, provider organizations functioning as EAPM entities should look at maximum downside risk. In general, mature, high-performing physician practices and other health care entities with a corresponding level of practice management sophistication have a higher threshold as it relates to "nominal financial risk." However, even in such practices/entities, the level of risk in question should not exceed 1 percent.

We do not believe that most physician practices have reached the level of maturity or sophistication necessary to assume even that level of "nominal financial risk." In particular, many family medicine practices run on a very tight margin. Thus, for such practices, "nominal financial risk" is best set at a level not to exceed one percent, with 0.5 percent being the best suggestion. Risk models should have an upside that is motivating but the downside risk be limited to 1 percent. This framework provides the sustainability to escalate upwards to success rather than failure.

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 under sections 1833(z)(2)(B)(iii)(II)(cc)(AA) and 1833(z)(2)(C)(iii)(II)(cc)(AA) of the Act?
The AAFP believes that "more than nominal financial risk" should be defined and used in the same manner for both cases. As articulated before, in general, mature, high-performing physician practices and other health care entities with a corresponding level of practice management sophistication have a higher threshold as it relates to "nominal financial risk." However, even in such practices/entities, the level of risk in question should not exceed one percent.

We do not believe that most physician practices have reached the level of maturity or sophistication necessary to assume even that level of "nominal financial risk." In particular, many family medicine practices run on a very tight margin. Thus, for such practices, "nominal financial risk" is best set at a level not to exceed one percent, with 0.5 percent being the best suggestion. The importance of transparency between all entities involved is key to using the Combination and All-Payer and Medicare Payment Threshold. It is critical to provide transparency, harmonization of measures, reports, and payment models and aggregation of data from all payers.

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?
Physicians should not take on insurance risk but should be responsible for performance risk (i.e., managing the rates of utilization of services along with the quality and availability of those services). We continue to propose that primary care physicians could manage the total cost of care for their patient panel if, and only if, they were provided, at a reasonable frequency, cost and quality data on other physicians and health care providers, Contracts that require physicians to assume performance risk should take into account demographic and socioeconomic factors, patient compliance, and number of chronic diseases. If these are not factored in, physicians will be concerned about taking on risk while keeping these patients on their panel.

Allowing entities to take on more risk than is in their best interest could result in that happening with EAPMs. **The goal is to promote and incentivize continuous quality improvement, not to punish poor performers or restrict their participation in the Medicare program.** If a practice is not performing well over time, the upside and downside risk needs to be attenuated, so the organization providing access to care does not go out of business.

Many points of reference should be considered when establishing criteria for the appropriate type or level of financial risk. Among the most important are financial resources, the size of the practice in both the number of patients and the number of physicians, severity of illness among the patient population, practice sustainability, staff resources, performance capabilities, patient population, and how to treat high performing practices. Furthermore, we stress the need for a highly functioning, interoperable, health information system. We view the presence of an interoperable infrastructure as fundamental to any program and remain highly concerned at both

the lack of progress on establishing this infrastructure and the lack of concern demonstrated by CMS and others at the poor performance of the national HIT system. This must be taken more seriously or the entire APM program will struggle to realize its potential.

The financial resources of the entity should be taken into consideration. Smaller practices will have a narrower risk corridor compared to larger practices or large group practices or integrated health systems. Small practices may need to work together in virtual groups, IPAs, or clinically integrated networks to meet value-based payment expectations. The development of these relationships takes time and it will be difficult for those entities to take on any risk at the initial implementation of MIPS.

The AAFP believes that practices should not take on risk before they are ready, and practices need to determine their readiness before accepting contracts with risk. In general, mature, high-performing physician practices and other health care entities with a corresponding level of practice management sophistication have a higher threshold as it relates to "nominal financial risk." However, even in such practices/entities, the level of risk in question should not exceed one percent. We do not believe that most physician practices have reached the level of maturity or sophistication necessary to assume even that level of "nominal financial risk." In particular, many family medicine practices run on a very tight margin. Thus, for such practices, "nominal financial risk" is best set at a level not to exceed one percent. If this is not done correctly, it is possible that these practices could go out of business.

Practices need to have appropriate staff resources, which include a well-rounded team and adequate training to care for the patient panel attributed to the practice. Practices are also concerned about the investment in their health information technology systems to manage each patient. Even if physicians have access to a registry through their EHR, it may not be functional and effective for a practice to use. If payment models, measures, and reporting are harmonized, staff can more easily understand where they can make changes and monitor performance and cost improvement saving physician and staff time at the practice level.

Performance capabilities are important. Practices must have demonstrated leadership, data-driven improvement, empanelment, and team-based care need to be in place before a practice can perform higher functions such as patient-team partnership, population management, continuity of care, prompt access to care, comprehensiveness and care coordination, and readiness to move into additional changes/expectations in the future.

An entity's patient population should be determined to establish the type and level of financial risk. The AAFP supports reducing health disparities as a part of care delivery and urges CMS to move forward with expanding its risk-adjustment methodology in quality measures and incorporate social and economic determinates of health such as race, income, education, and geography. It will be important to give providers points for caring for the unhealthiest patients, since they typically have more barriers to care due to income or education. In these cases, improvements against their own baseline may be appropriate when determining incentives and level of risk.

The AAFP recommends a fixed baseline to assess improvement, so the incentive to improve is not undermined. EPs should be recognized for their continued success compared to their fixed baseline. Updating the baseline would weaken movement towards improvement. Additionally, the AAFP urges CMS to hold the benchmark steady for at least two years if not longer, as is done in the ACO MSSP, instead of reassessing after each performance year. Frequent updating of these benchmarks undermines the business case for investments by providers to improve the effectiveness of care delivery.

e. Medicaid Medical Homes or other APMs Available under State Medicaid Programs

In the RFI, CMS seeks comment on the following questions:

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?

CMS should consider the *Joint Principles of the Patient-Centered Medical Home* and the key functions of the Comprehensive Primary Care (CPC) initiative as criteria for determining comparability of state Medicaid medical home models to medical homes expanded under Section 115A(c) of Title XIX. The Joint Principles, as defined by the AAFP, American Academy of Pediatrics, American College of Physicians, and the American Osteopathic Association, include the following characteristics as essential to the Medical Home:

- Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- Physician directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- Whole person orientation – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care, chronic care, preventive services, and end of life care.
- Care is coordinated and/or integrated across all elements of the complex health care system and the patient's community.
- Quality and safety are hallmarks of the medical home.
- Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.
- Payment appropriately recognizes the added value provided to patients who have a PCMH.

The key functions of the Comprehensive Primary Care initiative, listed below, align with one or more of the Joint Principles and include:

- Risk-stratified care management
- Access and continuity
- Planned care for chronic conditions and preventive care
- Patient and caregiver engagement
- Coordination of care across the medical neighborhood
- These functions along with the milestones established for each of the four years of the CPC provide guidance to primary care practices regarding how to implement each of the functions for a medical home within or outside of Medicaid.

Which states' Medicaid medical home models might meet criteria comparable to medical homes expanded under section 1115A(c) of the Act?

Before discussing state Medicaid medical home models, on principle **the AAFP would strongly object to and oppose any requirement that physicians and/or practices must accept Medicaid patients; however, the AAFP encourages CMS to measure and recognize those practices that do.**

According to a recent *Health Affairs* report, forty-six states and the District of Columbia have implemented some type of PCMH program for Medicaid and the Children's Health Insurance Program (CHIP). The report highlights North Carolina as the best evidence about PCMH use in Medicaid, where a statewide managed care program for the Medicaid population achieved significant cost savings over a five-year period after implementing a medical home for nonelderly disabled Medicaid beneficiaries.

According to another *Health Affairs* study, Minnesota was an early innovator in efforts to focus on chronically ill populations. The state designed a care management fee that was adjusted according to the number of a patient's chronic conditions and added to a practice's fee-for-service payments. The adjustment was designed to take into account the time and resources, including staff and information technology, that a primary care practice required to manage the care of patients with complex conditions. In addition, starting in 2012, Alabama, Maine, Michigan, and Minnesota added shared, locally based teams or networks to help practices—particularly small ones—become medical homes and provide resources to better address the needs of Medicaid patients with complex conditions. The shared teams may include registered nurses, behavioral health specialists, pharmacists, nutritionists, and community health workers. Teams are often based at a hospital or a community health center.

New York, North Carolina, Oklahoma, and Vermont had team or network care models under way before 2012. In Massachusetts, the PCMH initiative paid practices their first payments several months in advance of their first monthly care management fees in 2011. Payments were as high as $15,000 in the first year of the program and $3,500 in the second year. These funds supported activities such as populating patient registries with patient data and supporting practice team training.

The use of shared savings is most often seen in states with multi-payer initiatives, such as Maryland, Massachusetts, Pennsylvania, and Washington. Using shared savings may result in more buy-in on the part of payers, because it allows them to avoid some of the financial risks of participating in a PCMH pilot program: Payments are made only if practices produce savings by meeting certain agreed-upon targets. Sharing savings is often a harder sell among primary care providers, because provider performance, typically measured as reductions in emergency department visits or thirty-day readmission rates, is based on many factors beyond a primary care provider's control. In 2011, Colorado launched seven regionally based organizations, supported by a central informatics center, to work with Medicaid providers to address costs and quality goals. Colorado's Accountable Care Collaborative uses a payment model like North Carolina's, and Colorado plans to use shared savings as a way to prepare regional organizations and providers to share financial risk.

A recent *Health Affairs* blog highlighted an Oregon project using a finance and delivery model that the AAFP refers to as Direct Primary Care (DPC). Oregon launched the Alternative Payment Methodology (APM) demonstration project, where participating community health centers (CHCs) no longer earn revenue based on the number of individual patients seen. Instead, CHCs receive a monthly payment based on the size and composition of their patient population, shifting the paradigm from the number of doctor visits to the provision of high-quality, team-based, patient-centered care. In the this model, the primary care team plays a critical role in providing comprehensive patient-centered care and is able to focus on population health in order to reduce the prevalence of chronic conditions, manage chronic conditions when they occur, and help to coordinate different types of care over time and across multiple locations and settings. The Oregon APM works as follows: Medicaid pays participating CHCs a set monthly payment for each enrollee, whether or not the person seeks care. We believe the Oregon program is consistent with the AAFP global payment proposal outlined earlier in this document. This type of global payment structure shifts the incentives from those focused on volume and revenue towards patient-centric models that focus on achieving quality and access. The participating pilot sites see a varied patient population, so each site has its own customized per-member-per-month rate. To come up with the rate, actuaries considered both individual fee-for-service rates and the utilization experience of each center in a given year. Because Medicaid patients are not necessarily consistently enrolled for 12 months, the rate was developed to take into account the average length of time that individuals remained as patients of a given health center. The state will study patient encounter data for the March 2013-March 2014 pilot year and compare the payment each site would have received under the traditional fee-for-service structure with the amount they received under this model. If the payment amount is less, the state will make a supplementary payment to help the health center recoup its costs. The state will also monitor a set of quality and access measures to ensure that health center performance either improved or held steady.

f. Regarding Eligible Alternative Payment (EAPM) Entity Requirements

In the RFI, CMS seeks comment on the following questions:

1) Definition

What entities should be considered EAPMs?

The AAFP believes solo, small, and group practices, accountable care organizations, clinically integrated networks, independent practice associations, health systems, and critical access hospitals, rural health centers; and federally qualified health centers should all be considered.

The CMS FAQ document related to the MACRA RFI states that an eligible alternative payment entity is an entity that "either bears more than nominal financial risk for monetary losses under the APM or is a medical home

expanded under CMS Innovation Center authority." The AAFP urges CMS to ensure that family medicine practices that have worked toward becoming a medical home be included as APMs under the forthcoming regulations. **We urge CMS to make that medical home category as broad as possible and reward those physicians— many of whom are currently struggling because of the limited initial return on investment— who are offering expanded access, care management services, etc. We also encourage CMS to expand the Virtual Group framework to the APM program to provide increased opportunities for solo and small practices to participate.**

2) 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.

The AAFP believes measures should be aligned across federal programs and private payers to maximize the comparability of all programs, not just to the MIPS or to an EAPM entity. **The AAFP strongly recommends CMS use the core measure sets developed by the multi-stakeholder Core Measure Collaborative to ensure alignment and harmonization and the avoidance of competing quality measures among payers. The PCMH/ACO core measure set contains a variety of measure types, using various data of sources that are appropriate for each measure.**

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? 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.

Harmonization is imperative to make this program less burdensome for participation and meaningful improvement. Measures should be aligned across federal programs and private payers to maximize the comparability of all programs, not just MIPS to an EAPM entity. **Again, the AAFP strongly recommends CMS use the core measure sets developed by the multi-stakeholder Core Measure Collaborative to ensure alignment, harmonization, and the avoidance of competing quality measures among payers. The PCMH/ACO core measure set contains a variety of measure types (process, outcome, patient-reported outcome measures, etc.), using various data of sources that are appropriate for each measure.**

3) Use of Certified EHR Technology

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?

The focus should be on health outcomes and quality measures, not on the technology that must be used. The current certification program and the requirements of meaningful use are overly prescriptive and the program is not performing at an expected level. As stated several times in our response, the AAFP is deeply concerned at the poor performance of the meaningful use program, the lack of interoperability standards, and the overall poor performance of EHR products as tools that improve patient care. The AAFP calls for further innovation in care delivery and the technology that supports it. We believe being overly prescriptive stifles innovation and progress. A primary indicator of the APM programs success will depend on a vastly improved health information infrastructure.

What are the core health IT 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 health IT products (for example, referral management or population health management functions) help providers succeed within APMs?

It depends on the specifications of the APMs. Without specifics around the capabilities that practices must perform, we are unable to define the technology functions to support them.

The AAFP has done work in detailing the capabilities and functionalities as it relates to practice transformations toward becoming a PCMH. The current crop of health IT solutions are inadequate to support the PCMH and populations management in general. See the Key Capabilities for Family Medicine Practices appendix as an example of the types of capabilities we see as important to support value-based payment models.

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 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?
The focus should be on the delivery model and quality measures, not on the technology that must be used. Regarding submission of quality measures to all payers, the payer must want to receive the quality measure. Otherwise, it will be unvalued work on behalf of the practice to submit measures that are not needed or used by the payer. There must be work to harmonize measures across the public and private payers. As long as a practice is submitting valid quality measures using the appropriate standards, it should not matter which "technology" is used for submission.

2. Information Regarding Physician-Focused Payment Models

a. Definition of Physician-focused Payment Models

We note that the MACRA does not provide any insights into the definition of this term. The AAFP also notes that, elsewhere in the RFI, CMS juxtaposes this term with the term "hospital-focused APMs." For instance, on page 59111, regarding payment incentives for APM participation, CMS asks, "What are the effects of those policies on different types of EPs (that is, those in physician-focused APMs versus hospital-focused APMs, etc.)?"

We think this juxtaposition may be a good place to start in defining the term "physician-focused payment model." A physician-focused payment model is a mode of compensation in which payment is aimed primarily, if not exclusively, at physicians or physician organizations, rather than other types of health care entities, such as hospitals, post-acute care facilities, etc. Other types of health care entities may be part of physician-focused payment models, but only secondarily or on the periphery. In much the same way that accountable care organizations are often categorized as physician-led or hospital-led, so too can payment models. A physician-focused payment model is physician-led, even if payments made under the model subsequently find their way to hospitals and other health care entities.

The AAFP encourages CMS to adopt a delivery and payment model that supports advanced primary care practices. As outlined previously, we continue to believe that an advanced primary care is one that incorporates the core functions of the *Joint Principles of the Patient-Centered Medical Home* and essential five functions of the Comprehensive Primary Care (CPC) initiative. We have proposed earlier in this document a payment model to support this delivery model. Given the overall importance of primary care to achieving our national and individual health care goals, we believe that this advanced primary care medical home model must be included as an APM.

b. Criteria for Physician-focused Payment Models

In the RFI, CMS seeks comment on the following questions:

What criteria should be used by the Committee for assessing PFPM proposals submitted by stakeholders? We are interested in hearing suggestions related to the criteria discussed in this RFI as well as other criteria.
First and foremost, PFPMs should be primary care-centered. There is ample evidence that health systems that are more primary care-oriented are more effective, more efficient, and yield better outcomes than those that are not. We believe that the same is true for physician-focused payment models (PFPMs). Thus, the first criterion used by

the PFPM Technical Advisory Committee (TAC) in assessing PFPM proposals should be "How primary care oriented is the proposed PFPM?"

Equally important would be to assess and to what extent does the proposed PFPM use medical homes expanded under section 1115A(c) and to prioritize consideration of such proposals.

Other criteria that we believe the PFPM TAC should use in assessing PFPM proposals include:

- Is the entity to which payment will be directed physician-led? Is a majority of the governing board(s) comprised of independent physicians, members of a participating IPA, or physicians employed by physician organizations, and is a majority of those physicians comprised of family medicine and other primary care representation?
- To what extent is the proposed PFPM likely to contribute to improvements in quality of care, access to care, and positive health outcomes? It is AAFP policy on physician payment that these must be the primary goals of any physician payment system.
- To what extent is the proposed PFPM based on comprehensive, continuous, coordinated, and connected primary care, and to what extent does it encourage treatment on an ambulatory basis rather than in a costly institutional setting? If it is physician-led and primary care-centered, it should do both of these things.
- Where applicable, is patient attribution prospective rather than retrospective? Prospective attribution is preferable, because it allows physicians to know up front for which patients they will be responsible under the payment model. Particularly if CMS expects PFPMs to involve EAPM entities, which, in turn, involves bearing financial risk, the physicians involved need to know for which patients they are at risk.
- To what extent does the payment model rely on fee-for-service? As has been observed, "Fee-for-service, the predominant physician payment scheme, has contributed to both the continuing decline in the primary care workforce and the capability to serve patients well." Fee-for-service is a significant part of the problem that APMs are designed to solve. PFPMs that continue to rely on fee-for-service have little chance of success, in our opinion. We believe the goal of APMs, especially PFPMs, should be to eliminate fee-for-service as a baseline formula. The less fee-for-service involved in the model, the better.
- Is payment appropriately risk adjusted? As outlined before, the AAFP remains concerned that the MIPS and APMs will be built upon the current biased and inaccurate relative value utilization data currently used in the fee-for-service system. We feel more must be done to ensure that Medicare is paying appropriately for primary care physician services in these new payment models rather than paying based on this biased actuarial data that further exacerbates the undervaluation of primary care services. We strongly urge the PFPM TAC to consider these current deficiencies.

In the RFI, CMS states that it is interested in criteria that would support development of PFPMs that involve EAPM entities. If so, then other criteria that suggest themselves include:

- To what extent does the proposed PFPM involve one or more EAPM entities?
- Does the proposed PFPM require participants to use certified EHR technology?
- To what extent does the proposed PFPM involve quality reporting using measures comparable to those described in section 1848(q)(2)(B)(i)?
- Does the proposed PFPM require participants to bear financial risk for monetary losses in excess of a nominal amount? (Please see our comments elsewhere on the definition of "in excess of a nominal amount.")

Are there additional or different criteria that the Committee should use for assessing PFPMs that are specialist models? What criteria would promote development of new specialist models?

We believe the PFPM TAC should evaluate all PFPMs, including "specialist models," using the same criteria. CMS should focus on and promote the development of sustainable primary care models. The criteria for any specialists or disease-specific PFPM should be its connection to and integration with a primary care model.

The evidence related to primary care orientation illustrates that, in terms of its own population, the existing US health care system is one of the least effective, least efficient, and least able to produce good health in relation to other developed countries. Our current situation is reflective of our collective resistance to establish a delivery system built on a comprehensive, continuous, coordinated, and connected primary care system. We now have an opportunity to change this and the AAFP encourages CMS to seize this opportunity.

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?
It is the AAFP's impression that such criteria, procedures, and standards exist and that they likely include factors such as patient population, market geography (e.g. urban versus rural), etc. We do not know exactly what criteria, procedures, or standards other public or private payers may use in this regard, so we cannot say if any should be used by the PFPM TAC in assessing proposals it receives. We do know that many of the large, private payers are moving away from PCMH certification (recognition) as a requirement for value-based payment and instead are looking at certain practice functions, capabilities and outcomes as the criteria. We encourage CMS to contact the major private payers and their trade associations to answer this question.

c. Required Information on Context of Model within Delivery System Reform
In the RFI, CMS notes that it is considering specific criteria for the PFPM TAC to use to make comments and recommendations related to PFPM proposals submitted to it. CMS seeks feedback on whether these specific criteria should be included and, if so, whether they should be modified, and whether other criteria should be considered. CMS further notes that each of these criteria is considered for all models tested through the Center for Medicare and Medicaid Innovation (Innovation Center) during internal development.

We offer some general comments and then address each of the specific possible criteria on which CMS has requested comment.

We reviewed the Innovation Center criteria referenced in the RFI and find many or most of them to be worthy of consideration as CMS develops criteria for use by the PFPM TAC. There is some overlap with the criteria that we suggested earlier in our comments on the RFI (e.g., To what extent is the proposed PFPM likely to contribute to improvements in quality of care, access to care, and positive health outcomes?). It is not immediately apparent, however, that most of the criteria we have recommended are captured in the Innovation Center criteria. We encourage CMS to strongly consider what we have already suggested in this regard.

In response to the specific criteria on which CMS has invited comment, we observe the following:

We are considering that proposed 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.
This criterion appears to relate to Innovation Center criterion No. 5, which reads, "Demographic, clinical and geographic diversity – Does the model target key diverse patient and practitioner populations that CMS has yet to engage in other models, or geographic regions with previously low participation in CMS models?" We agree with the Innovation Center criterion, especially as it relates to patient populations. **However, we strongly disagree that proposed 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."**

We disagree with this proposed criterion for at least two reasons. First, we believe that the opportunity for physicians to participate in proposed PFPMs should not be limited by the fact that they may have had the opportunity to participate in another PFPM with CMS. Prior opportunity does not equate to prior participation, and

prior participation should not restrict a physician from future participation in innovative payment models. The Innovation Center criterion is about increasing equal opportunity across the board. The proposed CMS criterion seems to flip that notion on its head by limiting opportunity primarily to those who either did not have the opportunity before or did not take advantage of it when they did. PFPMs should be an opportunity for participants in other models to "upgrade," not just a market expansion.

The other reason we disagree with this particular proposed criterion is that it seems intent on fostering a plethora of specialty-specific PFPMs and we believe CMS should focus on primary care PFPMs. As we have stated elsewhere in our comments on this RFI, we do not need to replace the current fee-for-service system, and its multiplicity of subspecialists driving volume rather than value, with APMs driven by a multiplicity of sub-specialist PFPMs. If proposed PFPMs must "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," we fear that the PFPM TAC will only receive proposals that are increasingly narrow in scope, rather than broad in vision. We do not believe that is what is needed or called for in the law.

We strongly urge CMS not to include this criterion. Failing that, we urge CMS to modify it, so it is more in line with Innovation Center criterion No. 5.

Proposals would state why the proposed model should be given priority, and why a model is needed to test the approach.
In general, this criterion seems to be a reasonable expectation of any proposal submitted to the PFPM TAC.

Proposals would include a framework for the proposed payment methodology, how it differs from the current Medicare payment methodology, and how it promotes delivery system reforms.
Again, this seems to be a reasonable expectation of any proposal submitted to the PFPM TAC.

If a similar model has been tested or researched previously, either by CMS or in the private sector, the stakeholder would include background information and assessments on the performance of the similar model.
This criterion appears to relate to Innovation Center criterion No. 3, which reads, "Strength of evidence base – What data or prior experience (of CMS or other payers) supports the intervention proposed in the model?" The AAFP is a strong proponent of evidence-based medicine, and we believe it is entirely reasonable and appropriate to request the evidence behind a proposed PFPM. We support inclusion of this criterion in the assessment made by the PFPM TAC.

Proposed models would aim to directly solve a current issue in payment policy that CMS is not already addressing in another model or program.
We strongly disagree with this proposed criterion. **As noted earlier, we strongly disagree that proposed 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." We believe that payment models should support delivery models that promote quality over volume. With respect to primary care, we believe the core functions of the PCMH as articulated through the Joint Principles and the CPC milestones represent the most appropriate means of tying an advanced delivery model with an APM.**

This proposed criterion seems designed to preclude innovation in the form of alternative or new ways of addressing existing problems. We believe the PFPM TAC criteria should, instead, support delivery models that promote quality over volume**.** Innovation is not, and should not be, limited to uncharted territories. We strongly urge CMS not to include this criterion.

The core values of family medicine can transform America's health care for the better. In areas of the country where there are more primary care providers per capita, death rates for cancer, heart disease, and stroke are

lower and people are less likely to require hospitalization. Family physicians deliver acute, chronic, and preventive care, either directly or indirectly through established relationships with clinicians outside their practice, and are in the best position to deliver high-value population health management and coordination. Furthermore, family physicians deliver care to Americans from cradle to grave, based on a broad scope of services, and according to their patients' needs. These needs are best understood by family physicians because of the longitudinal and ongoing relationship between them and their patients, all in the context of their community and health system. This integrative approach is nothing new to family physicians and they already use innovative approaches for improving patient outcomes that would, most likely, not be achieved by less-integrated models of care. The value proposition of family medicine and primary care in general is: if payers and purchasers increase investments in primary care services, the total cost of health care services care will reduce and all stakeholders will realize the Triple Aim. The family medicine specialty will meet the nation's health care needs and, ultimately, improve the health of every American.

In medicine, there is often more than one way to address a problem, and the preferred solution may vary depending on the circumstances. Further, new solutions may prove preferable to old ways of doing things. For example, the treatment of polio gave way to prevention with the introduction of the polio vaccine.

d. Required Information on Model Design

In the RFI, CMS notes that it is considering a requirement that PFPM proposals must include the same information that would be required for any model tested through the Innovation Center. In response to the specific criteria on which CMS has invited comment, we observe the following:

We reviewed the Innovation Center criteria referenced in the RFI and the list of information that CMS might require for a complete proposal of a PFPM. As noted elsewhere in our comments on this RFI, we find many or most of the Innovation Center criteria to be worthy of consideration as CMS develops criteria for use by the PFPM TAC. Likewise, we think that most of the information that CMS is considering as necessary for a complete proposal is useful and appropriate, especially if CMS is interested in criteria/information that would support development of PFPMs that involve EAPM entities, as discussed elsewhere in the RFI and our comments. The pieces of information that we question are as follows:

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.

The AAFP strongly recommends CMS use the core measure sets developed by the multi-stakeholder Core Measure Collaborative to ensure alignment and harmonization and the avoidance of competing quality measures among payers. These sets contain a variety of measure types. We think it is appropriate and reasonable for CMS to request specific proposed quality measures to be used in the model, their prior validation (e.g., Are they endorsed by the National Quality Forum?), and how they would further the model's goals, including measures of beneficiary experience of care. We question the inclusion of "quality of life" and "functional status" measures. Neither is referenced in the Innovation Center criteria, and measuring both in addition to beneficiary experience of care and other quality measures may be beyond the reach of many PFPMs. Thus we believe that CMS is overreaching by including "quality of life" and "functional status" measures among its required information, and we would recommend that CMS refrain from doing so.

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.

The AAFP agrees with the spirit of what CMS is suggesting. However, we are concerned that this requested information represents an unnecessary level of detail that will otherwise require PFPM participants to capture the race, ethnicity, gender, and disability status of all Medicare participants and track the impact of the model on care provided across all of those variables. We believe that an appropriately functioning health information system could help significantly accomplish this without placing additional burdens on physicians. We note that Innovation

Center criterion No. 7 asks: “Potential for quality improvement – To what extent do we expect the model to result in improved clinical quality or patient experience of care, including but not limited to . . . reducing disparities in health care quality experienced by vulnerable populations?”
From the AAFP’s perspective, this language is a more reasonable and useful expression of what we believe CMS intends, and we encourage CMS to substitute it for the language used in the RFI. Furthermore, the AAFP is supportive of this data being collected, but we are also concerned with the undue burden that this may place on practices if EHRs are unable to capture it easily or at a reasonable cost. Additionally, to truly capture health disparities, an EHR must be able to capture data such as income, health literacy level, and other socio-demographic factors. We support the collection of this data and use in performance measures; however, EHRs will need first to add this capability into their systems.

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.
The word “mechanisms” does not seem to fit in this context. We encourage CMS to revise this item to read as follows: “Description of 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.” The goal of MACRA is to depart from current Medicare payment formulas so why would we evaluate proposals based on how they “fit into existing Medicare payment systems.”

What payment mechanisms would be used in the model, such as incentive payments, performance-based payments, shared savings, or other forms of payment.
This information is incomplete, in our opinion. As noted elsewhere in our comments on the RFI, we think this item should also include, “Is payment appropriately risk adjusted?” For primary care, we believe that our proposal to establish a comprehensive payment model that supports advanced primary care delivery models is most appropriate. **The AAFP strongly supports the goal of moving a larger percentage of payments from the traditional fee-for-service towards alternative payment models. We believe that payment models should support delivery models that promote quality over volume. With respect to primary care and as outlined elsewhere in this response, we believe the core functions of the PCMH as articulated through the Joint Principles and the CPC milestones represent the most appropriate means of tying an advanced delivery model with an APM.**

The AAFP proposes that payments for primary care services under this advanced primary care delivery model, provided through an advanced delivery model as outlined above, be made on a per-patient basis through the combination of a global payment for direct patient care services and a global care management fee. The global payment for primary care services would capture the “core primary care” services, a majority of which are provided by family physicians. AAFP records indicate these services number approximately 80. Any services provided by the family physician that fall outside the core primary care suite would be paid on a fee-for-service basis, through an appropriate bundle, or via a global payment structure. The second element of this blended payment model — a global care management fee—would capture those services performed by the physician or practice that contribute to the continuity and coordination of care, promote compliance and adherence, and facilitate appropriate use of health care resources. We further propose that both the global payment for core primary care services and the global payment for care management be risk-adjusted, based upon patient health status, as well as demographic, socioeconomic, and geographic factors. We believe both core primary care and care management payments should be eligible for the five percent bonus payment under the APM program.

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?
The AAFP believes CMS must include all payers, including Medicaid and private payers. That being said, this question seems duplicative of the one that immediately precedes it, “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.” Also, it does not seem useful

to ask why the model does not engage payers other than Medicare, if that is the case. It either does or does not; the reasons seem immaterial to us. We recommend that the latter part of this item, which is useful information, be combined with the item immediately preceding it to form a single item, which would read as follows:

"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. If the model includes payers other than Medicare, what proportion of the model's patients is covered by Medicare as compared to other payers?"

Beyond the items listed in this section of the RFI, we recommend that CMS also consider the following additional criteria, noted elsewhere in our comments on this RFI:

- How primary care oriented is the proposed PFPM?
- To what extent is the proposed PFPM based on continuing, comprehensive care, and to what extent does it encourage treatment on an ambulatory basis rather than in a costly institutional setting?
- Is the entity (or entities) to which payment will be directed physician-led? Is a majority of the governing board(s) comprised of independent physicians, members of a participating IPA, or physicians employed by physician organizations, and is a majority of those physicians comprised of family medicine and other primary care representation?
- To what extent does the proposed PFPM involve one or more EAPM entities?
- To what extent does the proposed PFPM use medical homes expanded under section 1115A(c) of the Social Security Act?

e. Technical Assistance to Small Practices and Practices in Health Professional Shortage Areas.
In this RFI CMS seeks comment on the following questions:

What should CMS consider when organizing a program of technical assistance to support clinical practices as they prepare for effective participation in MIPS and APMs?
CMS should consider the various types of practices requiring support. Challenges and barriers differ between independent and employed practices, rural and metropolitan locations, etc.

CMS should also consider the delivery method of the information. Typically, scripted didactic conference calls are ineffective. Physicians want to hear from their peers who have made progress or overcome challenges in preparing for value-based payment. CMS should consider offering collaborative calls—at multiple times—to allow more physicians to attend and develop tools or calculators to allow physicians to compare how their practice would perform under both programs (i.e., MIPS and APMs). The AAFP believes CMS should also consider using the extension centers, physician organizations, and state organizations to host conferences and webinar/teleconference/in-person meetings for providers to be able to share challenges and engage in collaborative learning. Collaborative sessions mirroring the Academic Chronic Care Collaboratives (IHI Breakthrough Series) used to implement the chronic care model would be beneficial.

CMS should consider contracting with extension centers, state organizations, and physician organizations such as the AAFP to disseminate information, host webinar/teleconference/in-person meetings in order to allow providers to share challenges and engage in collaborative learning, and to leverage existing channels of communication. Such channels could include journal articles; online educational modules, such as *Primary Advantage*, educational sessions at conferences, local or state chapter meetings, digitized learning and other communications.

What existing educational and assistance efforts might be examples of "best in the class" performance in spreading the tools and resources needed for small practices and practices in HPSA? What evidence and evaluation results support these efforts?

The Institute for Healthcare Improvement (IHI) has developed the Breakthrough Series Model of learning collaboratives for practice improvement. This model has been adopted by several transformation consultants and health care organizations and has proven to be effective when coupled with additional support such as office hours, affinity group webinars/conference calls, one to one coaching, onsite facilitation, online education, and project specific action networks.

Additionally, a previous AAFP subsidiary— using funding procured via a Health Care Innovation Award—utilized multi-market collaboratives and connections to facilitate shared learnings and collaborative problem solving to develop medical neighborhoods. Final reporting for this project is pending.

The AAFP has developed an online practice transformation tool, Primary Advantage, to educate subscribers on change concepts and how to implement such functions as risk-stratified care management, care coordination across the medical neighborhood, improved access to care, patient engagement and other advanced primary care functions. CMS could collaborate with the AAFP to develop modules for this tool to educate physicians about the MACRA, the criteria for qualifying for and selecting MIPS or APM, understanding, interpreting, tracking and monitoring cost and quality measures and outcomes, reporting requirements and options, appropriate staffing models, etc.

As in the Transforming Clinical Practices Initiative (TCPI) Support and Alignment Networks (SAN), CMS could collaborate with the AAFP to develop articles for the *Family Practice Management* journal, *AAFP News* online newsletter, and updates to the MACRA webpage. CMS could also collaborate with AAFP chapters to target communications geographically and by practice environment via chapter newsletters and webpages on the AAFP website (AAFP.org).

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 storage areas, and what solutions have been successful in addressing these issues?
The most significant challenges are insufficient staff, provider time, poor EHR systems, and added costs that do not translate to better patient care. Other significant challenges include:

- The administrative/paperwork burden (especially for small practices) takes providers away from patient-care;
- Creating a vision and developing change leadership in the practice;
- Effective means to train staff and communicate change;
- Lack of standardization in expectations from outside entities (public payers, private payers, MOC, etc.)

For small or solo independent practices and those in rural communities, additional challenges include, but are not limited to, finite technological resources, lack of supportive community infrastructure (i.e. internet capability and speed), and proximity to medical neighbors.

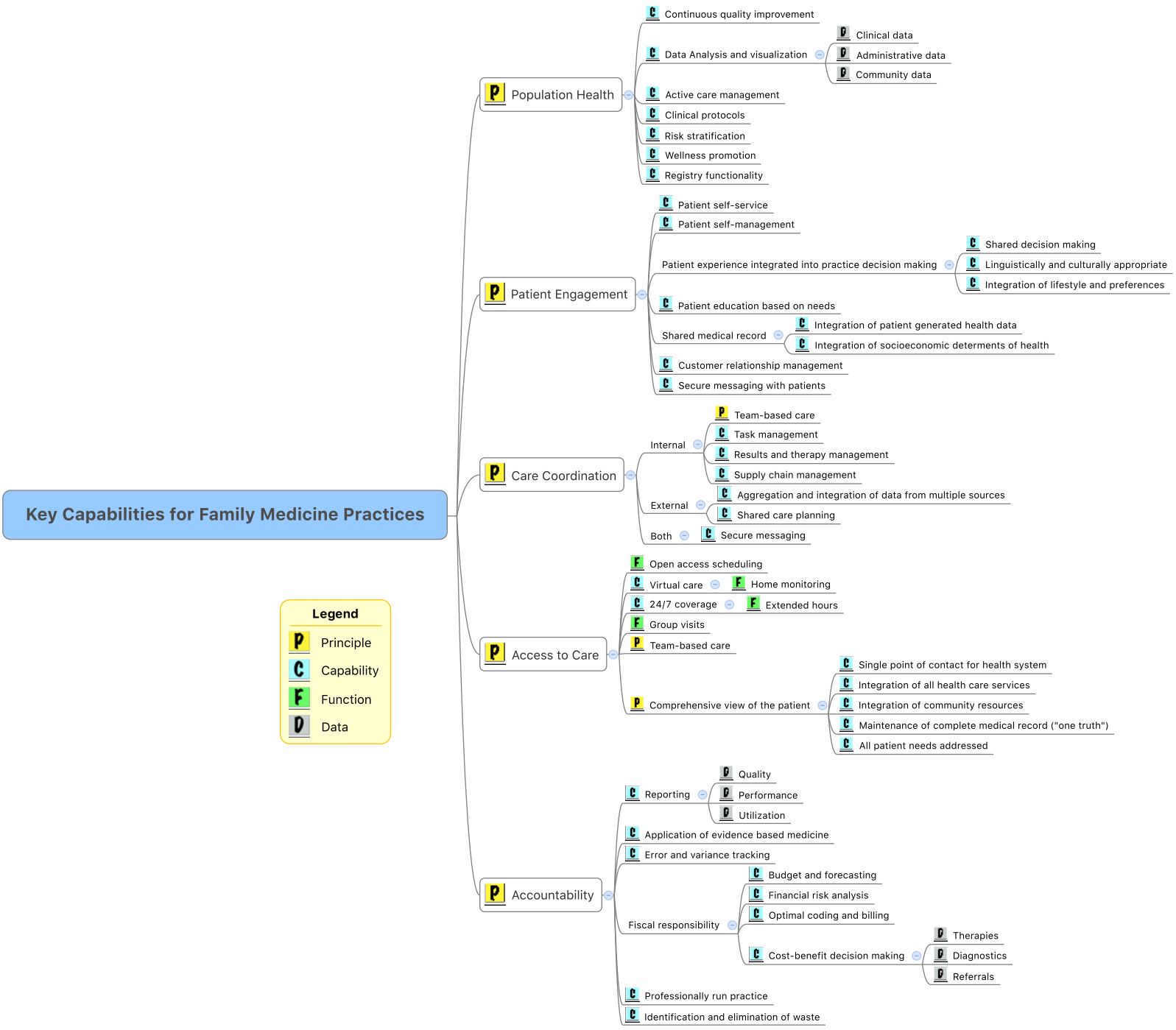
What type of support should CMS offer in helping providers understand the requirement of MIPS?
A strategic communication plan, developed in collaboration with physician organizations, should be implemented in a collaborative manner to ensure the right message is getting to the right audience at the right time. CMS should also utilize its traditional modes of communication and offer support though office hours, affinity group webinars/conference calls, FAQs, and other job aides. CMS should also provide venues for asking questions and collaborate with partners to help communicate messages through channels such as, for example, journal articles, and conference sessions. CMS should obtain continuous feedback during this process to confirm the plan is effective and adjust based on feedback.

Should such assistance require multi-year provider technical assistance commitment or should it be a one-time basis?

Technical assistance should be available over multiple years to cover the stages of implementation, such as planning, execution, evaluation, and adjustment of intervention based on outcomes.

Should there be conditions of participation and/or exclusion in the providers eligible to receive such assistance such as providers participating in delivery system reform initiatives such as TCPI or having a certain level of need identified?

Support should not be limited to participation in other initiatives. In fact, support should be targeted to those physicians and physician practices that are not actively engaged with other transformation projects, since they have the highest probability of falling behind. Excluding support from these physicians could result in insufficient information and resources for a large percentage of physicians.


Key Capabilities for Family Medicine Practices
Legend
Principle
Capability
Function
Data
Population Health
Continuous quality improvement
Data Analysis and visualization
Clinical data
Administrative data
Community data
Active care management
Clinical protocols
Risk stratification
Wellness promotion
Registry functionality
Patient Engagement
Patient self-service
Patient self-management
Patient experience integrated into practice decision making
Shared decision making
Linguistically and culturally appropriate
Integration of lifestyle and preferences
Patient education based on needs
Shared medical record
Integration of patient generated health data
Integration of socioeconomic determents of health
Customer relationship management
Secure messaging with patients
Care Coordination
Internal
Team-based care
Task management
Results and therapy management
Supply chain management
External
Aggregation and integration of data from multiple sources
Shared care planning
Both
Secure messaging
Access to Care
Open access scheduling
Virtual care
Home monitoring
24/7 coverage
Extended hours
Group visits
Team-based care
Comprehensive view of the patient
Single point of contact for health system
Integration of all health care services
Integration of community resources
Maintenance of complete medical record ("one truth")
All patient needs addressed
Accountability
Reporting
Quality
Performance
Utilization
Application of evidence based medicine
Error and variance tracking
Fiscal responsibility
Budget and forecasting
Financial risk analysis
Optimal coding and billing
Cost-benefit decision making
Therapies
Diagnostics
Referrals
Professionally run practice
Identification and elimination of waste