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August 21, 2017

VIA ELECTRONIC SUBMISSION

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5522-P
P.O. Box 8013
Baltimore, Maryland 21244-8013

Dear Administrator Verma:

On behalf of the American College of Osteopathic Family Physicians (ACOFP), we appreciate the opportunity to respond to the Centers for Medicare & Medicaid Services (CMS) proposed rule, *Calendar Year 2018 Updates to the Quality Payment Program (QPP) Proposed Rule* (Proposed Rule).

The ACOFP is the professional organization representing more than 20,000 practicing osteopathic family physicians, residents, and students throughout the United States who are deeply committed to advancing our nation's health care system by improving health care delivery and outcomes, and ensuring that patients receive high-quality care. Generally, we are supportive of CMS' focus on patient-centered, value-based care. Value-based care emphasizes wellness and prevention, which are at the core of our osteopathic philosophy and training.

Overall, as an organization with many osteopathic family medicine physicians in small and rural practices, we support CMS' efforts to reduce provider burden and to simplify various components of the QPP. While we have some concerns, we are hopeful that CMS will continue to keep in mind family medicine physicians and ensure that programs like the QPP enable them to deliver high quality and efficient care.

Our full comments are detailed on the following pages. Thank you for the opportunity to share these with you. Should you need any additional information or if you have any questions, please feel free to contact Michael Park, ACOFP Director of Government Relations, at michael.park@alston.com or at 202-239-3630.

Sincerely,

Rodney M. Wiseman, DO, FACOFP *dist.*
ACOFP President

1. Low-Volume Threshold

ACOFP supports the proposal to increase the low-volume threshold (LVT) to ensure that Merit-based Incentive Payment System (MIPS) eligible practitioners have sufficient data to yield a statistically valid comparison with other providers. While we appreciate CMS' proposal to increase the LVT to $90,000 or less in Part B allowed charges or 200 or fewer Part B beneficiaries served, we urge CMS to increase the LVT even more to ensure solo and small practices and rural practitioners are sufficiently protected and insulated from the costs associated with MIPS participation. CMS notes that the proposed LVT will only result in a 5 percent difference in the number of MIPS eligible clinicians who deliver care in solo and small practices and will have "little impact" on MIPS eligible clinicians from practices in designated rural areas. This change does not sufficiently protect or alleviate CMS' previously identified burdens on small practices or solo practitioners. We therefore urge CMS to revisit the LVT to ensure that the LVT provides practitioners serving rural areas or operating as small or solo practices enough flexibility to continue to serve their patient population.

For the calendar year (CY) 2018 performance period, CMS also is considering an LVT based on a set number of Part B items and services. ACOFP urges CMS to consider practitioners in solo and small practices and rural areas when defining and establishing the threshold so that the flexibility intended by the LVT is truly meaningful.

ACOFP also appreciates CMS' efforts to allow flexibility through an "opt-in" process in which practitioners may opt-in even if they meet an LVT. However, we are concerned that this would allow self-selecting practitioners to participate in MIPS and would present challenges in terms of data collection, analysis, and comparison. This would create an uneven pool of MIPS practitioners and comparison across those practitioners may not provide an appropriate or accurate assessment of practitioner performance.

2. MIPS

ACOFP generally supports the proposed changes to the four performance categories. Specifically, we support: (1) the continued protections for solo, small, rural, and Health Professional Shortage Areas (HPSA) practices; (2) weighting the cost category to zero percent for Year 2; and (3) retroactively excluding the e-prescribing and health information exchange measures and retroactively adding a decertification exemption under the Advancing Care Information performance category. We also support the additional bonus points for practitioners treating complex patients and for solo and small practices. ACOFP's comments are detailed further below.

Improvement Activities Performance Category

ACOFP appreciates CMS continuing to allow MIPS eligible clinicians in solo, small and rural area practices to report on no more than 2 medium or 1 high-weighted activity to achieve the highest score for this performance category. In terms of group reporting, we urge CMS to continue to require only 1 MIPS eligible clinician to perform an Improvement Activity for a TIN to receive full credit. Practitioners will need sufficient time to ramp up and adapt to the

requirements of this new performance category. Solo, small and rural practices especially will need this flexibility in order to fully participate in MIPS. Therefore, we support and urge CMS to remain consistent and provide stability for practitioners.

ACOFP also supports the proposed new Improvement Activity, "Provide Education Opportunities for New Clinicians." This reflects the importance of educating clinicians-in-training and ensuring there are sufficient clinicians available to provide care in underserved and rural areas.

Quality Performance Category

Similar to our comments on the Improvement Activities performance category, ACOFP supports the continued protections for solo, small and rural practices. Specifically, we appreciate continuing to provide solo and small practices with 3 points for measures that do not meet data completeness criteria.

ACOFP is, however, concerned with the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey. While we support ensuring patients have access to provider data and scores (*i.e.,* through Physician Compare), we are concerned that patient satisfaction scores do not necessarily reflect best practices or the provision of high quality care. Patient surveys are highly subjective and at times unfair to practitioners. For example, our practitioners have reported receiving poor patient satisfaction survey results due to not prescribing opioids. In order to ensure the appropriate care is delivered, as opposed to care solely expected to improve patient satisfaction survey results, we urge CMS to revisit how CAHPS survey results are connected to and impact performance scores. One suggestion would be to include additional, required follow-up questions if a patient has responded negatively. This could replace open text fields for patients to provide comment or could be used in conjunction.

Advancing Care Information Performance Category

ACOFP strongly supports CMS' proposals to retroactively add exclusions for the e-prescribing and health information measures. We believe this addresses a previous oversight that is proving to be very burdensome. We also support the retroactive decertification exemption for practitioners whose EHR was decertified and appreciate the proposal to extend the application deadline for a significant hardship to December 31 of the performance period.

We also support the proposal to reweight this performance category to zero and allocate the 25 percent to the Quality performance category for solo, small practices and practices in HPSAs. This change provides much needed protection for solo practitioners and practitioners in small practices and HPSAs who may not be able to immediately afford or support the required administrative and technological updates. We urge CMS to continue to consider and be mindful of MIPS' impact on such practitioners and the need to alleviate burdens resulting from this performance category.

Cost Performance Category

ACOFP is concerned with the assessment and attribution of costs and how these costs relate to assessing quality. Generally, ACOFP believes that costs should be controllable by and attributable to the practitioner being assessed. Family medicine practitioners provide services and use resources that are often desirable and medically more effective and efficient than alternative and more expensive services. For example, chronic disease management is a preventive service that can often reduce the need for emergency or higher cost specialty care. Measuring primary care costs in a vacuum can skew the analysis of resource utilization.

With regards to rural practitioners or practitioners in health professional shortage areas, the cost issue is further exacerbated. For example, these practitioners typically provide services that would adversely impact their cost performance as these services typically would be provided by specialists in other areas. For example, rural practitioners often perform minor surgical procedures, fracture care, emergency care, and even obstetrical care. These are critical and necessary services provided by rural family physicians that would not otherwise be readily available to beneficiaries in rural areas. Subsequently, these practitioners' cost performance would be unfairly skewed as a result of providing much needed and appropriate care. Therefore, ACOFP urges CMS to continue to weight this category to zero percent until CMS has developed a definition and methodology to determine appropriate costs for both urban and rural primary care services.

Also, ACOFP is concerned with the attribution of costs and quality to the appropriate practitioner. We urge CMS to exclude certain primary care services that are desirable and medically more effective and efficient from the Resource Use consideration or to develop a methodology so that costs related to appropriate primary care services do not negatively impact a practitioner's performance assessment under this performance category.

Further, we have concerns about the agency's proposal to increase the weight of the cost performance category from zero percent in 2020 to 30 percent in 2021. Increasing the weight from zero percent to 30 percent in one year will dramatically impact practitioners by driving the focus away from quality to resource management. We stress that a patient's quality of care must be the first priority. Practitioners also will be incentivized to simply provide fewer services, which is counter to primary care best practices and the importance of preventive services. If CMS chooses to begin weighting cost in future years, ACOFP urges CMS to phase-in the weighting. This proposed drastic increase is unworkable for many practitioners and will adversely impact patient care.

Scoring and Bonus Points

ACOFP supports the proposed Year 2 final score weighting and flexibility across the performance categories, as detailed previously. We believe CMS' proposals to reweight performance categories and added exceptions alleviate several existing burdens especially for solo, small and rural practices.

ACOFP also supports the proposed changes to improvement scoring for quality and cost. Due to the administrative and technical challenges solo, small and rural practices face, rewarding improvement through additional points will help to incentivize and offset the upfront costs of MIPS participation.

ACOFP appreciates the additional bonus points for complex patients. However, practitioners face different challenges and limiting the complex patient bonus to the HCC risk score ignores the variations across states in terms of the characteristics of each state's Medicaid population. In response to CMS' request for comments, we urge CMS to allow and offer the higher of the HCC risk score or dual eligibility patient adjustment when providing the complex patient bonus.

Similarly, ACOFP supports the small practice bonus, but urges CMS to extend the bonus to practitioners in rural areas. This will ensure eligible practitioners are not penalized for the patient population served or where they provide services.

3. Virtual Groups

ACOFP appreciates CMS' commitment to virtual groups and for providing this option for Year 2. Virtual groups can offer small and solo practitioners an important pathway to achieve success under MIPS. Specifically, we appreciate that CMS has not placed any limits on geographic area, specialty, or number of TINs that may form a virtual group.

ACOFP is concerned, however, that small practices and solo practitioners may establish virtual groups and then be subject to future classifications that would prevent them from future participation. The uncertainty poses a significant challenge to practitioners who would otherwise look to participate in MIPS through a virtual group. We urge CMS to allow flexibility and not curtail participation through future rulemaking. Further, we encourage CMS to incorporate participant feedback prior to making any future adjustments to virtual groups. We also urge CMS to offer additional flexibility for practitioners – especially those in rural and health professional shortage areas – to change participation status and be evaluated individually. While we understand CMS' position in terms of protecting against "double-dipping," we believe this added flexibility will help ensure rural practitioners can meaningfully participate in MIPS and adapt to any unforeseen issues with participating as part of a virtual group.

We also urge CMS to provide more clarity on how virtual groups can be assembled. While CMS has made it clear who can be included in a virtual group and that virtual groups are not a data submission method, we would appreciate guidance and clarification on whether a state or national association, such as a specialty organization, would be allowed to convene a virtual group. It would be extremely beneficial for solo, small and rural practices to have an organization assist with assembling and managing their MIPS participation, even if they do not formally submit data on the virtual group's behalf.

4. Advanced APMs and Primary Care

ACOFP appreciates CMS' proposals to reduce the burden for certain Advanced APMs. Specifically, ACOFP is encouraged by CMS' proposals to: (1) extend the 8 percent revenue-based nominal amount standard for two additional years; (2) reduce the growth rate of potential risk for the Medical Home Model; and (3) exempt Round 1 Comprehensive Primary Care Plus (CPC+) Model participants from the requirement that the Medical Home Model standard only applies to APM entities with fewer than 50 eligible clinicians.

ACOFP continues to be concerned, however, that there are limited APM opportunities for small practices and solo practitioners. Such practitioners are essentially precluded from participating in an Advanced APM. Further, the opportunities for primary care participation are limited, despite the expansion of the CPC+ model. We encourage CMS to ensure a wide variety of Advanced APM options are available to accommodate osteopathic family medicine and small and solo practices. To partially address this concern, we suggest reducing the reporting burden and requirements for MIPS eligible clinicians participating in APMs. For example, our members who participate in CPC+ (Round 2), which are also part of an Accountable Care Organization, still have to report quality data through MIPS instead of through the APM. Essentially, these practitioners are required to perform duplicative work, which is an added burden and expense that shifts the focus away from care delivery redesign.