August 21, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-5522-P – Medicare Program; CY 2018 Updates to the Quality Payment Program

Dear Administrator Verma:

On behalf of the American Congress of Obstetricians and Gynecologists (ACOG), representing over 58,000 physicians and partners in women’s health, I am pleased to offer these comments on the Centers for Medicare and Medicaid Services’ (CMS) proposed rule on the CY 2018 Updates to the Quality Payment Program. As physicians dedicated to providing quality care to women, ACOG appreciates CMS’s willingness to continue seeking input from the physician community to implement sound policies for Medicare. We also applaud CMS for proposing to continue providing flexibility in the second performance period to ensure that physicians are able to transition to this new payment system. Ongoing implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) should ensure that physicians trust the Medicare payment system and that women’s unique health needs are being met, and it is with these goals in mind that we make the below recommendations on the Quality Payment Program.

**Merit-based Incentive Payment System**

§414.1305. Definitions.

Low-volume threshold. ACOG supports increasing the low-volume threshold to the level proposed by CMS for individual eligible clinicians. Allowing obstetrician-gynecologists (ob-gyns) and other providers who submit $90,000 in Medicare Part B allowed charges or care for 200 or fewer Medicare patients during the determination period to be exempt from the Merit-based Incentive Payment System (MIPS) will help ensure that ob-gyns are not forced to report without the ability to be scored due to too few cases for measures.

However, ACOG continues to believe that the threshold should only apply to individual clinicians and that CMS should develop a new, separate definition if the Agency believes that groups should also have a low-volume threshold. Setting the low-volume threshold at both the individual and group level introduces unnecessary complexity into the program because the other exclusions for MIPS only apply to individual clinicians. We believe that individual clinicians who practice in a group should be exempt from group reporting and payment adjustments because measurement is not meaningful for them if they do not see a sufficient volume of Medicare patients or submit a certain level of allowed claims. Additionally, ACOG opposes including items or services beyond the physician fee schedule, particularly
Part B drugs, when determining MIPS eligibility. We believe that changing this policy would create significant inequities and potential legal challenges in administering the MIPS program. ACOG recommends that CMS extend its own logic behind setting a group practice equivalent for the non-patient-facing definition by exempting group practices when 75 percent or more of the National Provider Identifiers (NPIs) who bill under the group’s Tax Identification Number (TIN) meet the threshold on an individual basis.

We encourage CMS to notify individuals and groups as soon as possible that they meet the low-volume threshold requirement. Ideally, this notification should occur before the 2018 performance period. The delay of low-volume letters for the 2017 program left many confused and potentially unprepared to meet the MIPS requirements. Notification for 2018, if the proposal is finalized, will be even more important since some participants who reported in 2017 may not realize that they now qualify for an exemption. Therefore, ACOG urges CMS to issue these notices in a timely manner and explain the potential change in its policy from the 2017 performance year.

Finally, CMS solicited comments on whether it should add a threshold for items and services furnished to Part B individuals in determining the low-volume threshold. We believe this is unnecessary and that the current process of looking at the minimum number of individuals treated and allowed charges will generally capture those who should qualify for an exemption. In addition, we think adding a third criterion will create more complexity for CMS as well as physicians and could further delay notices to those practices who have met the low-volume threshold. Instead, we urge CMS to create stability by maintaining the current approach to calculating the low-volume threshold. Also, CMS should not reduce the low-volume threshold; otherwise physicians will face uncertainty about their status and could be unfairly penalized.

Small practices. CMS determines a small group size by the number of NPIs associated with a TIN, which includes clinicians who may be excluded from MIPS participation and do not meet the definition of a MIPS eligible professional. For example, a small group would include clinicians who had been excluded from MIPS participation, clinicians newly enrolled in Medicare, qualifying participants in APMs, partially qualifying participants in APMs and clinicians who fall below the low volume threshold.

In addition, small groups would include other eligible professionals defined by 1848(k)(3)(B) of the Social Security Act that may not be counted as MIPS eligible professionals in performance year 2018 including:

- A certified nurse- midwife;
- A clinical social worker;
- A physician or occupational therapist or qualified speech-language pathologist;
- A qualified audiologist;
- A clinical psychologist; and
- A registered dietitian or nutrition professional.

MIPS eligible professionals are more narrowly defined as follows:

“(I) for the first and second years for which the MIPS applies to payments (and for the performance period for such first and second year), a physician (as defined in section 1861(r)), a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1861(aa)(5)), a certified registered nurse anesthetist (as defined in section 1861(bb)(2)), and a group that includes such professionals;
“(II) for the third year for which the MIPS applies to payments (and for the performance period for such third year) and for each succeeding year (and for the performance period for each such year), the professionals described in subclause (I), such other eligible professionals (as defined in subsection (k)(3)(B)) as specified by the Secretary, and a group that includes such professionals.

ACOG urges CMS to only include MIPS eligible professionals in determining whether a practice qualifies as a small practice with 15 or fewer eligible professionals. While ACOG understands that CMS may be constrained by statutory definitions, we are also concerned that the definition of a small practice could cause confusion and be misinterpreted by physician practices. Specifically, we have concerns that a practice may assume it is small if it has fewer than 16 MIPS eligible professionals, when in fact it may have more than 15 NPIs within its TIN. Practices may incorrectly rely on beneficial scoring for small practices or on the overall small practice bonus, when calculating the data they need to report. It is likely that these practices may inadvertently receive a penalty for not reporting enough information because they misunderstood the definition of a small practice. Therefore, ACOG urges CMS to define small practices as those practices with 15 or fewer MIPS eligible professionals.

Alternatively, if CMS is not able to define small practices as only including MIPS eligible professionals, the Agency should provide significant education to physicians regarding who will be included in the definition of small practices. CMS should also display this information prominently on the Quality Payment Program website. Currently, the Program’s website participation look-up tool only lists the types of clinicians that are MIPS eligible professionals, but does not include an explanation of eligible professionals that count toward the definition of a small practice. This information should be included on the Quality Payment Program website and in educational materials CMS distributes to physicians.

Given the significant confusion around the definition of small practices, ACOG also believes that CMS should continue to make the small practice eligibility determination using claims data. While an attestation option may be easier for physicians, we are concerned that physicians may incorrectly attest that they are a small practice and find out later that they received a penalty based on an incorrect assumption that their practice was small.

**ACOG Recommendation:**
- Adopt the low-volume threshold as proposed for individual clinicians.
- Determine eligibility based only on the physician fee schedule.
- Exempt a group if 75 percent or more of the eligible clinician types in a TIN fall below the low-volume threshold.
- Limit the criteria for determining the low-volume threshold to the number of Medicare Part B patients and the amount of allowed Medicare Part B charges.
- Include only MIPS eligible professionals when determining whether a practice meets the small practice definition.
- Determine small practice size based on claims, not attestation.

§414.1320. MIPS performance period.

ACOG supports that for payment year 2021 and onward that the improvement activities and advancing care information performance periods are limited to a minimum of a continuous 90-day period. As we have noted previously, a full calendar year reporting period can create significant administrative burden while not necessarily improving the validity of the data. However, we encourage CMS to allow physicians to choose the length of the reporting period for the quality performance category. Having performance categories with differing reporting period lengths adds unneeded confusion and complexity. This would permit reporting on a full calendar year for those physicians who believe it is more appropriate for their practice. A MIPS participant would also have the flexibility to select a 90-day
quality period if they preferred to harmonize their MIPS reporting. We believe this flexibility would also resolve problems that may occur if a physician updates or switches their EHR during the performance year.

We understand that CMS’s systems and some vendors may have challenges in using a shorter reporting period or multiple reporting periods. We, however, urge the Agency to work with physicians to develop options and a specific plan to provide accommodations where possible. For example, CMS could allow physicians to select from one of four reporting periods: 90 days, 180 days, 270 days, or 360 days. This option could alleviate some of technical challenges while still providing flexibility to participants.

ACOG encourages CMS to investigate ways to shorten the time between performance periods and payment adjustment periods for future payment years in the Quality Payment Program. ACOG remains concerned that two years is far too long to impact practice patterns and lead to meaningful behavior change. What CMS is currently proposing is not a value-based system, it is a reward and punishment scheme where it is impossible to make behavior changes that can meaningfully impact payment because of the delays in feedback. Two years between performance and payment is contrary to behavioral economics and to the principle of immediacy, which is central to successful physician incentives.1

**ACOG Recommendations:**
- Adopt the proposal to require the advancing care information and improvement activities performance categories be subject to a minimum continuous 90-day performance period.
- Permit physicians to choose the length of the reporting period for the quality performance category.
- Revise the regulatory text to shorten the time period between the performance period and payment adjustment period to less than two years.

§414.1325. Data submission requirements.

ACOG supports allowing more than one submission mechanism within a given performance category for performance year 2018 and beyond. We believe that this flexibility will support reporting the highest quality data available. While we understand that this may add some burdens to reporting quality measures for ob-gyns because they will be required to report on six quality measures instead of only the number available via a given submission mechanism, we believe this will ultimately drive adoption of more robust measures based on clinical data and outcomes.

**ACOG Recommendation:** Adopt the proposal to allow multiple submission mechanisms within a given performance category.


ACOG supports reweighting this category to 60 percent. As we note below, we do not believe it is appropriate to measure cost in the second performance period and agree that the cost category’s weight be redistributed to quality in performance period 2018.

ACOG still has concerns with CMS’s use of the all-cause readmission (ACR) measure for groups with 15 or more clinicians. The ACR measure lacks transparent evaluation on whether it is appropriate to use at the physician-level. ACOG is extremely concerned with potential unintended consequences related to the use of the measure at the group practice level (16 or more eligible clinicians) without the proper vetting of the measure’s reliability and validity. It remains unclear how CMS determined the reliability of the readmission measure at the physician level and there is not enough information in the 2017 or 2018 QPP rules or the Value-based Payment Modifier Program (VM) Quality and Resource Use Reports (QRURs).
to ensure that physician performance is accurately represented, even when applied only to practices of 16 or more eligible clinicians.

Furthermore, the continued lack of sociodemographic factors in the risk adjustment model is concerning and could lead to potential negative consequences. When the measure was used in the VM, practices that served a higher number of patients with social risk-factors were more likely than other practices to have received a negative adjustment.ii,iii If the ACR measure remains in the MIPS program, the measure may create inequities rather than enhancing quality of care. The Institute of Medicine (IOM) Committee on Accounting for Social Economic Status (SES) in Medicare Payment Programs has recently outlined concerns that decreased payments, particularly for those physicians caring for patients who are socially at-risk, could lead to underinvestment in the quality of care and that maintaining the status quo will introduce new ills into the healthcare system, as opposed to improving care.iv If CMS continues the use of the ACR measure, at a minimum physician or group performance should not affect payment or be publicly reported unless a reliability of 0.80 can be demonstrated and the risk adjustment model is developed, tested, and released for comment prior to implementation.

ACOG does not believe it is useful to adopt cross-cutting measures and CMS should abandon future proposals that seeks to incorporate these measures into the reporting requirements for the quality performance category. We believe it is most important for ob-gyns to report on measures that are most applicable to their practice, not an arbitrary subset of measures.

ACOG supports CMS’s phased-in approach for removing topped out measures from MIPS, however, we do not support CMS’s proposed timeline for classifying measures as “topped out” or its proposal to cap achievement points for such measures at six points. CMS’s current strategy bases performance scores and benchmarks on data that may or may not have sufficient sample sizes and utilizes Physician Quality Reporting System (PQRS) reporting rates as a starting point. PQRS had low participation rates, and it is questionable whether the numbers represent a true indication of quality. MIPS should be based on MIPS reporting, not a program that sunset in 2016. Beginning the phased-in removal of “topped out” measures with only one year of MIPS data is also problematic due to the 2017 transition year. Because of the pick-your-pace approach used in 2017, the first performance period’s data may not be representative sample of how ob-gyns and other health care providers are actually performing on quality measures. CMS has already removed a significant number of measures under MIPS, particularly measures available under the claims and electronic health record (EHR) reporting methods, and we continue to remain concerned that removing and capping measures too soon may lead to a gap within the measure portfolio.

Furthermore, CMS should not penalize physicians for reporting on “topped out” measures by capping the number of achievement points at six. Physicians should be eligible to earn maximum achievement points for reporting such measures until a measure is removed. As stated in our section on Physician Compare and Quality Scoring Benchmarks, CMS should explore using the Achievable Benchmark of Care (ABC) methodology to evaluate measures that may not have much variation in performance. Capping achievement points adds to the complexity of scoring and ignores that there are multiple factors that go into the decisions physicians make for reporting on specific measures. It also ignores that CMS is making classifications on measures based on extremely faulty data with low reporting rates.

ACOG Recommendations:
- Reweight the performance category to 60 percent.
- Remove the all-cause readmission measure from the performance category.
- Do not pursue mandated reporting of cross-cutting measures.
- Adopt the phased-in approach for identifying “topped out” measures in performance period 2019 or later.
- Do not cap the number of achievement points available for “topped out” measures.
§414.1335. Data submission criteria for the quality performance category.

ACOG has concerns with CMS’s proposal to remove two Summary Survey Measures (SSMs), specifically “Helping You to Take Medication As Directed” and “Between Visit Communication,” for performance period 2018. We believe that the changing payment and practice environment necessitates holding off on removing these SSMs for at least the next few performance periods. As the health system, specifically Medicare, moves toward value, it may be possible that the resources for “Between Visit Communication” and the additional time necessary for “Helping You to Take Medication As Directed” are areas that practices could skimp on to reduce their overall resource use, but be negatively impacting quality of care. Without alternative domains or better patient experience or patient-reported outcomes measures to replace these SSMs, we believe it is best at this juncture to leave the SSMs in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey.

ACOG is supportive of expanding patient experience data and the patient’s empowered and engaged voice by adding five open-ended questions to the CAHPS for MIPS survey. However, we believe that until these questions have undergone National Quality Forum (NQF) endorsement, they should not be used for accountability purposes and should not be reported on Physician Compare.

**ACOG Recommendations:**
- Do not remove the SSMs, “Helping You to Take Medication As Directed” and “Between Visit Communication,” for performance period 2018.
- Add the proposed five open-ended questions to the CAHPS for MIPS survey, but do not include responses on Physician Compare until the questions have undergone NQF endorsement.

§414.1340. Data completeness criteria for the quality performance category.

ACOG appreciates CMS’s proposal to keep the data completeness thresholds at 50 percent of Medicare patients for claims submission and 50 percent of all patients for other data submission mechanisms. ACOG believes a gradual increase as CMS proposes for performance year 2019 to 60 percent is reasonable and should be finalized. Requiring physicians to report on a higher percentage of their patients would potentially limit the types of measures physicians would be able to report.

ACOG also supports CMS’s proposal to assign one point for measures that fall below the data completeness threshold for non-small practices and maintaining the three-point floor for small practices that fall below the data completeness threshold. We appreciate that CMS is still affording physicians and other health care providers the ability to report without completely negating their effort if they fail to report on the necessary number of patients during the performance period.

**ACOG Recommendations:**
- Adopt the data completeness criteria for performance periods 2018 and 2019.
- Allow quality measures that fall below the data completeness threshold to receive one point or three points if an eligible clinician is in a small practice.


ACOG supports reweighting this category to zero percent in performance year 2018 particularly in light of the proposal to abandon the 10 episode measures that were previously put forward. While we appreciate that eligible clinicians may face a “cliff” in performance period 2019 when the performance category is statutorily required to be weighted at 30 percent of the final score, we remain concerned by the lack of testing of these new measures and the patient attribution methodology. Without robust testing of these elements, along with the patient relationship codes and the risk- and specialty-adjustment...
recommendations from the congressionally-mandated Assistant Secretary for Planning and Evaluation (ASPE) report, it is not prudent to adjust physicians’ and other eligible clinicians’ reimbursement based on this underdeveloped performance category. The most important reason for delaying full implementation of the cost category is the current lack of any reliable and valid cost measures. It will take longer than a year to produce, test and refine enough appropriate cost measures to cover large percentages of physicians and then educate physicians about them.

Additionally, ACOG continues to be very concerned by the inclusion of total per capita cost (TCC) measure and the Medicare Spending Per Beneficiary (MSPB) measure because they include Part A claims, which ob-gyns have little control over. These measures were designed at the hospital level and lack reliability and validity at the physician level. Both measures hold clinicians responsible for total Part A and B expenditures, including costs that the physician had no control over and that may even have occurred before the physician ever saw the patient. As a result, the measures are largely irrelevant to many physicians and inapplicable to others. The MSPB measure fails to adjust for physician specialty or type of service despite the fact that CMS previously determined that specialty adjustment is an important factor in evaluating cost. The TCC was never endorsed by NQF, which questioned the measure’s validity and its method of attributing costs. Resource use measures should only be based on Part B claims and exclude Part B drugs; therefore, if CMS continues to include these measures, the Agency should not consider including Part D costs in the future.

While we are pleased that CMS is pursuing improvements in the TCC and MSPB measures, we firmly believe that until that work has been completed, tested and validated, neither should be used in any way that would affect ob-gyns’ Medicare payment rates. We also continue to believe that appropriately-designed episode cost measures have the potential to measure costs more accurately and agree with CMS that the eight episodes finalized for use in the 2018 performance year should be replaced with episodes that have had more clinical input. None of these improvements could be implemented before 2019 at the earliest, however, and at least in the case of the new episode-based measures, we believe it will take several years to develop a set of measures that would cover a large percentage of physicians. Many Medicare beneficiaries have multiple health problems, and in most cases, those different health problems are treated by multiple physicians and other providers. QRURs consistently show that the services delivered by an individual physician represent a tiny fraction of the total cost of care for their patients. Moreover, under Medicare rules, beneficiaries have the freedom to see any physicians they wish to obtain treatment for their health problems. Even if each of the individual physicians whom a patient sees is “efficient” in the services they deliver and order, the overall spending on the patient’s care may be higher than for other patients because of the number and types of physicians and other providers the patient chooses to use.

There is widespread recognition that Medicare spending and resource use measures are penalizing both physicians and hospitals that care for lower income and more challenged patient populations. CMS acknowledges in the preamble to the proposed rule that physicians treating the largest shares of Medicare’s sickest patients are most likely to be penalized under the current VM program. There is a serious risk that continuing to penalize physicians using these problematic measures under the MIPS program could force them to avoid caring for patients who have the greatest needs. Incorporating cost measures in MIPS before CMS has made and tested significant improvements such as accounting for sociodemographic factors in the risk adjuster would be a serious error in judgment. In the preamble, CMS acknowledges the extensive comments it has received describing the many problems with these measures, but the Agency then proposes to continue using them with modifications that do not address and may even exacerbate the underlying flaws. Instead, we recommend that both measures be removed entirely and replaced with better measures as they become available.

ACOG Recommendations:
• Reweight the cost performance category to zero.
• Remove the total per capita cost and Medicare Spending Per Beneficiary measures.

§414.1355. Improvement activities performance category.

ACOG continues to strongly support the overall simplicity of this performance category and urges CMS not to make significant changes to the scoring methodology in the initial performance periods of the Quality Payment Program. ACOG would encourage CMS to wait until physicians and other eligible clinicians have more experience with this performance category and MIPS as a whole before assessing performance and improvement in the improvement activities performance category. Physicians need more experience with the Program and this performance category before changes are made. ACOG appreciates that CMS is not making any changes to the accommodations for practices that are small or in a rural or Health Provider Shortage Area (HPSA).

CMS is requesting comment to inform future proposals to remove activities from the improvement activity inventory. We believe removing activities is contrary to the intent of this performance category and strongly urge CMS to refrain from establishing such a process. CMS’s primary goal in the improvement activity performance category should be to support the performance of any activity that improves patient care. Yet, a policy that removes activities from the inventory would stymie this goal, suggesting that practices should only implement temporary rather than long-term changes. In fact, removing activities could harm practices and patients, particularly those in small and rural practices, which often have limited financial and personnel resources. Furthermore, many practices have made financial investments to perform a particular activity. CMS’s removal of activities could jeopardize the practice’s return on that investment while requiring new program costs. We therefore believe CMS should not proceed with a proposal to remove activities from the improvement activity inventory.

CMS is requesting comment on whether it should establish a minimum threshold (for example, 50 percent) of the clinicians (NPIs) that must complete an improvement activity in order for the entire group (TIN) to receive credit in this category in future years. ACOG disagrees with this proposed change, especially during the early program years. Creating a separate threshold at this time will add to complexity of the program, which we believe CMS should avoid. Furthermore, the 50 percent threshold would be a significant change and would create complexity for groups who would need to evaluate members of their TIN to determine which improvement activities would be appropriate to meet the 50 percent threshold. This adds to administrative burden and may deter reporting on certain activities.

ACOG Recommendations:
- Do not alter the scoring methodology for the improvement activities performance category.
- Do not remove improvement activities from the performance category’s inventory.
- Do not pursue a minimum number of clinicians in a practice who must meet a threshold for completion of an improvement activity.

§414.1360. Data submission criteria for the improvement activities performance category.

ACOG supports CMS’s proposal to allow multiple submission mechanisms within this performance category. Although we believe that many physicians and other eligible clinicians will likely opt to use the same mechanism to submit improvement activities, we believe it is important to have the option to use multiple mechanisms standardized across performance categories.

ACOG Recommendation: Adopt the proposal to allow improvement activities to be submitted via multiple mechanisms.
§414.1375. Advancing care information performance category.

We continue to believe that the advancing care information performance category still possesses much of the same administrative burden as the Medicare EHR Incentive Program and that CMS should move away from the proposed objectives and measures that compose the base and performance scores. The complexity of the base and performance score that compose this performance category is difficult for physicians to understand and holding physicians and other eligible clinicians to process-oriented measures does little to improve clinical care. In recognition of the fact that the purpose behind measurement of EHR use is no longer to track the use of funds to purchase EHR systems, ACOG strongly believes that CMS should require that physicians attest that they are using an EHR that meets the 2014 edition standard and/or 2015 edition standard rather than subject physicians to “check-the-box” measures. CMS should work with the Office of the National Coordinator for Health Information Technology (ONC) to develop standards that EHR vendors must meet in order to market these systems to physicians.

However, if CMS continues to move forward with the objective and measures, we do support CMS’s proposal to modify scoring in the 2018 performance period for Public Health and Clinical Data Registry Reporting objective if a physician cannot fulfill the Immunization Registry Reporting Measure. Not all ob-gyns, particularly subspecialists, provide immunizations as a part of their practice, making this measure irrelevant, and we appreciate that CMS recognizes this variation in practice characteristics.

ACOG supports the continuation of a 90-day reporting period for this performance category for performance periods in 2018 and 2019. We would encourage CMS adopt this policy for 2019 and to carry it forward in future performance periods.

We greatly appreciate CMS’s proposal to allow physicians and other eligible clinicians to continue using the 2014 edition certified EHR technology (CEHRT) standard in performance year 2018 in recognition of the limited availability of 2015 edition CEHRT. ACOG believes that the proposed bonus for using 2015 edition technology for the 90-day reporting period is an appropriate solution and should be carried forward into the 2019 performance period. We do not believe it should be limited to new MIPS participants or small practices. The investment necessary to upgrade systems can be burdensome on practices of all sizes and localities, regardless of whether the practice has previous experience with this performance category.

ACOG supports the proposal to remove the five-year limitation on the significant hardship exception for this performance category. As CMS notes, there may be extenuating circumstances outside a physician’s control that prevents her or him from participating in the advancing care information performance category for more than five years.

ACOG believes that ob-gyns should be exempted from the Patient Care Record Exchange measures if they so choose. While ACOG strongly supports interoperability, we believe there must be an exception for ob-gyns who routinely provide care that is sensitive in nature and may increase stigma for patients who receive these services. Specifically, if an ob-gyn or other provider opts to disable functionality for care delivered related to rape, intimate partner violence, abortion, or some other sexual or reproductive health service, the provider should not be penalized for data blocking. Some women may not want any other physician to know that they had an abortion or were raped. Further, some ob-gyns may opt to disable the exchange of data around certain sensitive services to protect their own personal safety.

ACOG Recommendations:
- Discontinue use of objectives and measures for the advancing care information performance category and instead require eligible clinicians to attest to using CEHRT.
Adopt the proposal to modify the scoring of the Public Health and Clinical Data Registry reporting objective for practices that cannot fulfill the Immunization Registry Reporting Measure.

Adopt the proposal for at least a consecutive 90-day performance period for 2019 and beyond.

Adopt the proposal to allow eligible clinicians to use the 2014 edition CEHRT standard in performance periods 2018 and 2019.

Adopt the proposal to provide bonus points for eligible clinicians who report at least 90 consecutive days using the 2015 edition CEHRT standard.

Adopt the proposal to remove the five-year limitation for the advancing care information hardship exception.

Create a data blocking exception for sensitive services that ob-gyns routinely provide.

§414.1380. Scoring.

General. ACOG appreciates CMS’s ongoing use of administrative flexibility when setting the performance threshold and scoring the performance categories. ACOG was extremely supportive of the pick-your-pace approach CMS adopted for the first performance year and the decision to set the performance threshold at three points. This provided ob-gyns and other eligible clinicians with an opportunity to learn the MIPS program and adopt practices that will help them to successfully participate in the future. We believe that CMS should maintain its transitional year policies and continue to set the performance threshold at an achievable level for all participants as they gain experience with the MIPS program. We therefore urge CMS to set the performance threshold for the second program year at six points.

Setting a lower threshold is especially important since we still do not have data from the first performance year and are unsure how well physicians understand MIPS requirements and whether physicians are ready for a more challenging program. CMS notes in the proposed rule that “[b]y the 2021 MIPS payment year, MIPS eligible clinicians would likely need to submit most of the required information and perform well on measures and activities to receive a positive MIPS payment adjustment.” Yet, we believe CMS’s current program estimates are overly optimistic and that these numbers are significantly inflated. Discussions with our own members suggest that most ob-gyns are working to gain a basic understanding of the program and will likely seek to meet the 2017 threshold of three points, rather than try for much higher reporting requirements.

A goal that should be set throughout the MIPS program is to create stable requirements that do not change from year to year. This is the easiest way to ensure participants can learn about and prepare for the MIPS requirements. Accordingly, we urge CMS to avoid changes or short-term policies that disrupt understanding of the program. If such changes are necessary, they should generally be made in a fashion that protects participants as opposed to placing more individuals at risk for a financial penalty.

For example, if CMS adopts certain bonus points, these incentives should be maintained over time and not be taken away from one year to the next. Similarly, exemptions should not drastically shift to avoid catching physicians off-guard regarding what is required in the upcoming program year. Throughout the scoring methodology, we encourage CMS to try and keep the program as consistent as possible so that physicians can learn the new requirements and successfully participate.

ACOG has reservations with CMS’s proposal to add an improvement scoring methodology to the quality and cost performance categories. The MACRA statute requires that the MIPS program take into account improvement with respect to the quality and cost performance categories “if data sufficient to measure improvement is available.” CMS is therefore proposing that it will start measuring improvement in 2018
at the performance level for the quality category and at the measure level for the cost category; although
the cost improvement methodology would not impact final MIPS scores if CMS finalizes its proposal to
keep this category weight at zero.

ACOG supports several of CMS’s proposals with respect to improvement. In particular, we agree that
improvement should be counted as bonus points and not used to penalize participants. Physicians should
also still be able to receive full credit based on achievement so they are not penalized for their previous
high performance. We also appreciate that under the proposed rule, improvement could only increase, not
decrease a physician’s pay. In a budget neutral system, however, improvement-related bonuses for some
physicians will mean smaller bonuses for others.

In addition, we are concerned that trying to establish improvement scoring now will only complicate the
MIPS program. In particular, we do not believe that the one year of data on the MIPS program is
sufficient to begin measuring improvement, as required by the statute. The data may not be representative
given the pick-your-pace approach that was adopted for the 2017 performance year. Also, this additional
scoring consideration will add complexity to an already complicated program and require physicians to
factor in additional considerations when they are just trying to learn the program.

In addition, we are concerned with the different improvement approaches proposed for the cost and
quality components. Two separate methods will add further complexity to the MIPS program. Until a
stable set of cost measures has been developed and in place for several years and until there is more data
to base a decision on, we do not think it is possible to judge the impact or appropriateness of either of
these two approaches. For example, the improvement scoring appears to assume that the quality measure
benchmarks will remain static when, in fact, the deciles will likely shift over time. Consequently,
physicians may be improving their performance but this will not be captured in their overall points in the
quality category. We recognize this is the trade-off of scoring improvement on a category versus measure
basis but, without more experience with the MIPS program, we are unclear how often this will happen
and if it warrants a different approach.

Quality performance category. ACOG is still concerned with CMS’s quality scoring policy. CMS’s
ongoing scoring of individual quality measures through the use of deciles breakdown does not seem to
account for confidence intervals around each measure’s score. The ability to tell the difference between
the top decile and the bottom decile (or even quartile) would be considered valid; however, the ability to
distinguish between 90-100 and 80-90 is much less clear. Additionally, ob-gyns and other providers who
have less than 12 months of charges may have a different confidence interval around their measurement
scores than those with a larger number of patients. They may be misidentified as lower performing.
ACOG recommends using a scoring methodology that takes into account confidence intervals.

As noted above, ACOG has concerns with CMS’s proposal to cap “topped out” measures. Many
specialties, particularly sub-specialists, have a limited number of applicable measures and are constrained
to a small set of measures that may be in the topped out range compared to other specialties. CMS is also
making the blanket assumption that, when there is no difference between the third decile and the tenth
decile, that it is a negative as opposed to a positive. Instead of encouraging physicians to be striving
towards providing the best possible care and rewarding top quality, CMS is overly scrutinizing physicians
and arbitrarily assigning a poor quality designation when performance differences may be less than one
percent. The proposal also adds complexity to the quality scoring system for future performance periods.

ACOG supports CMS’s proposal to score the measures submitted via two different mechanisms and
include the measure in the final score with the highest achievement points. By allowing physicians and
other clinicians who submit the same measure via multiple mechanisms to have the measure with the
higher score included in the quality performance category score, CMS is providing a necessary transition to more robust submission mechanisms.

To encourage reporting on new measures, CMS should institute protections to ensure that physicians are not penalized for reporting on new measures. Under the current scoring criteria, CMS does not create a benchmark or provide associated achievement points on a measure until after receiving first year data. If CMS cannot create a benchmark because less than 20 physicians or other health care providers report on the measure the maximum amount of points a physician can earn for reporting on the measure is three achievement points. CMS is also contradictory in its statements because, on the one hand it caps achievement points on “topped out” measures at six points to encourage reporting on new measures; however, a physician may potentially only earn a maximum of three points for reporting on a new measure. To encourage reporting on new measures, we recommend that CMS automatically award maximum achievement points for reporting on new measures as long as the physician meets CMS’s data integrity requirements.

Cost performance category. ACOG does not support measuring improvement in the cost performance category. ACOG believes measurement of improvement should not factor into the cost performance category score until physicians and other eligible clinicians have had sufficient experience with the cost category over multiple performance periods before improvement is included.

As noted earlier, it is impossible to evaluate this proposal without more information and data regarding the potential number of practices that would receive scores, how different ob-gyns would be affected, and how changes in the measures from year to year would affect improvement scores. Also, at a time when cost measurement is still an immature science, changes in the measures and accompanying methodologies such as attribution and case minimums are still occurring on an almost annual basis. While CMS notes that there were no changes in how they calculated MSPB and TCC between 2017 and 2018, there were significant changes between 2016 and 2017 when changes were made in the TCC attribution method and the MSPB minimum case threshold. Also, as discussed earlier, CMS is contemplating changes in both of those measures as well as complete replacement of the cost episode measures between 2018 and 2019. Continual updates of “specifications, risk adjustment and attribution” are expected as well. We do not see how it will be possible to compare apples to apples and identify improved performance so long as such changes, which in many cases are helpful, are occurring.

Finally, for the same reasons noted elsewhere, we continue to oppose CMS including Part B drugs in the cost score calculations. Given the life-changing impact of many Part B drugs, items, and other services and the significant adverse consequences that inclusion in MIPS could have for some of Medicare’s frailest patients, we urge CMS to limit MIPS applications to the physician fee schedule. At a minimum, CMS should ask Congress to clarify its intent before it proceeds to apply MIPS adjustments more broadly.

Final score. ACOG supports CMS’s proposal to include a bonus for complex patients. Without more information, however, we cannot tell which of the two options— hierarchical condition category (HCC) coding or dual eligibility—is the best way to determine the bonus. We appreciate CMS’s effort to provide specialty specific statistics that provide some indication of how each of the options might play out for ob-gyns and other specialties, though we have some concern that the statistics are based only on practices that successfully reported at least six quality measures since those with larger numbers of high-risk patients may have been unable to successfully report. It would also have been helpful to know how many groups and how many physicians would be eligible for a bonus under each of the two options and how big the overlap between the two would be.
A simpler process might be to provide some set number of bonus points to a set of practices that qualified based on either of the two potential criteria. For example, the bonus could be awarded to the 25 percent of practices that have the highest average HCC scores and to those with the highest percentages of dual eligibles. Or it could be provided to all practices with either above average HCC risk scores or dual eligible percentages. Furthermore, as described above, we believe that assigning different points for this bonus is overly complex. Rather, CMS should align the bonus points with those awarded for small practices.

ACOG supports adding a bonus for small practices and would encourage CMS to extend this bonus to rural and underserved areas. We note that some physicians in these settings face challenges that are similar to those of small practices, especially with respect to adopting health information technology and the other resources required for successful MIPS participation. In addition, CMS should consider whether adding a new participant bonus would help encourage entrance to the program and avoid disadvantaging those who are unfamiliar with the requirements.

ACOG Recommendations:
• Set the performance threshold at six points for performance period 2018.
• Do not incorporate improvement scoring in the quality and cost performance categories in performance period 2018.
• Use an alternative scoring methodology for the quality performance category that does not rely on deciles.
• Do not cap the number of achievement points available for “topped out” quality measures.
• Do not incorporate Part B drugs in the cost performance category score.
• Allow bonus points for complex patients.
• Allow bonus points for small practices along with practices in rural and underserved areas.

§414.1385. Targeted review and review limitations.

Section 1848(q)(13)(A) of the statute requires CMS to establish a process under which physicians may request an informal review of the calculation of the MIPS payment adjustment factor. In the 2017 Quality Payment Program final rule, CMS finalized a 60-day period for physicians to request a targeted review beginning on the day CMS makes the MIPS payment adjustment factors available to physicians. ACOG believes that CMS should not limit the request for a targeted review to within 60 days after the close of the data submission period. Most physicians will not know if they should request a review of the MIPS adjustment factor until they receive information from CMS about whether they have earned a MIPS incentive or penalty. Ob-gyns will then need to assess what may have impacted their performance, which will take significant time especially in the beginning of a new program. We recommend that CMS allow at least 90 days for targeted review after a physician is notified of their performance in MIPS.

ACOG Recommendation: Allow 90 days after receipt of performance notification to request a targeted review.

§414.1395. Public reporting.

ACOG supports public reporting of physician data when it is valid, reliable, and meaningful to both consumers and physicians. Recognizing the MACRA statute requires increased public reporting on the Physician Compare website, we want to continue to work with CMS to ensure information is accurate, not misleading, and presented in a format that consumers can understand and use appropriately.

We encourage CMS to include new data on Physician Compare gradually. ACOG is concerned with CMS’s ability to move forward with posting additional information, such as cost and improvement
activities given the issues that have occurred previously with the accuracy of published data. MIPS is a new program that includes new measures, data sets, and reporting categories. We believe there is still significant testing and evaluation of MIPS performance data that must be completed. In addition, there are still problems with the comparison of practices that report the same measures through different reporting methods. ACOG also continues to have concerns regarding risk-adjustment and lack of timely feedback CMS is able to provide to physicians. Given these limitations, we believe CMS should increase data publicly reported on the Physician Compare website gradually.

ACOG is again urging CMS to extend the preview period from 30-days to 90-days, in order for ob-gyns and other eligible clinicians to review and ensure the accuracy of their information. To expect physicians to access, review, and contest their Physician Compare data in 30-days ignores the demands of patient care and competing priorities physicians face on a daily basis. ACOG strongly encourages CMS to extend the preview period to at least 90-days to allow physicians reasonable time to review and correct their data.

CMS has previously finalized that they will not report first year measures that have been in use for less than one year. ACOG encourages CMS to expand this exclusion to measures that have been in use for less than three years. Including measures after one year of reporting does not allow CMS to adequately evaluate meaningful trends over time or provide physicians with an adequate period to fix data collection issues. Allowing physicians three years to report on measures prior to posting measure data on Physician Compare will improve the chances that only robust and meaningful data is included on the website.

**ACOG Recommendations:**
- Implement public reporting on Physician Compare in a gradual manner.
- Allow physicians and other eligible clinicians to preview data for at least 90 days.
- Exclude measures that have been in use for less than three years from public reporting.

§414.1405. Payment.

ACOG was extremely supportive of the pick-your-pace approach CMS adopted for the first performance year and the decision to set the performance threshold at three. This provided physicians with an opportunity to learn the MIPS program and adopt practices that will help them to successfully participate in the future. We believe that CMS should maintain its transitional year policies and continue to set the performance threshold at an achievable level for all participants as they gain experience with the MIPS program. We therefore urge CMS to set the performance threshold for the second program year at six points.

Our reasoning for setting the performance threshold at six reflects several considerations. First, we continue to believe that the MIPS program should adopt a “do no harm” mentality, whereby the program seeks to promote participation and allow physicians to learn the requirements before repositioning towards penalties. By setting the threshold hold at six, CMS is moving the needle of MIPS performance forward without discouraging physicians or creating a bar that is unachievable, especially for small practices and new participants. This benefit is highlighted in the proposed rule, where CMS notes a lower threshold could result in “potentially smaller total amount of negative MIPS payment adjustment.” In comparison, the trade-off of a higher threshold would be “potentially higher positive MIPS payment adjustment for those that exceed the performance threshold.” We continue to believe that, at this stage of the program, CMS should focus first on protecting ob-gyns and other health care providers before increasing bonus payments to a group of high performers.

Second, setting the performance threshold at six creates stability in the MIPS requirements. MIPS participants are still learning the program and will only have had one year of experience with the different
categories, scoring methodology, timelines, and other requirements. Gradually increasing the threshold for the second performance year ensures that participants can continue to gain familiarity with the program and can work to restructure their practices to prepare for future MIPS reporting.

We acknowledge CMS’s concerns that setting a lower performance threshold in year two could lead to a jump in the performance threshold for the 2019 reporting period, when CMS is required to use the mean or median score from a previous MIPS period. However, setting a lower threshold actually mitigates against this problem by focusing achievement at six points, driving most participants towards this lower final score. Conversely, increasing the threshold to 15 points will likely drive up the mean or median performance, resulting in even higher subsequent thresholds.

Setting a lower threshold is especially important since we still do not have data from the first performance year and are unsure how well participants understand MIPS requirements and whether physicians and other health care providers are ready for a more challenging program. CMS notes in the proposed rule that “[b]y the 2021 MIPS payment year, MIPS eligible clinicians would likely need to submit most of the required information and perform well on measures and activities to receive a positive MIPS payment adjustment.” Yet, we believe CMS’s current program estimates are overly optimistic and that these numbers are significantly inflated. CMS should use the 2017 data to set subsequent MIPS performance thresholds, which could avoid a steep jump for future program years. We, however, urge CMS to share additional information and data that it may have to understand how it will establish future performance thresholds and the differences in selecting the mean versus the median.

ACOG remains concerned with the structure of the MIPS scoring, which creates a single cut-off that divides participants into penalties or incentives. While we understand the MACRA statute requires that the MIPS program be budget neutral and assign values on a “linear sliding scale,” CMS should seek to avoid arbitrary cutoffs for participants who are near the performance threshold. Rather than a structure where everyone is either a “winner or a loser,” CMS should adjust payments mainly for those on the high and low-end of MIPS performance. Clinicians at or near the performance threshold should be held harmless. We believe this is a more accurate way to judge physicians and will avoid subjective penalties and incentives for those whose performance is very similar to one another or where scores are based on relatively low numbers of beneficiaries and therefore likely to shift around from year to year.

We agree with CMS’s proposal that the additional performance threshold should be maintained at 70 points. This avoids shifting program requirements and rewards those who submit data on multiple MIPS performance categories. Raising the threshold above 70 points would be challenging for participants since it would potentially require a perfect score in the quality performance category as well as additional points in another category or mandated use of an EHR to earn points in the advancing care information category. Given that we are still in the early stages of the program, we believe that the current threshold is sufficient to drive improvement and reward those with high performance.

ACOG opposes including items or services beyond the physician fee schedule, especially Part B drugs, when applying the MIPS payment adjustment. We believe that changing this policy would create significant inequities and also potential legal challenges in administering the MIPS program. Including these additional items and services would be a significant departure from previous policy. Although in the past CMS has counted Part B drugs in the calculation and comparison of physician costs in VM, none of the MIPS legacy programs, including the Medicare EHR Incentive Program, PQRS, and VM applied related adjustments to reimbursement for the drugs. MACRA was intended to build-off of these previous programs. Yet, nowhere in the legislative history is there notice or discussion of making a significant change to include additional items and services. We therefore believe Congress intended and CMS should carry over a similar policy under the MIPS program. At a minimum, CMS should seek
clarification from Congress before unilaterally making this change that does not appear to be addressed when passing the law.

In particular, changing this policy would create serious challenges and potentially negative consequences for participants and patients that we believe are not intended by the MACRA statute. In these instances, the Medicare payment is merely a pass-through that covers physicians’ acquisition costs but the impact of the policy will be particularly acute for Part B drugs due to their high cost and utilization within a few specialties and subspecialties, including gynecologic oncology. To now apply the payment adjustment to the physicians’ reimbursement for the drug, as well as its administration, would magnify differences between specialties and subspecialties and would not be an accurate assessment of resource use that physicians and other health care providers can control.

Medicare already makes a negative two percent sequestration adjustment to physician’s Part B drug reimbursement, which brings Medicare’s drug payment rate of Average Sales Price (ASP) plus six percent down to ASP plus 4.3 percent. Even in the first year of MIPS, a physician subject to MIPS’s maximum four percent penalty would barely cover the direct cost of the drug with nothing left over for other associated costs such as storage and compliance with various safety regulations. With a nine percent penalty, payment for the drug would be well below its actual cost to the physician. Many physicians who provide these critically important drugs will have little choice but to refer their patients to hospital outpatient departments where Medicare and its beneficiaries will face higher costs. Some might simply avoid Medicare patients or those with the most advanced diseases. Those in a position to do so could potentially influence gains and losses through their choices of which drugs are purchased by a facility and which by physicians.

CMS itself notes that it cannot administer a policy on the additional Part B items and services in a cohesive manner. The proposed rule recognizes that when a participant is both a supplier and MIPS eligible clinician there are operational issues that will lead to significant differences in the size and application of MIPS payment adjustments depending on where physicians practice and the drug purchasing polices employed there. We understand that there could also be variations across Medicare Administrative Contractors (MACs) that will create inconsistencies. We therefore believe it is inappropriate and arbitrary to apply such a policy.

We also oppose including Part B items to the 2017 performance year given the lack of notice provided to participants. Questions about how Part B drugs would factor into MIPS were brought up during the 2017 comment period; however, CMS answered by stating “we did not address this issue in the proposed rule. We will consider this issue and intend to provide clarification in the future.” Given this lack of guidance and the significant impact it would have on participants, we believe it is inappropriate for CMS to apply this change retroactively and without flexibility for participants. Participants for 2017 already evaluated whether it was appropriate for them to participate in the program and likely relied on the fact that these items and services were not applied in previous programs along with the lack of clarity provided in the final rule. Without notice and comment of this change, we do not believe it should be applied to the 2017 performance period.

**ACOG Recommendations:**
- Set the performance threshold at six points for performance period 2018.
- Maintain the exceptional performance threshold of 70 points for performance period 2018.
- Apply payment adjustments only to services in the physician fee schedule.

**Advanced Alternative Payment Models**

§414.1415. Advanced APM criteria.
ACOG firmly believes that CMS should not include Part B drug costs when calculating the Part B revenue that is at risk when determining whether an alternative payment model (APM) is advanced. Medicare payments for drugs under Part B are almost entirely a pass-through from Medicare to a drug wholesaler, not compensation to the physician practice for its services. For some physician practices, such as gynecologic oncology, the revenues for these drugs are many times higher than the revenues used to pay for the physicians’ professional services, and the practice’s spending on the drugs is many times higher than the practice’s other expenses. This means that placing such a practice at risk for eight percent of its total Part A and B revenues could place it at risk for losing most or all of the revenues it receives to pay for its professional services to patients. That could bankrupt the physician practice and/or reduce access to care for Medicare patients.

ACOG does not believe that medical home models should be limited to organizations with 50 or fewer clinicians. The fact that a primary care practice has 50 physicians or other health care providers does not mean that it has the ability to manage four times the financial risk that a practice with 49 physicians does, yet that is what the proposed regulations would require. In 2018, a medical home model operated by an entity with fewer than 50 clinicians would need to be at risk for two percent of total Part A and B revenues, whereas an entity with 50 clinicians would have to be at risk for eight percent of total revenues.

This regulation appears to be driven by a CMS assumption that it is preferable for larger practices to participate in ACOs instead of medical home models. As CMS did not expand the only ACO model that was certified by the Medicare Actuary to qualify for expansion, the Pioneer ACO model, it is not clear to us what the basis is for this CMS assumption. Except for 42 Track 2 and 3 ACOs, all of the APMs that count toward QP status are models that are still being tested, so it is premature for CMS to make policy decisions based on assumptions about which of these models is better for Medicare than others.

ACOG Recommendations:
• Exclude Part B drugs and other non-physician fee schedule costs from the revenue at risk calculations for Advanced APMs.
• Remove the requirement that medical home models must be limited to organizations with fewer than 50 clinicians.

§414.1425. Qualifying APM participant determination: In general.

The proposed rule notes that CMS has received feedback in support of creating a way for those participating in Advanced APMs that include Medicare Advantage (MA) to receive credit for that participation in qualified participants (QP) determinations under the Medicare Option, and seeks comment on such opportunities. ACOG supports CMS allowing participation in MA APMs to be included under the patient count test for QP status determinations affecting 2019 and 2020 payment adjustments. Section 1833(z)(2)(D) of the Social Security Act provides the necessary flexibility to support this policy:

The Secretary may base the determination of whether an eligible professional is a qualifying APM participant under this subsection and the determination of whether an eligible professional is a partial qualifying APM participant under section 1848(q)(1)(C)(iii) by using counts of patients in lieu of using payments and using the same or similar percentage criteria (as specified in this subsection and such section, respectively), as the Secretary determines appropriate.

This section does not include any language that requires CMS to consider only Medicare fee-for-service (FFS) patients but instead refers in general terms to “counts of patients.” This is an important distinction and gives the Agency the latitude to interpret this provision to include MA enrollees in the patient count
methodology beginning in payment year 2019, “as the Secretary determines appropriate.” CMS has already used this flexibility to set the patient count thresholds lower than the revenue test for QP status.

To avoid unintended consequences, ACOG recommends a two-step process. For those clinicians who have MA contracts but do not yet have Advanced APM structures within those contracts, simply adding MA beneficiary counts would dilute the denominator with no commensurate addition to the numerator. Instead, we suggest that CMS first test clinicians’ satisfaction of the Medicare FFS revenue and patient thresholds, and then only proceed to test Medicare FFS and MA together for a second stage patient count test if the APM participant does not reach the threshold using Medicare FFS alone.

**ACOG Recommendation:** Permit physicians and other health care providers to be QPs in the Medicare Option for Advanced APMs if they participate in Medicare Advantage APMs and meet the patient count threshold.

§414.1440. Qualifying APM participant determination: All-payer combination option.

CMS has proposed that if a physician’s QP status is being determined based on the “Medicare Option,” the threshold score will be calculated collectively for all of the physicians in the APM entity, but if QP status is being determined based on the “All-Payer Combination Option,” the threshold score will be calculated for each physician individually. The rationale given for this policy is a belief that “in many instances … the eligible clinicians in the APM Entity group … would likely have little, if any, common group-level participation in Other Payer Advanced APMs.”

ACOG disagrees. If it makes sense to determine the threshold score at the APM entity level for the Medicare Option, then it is problematic not to do so if the APM entity is participating in Other Payer Advanced APMs. APM participation decisions are likely to be made at the practice level, not the individual physician level, regardless of the payer. Making determinations at the individual level could force physicians to try and selectively see patients of the Other Payers under an APM rather than Medicare patients in order to increase their individual Threshold Score.

**ACOG Recommendations:** Align the QP determination standard for the All-payer Combination Option with the Medicare Option and allow determinations to be made at the APM entity level.

§414.1445. Determination of other payer advanced APMs.

CMS proposes that its determinations as to whether payment models implemented by other payers meet the requirements for Other Payer Advanced APMs would only be in effect for one year at a time. This creates unnecessary uncertainty for physicians and unnecessary administrative burden on CMS. CMS should automatically renew its determination of an Other Payer Advanced APM as long as either the payer or the physician attests that the key characteristics of the APM that were used to make the initial determination remain in place.

CMS is proposing to use information and documentation provided by physicians to validate that other payer arrangements (i.e., Other Payer Advanced APMs) require at least 50 percent of participating physicians use CEHRT. ACOG appreciates CMS’s flexibility in this proposal; however, we are concerned that other payer contracts may not explicitly cite CEHRT or may refer to EHRs by another name, preventing physicians from receiving credit. For instance, some contracts may only use the term “EHR,” and not specifically reference certification, while other contracts may use the term “electronic medical record (EMR),” which is often used interchangeably with “EHR.” While we recognize the need for Other Payer Advanced APMs to conform to requirements, we also believe CMS should recognize that contract language is typically outside of the control of physicians.
A 2015 National Electronic Health Records Survey (NEHRS) found that 86.9 percent of office-based physicians were using an EHR or EMR system, with 77.9 percent using CEHRT. According, the majority of physicians using EHRs are using certified EHRs, and we believe that in 2017 this ratio is even higher. In line with CMS’s stated goal of reducing regulatory burden and promoting APM participation, we recommend: 1) that CMS accommodate more flexible contract terminology used to describe EHRs; and 2) if CMS seeks alternative information on the use of CEHRT, CMS should accept EHR vendor’s Certified Health IT Product List’s (CHPL) identification number in lieu of other payer contract language.

ACOG Recommendations:
- Renew determinations of Other Payer APMs automatically if the payer or physician attest that the key characteristics of the model remain in place.
- Accommodate more flexible contract terminology for CEHRT use in Other Payer APMs or accept EHR vendor’s Certified Health IT Product List’s (CHPL) identification number.

§414.1465. Physician-focused payment models.

ACOG strongly supports CMS’s proposal to expand physician-focused payment models (PFPMs) that the PFPM Technical Advisory Committee (PTAC) reviews to include models that affect populations in Medicaid and the Children’s Health Insurance Program (CHIP). We believe it is imperative that value-based payment models extend beyond the Medicare population to affect the care and health outcomes earlier on in life, including during pregnancy. Incentivizing value for younger populations is an investment in the health of our nation. Further by considering models that are not limited to the Medicare population, private payers can also align with models that affect younger populations in the group and individual markets, where patients are more likely to churn between coverage.

ACOG Recommendation: Expand PFPMs to include models that primarily target populations enrolled in Medicaid and CHIP, not just Medicare.

Thank you for the opportunity to comment on the proposed rule on the CY 2018 Updates to the Quality Payment Program. We hope you have found our comments helpful. We look forward to working with CMS to implement the Program. Should you have any questions, please contact Elizabeth Wieand, Program Director for Payment and Delivery System Policy, at ewieand@acog.org or 202-314-2356.

Sincerely,

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Vice President, Health Policy


