



June 24, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5517-P
7500 Security Boulevard,
Baltimore, MD 21244-1850

Re: Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed Rule; 81 Fed. Reg. 414 and 495 Reg. 405, 424, 455 (May 9, 2016)

Dear Acting Administrator Slavitt:

The American College of Radiology (ACR), representing more than 36,000 diagnostic radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians and medical physicists appreciates the opportunity to comment on the Proposed Rule (CMS-5517-P) implementing the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models (PFPM).

In this comment letter, we address the following issues:

- **General Comments about the proposed Quality Payment Program (QPP)**
- **Merit Based Incentive Payment System (MIPS)**
 - Identifying MIPS Eligible Clinicians (EC)
 - Group vs. Individual Participation
 - Virtual Groups
 - Performance Period
 - Targeted Review
 - Scoring and Performance Standards
 - CPS Performance Category Weights
 - MIPS: Quality Performance Category
 - MIPS: Advancing Care Information (ACI) Performance Category
 - MIPS: Resource Use Performance Category
 - MIPS: Clinical Practice Improvement Activity (CPIA) Performance Category
 - MIPS: Third Party Data Submission



- **Alternative Payment Models (APMs)**
 - Advanced APMs
 - Physician-Focused Payment Models (PFPM)
 - Proposed PFPM Criteria

- **Impact on Small and Rural Practice**

General Comments

The ACR would first like to thank CMS for its considerable effort in proposing rules for implementing the landmark Medicare Access and CHIP Reauthorization Act (MACRA) legislation. The proposed rule provides a comprehensive outline of the proposed regulations. We also appreciate the considerable outreach efforts, webinars, and face-to-face opportunities CMS has provided during the proposed rule phase. The ACR values the collaborative approach taken by CMS in implementing this complex legislation. We look forward to continuing our working relationship with the agency and furthering our shared goal of providing high value care to Medicare beneficiaries.

Merit-Based Incentive Payment System (MIPS)

Identifying MIPS Eligible Clinicians

Low Volume Threshold Exclusion

MACRA mandates that CMS select a low volume threshold below which clinicians would be excluded from MIPS [not considered MIPS eligible clinicians (ECs)] CMS proposes the following low-volume threshold: an individual clinician or group who, during the performance period, has Medicare billing charges less than or equal to \$10,000 **AND** provides care for 100 or fewer Part B-enrolled Medicare beneficiaries.” CMS “believes this strategy aims to retain as MIPS eligible clinicians those who are treating relatively few beneficiaries, but engage in resource intensive specialties, as well as those treating many beneficiaries with relatively low-priced services.”

The ACR is concerned that the same low-volume threshold would apply to clinicians reporting as individuals and those reporting as groups. We understand CMS’ efforts to minimize confusion and adopt consistent methodologies, but this proposal would make it considerably more difficult for group practice exclusion from MIPS. This could result in situations where a single individual who does not necessarily represent the practice patterns of the overall practice disqualifies that group from what would otherwise be a



clinically appropriate exemption. For example, if only one member of the group has charges or provides care to a number of beneficiaries above the threshold, the entire group is considered MIPS eligible, even if no other member of the group exceeds the threshold. A potential solution would be to scale the minimum number of Part B-enrolled Medicare beneficiaries and Medicare billing charges to the number of group members. For example, a group of five clinicians during the performance period, would have Medicare billing charges less than or equal to \$50,000 AND provide care for 500 or fewer Part B-enrolled Medicare beneficiaries before they would be deemed a MIPS eligible group. **The ACR recommends that the low-volume threshold be scaled upwards at the group level.**

General Comments: Facing vs Non-Patient-Facing

The ACR thanks CMS for acknowledging that MACRA mandates considerations for clinicians who “typically furnish services that do not involve face-to-face interaction with a patient” and for proposing a means to accommodate physician specialties that cannot directly control the resources used by the beneficiaries under their care. MACRA also requires that clinicians referred to as “non-patient-facing” should be consulted in carrying out the provisions in the statute, we appreciate the continued collaborative approach we have with CMS in developing specialty-specific measures within all categories of MIPS which may make special considerations for non-patient-facing physicians unnecessary in the future.

Although we understand the intent in describing physicians as “non-patient-facing”, we are concerned that this terminology mischaracterizes radiologists, who are invariably patient-centric in the care they provide. In addition to face-to-face encounters, radiologists also use diverse forms of communication, such as instant messaging and telephone conversations to discuss imaging options, the results of diagnostic tests and follow-up recommendations with their patients and referring clinicians. Radiologists’ practice of medicine may appear different than that of many medical specialties; however, to promote the evolution of more patient-centric care we believe the terminology “non-patient-facing” can be removed for MIPS eligible clinicians. The ACR believes the patient-facing/non-patient-facing terminology is reasonable when describing a CPT code but not when describing a clinician for quality improvement purposes. The MIPS eligible clinician performance category considerations should be determined by the number of patient-facing encounters tabulated from specific CPT codes, without having to label the MIPS clinician as “patient-facing” or “non-patient-facing”. **The ACR requests that CMS abandon the term “non-patient-facing” in reference to MIPS eligible clinicians (ECs) or physician specialties.**



Patient-Facing vs. Non-Patient-Facing Definition

CMS proposes to define a patient-facing encounter “as an instance in which the MIPS eligible clinician or group billed for services such as general office visits, outpatient visits, and surgical procedure codes under the PFS” and further states, “intend to publish the proposed list of patient-facing encounter codes on a CMS website similar to the way we currently publish the list of face-to-face encounter codes for PQRS.”

CMS asserts that on the basis of this definition and analysis of non-patient-facing HCPCS codes billed by MIPS eligible clinicians, one quarter of MIPS eligible clinicians would be non-patient-facing but did not indicate how it reached this determination or provide a means for specialty societies to determine which of its members would be predominately non-patient-facing. The ACR seeks clarification from CMS regarding the proposed definitions for patient-facing and non-patient-facing MIPS eligible clinicians, particularly the patient-facing encounter CPT codes that will be applied in this determination. To our knowledge, this list of codes has not been released which limits our ability to determine the impact on our members and provide informed comments to CMS. **We urge CMS to provide the applicable patient-facing encounter CPT codes as soon as possible (preferably, before the final rule) so we can provide comments to the agency on the impact of these designations on our members.**

Absent these specific codes, the ACR provides the following general comments and recommendations regarding the codes to be applied. The ACR believes the intent of the non-patient-facing designation is to protect physicians who would have limited opportunity for success in MIPS performance categories such as cost, for which the specialty currently lacks accurate and reproducible measures, as well as ACI, which has measures tailored for evaluation and management-type services as opposed to imaging or procedural services. The ACR has concerns that the broad definition CMS proposes fails to recognize the diverse nature of radiology practice. Specifically, we believe that including 000 global codes among the “surgical procedure codes” in the above definition will inappropriately classify many radiologists as patient-facing and limit their ability for success under MIPS.

In general, most radiologists care for patients through image interpretation, radiation dose counseling/management, and consultation with other clinicians. These imaging related services are reported by the 70000 series radiology XXX global period codes with no separate evaluation and management services (E/M) reporting. A common example is diagnostic mammography during which significant patient interaction occurs without billing a separate E/M service. Many radiologists perform services reported by zero day (000) global surgical CPT codes such as breast biopsy procedures and other minimally invasive image-guided procedures. Among radiologists providing 000 global services, the number of E/M services reported can be markedly different. For example, some radiologists focus their practice entirely on interventional radiology and provide a significant number of E/M services for patients seen in consultation before a procedure or



after the 000-day global period for follow-up care. Such physicians should be considered “patient-facing” in MIPS based on the number of E/M services provided. However, other radiologists focus almost entirely on diagnostic imaging services, but also perform a significant number of imaging-guided procedures such as thoracentesis, paracentesis, and imaging-guided biopsy as ordered by the patients’ primary physicians. The difference between these two types of radiologists is important. In the latter scenario, the patients are not typically seen in consultation prior to the procedure or in follow-up after the 000-day global period, nor would these radiologists typically have a separate office or clinic to provide any pre- or post-procedural care. Thus, these 000-day services, if deemed a face-to-face encounter, could inappropriately classify many radiologists whose primary focus is diagnostic imaging as patient-facing for MIPS.

Finally, we have concerns regarding the impacts on general radiologists working in rural or small practices composed of general radiologists having a full array of patient encounters including XXX radiology services, 000 global surgical services, and an occasional E/M service. These rural and small practice radiologists are at a significant disadvantage compared to larger group practices that might be able to have only a few radiologists dedicated to providing E/M or 000 global surgical services. However, even for larger practices to report most effectively under MIPS, they may be compelled to create a separate Tax Payer Identification (TIN) for their interventional radiology and E/M services, adding significant administrative burden and expense. Excluding the surgical services, and in particular the 000 global services, from the patient-facing encounter codes would alleviate many of these burdens for radiologists without leading to misclassification of other physicians as non-patient-facing who provide a significant number of E/M services in addition to 000, 010 and 090 surgical services.

When factoring in all of the diverse array of radiology practice patterns, the ACR recommends that only E/M services (the denominators for the Table C cross-cutting measures) be considered when determining whether a MIPS eligible clinician provides face-to-face services.

Patient-Facing vs. Non-Patient-Facing Threshold

CMS discusses several options for determining which individual MIPS eligible clinicians are non-patient-facing and proposes to define non-patient-facing MIPS eligible clinicians as “an individual MIPS eligible clinician or group that bills 25 or fewer patient-facing encounters during a performance period” and states, “general office visits, outpatient visits, and surgical procedure codes under the PFS” will be used to determine eligibility for non-patient-facing status. The ACR is concerned that the proposed number of 25 encounters is too low. A MIPS eligible clinician with as few as 25 patient-facing encounters would be inappropriately considered patient-facing even though these services are performed as infrequently as twice per month, constitute only a small fraction of total Medicare services provided by this clinician. Furthermore, a clinician with such a low



number of patient-facing encounters may not realize they will be considered patient-facing and be subject to additional reporting requirements, such as the cross-cutting measures under MIPS. A significantly larger number of patient-facing encounters should be required before MIPS eligible clinicians are considered patient-facing.

In a different section in the MACRA proposed rule, CMS proposes a 100 Medicare patient low-volume threshold before a clinician would qualify as a “MIPS eligible clinician” (page 67). Extrapolating from this 100 patient proposal, the ACR suggests the same threshold of 100 patient-facing encounters as the threshold for the non-patient-facing designation as this number of encounters would represent a somewhat larger portion of the clinician’s practice, averaging approximately two patient-facing encounters per week. The 100 patient-facing encounter threshold, would ensure the MIPS eligible clinician is truly facile at reporting into all the MIPS performance categories, and would be in parity with CMS proposal for low-volume threshold for determining eligibility of a clinician for MIPS. **The ACR recommends a minimum threshold of 100 patient-facing encounters for determining the level at which the MACRA mandated non-patient facing considerations apply.**

The ACR is also concerned about the proposed extrapolation of the 25 patient-facing encounter threshold to the Group Practice Reporting Option (GPRO) without scaling by the number of clinicians in a group practice. Our concerns are similar to those expressed for the low-volume threshold. Specifically, a single individual clinician providing patient-facing services could push the entire group into the patient-facing category, even if the other individuals in the group would be considered non-patient-facing. The potential impacts are even greater for small and rural practices whose general radiologists perform more interventional procedures, potentially exceeding the threshold as an individual even though these patient-facing encounters represent only a very small fraction of the group’s total Medicare services. Applying the proposed definition, the entire group would be considered patient-facing, significantly limiting their ability to report under the group option.

A solution to this potentially unintended consequence would be to scale the minimum threshold for patient-facing encounters based on group size. For example, CMS could apply a multiple of the patient-facing encounter threshold to accommodate larger groups. A cap to the scaling could be applied for larger groups with larger numbers of patient-facing encounters to prevent them from receiving an unequal advantage with the respect to these proposed considerations in MIPS. Based on our prior recommendation that the threshold be 100 patient-facing encounters, a scaling factor up to 5, representing up to 500 encounters for a large group would seem reasonable. **The ACR recommends CMS provide scaling of the patient encounter codes when defining whether a group practice is eligible for the MACRA-mandated special considerations for non-patient-facing clinicians.**



Eligibility of Clinicians Providing Services at Independent Diagnostic Testing Facilities (IDTFs)

After several policy determination iterations in late 2014 and through June 2015, CMS issued final guidance that eligible professionals who provide services through an Independent Diagnostic Testing Facility (IDTF) are “eligible but not able” to participate in PQRS during the 2015 reporting year and subsequently in 2016. Specifically, the CMS guidance “2016 Physician Quality Reporting System (PQRS) List of Eligible Professionals” directs:

Eligible but Not Able to Participate

Scenario 2: Does not submit individual rendering National Provider Identifier (NPI)

*An EP who **does not** bill Medicare at an individual NPI level, where the rendering provider’s individual NPI is entered on the professional or institutional form associated with specific line-item services, is not able to participate in PQRS. Independent Diagnostic Testing Facilities (IDTF) and Independent Laboratories (IL) are examples of organizations that fall into this category and would not be subject to the PQRS payment adjustment.*

In the proposed rule, CMS does not address the MIPS eligibility status of clinicians providing Medicare Part B services under IDTFs. The ACR would like to avoid a similar multi-year period of confusion surrounding the requirements for IDTF clinicians in the MIPS program. Additionally, because of the various billing and coding practices for IDTFs, e.g. placement and use of facility and physician NPIs on the claim according to type of services billed (TC only, PC only, global or fixed/different payment location), as well as the varied coding directives by MACs, a statement such as that in “Scenario 2” does not provide adequate guidance. **The ACR requests that CMS determine and state eligibility status for these clinicians and to provide clear, detailed guidance under what circumstances eligibility would occur.**

Group vs. Individual Participation

CMS is proposing to expand the group practice reporting option so that it applies to all MIPS categories. While the ACR appreciates this proposal, it is unclear how CMS will evaluate group performance for each distinct performance category. It is also unclear how CMS will evaluate each individual EC within the group and combine that into a composite group score or whether CMS will look at the group’s performance as a whole (e.g., did the group, as a whole, report on 6 measures for 90% *of the group’s* applicable patients?). It might be feasible for CMS to evaluate group level performance for quality and resource use. That score could then be applied to every EC in the TIN regardless of whether all individual ECs in the group contributed to the score. However, that strategy



does not necessarily translate to the new ACI or Clinical Practice Improvement Activity (CPIA) categories, since these categories rely on individual attestation. We request that CMS clarify how it intends to evaluate group practice performance in each performance category and to ensure that CMS' methodology protects groups from unnecessary participation burden compared to individual reporting.

Virtual Groups

CMS is not proposing an option to participate in the MIPS or becoming a qualified APM as part of a virtual group for the 2019 payment adjustment (proposed performance period in 2017). Although we understand the need for CMS to carefully implement this option, we urge CMS to work to operationalize the virtual group option as soon as possible since it better recognizes the realities of modern-day medical practice than current quality programs. For example, a common practice in radiology is the use of multiple different TINs for a single group practice. These multiple TINs are often necessary because a group may practice in different settings including, hospitals, joint venture imaging centers, and privately owned imaging centers. Each of these settings may have different ownership structures requiring a separate TIN; however, the same radiologists work across all of these TINs. The proposed requirements of reporting MIPS or becoming a qualified APM at the TIN level or NPI/TIN level dictates that this single group or clinician would have to report multiple times based on each TIN. Meeting reporting requirements under TIN/NPI is complex, burdensome, and may result in payment adjustments based on groupings of providers that are not necessarily reflective of team-based/coordinated care or appropriate for quality improvement. Further, these types of NPI/TIN combinations may involve smaller or independent practices that do not have the resources, negotiating power, or overall influence over more comprehensive care that larger group practices and systems have.

The virtual group concept might serve to resolve these NPI/TIN-related issues but the 10 EC limit would not be a complete solution, as many group practices using multiple TINs could easily have unique TINs greater than 10 ECs. In addition to increasing the number of ECs allowed to form virtual groups, CMS could also consider allowing virtual groups based on similar clinical conditions or specialties. In implementing this suggestion, CMS could develop minimum standards to ensure that the members of a virtual group are caring for a common population, are responsible for decisions that could affect the group as a whole, or otherwise have a mutual interest in quality improvement.

The uniting feature of such virtual groups could be as broad as a common specialty (with a specialty-sponsored registry being the source of data), a clinical service line, or a geographic area. However, there should be a minimum standard to ensure that virtual groups do not result in arbitrary alignments aimed simply at maximizing payment incentives or otherwise "gaming" the system.



At the same time, CMS should not limit the number or size of virtual groups, adopt prescriptive geographic standards, or limit the reporting mechanisms available to these groups, as long as they are able to satisfy the minimum criteria. Such limitations would be arbitrary, would ignore the unique and diverse needs of virtual groups, and could impede collaborations that might benefit from this option.

We encourage CMS to continue evaluating a voluntary method for identifying a group practice that may cross TINs. If CMS does not feel comfortable with the virtual group concept, then perhaps the current GPRO registration process could be used in a slightly different way, so that a group practice (agnostic of TIN) registers as an entity and indicates which TINs and NPIs should be associated under that registration. This could be an “internal” identifier, solely for use by CMS.

The ACR recommends the MACRA-mandated formation of virtual groups be allowed for the 2017 performance period and that the limit of 10 ECs be removed. Alternatively, the ACR recommends a mechanism to lessen the complexity of reporting MIPS or qualifying for APMs across multiple TINs that share the same clinician NPIs.

Performance Period

MACRA states, “The Secretary shall establish a performance period (or periods) for a year (beginning with 2019). **Such performance period (or periods) shall begin and end prior to the beginning of such year and be as close as possible to such year.** In this subsection, such performance period (or periods) for a year shall be referred to as the performance period for the year”. MACRA does not require CMS to adopt an initial performance period that begins on January 1, 2017, nor does it require CMS to rely on a calendar-year performance period.

CMS proposes that, for 2019 and subsequent years, the performance period under MIPS would be the calendar year (January 1 through December 31), 2 years prior to the year in which the MIPS adjustment is applied. For the 2019 adjustment, CMS proposes January 1, 2017, as the first date of the performance period. The ACR believes a later start date and shorter reporting period would be more appropriate for this first reporting period. Assuming the MACRA final rule is released around November 1, 2016, two months is insufficient time for clinicians to interpret and implement the new regulations and insufficient time for organizations like the ACR to provide guidance and tools for the success of our members. In particular, modifying the timeline would also give CMS and third-party vendors more time to conduct supportive outreach and education and to build a sufficient foundation of data on which to set meaningful and fair benchmarks. Furthermore, beginning January 1, 2017 prevents CMS from gathering MIPS-related data to set more accurate and actionable performance benchmarks in the initial years of the program.



The ACR recommends that CMS delay the start date of MIPS until at least July 1, 2017 and that the initial reporting period last for 6 months similar to the first reporting period for PQRI, which was a shortened 6-month period from July 1, 2007 through December 31, 2007.

Targeted Review

CMS proposes to adopt a targeted review process under MIPS wherein a clinician may request that CMS review the calculation of the MIPS adjustment factor applicable for a year. All requests for a targeted review would be submitted by July 31 after the close of the data submission period or by a later date that CMS would specify in guidance. **The ACR recommends that CMS give clinicians as much time as possible to submit these requests since the adjustments will take time to understand and clinicians will simultaneously be working to comply with the subsequent performance period.**

As part of this proposal, if CMS or its contractors request additional information from the clinician, the supporting information must be received from the MIPS eligible clinician within 10 calendar days of the request. Non-responsiveness to the request for additional information will result in the closure of that targeted review request, although another review request may be submitted if the targeted review submission deadline has not passed. Ten days does not account for the time it takes to process such a request, understand the required actions and gather requested supporting evidence. Ten calendar days also leaves very little room for error, such as the request or response getting lost in the mail or being sent to the wrong email address. **The ACR urges CMS to give clinicians at least 60 days to respond to these requests.**

Scoring and Performance Standards

Baseline Period/Benchmarks

CMS intends to adopt baseline periods that are as close as possible in duration to the performance period. For each MIPS payment year, CMS proposes that the baseline period would be two years prior to the performance period for the MIPS payment year. Therefore, for the first MIPS payment year (CY 2019 payment adjustments) and for the quality performance category, CMS proposes that the baseline period would be calendar year 2015 which is two years prior to the proposed calendar year 2017 performance period. CMS proposes some exceptions to this rule. For example, for new quality measures, CMS would set the benchmarks using performance in the performance period. For resource use, CMS also proposes to set the benchmarks using performance in the performance period and not the baseline period. In these situations, CMS would not be able to determine the benchmark until after the performance period.



Although the ACR appreciates that CMS would make the performance standard and scoring methodologies available to clinicians in advance of the performance period, we are concerned by CMS' commitment to provide the actual performance standards *only when possible*. Given the heavy emphasis on pay-for-performance in MIPS, clinicians must know the benchmark for the measure they are reporting ahead of time. If CMS cannot provide benchmark information to clinicians prior to the start of the performance year, it should not hold a clinician accountable for meeting a specific benchmark but should give credit to physicians reporting the measure as a “process measure”. When CMS does not have benchmark data (e.g., first year measures), reporting the measure should not impact the total quality score (e.g., do not assign a zero, which would impact their overall performance score). At a minimum, clinicians should receive credit for reporting the measure, especially since reporting will help build a foundation of data that can eventually serve as a baseline for future performance benchmarks.

Although we support policies that allow CMS to provide clinicians with actual performance standards prior to the performance period, we also strongly advise CMS against the use of 2015 data to set the 2017 benchmark. Since MIPS did not exist at that time and the programs that were in existence relied on a different set of measures and reporting mechanisms, and in some cases, applied to different populations. **The ACR recommends that CMS not set benchmarks or hold clinicians accountable for performance until it has established an adequate foundation based on MIPS data.**

Composite Performance Score (CPS) Performance Category Weights

In accordance with Section 1848(q)(5)(E)(i) of the Act, CMS proposes to assign the following weights to each performance category:

- Quality: 50% for the 2019 payment year; 45% for the 2020 payment year
- Resource use: 10% for the 2019 payment year; 15% for the 2020 payment year
- Advance Care Information: 25% for the 2019 and 2020 payment years
- Clinical Practice Improvement Activities: 15% for the 2019 and 2020 payment years

Within the proposed rule, CMS describes scenarios where certain MIPS eligible clinicians might not receive a performance category score in the quality, resource use, or advancing care information performance categories due to inadequate measures for scoring. CMS proposes that it would, in such scenarios, use the authority under section 1848(q)(5)(F) of the Act to assign a weight of zero to the performance category and redistribute the weight for that performance category or categories as described in the next section.

CMS offers a number of proposals that would either redistribute all of the weight to the quality category or proportionately to all of the remaining categories. For the clinical



practice improvement activity (CPIA) category, CMS does not propose any scenario where a clinician would not receive a CPIA performance category score. CMS also proposes that if a clinician receives a score for only one performance category, it would assign the clinician a CPS equal to the performance threshold, which means the clinician would receive a MIPS adjustment factor of 0% for the year.

For example, if an eligible clinician does not receive a resource use or ACI performance category score, CMS proposes to reassign the weight to the quality category. CMS also proposes an alternative that would reassign the weight proportionately to each of the remaining performance categories. **ACR supports the alternate proposal and recommends that if CMS cannot score the resource use or ACI category, CMS it reweight those points evenly across the quality and CPIA categories. If the MIPS clinician ALSO lacks measures to report into the quality performance category, then the ACR recommends assigning a neutral composite performance score that meets the performance threshold and thus a 0% update.**

Quality MIPS: The Quality Performance Category

Reporting Criteria

The ACR very much appreciates that CMS is proposing to lower the reporting threshold from nine to six measures and no longer require that clinicians report on measures that span three National Quality Strategy domains. Nevertheless, we are very concerned that the benefit of these policies will be undermined if CMS simultaneously adopts its proposal to substantially increase the reporting thresholds, which are significantly higher than the 50% threshold that is currently used under the Physician Quality Reporting System (PQRS). This will result in either a larger number of clinicians who fail the reporting requirements or create a perverse incentive for clinicians to select low-bar measures simply for the sake of compliance rather than meaningful quality improvement. We strongly oppose CMS' proposal to increase the reporting threshold to 90% for Qualified Clinical Data Registries (QCDRs) and 80% for claims-based reporting mechanisms because this leaves clinicians and third-party data submission vendors with very little room for expected error. CMS has made clear in this and previous regulations that reliable data is achievable at much lower sample sizes and can be collected without imposing such unreasonable and impractical reporting burdens on clinicians. For example, when CMS first required eligible professionals (EPs) using the qualified registry under PQRS to report on at least 80% of patients, EPs were only required to report on three measures. When CMS increased this requirement to nine measures in the 2014 PFS final rule (78 FR 74459-74461), CMS also lowered the reporting threshold to 50% of patients to compensate for the increase in the reporting threshold. While CMS is proposing to lower the number of measures required to be reported under MIPS to six, the reporting burden would still be significantly higher than when the 80% threshold was



used for PQRS. In addition, CMS is now proposing reporting on “all-payer” data using a QCDR, registry, EHR, or web-interface and that clinicians and groups report on a cross-cutting measure, as well as an outcome or high priority measure.

Overall, CMS’ proposal to raise the reporting thresholds runs counter to CMS’ goal of simplifying reporting, especially considering that clinicians also now must report on CPIAs, which is a new requirement. This contradicts MACRA’s goal of supporting the use of registries by creating a disincentive for clinicians to move away from claims-based reporting. The “90% of all applicable patients” requirement could pose a large burden on hospital-based clinicians, who often face barriers gaining permission to access hospital data, as well as clinicians who practice at multiple sites because not all sites may be enrolled in a registry.

The ACR is also concerned about the current availability of administrative and IT infrastructure required for reporting this category. For instance, QCDR has only recently been introduced as a reporting mechanism into the existing PQRS program as of 2014 for individuals and 2016 for groups. This has not allowed the IT vendors and the QCDR entities adequate time to automate the data submission process. ACR QCDR participants have generally been submitting data either by web portals, or through labor intensive Certified Electronic Health Record Technology (CEHRT) downloads that produce a large volume of spreadsheets that have to be subsequently imported into QCDR.

Radiologists rely heavily on the IT infrastructure purchased, maintained, and operated by our hospitals. Many hospitals are just beginning to support data collection for facility based physicians; however, hospital IT departments are also burdened by their own set of quality reporting requirements. Lastly, hospital consolidation has led to radiology group consolidation and new contracts in hopes of providing more uniform care across our larger hospital networks. These complex mergers between radiology groups often result in a creation of a new TIN. Although this new TIN would be exempt from reporting into MIPS for 1 year as proposed, this time frame maybe inadequate to merge governance, best practice, culture, and MIPS reporting requirements to satisfy the proposed 90% threshold.

A similar issue exists for groups acquiring new hospital or imaging center contracts under a pre-existing Medicare participating TIN. In this scenario, the radiology group already reporting to QCDR would either have to immediately create the ability to collect and report QCDR measures at the newly acquired hospital/center, change quality reporting mechanisms, or only acquire contracts which represent less than 10% of their total volume as to not fall below the 90% minimum. The 90% reporting rate is also problematic for TINs that provide services at multiple locations and who will need to establish data submission to a QCDR at each site. This multiple facility challenge by itself requires time and effort but this is made even more so if the facility is not able or willing to provide support. With a 50% reporting rate, a TIN in this situation may not need to report from all sites to meet the requirement.



The ACR believes CMS should initiate with a 50% reporting rate for claims, qualified registry, and QCDR, and any necessary subsequent increases in reporting rate should be phased in through rule-making. The 50% reporting rate allows those clinicians just starting to report a quicker pathway to success, while the advanced announcement of an increase in reporting rate through future proposed rulemaking provides those clinicians already reporting sufficient time to implement changes to their practice to meet the higher standards.

Bonus points

We seek clarification on the proposed bonus points allowed for quality measures that are reported electronically; this is described by CMS as “end to end electronic reporting”. The proposed rule lists three steps, the first of which indicates a MIPS eligible clinician uses CEHRT to “record the measure’s demographic and clinical data elements in conformance to the standards relevant for the measure and submission pathway, including but not necessarily limited to the standards included in the CEHRT definition proposed in 414.1305”.

The ACR is concerned that limiting data sources to CEHRT alone would eliminate the potential for obtaining bonus points for many radiologists. Some data sources for radiology QCDRs may not meet CEHRT standards. Thus, we suggest that "in conformance to the standards relevant for the measure and submission pathway" allow the manner in which the specific registry requires the data submission, such as data derived from an electronic source, which might not be CEHRT, and the destination is electronic. We ask that CMS consider any measures coming from an electronic source to an electronic source, following registry standard, as eligible for the electronic reporting bonus points.

Quality Measures

The ACR appreciates that CMS has included all current PQRS measures relevant to radiology for the MIPS quality category. However, there is an error in Table E listing Measure #145 Exposure Time Reported for Procedures Using Fluoroscopy as “registry only”, while it is listed as “registry and claims” in Table A. This measure is currently reportable through claims or registry.

High Priority Measures

CMS proposes scoring adjustments to create incentives for clinicians to submit certain high priority measures (i.e., outcome, appropriate use, patient safety, efficiency, patient experience and care coordination measures) and to allow these measures to have more



impact on the total quality performance category score. Specifically, CMS proposes to provide two bonus points for each outcome and patient experience measure and one bonus point for other high priority measures reported in addition to the one outcome/high priority measure that would already be required under the proposed quality reporting criteria.

CMS proposes to classify which measures are high priority during the measure review process, for both MIPS and non-MIPS measures. In recent years, the determination of National Quality Strategy domain for a measure has appeared inconsistent and not fully transparent to the measure steward. The process that CMS uses to determine whether a measure is deemed “appropriate use” and is classified as a high priority measure is confusing. In Table A, CMS indicates appropriate use measures with “(!)” – across domains and measure types, e.g., a process measure in the patient safety domain has been determined as appropriate use and an outcome measure in the patient safety domain is also considered appropriate use. **The ACR urges CMS to be more transparent on how these designations are determined. Since bonus points are factored into the determination of a domain or a measure’s priority, it is vital that CMS considers recommendations from measure stewards and QCDR entities for this determination.**

Furthermore, the ACR is concerned that CMS has not classified measure #405 Appropriate Follow-up Imaging for Incidental Abdominal Lesions as high priority/appropriate. Measure #406 Appropriate Follow-Up Imaging for Incidental Thyroid Nodules has been identified in Table A and these two measures are identical in structure, rationale and logic. **The ACR strongly recommends that CMS identify both measure #405 and measure #406 as high priority/appropriate use measures.**

ACR also requests that CMS closely track whether the number of high priority MIPS measures available to specialists approximates the number available to primary care physicians. Should the measures available to specialists be considerably lower, we recommend that CMS expedite the creation of specialty specific high priority measures within its measure development process to assure parity in reporting opportunity across specialties. QCDR measures may be a meaningful solution in the future, but we expect a large number of specialists will continue to rely on the traditional MIPS measure set. **The ACR recommends CMS ensure the availability of high priority MIPS quality measures for specialists.**

Topped Out Measures

Using 2014 PQRS quality reported data measures, CMS modeled the proposed benchmark methodology and identified that approximately half of the measures proposed under the quality performance category are topped out. While we acknowledge the importance of including measures only where there is an identified gap in care and



opportunity for improvement, nevertheless, the ACR appreciates that CMS acknowledges that removing such a large volume of measures would make it difficult for some specialties to have enough applicable measures to report. By maintaining these measures in MIPS, CMS and QCDRs can track performance over time and clinicians who might not have reported them in the past continue to have the opportunity to do so.

At the same time, CMS does not believe that clinicians electing to report topped out process measures should be able to receive the same maximum score as clinicians electing to report preferred measures, such as outcome measures. As such, CMS proposes to limit the maximum number of points a topped out measure can achieve based on how clustered the scores are. CMS would notify clinicians about which measures are topped out when benchmarks are published. To keep things administratively simple in the initial years of MIPS, we recommend that CMS not differentiate between topped out and non-topped out measures because it adds another level of complexity to an already complex program. We request that CMS refrain from making policy decisions that rely on data collected prior to MIPS because measure sets, reporting options, and overall incentives for participation were different. Additionally, a topped out measure based on PQRS participation, may result in lower performance rates with increased participation under MIPS. We believe it would be appropriate for CMS to consider this proposal again in the future, once it has established a reliable foundation of data under MIPS.

Additionally, some measures that may be considered topped out by customary criteria are worthy of continued effort due to their critical position in clinical care pathways, and the integrity of other metrics. At least two examples of this phenomenon are germane to radiology. One is the Measure #146 Inappropriate Use of Probably Benign Code, which ensures compliance with effective breast cancer diagnosis guidelines, and importantly in this context, ensures the integrity of the publicly disclosed mammography recall metric in the Hospital Outpatient Quality Reporting program. Another example is the use of Measure #195 Stenosis Measurement in Carotid Imaging. Since the utility of treatment depends in large part on the degree of stenosis, and the recommended method in the measure for quantifying stenosis is the most reproducible method with the greatest evidentiary support, its use is crucial to the effective utilization of carotid intervention.

We also request that CMS identify in proposed rulemaking (or through another timely channel) measures that it considers topped out so that the public has an opportunity to provide meaningful feedback on why some of these measures should be continued.

Finally, we encourage CMS to adopt a broader policy of maintaining measures in MIPS for a minimum number of years (e.g. at least 5 years) to limit scenarios where CMS does not have historical data on the same measure to set a benchmark or otherwise evaluate performance.

CMS' proposal for identifying topped out measures is to use the approach in the Hospital Value-Based Purchasing (HVPB,) that is, Truncated Coefficient of Variation is less than



0.10 and the 75th and 90th percentiles are within 2 standard errors; or median value for a process measure that is 95% or greater. In the HVPB program, all hospitals are evaluated using the same measures and all provide data for these measures. This is not true for measures under MIPS. **The ACR encourages CMS to use median over 95% to identify such measures because it is easier to understand and is a good heuristic.**

Specialty Specific Measure Sets

As noted in Table 3 of the proposed rule, CMS proposes options for eligible clinicians to meet quality data submission requirements using various mechanisms and measure sets. For reporting options other than the Web Interface or use of “non-MIPS” measures in QCDRs, clinicians and groups will have to select their measures from either the list of all MIPS measures in Table A (consisting primarily of current PQRS measures) or a set of “specialty-specific” measures as listed in Table E.

CMS designed the specialty-specific measure sets to address concerns that the quality measure selection process can be confusing (e.g., under PQRS, EPs were asked to review close to 300 measures to find applicable measures for their specialty). The specialty measure sets in Table E are the same measures that are within Table A, but sorted consistent with the American Board of Medical Specialties (ABMS) specialties. CMS notes that these specialty-specific measure sets are not all inclusive of every specialty or subspecialty. CMS requests comments on the appropriateness of measures proposed under each of the specialty-specific measure sets and whether there are additional proposed measures that should be included in a particular measure set.

The proposed rule is unclear about how CMS would score clinicians with less than six measures, particularly if the specialty-specific set has six measures but not all are applicable to a clinician’s practice. It would be helpful for CMS to acknowledge that all individual measures in identified specialty-specific sets with six measures may not be applicable, and thus reportable, by some eligible clinicians in that specialty. For example, the diagnostic radiology subset 20a contains 14 measures. However, a diagnostic radiologist who only performs breast imaging services, nuclear medicine or stroke imaging would not have six measures applicable to their practice in set 20a. In the proposed rule, CMS indicates that in Table 3 “if less than six measures apply then report on each measure that is applicable. MIPS eligible clinicians and groups will have to select their measures from either the list of all MIPS Measures in Table A or a set of specialty specific measures in Table E”. **The ACR would appreciate clarification on reporting requirements when using the “specialty-specific” sets.**

CMS should not limit the scoring potential of specialists and subspecialists that CMS has expressly identified as having less than six measures. These clinicians should have an equal opportunity to earn the maximum number of performance points in the quality category as do clinicians with six available measures. CMS should not score the missing



measure values as zero or require these specialists report on additional, non-relevant measures outside their specialty or sub-specialty specific measure set simply for the sake of filling a gap. We believe this is critical to not disadvantage eligible clinicians and groups for which few applicable measures would exist under MIPS. We also believe it is easier for eligible clinicians to choose applicable measures from a smaller specialty set, rather than to have to review all 300+ measures to determine which apply to them. **The ACR supports CMS’ proposal to allow the reporting of specialty and sub-specialty specific measure sets to meet the submission criteria for the quality performance category, even if it would mean an eligible clinician or group would report on fewer than six measures.**

We also recommend that CMS recreate the specialty set tables so that they list specialty measure sets by reporting mechanism. Many of the sets include a mix of measures that are only available via specific reporting mechanisms. CMS’ proposes that clinicians can only choose one reporting mechanism per performance category. This prohibit a clinician from reporting on all measures in a set (e.g., a clinician using claims to report measures in a set will not be able to report measures in the set categorized as registry-only and thus, might not be able to achieve the six-measure requirement).

Qualified Clinical Data Registry (QCDR) Measures

In implementing the MIPS, section 1848(q)(1)(E) of the Act requires the Secretary to encourage the use of QCDRs under section 1848(m)(3)(E) of the Act. Since the implementation of QCDRs in 2014 as authorized by the American Taxpayer Relief Act (ATRA), CMS has encouraged the development of QCDRs for the purposes of participating in the PQRS program. The ACR is proud to be an approved QCDR since 2014 and applauds CMS’ rapid implementation of this viable and flexible quality reporting mechanism. QCDRs provide eligible clinicians many opportunities for meaningful evaluation of the quality of care they provide and through frequent comparative feedback and offer a means to quickly affect change for improved patient care.

Currently in the PQRS program and as proposed for MIPS in this proposed rule, CMS limits the number of “non-PQRS/MIPS” measures that QCDRs can offer to 30. Even with the substantial reporting opportunities enabled by QCDRs, the 30 measure limit creates challenges for clinicians. In particular, to accommodate the various needs of subspecialists within a specialty and to include measures across a range of high priority areas, a QCDR may need to offer many more non-PQRS/MIPS measures, beyond the 30 measure limit. While many specialty societies who maintain an approved QCDR are continuing to develop and propose measures for inclusion in PQRS and MIPS under the annual CMS call for measures, continuing to allow the rapid cycle of measure implementation through QCDR is an important adjunct to the formal and traditional process. **While we appreciate the volume of QCDR applications and their associated**



measures requiring thorough review by CMS annually, the ACR strongly urges CMS to increase the number of allowed non-PQRS/MIPS measures to be well above 30, potentially incrementally on an annual basis.

Measure Applicability Validation Process

The above discussion on applicability of measures in the specialty-specific sets raises questions regarding CMS' intention to develop a validation process to review and validate a MIPS eligible clinician's inability to report on quality measures as required. CMS states that it anticipates using a process similar to the PQRS Measure Applicability Validation Process (MAV) but to conduct that assessment within the overall scoring approach rather than after an EP is determined not to be a satisfactory reporter. The ACR would like clarification that CMS intends to use a MAV-like process for eligible clinicians using the QCDR mechanism, in addition to the qualified registry and claims reporting mechanisms. As mentioned above, Table 3 does indicate for QCDRs "if less than six measures apply then report on each measure that is applicable". Even with the increased reporting opportunities made available by "non-MIPS" measures, there are many cases where eligible clinicians may not find six measures within a QCDR. Although this is less of a problem with the ability for groups (GPROs) to use QCDRs and with the National Quality Strategy domain requirement removed, there will be circumstances where individuals or groups that subspecialize will not be able to meet the reporting criteria, particularly with the 30 measure maximum that are currently allowed for QCDRs. An example of this scenario is a radiology group that provides only MRI services. **The ACR would appreciate CMS considering employing a MAV process for QCDRs or at minimum clarifying its intent for using such a process.**

Advancing Care Information (ACI)

CMS's proposal for the ACI performance category offers significant improvements and an increase in flexibility over the current Meaningful Use (MU) Program. Radiologists have been early adopters of technology since the specialty's inception, and may use CEHRT daily to read clinical notes, review labs, as well as form the foundation of their own private practice. Radiologists also generate a large amount of useful data by generating reports interpreting diagnostic imaging studies for their patient's and referring clinicians. Interoperability and proper use of CEHRT is of paramount importance to the entire medical community, not excluding radiologists. Many of the ACI measures are geared towards clinician-clinician and clinician-patient interactions, yet many valuable IT activities occur daily in the medical community that do not require direct patient interactions, or are not captured by the proposed ACI measures. The ACR is encouraged by the language of the proposed rule inviting comments on how clinicians without enough patient-facing encounters can participate in ACI. **The ACR plans to convene a**



work group tasked with collaborating with CMS in creating activities that capture a typical radiologist’s use of CEHRT in communicating with patients and clinicians.

“Unique Patients Seen By the Eligible Clinician” Denominator

The ACR is uncertain what CPT codes and/or other services are reportable into the denominators of the eight measures proposed to encompass the performance score. It is unclear whether the denominators are limited to outpatient patient-facing encounters, or if they are meant to include all encounters regardless of whether or not the patients were seen by the eligible clinician and regardless of setting (for multi-location/practice ECs).

In the prior EHR Incentive Program paradigm, eligible professionals (EPs) had the flexibility to define what it means to “see” patients within certain limitations outlined in CMS FAQ #3307 for denominators that use “unique patients seen by the EP”. The ACR strongly recommends that either this flexibility continue to exist in ACI, or that an eligible clinician could opt to limit their ACI denominators to only patient-facing encounter codes that are used in the non-patient-facing MIPS eligible clinician determination.

Eligible clinicians with a combination of billable patient-facing encounters and non-patient-facing encounters need a way to limit their ACI denominators to the patients they see, because several of the proposed ACI measures assume a direct and ongoing relationship between the eligible clinician and the patient. For example, high performance thresholds on ACI measures related to patient view/download/transmit, secure messaging, and patient-generated health data, essentially requires communication with and management of the patient over an extended period of time. Conversely, patients do not generally consult their radiologist for remote access to basic, non-imaging health data unrelated to the radiologist’s role on the care team, securely messaging, or uploading data to the radiologist’s health system’s IT system. In the spirit of fairness and the desire to promote an emphasis on value-based care embodied by the MACRA, specialists should be able to limit their ACI measurement to only those patients with whom they have direct interaction.

90-Day ACI Performance Period

The ACR recommends an ACI performance period of any consecutive 90 days within the calendar year. This would allow MIPS eligible clinicians additional time and flexibility to acquire and implement certified health IT products, as well as plan for the participation requirements of ACI. A 90-day performance period for this category would also be consistent with the original requirements for first-year participation in the previous EHR Incentive Program.



Null Value Reporting Needed for Additional ACI Measures

As proposed, failure to generate a numerator/denominator of at least one for any ACI measure, with the exception of the measures related to e-prescribing and immunizations registries, would result in failure to obtain a base score. However, generating a numerator of at least one is not always possible for all measures. For example, the “patient care record exchange” measure could conceivably result in zero denominators for certain radiologists (and other consultation- and procedure-based specialists), because some eligible clinicians do not refer their patients to other providers or transition care.

To address this problem, the ACR recommends that CMS allow null value reporting for additional ACI measures beyond just electronic prescribing and immunizations. In Meaningful Use (MU) Stage 3 (as well as previous stages), EPs could “exclude” themselves from various measures if they met certain criteria. The ACR recommends that CMS maintain these exclusions in the form of “null value reporting” to achieve full base and performance score credit for any measures that had corresponding exclusions in the earlier EHR Incentive Program. This would minimize the possibility of an eligible clinician generating zero numerators and reintroduce fairness into what are otherwise primary care-centric measures of ACI performance. Additional details are provided below.

Specific ACI Measure Recommendations

The ACR recommends the following clarifications and modifications to the proposed ACI measures:

Electronic Prescribing

As with MU medication orders, the ACR requests clarification in the final rule that providers are permitted to optionally exclude from the denominator any “standing” or “protocol” orders for medications that are predetermined for a given procedure or a given set of patient characteristics. Many EPs who were excluded from the MU e-prescribing measure using the “less than 100” exclusion were able to do so because medications used in their performed procedures were protocol/standing orders and thus handled much differently than prescribed medications electronically submitted to an internal or external pharmacy for dispensing to patients.

Patient Access

Consistent with the MU Stage 3 exclusion for all “view/download/transmit” (VDT) measures, the ACR recommends that eligible clinicians with no office visits during the performance period be permitted to report a “null value” and achieve full base and performance score credit for this ACI measure. The minimal data elements shared via



the VDT functionality in CEHRT are not always directly pertinent to the specialist's specific services. As learned with the MU experience, it would be redundant for patients to receive portal/API access to their active medications and problem lists, vitals, etc., from multiple specialists on their care team in addition to the patient's primary care manager who typically maintains and updates these basic data elements. It would be more appropriate for patients to access service/procedure-specific information from their specialists and the common clinical data elements only from their primary care provider/care management specialists.

Patient-Specific Education

Consistent with the MU Stage 3 exclusion for this measure, the ACR recommends that eligible clinicians with no office visits during the performance period be permitted to report a "null value" and achieve full base and performance score credit. In general, specialists would be interested in providing information tailored to the procedure or consultation they are providing to the patient, and not necessarily educational resources based on the limited data elements used by the corresponding certified health IT functionality. Additionally, some subspecialists may serve in consultative roles to primary care providers or other specialists, with the other providers conveying related education to the patient in the context of the overall care being provided.

VDT

Consistent with the MU Stage 3 exclusion for this measure, the ACR recommends that eligible clinicians with no office visits during the performance period be permitted to report a "null value" and achieve full base and performance score credit. While the ACR staunchly supports patient access to their imaging data, the requisite VDT functionality in certified health IT is focused on relatively basic data elements maintained and updated by others on the patient's care team, particularly the primary care provider/care manager. It would be unfair to measure radiologists on the percentage of all patients who viewed, downloaded, or transmitted their medications, problems, allergies, etc., on the radiologists' systems because patients typically access this type of data from their primary care provider, and thus specialists would be at a significant disadvantage.

Secure Messaging

Consistent with the related MU Stage 3 exclusion for this measure, the ACR recommends that eligible clinicians with no office visits during the performance period be permitted to report a "null value" and achieve full base and performance score credit. Specialists may not always have a clinical need to leverage the specific certified secure messaging capabilities of CEHRT to directly contact patients. Moreover, patients may not always have the technical capability to leverage secure messaging themselves.



The ACR also recommends changing the measure’s numerator to “responses to secure messages sent by patients,” and the denominator to “all secure messages sent by patients,” to address the apparent misalignment between the numerator and denominator in the proposed version of the ACI measure. There is not always a clinical use for leveraging the capabilities of CEHRT to securely message all patients. Thus, the measure as proposed would either result in unusably low thresholds for specialist eligible clinicians, or it would generate numerous unhelpful (and unwanted) messages/spam to patients in order to check the box.

Patient-Generated Data

Consistent with the related MU Stage 3 exclusion for this measure, the ACR recommends that eligible clinicians with no office visits during the performance period be permitted to report a “null value” and achieve full base and performance score credit. Radiologists do not always have a clinical use for incorporating patient-generated health data into their health IT systems, and the usefulness of data such as self-monitored vitals and medications intake is limited mostly to primary care and related specialties that manage a patient’s overall health or condition/disease over extended periods of time.

As with the aforementioned “secure messaging” measure, the numerator and denominator of this proposed ACI measure are severely misaligned. The denominator should be “patient generated data submissions” and not “unique patients seen by the eligible clinician”. The proposed version of this ACI measure incorrectly assumes that every patient would want, or have the technical capability, to submit applicable self-generated data to the eligible clinician.

Patient Care Record Exchange

Consistent with the related MU Stage 3 exclusion for this measure, the ACR recommends that eligible clinicians with fewer than 100 referrals or transitions of care during the performance period be permitted to report a “null value” and achieve full base and performance score credit. As previously mentioned, there could conceivably be situations in which eligible clinicians without referrals/transitions of care have zero numerators and denominators for this measure. As proposed, if clinicians do not generate at least one, they would fail to obtain a base score. Therefore, null value reporting needs to be available for those who do not refer.

Request/Accept Patient Care Record

The ACR supports the specifying verbiage in the denominator, “and for which an electronic summary of care record is available,” and requests explicit clarification that “available” means a summary of care record was electronically provided by the referring/transitioning provider at the time of the referral/transition of care. Failure of the referring/transitioning provider to provide a summary of care record should disqualify



the encounter from the denominator of this measure. This clarification is particularly necessary when individuals or groups see numerous referred patients in a given performance period, and there is a lack of time, resources, or functionality to retroactively seek out all missing summary of care records.

Additionally, the ACR recommends clarification in the final rule that eligible clinicians are able to limit the denominator to the pool of patients defined as “seen by the eligible clinician”. We also recommend that eligible clinicians with no office visits, and those with fewer than 100 received referrals or transitions of care, be permitted to report a “null value” and achieve full base and performance score credit.

Clinical Information Reconciliation

The helpful verbiage included in the denominator of the Request/Accept Patient Care Record measure, “and for which an electronic summary of care record is available,” was omitted from the proposed ACI measure for Clinical Information Reconciliation. Out of necessity, and for the sake of consistency, the ACR recommends that this wording be inserted to reaffirm that the denominators of the two measures are indeed the same. Moreover, as with the previous measure, the ACR strongly recommends that failure of the referring/transitioning provider to provide a summary of care record should disqualify the encounter from the denominator. That way, receiving eligible clinicians would only be held accountable for reconciling data from summary of care records they were actually sent.

Additionally, the ACR recommends clarification in the final rule that eligible clinicians are able to limit the denominator to the pool of patients defined as “seen by the eligible clinician.” We also recommend that eligible clinicians with no office visits, and those with fewer than 100 received referrals or transitions of care, be permitted to report a “null value” and achieve full base and performance score credit.

Public Health/Specialty Registry Bonus

The ACR recommends additional bonus points for specialized registry participation. Most of the proposed ACI measures emphasize and/or assume care management and ongoing communication with patients in a primary care/office setting. The specialized registry bonus should award more value to equalize the ACI playing field between consultative/procedure-based specialists and primary care/care managers. We recommend that 10 bonus points be awarded for participating in a specialized registry and that eligible clinicians are allowed to participate in more than one specialized registry for an additional 10 bonus points each.



“Significant Hardship Exceptions”/Criteria for Application to Reweight to Zero

The ACR supports CMS’ proposal to reweight ACI automatically to zero for all non-patient-facing MIPS eligible clinicians. These specialties are uniquely disadvantaged in the proposed ACI paradigm due, in part, to the lack of exclusion criteria for the measures and the proposed ACI measure selections. We also recommend that CMS enable the small minority of non-patient-facing MIPS eligible clinicians equipped and able to participate in ACI to voluntarily report as an optional alternative to reweighting.

The ACR also recommends a new option to allow applications to reweight ACI to zero for eligible clinicians who did not previously intend to participate in MU in CY 2017, and instead planned to obtain a significant hardship exception to avoid the MU 2019 payment adjustments. Interventional radiologists, breast imagers, and groups could potentially be “patient-facing” under the proposed MIPS paradigm. The vast majority of these individuals and groups were not participating in the EHR Incentive Program and would have been able to avoid MU payment adjustments for five total years (through 2019 for most) under the previous significant hardship exception mechanism. CMS proposes to discontinue the significant hardship exception mechanism and instead move to “reweighting to zero” options. However, the new ACI reweighting options may not cover everyone (like interventional radiologists) who would have been covered under the MU significant hardship exceptions. This is problematic because these individuals and groups would not have plans, systems, or resources in place to accelerate their expected participation timetable by a full calendar year (2018 to avoid 2020 adjustments in MU) and to begin participating in ACI on January 1, 2017. To address this “gap” between the MU hardship exceptions and proposed ACI reweighting options, CMS should allow eligible clinicians to apply for reweighting ACI to zero for the 2017 performance period if they did not previously plan to participate in MU in 2017.

Finally, the ACR recommends that CMS explicitly clarify in the final rule that the “lack of influence over the availability of CEHRT” option for reweighting ACI to zero is not limited to multi-location/practice eligible clinicians. Eligible clinicians who practice exclusively in a single location do not always have influence over CEHRT availability. The EHR Incentive Program used the same “hospital-based” determination methodology and criteria (i.e., more than 90% covered professional services in inpatient or ER setting), and we found that the vast majority of hospital-located radiologists were not determined by CMS’ systems to be “hospital-based” due to their mix of Place of Service (POS) codes on Medicare claims associated with their NPI. Our experience with MU has shown that many hospital-located (but not “hospital-based”) radiologists are not provided the requisite certified health IT and/or adequate technical support in their workplace needed for compliance. Therefore, the “lack of influence” application criteria for ACI needs to be inclusive of all eligible clinicians who are in situations in which their physical workplaces are barriers to success, even if they only work in one physical location.



Resource Use (Cost)

Use of Current Value Modifier Measures

For the Resource Use category, CMS proposes to maintain use of the current total per capita cost measures and the Medicare Spending Per Beneficiary (MSPB) measure. The current measures have limited clinical relevance for many physicians. Some physicians have no costs attributed to their work. Other physicians are associated with costs for services they currently have no opportunity to control. As an example, due to the attribution methods for the per capita cost measures, the only current Value Modifier cost measure that conceivably could be attributed to radiology groups is the MSPB measure. The ACR remains concerned with CMS' proposal to maintain the MSPB for the resource use category since it has limited clinical relevance for many physicians. For the MSPB measure to be attributed to radiologists, the costs during the index hospital admission associated with the radiology group should be for directly controlled imaging services. Although the radiologist has some responsibility for ensuring appropriate imaging is provided, an order placed by a referring physician is usually executed by the radiologist. With the measure attributed to the radiology group, that group is then within a peer group of non-radiology groups for comparison. This current methodology is inequitable.

We are equally disappointed that CMS also proposes to lower the case minimum requirement for the MSPB measure to 20 from 125, which means more physicians will be held accountable for this measure than in the past. We remind CMS that originally under the Value Modifier (VM), it conducted a study and determined that the 125 case minimum was more appropriate for the MSPB measure than a 20 case minimum, particularly as smaller groups and solo practitioners were added to the VM. We believe the rationale used by CMS to increase the case minimum for the MSPB measure from 20 to 125 cases still holds true for the resource use performance category of the MIPS:

However, we continue to believe that it would not be appropriate to include this measure in the cost composite with a 20-episode minimum at a sample size that does not produce reliable results even for those groups that performed well. Rather, we believe that it is more important to ensure that only reliable measures are included in the VM, and we want to avoid a situation in which groups or solo practitioners who may have performed poorly on the measure using a 20-episode minimum may receive a downward adjustment to payments under the VM as a result of a measure that was not reliable (80 FR 71296).

Furthermore, CMS proposes to remove the specialty adjustment from the MSPB measure. This measure is currently risk adjusted to ensure that comparisons account for case-mix differences between practitioners' patient populations and the national average. However, CMS is unclear as to whether the current adjustment for physician specialty improves the accounting for case-mix differences for acute care patients, and thus, feels it might not be needed. We remind CMS that the MSPB measure is a relatively new



addition to the VM, and the specialty adjustment was only first added to the measure in 2016. This is much too short of a time to determine accurately that the adjustment is not effective. Overall, the ACR opposes CMS' decision to maintain and expand the MSPB measure. However, if CMS ultimately maintains the MSPB measure, we request that it also maintain the higher case minimum, as well as the specialty adjustment until it has better data on which to base potential modifications.

Alternative Measures

The resource use category is important to radiology so we encourage use of actionable, meaningful measures for radiologists. We believe there are relevant, valid resource metrics for radiology but currently there is no way to attribute costs effectively, while addressing Medicare Part A and B costs. The ACR was disappointed that CMS did not propose to allow clinicians to receive credit in the resource use category for quality measures considered appropriate use or efficiency.

We believe that valuable metrics can be identified to improve use of resources in the following areas in particular:

- Appropriate imaging recommendations for “incidentalomas” (over-diagnosis) (too many, too often) such as PQRS Measures #405 and 406.
- Use of prior images to avoid duplicative exams, such as PQRS Measures #362 and 363.
- Imaging appropriateness (actionable when done as a team with referring physicians, e.g. appropriate use of CT for headache in concert with neurologists using a similar measure, or in a facility setting).

Optional methods for calculating performance for radiology in this category could be:

- Use of hospital value based programs measures such as Imaging Efficiency measures in the Hospital Outpatient Quality Reporting (HOQR) program.
- Before having a hospital performance score attributed to a radiology group, an initial discovery/team-building period would be required with the hospital to understand how the radiology group could make positive change prior to selecting use of these measures. Community practice radiologists would likely require a discovery period more than academic practice radiologists who are predominantly in ACOs. Likewise, hospital-employed radiologists would likely have built relationships that would facilitate a joint effort. Allowing use of hospital measures as an option would enable this discovery period.

The ACR appreciates that CMS plans to work with non-patient-facing clinicians and specialty societies to propose alternative resource use measures for non-patient-facing MIPS eligible clinicians and groups under MIPS in future years. We request that CMS prioritize the development of alternative resource use measures for non-patient-facing clinicians.



Episode-Based Resource Use Measures

Despite CMS' proposal to add many episode-based measures for the resource use performance category, the number of those that will ultimately be included in the final rule remains uncertain. Since these measures have not yet been used for value-based payment purposes, CMS may choose to specify a subset of these measures in the final rule. CMS requests comment on which measures should be included in the final rule. In addition to considering public comments, CMS will consider the number of MIPS eligible clinicians to be measured, the episode's impact on Medicare Part A and Part B spending, and whether the measure has been reported through a Quality and Resource Use reports (QRUR). CMS also clarifies that it does not believe specialty adjustment is necessary for the episode-based measures, but seeks comments on this point.

The ACR strongly recommends that CMS stop investing in the existing set of flawed resource use measures and instead invest more heavily in the development and refinement of specific episode-based resource use measures, as well as the testing of alternative types of resource use measures. We appreciate all of the work CMS and its contractors have done to develop over 40 episode-based measures that are now available. However, much more work needs to be done before these measures can be used for accountability. This includes fine-tuning risk adjustment and attribution methodologies so that they accurately and comprehensively account for the multiple factors that contribute to the overall cost of caring for a patient.

Another major ongoing problem is the disconnect between what is being measured on the cost side of the equation and what is being measured on the quality side, which results in a flawed value equation. Ultimately, appropriateness of care (which accounts for both quality and spending) should be the goal, rather than measuring raw cost data in isolation.

Finally, we are concerned that some of the episode-based cost measures being proposed in this rule have not yet been included in CMS' QRURs, which means that the public has not had a sufficient opportunity to evaluate how they could affect payments. Among those that have appeared in QRURs, we question to what extent they have been analyzed given the ongoing issues with accessing and understanding these reports.

Reweight Resource Use Category

Given concerns with the measures and methodologies used to evaluate resource use to date, the ACR strongly urges CMS to use its authority under section 1848(q)(5)(F) of the Act to reweight the resource use performance category to zero for the 2019 MIPS payment adjustment and to redistribute the weight to the quality and CPIA categories. Unfortunately, the existing VM measures provide little value to clinicians and simply serve to confuse the public. More granular episode-based measures have not yet been carefully vetted; their development would benefit greatly from more granular patient



condition and patient relationship adjustments.

Overall, Congress understood that the VM methodology is seriously flawed and demonstrated this by weighting this category lower than the other three categories. CMS needs to replace, rather than supplement, these measures with more granular measures that rely on more meaningful and actionable attribution and adjustment mechanisms. We strongly urge CMS to devote significant data analysis and resources to this effort and not hold clinicians accountable under this category until this work is complete. The ACR very much looks forward to offering creative solutions as CMS complies with this mandate.

Clinical Practice Improvement Activity (CPIA) Performance Category

Submission Criteria

To achieve the highest potential score of 100%, CMS proposes that individual clinicians and groups must achieve a total of 60 points. CPIAs are categorized as high-weighted CPIAs (20 points each) and medium-weighted CPIAs (10 points each), and clinicians can choose any combination to achieve the maximum score. Those who select less than the designated number of CPIAs will receive partial credit based on the weighting of the CPIA selected.

Application of CPIA to Non-Patient-Facing MIPS Eligible Clinicians and Groups

CMS proposes to allow non-patient-facing MIPS eligible clinicians and groups to report on a minimum of one activity to achieve partial credit or two activities to achieve full credit to meet the CPIA submission criteria (irrespective of the weighting). For scoring purposes, these clinicians or groups would receive 30 points per activity, regardless of whether it is medium or high. The ACR appreciates CMS' accommodations for such clinicians.

Proposed CPIAs

The ACR also supports CMS' proposal that clinicians can simply designate a yes/no response for activities on the CPIA Inventory through a variety of mechanisms (web-based attestation, QCDR, EHR, etc.). We are concerned by CMS' stated intent to measure performance in this category in the future and strongly urge the agency to maintain its attestation strategy. Furthermore, we support CMS' requirement that clinicians and groups attest to performing CPIAs for at least 90 days during the performance period for CPIA credit. We also support CMS' decision to impose minimum reporting requirements in regards to each CPIA subcategory.



Transforming Clinical Practice Initiative

The ACR strongly supports the inclusion of “Participation in the Transforming Clinical Practice Initiative (TCPI)” as a high-weighted CPIA as many radiologists and their referring physicians will be participating in TCPI through the ACR’s Support and Alignment Network (SAN) program known as R-SCAN, as well as actively participating in Practice Transformation Networks.

Patient Surveys

The ACR appreciates that CMS proposes multiple opportunities for clinicians to receive credit for the use of a unique patient experience survey under the CPIA category. These include:

- Use of QCDR patient experience data to inform and advance improvements in beneficiary engagement.
- Collection of patient experience and satisfaction data on access to care and development of an improvement plan, such as outlining steps for improving communications with patients to help understanding of urgent access needs; and
- Collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan.

We reiterate our belief that CMS should allow for other types of patient-centric measures, not just Clinician Group-CAHPS and non-CAHPS “experience of care” measures and surveys, to count under the CPIA category. Radiologists and other typically non-patient-facing professionals may deliver services that factor significantly in the patient experience or care as well as ultimate clinical outcome. Surveys, measures or other means to improve patient experience should be considered for professionals who demonstrate better outcomes from: 1) Providing consultative care that leads to shared decision making about imaging utilization, 2) Delivering patient-centric reports, 3) Providing access via their websites to patient-empowerment resources such as radiologyinfo.org, or 4) Offering guidance on non-radiology health-related conditions such as smoking cessation and weight management as part of their care. To this point, the ACR has formed a Patient- and Family-Centered Care Commission with a goal of developing patient-defined outcomes measures for future use in radiology.

Use of Clinical Data Registries

We also very much appreciate that multiple CPIAs recognize participation in a QCDR. Because QCDR participation is so comprehensive and entails multiple activities that contribute to quality improvement, we request that CMS consider giving clinicians participating in a QCDR automatic credit for the CPIA category rather than having to attest to each individual CPIA. The ACR also suggests that CMS refer to the use of “clinical registries,” in general rather than QCDRs, throughout the CPIAs, since many



eligible clinicians may participate in clinical registries without using them for MIPS participation.

The ACR strongly urges CMS to consider Maintenance of Certification (MOC) Part IV participation as a CPIA in all CPIA sub-categories, not just the Patient Safety/Practice Assessment sub-category. It is likely that there are MOC activities that are relevant in each of the six CPIA sub categories. CMS should not limit the types of Part IV activities considered a CPIA. Instead, CMS should defer to the boards on what is an acceptable activity under Part IV.

Additional CPIA

Non-Patient-Facing Clinicians

In its discussion of CPIA related to non-patient-facing clinicians, CMS indicates that the number of activities for non-patient-facing clinicians or groups will increase in future years. CMS goes on to say that in the interim, activities appropriate for non-patient-facing clinicians or groups are reflected in the proposed CPIA Inventory across multiple subcategories such as the incorporation of Appropriate Use Criteria (AUC) into some of the activities. However, in the ACR's review of Table H Proposed Clinical Practice Improvement Activities Inventory we did not see CPIA related to AUC or clinical decision support. **In that light, the ACR recommends that CMS consider including use of imaging clinical decision support CPIA from three aspects under a care coordination sub-category:**

Establish effective care coordination that supports appropriate use of diagnostic imaging which could include one or more of the following:

- Employ appropriate use criteria when ordering advanced diagnostic imaging.
- Provision of radiological consultative services in association with appropriate use criteria for advanced diagnostic imaging.
- Participation in a clinical data registry demonstrating performance of activities that promotes use of imaging clinical decision support tools/appropriate use criteria and processes for quality improvement.

CPIA in Future Years/Adding New Activities and New Subcategories

CMS plans to develop a call for measures and activities process for future years of MIPS, where stakeholders may recommend activities for potential inclusion in the CPIA Inventory. As part of the process, MIPS eligible clinicians or groups would be able to nominate additional activities that CMS could consider adding to the CPIA Inventory. This nomination and acceptance process would, to the extent possible, parallel the annual call for measures process already conducted by CMS for quality measures. The final



CPIA Inventory for the performance year would be published in accordance with the overall MIPS rulemaking timeline and program.

CMS also suggests that *prospective activities submitted through a QCDR could also be included as part of a beta- test process that may be instrumental for future years to determine whether that activity should be included in the CPIA Inventory*. MIPS eligible clinicians or groups and groups that use QCDRs to capture data associated with an activity for a baseline and follow up period (multiple years) to identify how the activity contributes to improve outcomes. This data submission process will help to determine whether the activity is being regularly conducted and effectively executed, and whether the activity warrants continued inclusion in the CPIA Inventory.

If an activity is submitted and reported by a QCDR, it would be reviewed by CMS for final inclusion in the CPIA Inventory the following year, even if these activities were not submitted through the future call for measures and activities process.

Additionally, CMS discusses the fact that QCDRs may provide:

- For a more diverse set of measures and activities under CPIA than are possible to list under the current CPIA Inventory;
- Activities that can be validated and provide additional opportunities to specialty practices to report on more meaningful activities in future years;
- Longer-term data collection to show improvement; processes which will be needed for future year submission on improvement;
- Ongoing performance feedback;
- Allowance for implementation of continuous process improvements.

CMS concludes that for future years, QCDRs will be allowed to define specific CPIAs for specialty and non-patient-facing MIPS eligible clinicians or groups through the already-established QCDR approval process for measures and activities and requests comments on this approach. **The ACR whole-heartedly agrees with CMS in its assessment of the validity, usefulness, and comprehensiveness that QCDRs can provide in supporting the CPIA category. We recommend that CMS quickly integrate a “non-MIPS CPIA” submission process through QCDRs similar to the current and proposed process for “non-PQRS/MIPS quality measures”.**

MIPS: Third-Party Data Submission

Data Submission on the Quality, ACI, and CPIA Performance Categories

CMS proposes to allow QCDRs the option of reporting data for three performance categories: quality, ACI, and CPIA. In the rule, CMS is proposing that the QCDR



provide the categories for which the entity is self-nominating. The ACR supports this proposal as long as it remains an option and is not a requirement because many QCDRs might not yet have the capability to report across multiple categories.

Testing and Validation

CMS is not proposing to require third-party vendors to undergo testing and validation prior to submitting data. ACR believes it would be reasonable to require vendors to complete CMS-sponsored submission testing. Currently, CMS only strongly encourages that third-party vendors perform the file testing for the aggregate Extensible Markup Language (XML) file and/or Quality Reporting Document Architecture (QRDA) category III file, because it will help vendors understand what components are required and alleviate issues with the file format and submission errors that may occur when submitting the quality measure data. We believe it is critical that CMS receive accurate data because clinicians will now be scored on performance. At a minimum, to prevent eligible clinicians from being scored adversely due to data inaccuracies, vendors should test their ability to submit accurate data to CMS. To further ensure accurate submission of data, we request that CMS include in its testing tools and Submission Engine Validation Tool (SEVT) process, validation of data content as well as format.

Probation and Disqualification

CMS proposes that if at any time it determines that a third party intermediary (e.g., a QCDR, health IT vendor, qualified registry, or CMS-approved survey vendor) has not met all of the applicable requirements for qualification, CMS may place the third-party intermediary on probation for the current performance period and/or the following performance period, as applicable. In addition, CMS proposes to require a corrective action plan from the third party intermediary to address any deficiencies or issues and prevent them from recurring. CMS proposes the corrective action plan must be received and accepted by CMS within 14 days of the CMS notification to the third-party intermediary of the deficiencies or probation. Failure to comply with this would lead to disqualification from MIPS for the subsequent performance period.

If adequate opportunities for initial testing and validation as well as for correcting data issues are available and a QCDR, qualified registry or EHR vendor is still not submitting correct and valid data, then the QCDR should be placed on a corrective action plan. If after the probationary period the QCDR is still not adequately submitting data, the QCDR should be excluded from future performance periods until such time that it could show through testing that it is able to submit valid data.

To help resolve potential and on-going issues, CMS should develop a root-cause analysis toolkit that vendors could use to help self-identify issues. This analysis should be



conducted before corrective actions are initiated. This would help inform CMS and other vendors about new issues or those that may become systemic.

If a vendor is incapable of submitting accurate data, then ECs who used that vendor should be held harmless from any penalties. CMS must also recognize that there may be instances where the problem may reside with CMS and not just the vendor, such as a vendor not submitting complete information because CMS failed to provide necessary and/or timely information. In these instances, CMS should also hold physicians harmless from any penalties.

We also urge CMS to consider developing a fair process or methodology to deal with future situations where the physician makes the good faith effort to comply, but the data are deemed invalid and unreliable.

In the proposed MACRA rule, CMS is seeking comment on whether, through future rule-making, there should be proposals to require health IT vendors, QCDRs and qualified registries to have capabilities to submit data for all MIPS performance categories. The ACR favors this concept in future rule-making as a common electronic mechanism for reporting data into MIPS would lessen the burden on MIPS eligible clinicians, allowing them more time to care for their patients.

Access to 100% Carrier Standard Analytical Files (SAF)

As part of its ongoing efforts to improve transparency in the Medicare program, CMS has been seeking to release more data for stakeholders interested in understanding the impact of various Medicare policies. We strongly support these efforts, but we believe that improvements are necessary to aid physicians seeking to project the impact of MIPS, APMs and other provisions of MACRA. In particular, we believe that a 100% version of the Standard Analytic File (SAF) containing physician claims should be released as a limited data set to allow private sector researchers to assess the proposals that CMS has advanced in these areas.

Most of the SAFs that CMS releases are available in 5% or 100% samples of Medicare beneficiaries. However, CMS has thus far declined to release a 100% version of the Carrier SAF, the file that contains physician claims. The agency's stated reason for this policy is that the size of the 100% file would be too large. While we agree that size limitations were a reasonable concern when the policy was first announced, most analysts believe that changes to storage and computing power costs have made size issues much less meaningful. Moreover, the ability of stakeholders to analyze the impact of the changes CMS will be implementing under MACRA is significantly limited without access to a 100% file. Many of the changes CMS has proposed will have differential effects across physician practices and specialties. This impact cannot be effectively modeled using a 5% sample of beneficiaries. In addition, as ACR and other specialty



societies seek to further the goal of increased use of APMs, modeling the impact of potential policy proposals will be crucial—and would be significantly aided by access to a 100% Carrier SAF. While various files that CMS has released—including the Part B and Part D Public Use Files—have provided some of the tools necessary to do the sort of modeling that is necessary, privacy restrictions have necessarily restricted the utility of these files. Further, these PUF files do not provide claims level detail which contain key variables needed to conduct population and subpopulation analyses. ACR believes that a 100% Carrier SAF—made available in limited data set form to entities willing to enter Data Use Agreements and abide by CMS policies on data release—would be a necessary addition to the agency’s growing transparency efforts.

A 100% sample of physician claims would also be a significant benefit to a number of other areas of research that would be beneficial to the Medicare program. Much of the research done to date using Medicare claims has been limited in areas where the 5% file lacks a sufficient number of beneficiaries with a particular condition for meaningful research. In areas such as orphan drugs, rare diseases or personalized medicine, some research projects are impossible using the currently available physician claims file. In addition, such a file would also support the ability of researchers to assist participants and potential participants in analyzing their performance for purposes of Accountable Care Organizations and other APMs. The gap in availability of complete physician claims sharply hinders these efforts, as well as attempts to gain insight into geographic variation in health care. Release of such a file would be of significant benefit to Medicare beneficiaries and the American people.

In summary, ACR believes that a 100% Carrier SAF would significantly improve the ability of our organization—and many other stakeholders—to interact with CMS about the policies being implemented in this proposed rule, as well as advancing other policies to improve and modernize the Medicare program.

Alternative Payment Models (APMs)

The ACR agrees that alternative payment models (APMs) are important for our healthcare delivery system to reach the Triple Aim of higher value care and better patient experience at lower cost. Imaging is relevant to this effort as an integral component of patient care facilitating early and accurate diagnosis, assessing success or failure of the initial and subsequent treatment plans, guiding treatment plan modifications, and enabling minimally invasive therapies. Radiologists are stewards of this powerful technology advising on appropriate use, monitoring radiation doses, discussing results with patients and clinicians, as well as performing minimally invasive therapies. Radiologists are vital to radiology specific episodes-of care and team-based episode payment models because of the potential downstream costs of inappropriate imaging and cost savings of early diagnosis advanced imaging technology levies on the health care system.



MIPS APMs

APM Scoring Standard for MIPS Eligible Clinicians Participating in MIPS APMs

CMS proposes to establish a scoring standard for MIPS eligible clinicians participating in certain types of APMs to reduce participant reporting burden of submitting data for both MIPS and their respective APMs. The ACR appreciates this proposal, but we are disappointed by the restrictive definition of MIPS APMs, which was met by only nine models from CMS' portfolio. Six of these MIPS APM models are also identified as Advanced APMs. The three additional models from CMS' portfolio which reached MIPS APM status include the Comprehensive ESRD Care (CEC) (non-LDO arrangement), Oncology Care Model (OMC) one-sided risk arrangement, Medicare Shared Savings Program (MSSP) Track 1. There are no episode-based models that qualify and no additional disease-based models, leading to limited opportunities for non-primary care specialists.

Although we understand that the BPCI model currently lacks a quality measure component (a CMS criterion to become a MIPS APM), we hope that CMS will remedy the BPCI model design to provide a multi-specialty episode-based payment vehicle for participation under MIPS and potentially to qualify as an Advanced APM.

The ACR strongly believes the MIPS APM criterion should be broader to include the BPCI and other bundled payment models. The lack of APMs is a barrier for specialist participation, especially to radiologists whom typically do not serve as treating physicians but nonetheless provide considerable services during episodes of care.

Advanced APMs

The proposed rule lists only six of the twenty-four models of APMs from CMS' portfolio, which meet the criteria as a qualifying Advanced APMs. These include Comprehensive Primary Care Plus (CPC+); Next Generation ACO; Medicare Shared Savings Program (MSSP) Tracks 2 and 3; Oncology Care Model two-sided risk arrangement; Comprehensive End Stage Renal Disease Care (CEC) Large Dialysis Organization (LDO arrangement). Once again, none of these models is episode-based, and only two are disease-based (End Stage Renal Disease and Oncology).

The ACR is disappointed that the Bundled Payments for Care Initiative (BPCI) and the Comprehensive Care Joint Replacement (CJR) did not qualify as Advanced APMs; we believe this sends a discouraging message to physician specialists engaged in episode-based and disease based care.



As required under MACRA, the proposed rule lists three criteria for consideration as an Advanced APM, and we address each of the criteria below:

Require participants to use certified EHR technology (CEHRT)

In the proposed rule, BPCI and CJR models did not qualify as an Advanced APM because they did not meet the CEHRT criterion. We hope that CMS will revise the CJR and BPCI models or the CEHRT specifications to fulfill this criterion.

CMS proposes that using the same CEHRT definition for both MIPS APMs and Advanced APMs would allow eligible clinicians to continue to use shared EHR systems and give ECs flexibility of participation as a MIPS APM EC or an Advanced APM EC without needing to change or upgrade EHR systems. **The ACR agrees that electronic communication and sharing clinical information is essential in coordinating care delivery and fully support aligning the APM and MIPS definition.**

Require quality measures comparable to those used in the quality performance category of MIPS

CMS proposes a framework whereby, the Advanced APM measures should be comparable to MIPS measures, have an evidence-based focus, and include one outcome measure if an outcome measure is appropriate to the Advanced APM and is available on the MIPS measure list. **The ACR supports the alignment between the MIPS Quality reporting category and the qualified APM quality reporting category.** This alignment will allow for easier transition from MIPS to APMS, or vice versa. Additionally, the ACR supports the flexibility proposed by CMS allowing APMs to create or adopt additional non-MIPS measures that are relevant to the patients, diseases, clinicians, and care delivery pathways of each APM.

Bear more than a nominal amount of risk for monetary losses or be a Medical Home Model expanded under CMS Innovation Center Authority

CMS proposes that for an APM to meet the nominal amount standard, (1) the specific level of marginal risk must be at least 30% of losses in excess of expected expenditures: (2) a minimum loss rate, to the extent applicable, must be no greater than 4% of expected expenditures: and (3) total potential risk must be at least 4% of expected expenditures.

This criterion appears to mandate a two-sided risk assumption, which we believe, is too stringent. In the proposed rule, CMS does not specify the financial risk physicians would be held accountable for. The two-sided risk requirement applies at the APM level, not the individual physician level. The ACR believes the financial risk criterion of “nominal



risk” should be based on services that physicians can truly influence instead of requiring physicians to take responsibility for total spending of the APM. For example, physicians should not be at risk tied to the total costs of care for the patients treated under the APM, which could include inpatient, outpatient hospital, post-acute care, drug and other costs beyond the physician’s control.

In addition, CMS declines to incorporate APM start-up and investment costs as part of the financial risk criteria. Although we understand CMS’ desire to maintain objective criteria, we believe that these costs are not only critical to successful implementation of APMs, but also can create a substantial financial burden to meeting cost expectations. Furthermore, the high nominal risk standard could potentially be a barrier to the future qualification of other APMs as Advanced APMs. **The ACR recommends that CMS reduce the percentages associated with each of the financial risk standards to ensure that the Advanced APM financial risk criteria neither inappropriately restrict APM qualification nor take too narrow a view of financial risk proposed in the rule to account for these factors.**

Physician-Focused Payment Models (PFPMs)

The ACR strongly believes that radiologists should be able to participate in as many APMs as possible. About half of US radiologists provide services to multiple sites-of-service in both office and hospital settings. Because of the diversity of their practices, there will not be a one-size-fits-all APM for radiologists; instead, they will need access to a variety of APMs. This will enable radiologists’ success as they gain experience with nontraditional delivery and payment models. **The ACR supports the development of radiology-appropriate PFPMs as a pathway to APMs.**

Overview of the roles of the Secretary, the PTAC, and CMS

The ACR understands that CMS has no authority to appoint Physician-Focused Payment Model Technical Advisory Council (PTAC) members; however, the clinical make-up of PTAC is inherently limited with respect to its technical and clinical background. The ACR strongly believes that CMS should recommend, as part of the PTAC review process, that clinical experts are consulted for any specialty model that is being evaluated. PTAC should also be encouraged to communicate with the submitting parties during the review process to help clarify any deficiencies and maximize the APMs chance for PTAC support.

We realize that CMS cannot commit to testing every proposed PFPM; however, the ACR strongly supports pilot testing whenever possible.



Deadlines for the duties of the Secretary, the PTAC, and CMS

The ACR supports placing a priority on the timely development of APMs to enable more physicians to participate, particularly specialists such as radiologists.

We appreciate CMS proposing flexibility in the timelines for PTAC review and assessment of APM submissions. We agree that the submissions will vary in size, style and scope. In the proposed rule, CMS states that it takes approximately 18 months to develop an APM, including PTAC and Secretarial review and approval, then implementation for possible testing and use under the APM payment category.

The Congressional intent of including the provisions related to the PTAC and PFPMs was to encourage APM participation opportunities for physicians, including specialists, and therefore, the process should include a feedback loop that encourages submission alterations so that as many PFPMs as possible receive a positive recommendation from the PTAC. **The ACR believes there should also be an appeal process and opportunity for resubmission if an APM does not receive a positive recommendation from the PTAC or adoption by the Secretary.**

Definition of PFPMs

The ACR supports CMS' proposed definition of PFPMs. We agree that the intent of MACRA was to develop APMs for physicians based upon quality and value as a replacement for the flawed sustainable growth rate. Much work needs to be done to ensure that all physicians, including radiologists, have an opportunity to participate in APMs and work toward the goal of improved care and contributing to lowered costs.

CMS' definition of an APM should describe how specialty physicians could contribute in a meaningful way and have accountability for their contributions. However, a physician should not be accountable for being part of an APM in which they do not have a role to contribute. As with primary care physicians, specialty physicians should be rewarded for cost savings and improved care to which they contribute and be adjusted for risk when goals are not met.

National medical specialty societies have been working to develop PFPMs prior to the implementation and in anticipation of the MACRA legislation. These models take considerable time to develop, pilot test, and implement and therefore should qualify as APMs under MACRA. CMS' regulations should establish a clear means for PFPM proposals approval for implementation as APMs or Advanced APMs. The ACR looks forward to working with the PTAC and CMS on the development of APMs that focus on the quality care radiologists can provide to patients in a cost-effective manner.



Proposed PFPM Criteria

The ACR recommends that the Department of Health and Human Services provide all the necessary support to the PTAC so it can provide a detailed explanation of the review process and how the established criteria could best be met in a proposal. This should include transparency and guidance in developing proposals, providing feedback on drafts, and making data available up-front to help in modeling impacts. We also encourage CMS to explain in detail how it will evaluate the PTAC recommendations for APMs.

The ACR reviewed the PTAC proposed criteria and most of the elements seem reasonable. The ACR agrees with CMS' proposal that the submissions should include a discussion of the opportunity to improve patient care, reduce costs to the program, and disclose any perceived barriers to implementing those improvements under the current payment system and differences the model has to offer instead of traditional fee-for-service. We also believe that applicants should not only describe how an APM would affect disparities but also how the applicant intends to monitor changes in disparities during the model implementation. In addition, CMS should ensure that implementation of an accepted PFPM does not have excessive administrative requirements which discourage participation.

We urge CMS and PTAC to consider the proposal's impact on patient care, quality, and outcomes in addition to costs. We agree with CMS that applicants may not be able to analyze the full impact a proposed PFPM may have on quality of care and cost. For example, increased use of a preventive service will increase patient participation and early detection of cancers through imaging; however, the cost reduction may primarily exist in the reduction of unnecessary downstream tests and therapeutic interventions. The cost savings associated with early intervention and preventive services may take considerable time to quantify.

Relationship between PFPMs and Advanced APMs

CMS is not proposing to define PFPMs solely as Advanced APMs. The ACR believes this is appropriate. However, CMS should consider a timeline and criteria for APMs establishment and migration into the Advanced APM category.

We understand that not every proposal will be made with a goal of the PFPM becoming an Advanced APM. However, when that is the desired outcome and the PFPM is endorsed by the PTAC, we strongly believe that CMS has a responsibility to consider testing the model. These provisions were included in MACRA to expand the participation opportunities for physicians under the new payment mechanisms. To neglect models that receive a positive PTAC response and that could provide the opportunity for physician access to the APM Incentive Payment would be in direct contradiction to the goal of



MACRA to encourage movement of physicians from traditional fee-for-service to value-based reimbursement models.

Impact on Small and Rural Practice

The ACR is concerned how the MIPS and APM requirements will affect small and rural practices. Small and/or rural radiology practices have a unique and largely unrecognized place in the health care system. Some radiology practices, serve patients in small and rural hospitals, often with complex comorbidities and social determinants of health. Either the group is very small, as few as one radiologist, or the group serves multiple small hospitals with minimal in-patient beds. To offer radiological services to these communities, radiologists must travel from hospital to hospital, and render similar imaging services using multiple different imaging archiving systems, dictation and information systems, and imaging protocols. These radiologists are dedicated to keeping patients in their local hospitals for imaging services and treatment.

An unintended consequence of implementing MACRA may be forcing these groups into mergers with large systems, or acquisition by national enterprises. The administrative burden of making sure each hospital supports submission of the radiology group's required data for use in quality registries, coordinating IT in multiple systems, and often having to report under multiple different TINs is a near impossible hurdle for these small groups or individuals.

CMS should aim to preserve the livelihood of small and rural practices. Larger corporate/system structures may find the cost effectiveness of onsite radiological services in rural locations to be unnecessary. This may cause patients and their families to travel long distances to a larger hospital system to receive basic imaging services. These patients are often the poor and elderly who do not have adequate transportation and can be intimidated by a massive hospital setting. These scenarios can be avoided if small and rural practices are able to continue to provide quality and accessible care locally.

The ACR appreciates that CMS will allocate \$100 million in funding to help educate and train small practices located in rural areas and geographic health professional shortage areas (HPSAs). The ACR would like to feel confident that entities such as, quality improvement organizations, regional extension centers and regional health collaboratives are able to reach all small and rural physicians of all specialties when offering guidance and assistance in helping them to transform into the new payment systems. The concepts of MIPS and APMs are difficult for the average physician practice to understand or interpret how their practice may transition to these new payment systems. The ACR looks forward further guidance on how the technical assistance program will be implemented.



Definition of Small and Rural Practice

The ACR is concerned about how CMS defines small and rural practice and believes the current definition will unfairly disadvantage these physicians. Small radiology practices serve multiple sites including rural imaging centers and hospitals. Small and rural practices may have a 15 physician group covering 14 hospitals (10 to 15 beds) or these groups may cover a few major hospitals with 100 to 300 beds. A more accurate definition may be needed to recognize the practice size by site.

Measure Reporting

The ACR supports CMS' proposal to accommodate small and rural practices for the CPIA performance category by allowing MIPS eligible clinicians or groups to submit a minimum of one activity to achieve partial credit or two activities to achieve full credit (versus up to 6 activities for other clinicians). CMS anticipates the requirement on the number of activities for this population will increase in future years as it gathers more feasibility data. As stated above, the ACR believes radiologists should be eligible to report measures in all of the MIPS categories; however, this capability will need to evolve over time.

Conclusion

The ACR appreciates this opportunity to comment on the MACRA NPRM. The ACR stands ready to assist CMS in helping the radiology community to prepare for the transition to the Quality Payment Program. We appreciate CMS staff reaching out to us to hear our concerns during this comment period. Please feel free to contact us any time through Judy Burleson at jburlerson@acr.org, Pam Kassing at pkassing@acr.org or Laura Pattie at lpattie@acr.org with questions or requests.

Respectfully Submitted,

A handwritten signature in black ink that reads "William T. Thorwarth, Jr. MD". The signature is written in a cursive style with a stylized "W" and "T".

William T. Thorwarth, Jr., MD, FACR
Chief Executive Officer

cc: Amy Bassano, CMS
Molly MacHarris, CMS
James P. Sharp, CMS
Ezequiel Silva, III, MD, Chair, Commission on Economics
Jacqueline Bello, MD, Chair, Commission on Quality and Safety



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