December 16, 2016

Andrew Slavitt, MBA
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5517-FC
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; 42 CFR Parts 414 and 495.

Dear Acting Administrator Slavitt:

The American College of Radiology (ACR), representing more than 36,000 diagnostic radiologists, radiation oncologists, interventional radiologists, nuclear medicine physicians and medical physicists appreciates the opportunity to comment on the final rule 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.

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

PATIENT FACING VS. NON-PATIENT FACING

The ACR appreciates the modified definition of a non-patient facing MIPS eligible clinician (EC) that CMS finalized. Both the increased threshold of 100 patient-facing encounters during the non-patient facing determination period as well as providing for a separate group level threshold of 75 percent of the NPIs billing under the group's TIN will more accurately reflect the intent of the legislation.

The Centers for Medicare and Medicaid Services (CMS) is seeking additional comment on this modified non-patient facing determination policy for group practices in future years.

Headquarters
1891 Preston White Dr
Reston, VA 20191
(703) 648-8900

Government Relations
505 9th Street NW, Suite 910
Washington, DC 20004
(202) 223-1670

Clinical Research
1818 Market St, Suite 1600
Philadelphia, PA 19103
(215) 574-3150

As we discussed in our MACRA proposed rule comments, the ACR believes the intent of the non-patient facing designation is to protect physicians who would have limited opportunity for success in certain MIPS performance categories. In particular, the Advancing Care Information category has measures tailored for evaluation and management (E&M) services as opposed to imaging or image guided procedural services. The ACR has concerns that the broad patient-facing definition fails to recognize the diverse nature of radiology practice. Specifically, we believe that including 000 global codes, which do not include E&M services, among the patient-facing codes will inappropriately classify many radiologists as patient-facing and thus limit their ability for success under MIPS.

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. It is reasonable to consider these physicians as "patient-facing" in MIPS based on the number of E&M services provided.

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 care physicians. In the case of these minor procedures, radiologists do not typically see patients in consultation prior to the procedure, nor would radiologists typically have a separate office or clinic to provide any pre- or post-procedural care. Further, this latter type of practice is often hospital-based, and the radiologists rely on hospital EHR and hospital staff for support, making it unfeasible in most cases to control all aspects necessary to succeed under specific MIPS measures as currently defined. No E&M services are billed as part of these encounters. Thus, these 000-day services, if deemed a face-to-face encounter, could inappropriately classify many radiologists as patient-facing for MIPS whose primary focus is diagnostic imaging.

If CMS chooses to include the 000 global surgical service codes in the definition of patient-facing, the **ACR strongly urges CMS to increase the individual threshold to 200 cases and/or lower the finalized group percentage threshold to 50 percent**. Inclusion of services and procedures beyond evaluation and management services, particularly 000 global codes, will inappropriately classify many radiologists as patient-facing. Furthermore, many radiologists in small and rural practices will be general radiologists, performing mostly imaging, but also a number of 000 global minor procedures placing these practices at a distinct disadvantage.

At the time of our submission of this comment letter, we are only weeks away from January 1, 2017 the start of the first MIPS performance period. Yet, to our knowledge, CMS has not posted the patient-facing encounter code list. Therefore, we have not been able to comment to CMS, nor completely determine the impact on our members. CMS also has stated that notification to clinicians of their patient-facing status should be

disseminated "as early as possible" in 2017. However, the lingering uncertainty of the exact requirements for full participation in MIPS in 2017 makes it difficult for our members to adequately plan for a path to success. **Therefore, we strongly urge CMS for the initial MIPS performance year to fall back on the PECOS-based exemption of diagnostic radiologists (30), interventional radiologists (94) and nuclear medicine physicians (36) from the Advancing Care Information category and the reduced non-patient facing requirements for the Improvement Activities category. This should apply as well to groups with 75% or more of their NPIs enrolled in these PECOS specialties.**

QUALITY CATEGORY

Composite Performance Score, Performance Category Weights

CMS seeks comment on the topic of allowing combined scoring of measures across multiple submission mechanisms within a category, whether this would encourage electronic reporting and how to score measures across mechanisms.

The ACR supports the option of allowing a MIPS EC or group to use multiple submission mechanisms within a performance category. This would be beneficial in several situations, particularly within the quality performance category. In most situations, MIPS ECs who are motivated to begin using a Qualified Clinical Data Registry (QCDR) are already submitting measure data using claims and would prefer to supplement and potentially replace submission of MIPS measures with non-MIPS measure submission. Use of a QCDR for non-MIPS measure reporting takes time to implement. If clinicians were able to begin using a QCDR initially for a few non-MIPS measures while at the same time continuing MIPS measures claims submission and get credit for both types of measures it would ease the on-boarding process.

Another scenario where the multiple mechanism option would be beneficial is for multi-specialty groups who may wish to report using more than one QCDR. This would allow them to report a range of specialty specific measures and not be limited to one service line within their group.

In terms of scoring quality measures reported through multiple mechanisms, it seems most equitable to use the highest score that reported from one of the mechanisms. Alternatively, if a group practice reports some measures using a QCDR and separate measures using claims, then CMS should score them independently and each would contribute equally to the final score.

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1891 Preston White Dr
Reston, VA 20191
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Government Relations
505 9th Street NW, Suite 910
Washington, DC 20004
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Clinical Research
1818 Market St, Suite 1600
Philadelphia, PA 19103
(215) 574-3150

Topped Out Measures

CMS seeks comment on how topped out measures would be scored in the second year the measure has been identified as topped out, specifically whether a mid-cluster approach, removing topped out measures or to apply a flat percentage in building the benchmarks for topped out measures.

The ACR has concerns with CMS developing a separate scoring policy for topped out measures at this point in the MIPS implementation. CMS should allow clinicians the opportunity to participate in MIPS and assess their initial performance in the quality performance category through the first year MIPS feedback reports before CMS changes scoring of topped out measures. Scoring topped out measures differently will add to the already complex final score methodology.

However, if CMS does develop a policy to treat topped out measures differently, the ACR believes that simply allowing the use of the flat percentage is a better option, bearing in mind, even with the flat percentage, there could be some variation from measure to measure at what point a flat percentage would be assigned. For example, CMS notes that in the Shared Savings Program, a flat percentage is assigned to some measures when the 90th percentile was equal to or greater than 95.00 percent and other measures are assigned a flat percentage when the 60th percentile was equal to or greater than 80.00 percent (p. 1084).

ACR also urges CMS to preserve measures identified as "topped out" for two or more years in order to gain sufficient data to reliably determine true adherence to a measure. Under current rules, topped out status might be based on a handful of top performers; but, as MIPS is implemented over the next few years there may be a substantial number of physicians reporting who had not reported previously, potentially resulting in a lower performance benchmark.

Whichever method CMS chooses for scoring topped out measures, ACR strongly urges that CMS publish all information on topped out measures with ample time prior to the start of the performance period so clinicians may adjust their reporting strategies. We have concerns over how quickly CMS would be able to publish cluster-based benchmarks when there is already a substantial time lag in providing any measure benchmarks during the current performance period. For example, CMS has not yet published the previous year benchmarks for measures reported during the 2016 PQRS period for use in the 2018 Value Modifier determination. Clinicians must rely on the benchmarks from the 2014 performance period to gauge their level of performance for the 2016 reporting year.

Additionally CMS seeks comment on whether they should remove non-outcomes measures for which performance cannot reliably be scored against a benchmark (for

example, measures that do not have 20 reporters with 20 cases that meet the data completeness standard) for 3 years in a row.

CMS finalized a policy whereby new measures without benchmarks, and therefore not scored, but that are high priority or reported using end to end reporting would let an EC obtain associated bonus points. While this may incentivize some to report new measures, it may not be enough of an incentive to allow development of a benchmark. The ACR is concerned that this lack of incentive will let new measures dwindle out of inclusion resulting in a status of removal without a legitimate opportunity for use. Additionally, in some cases new measures may be difficult to achieve and should be allowed to exist over a substantial period to ensure uptake.

CMS did indicate that if there were no historical benchmarks, CMS would attempt to calculate a performance year benchmark when the measure has been reported by at least 20 clinicians who each meet the data completeness threshold and report on at least 20 patients. The ACR agrees with this approach, which offers support for full implementation of the measure for the following performance year. **The ACR also recommends CMS use a registry benchmark, when available, for first year QCDR measures.**

Cross-cutting Measure Requirement

CMS seeks comment on potentially adding a requirement that patient-facing MIPS eligible clinicians report at least one cross-cutting measure in addition to the high priority measure requirement for MIPS year two and beyond. CMS is interested in feedback on how it could construct a cross-cutting measure requirement that would be most meaningful to MIPS clinicians from different specialties and that would have the greatest impact on improving the health of populations.

As CMS continues to consider how cross-cutting measures meaningful across specialties, might be implemented, CMS should keep in mind that cross-cutting measures have historically utilized denominators that are based on evaluation and management services. If CMS requires in the future that patient-facing clinicians report a cross-cutting measure, and if the codes used for patient-facing determination include surgical and global day codes, CMS needs to recognize the inability of many ECs who will be considered patient-facing to report on such measures. **The ACR recommends that CMS hold harmless from any future cross-cutting measure requirement ECs who have less than 15 cross-cutting measure denominator instances during the performance year**. There is precedent in the PQRS program for this exemption.

Electronic End-to-End Reporting Bonus

Most diagnostic radiologists do not use certified electronic health records (CEHRT) or certified health information technology (IT) of any kind in their practices; however, they do rely on highly standardized health IT solutions (RIS/PACS, etc.). ACR enables end-to-end reporting for our QCDR participants by bridging radiology-specific health IT solutions to ACR's QCDR. This health IT-enabled flow of information into the QCDR aligns with CMS' description of end-to-end reporting; however, the radiology IT, QCDR tools, and bridge software are not certified for 45 CFR 170.314(c)(1) or 170.315(c)(1) or any other office of national coordinator (ONC) health IT certification criteria.

The final rule's explanation of acceptable end-to-end reporting needs additional clarification addressing health IT-enabled exchange scenarios that do not involve products certified under the ONC Health IT Certification Program. **We ask CMS to clarify in guidance that CEHRT is not mandatory, *and* that certification is not a requirement for any component of the end-to-end reporting process—particularly not when specialty-specific clinical quality measures (CQMs) are electronically reported through the QCDR by specialty-specific IT solutions.**

ADVANCING CARE INFORMATION

Measure Exclusions / Null Value Reporting

The ACR is concerned that the Advancing Care Information (ACI) measures finalized by CMS are significantly misaligned with the scope, workflow, and clinical needs of diagnostic radiologists and other non-primary care specialties. The EHR Incentive Program addressed "head on" similar concerns by allowing participants to exclude themselves from certain Meaningful Use (MU) measures—and achieve full credit for reporting those measures—if they met certain parameters (e.g. "no office visits," etc.). Unfortunately, the measures in ACI do not offer exclusions, meaning that CMS will not give credit to specialists for out-of-scope measures.

CMS argued in the final rule that the flexibility of the ACI scoring mechanics negated the need for measure exclusions. This perspective would only be accurate if there were enough *readily achievable* measures for all ACI participants to perform at high enough rates to accumulate a 50 percent performance score. The ACR does not believe that to be the case—the ACI measure set is largely inappropriate for referral/procedure-based specialists outside of office settings who do not manage patients' care over time, and it would be difficult and unduly burdensome at best to achieve a 50 percent performance score. We also have a related concern that some participants may be unable to generate a base score due to zero denominators/numerators (e.g., some eligible clinicians do not refer patients or transition care to other settings).

Headquarters
1891 Preston White Dr
Reston, VA 20191
(703) 648-8900

Government Relations
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Washington, DC 20004
(202) 223-1670

Clinical Research
1818 Market St, Suite 1600
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The inapplicability of the majority of ACI measures and added complexity of not having office visits or ongoing relationships with patients over time means that successful performance in ACI will be far more arduous for ACR's members than it is for primary care physicians and other specialists who manage patients' care on an ongoing basis. Therefore, there is an urgent need for a return of measure exclusions or equivalent "null value reporting" (for full credit) reflecting out-of-scope ACI measures. As mentioned above in the patient-facing determination section, the level of clinical integration inherent to the model of the typical hospital-based radiology practice already aligns with many of the objectives of patient-centered, value-based care and should be encouraged.

"Unique Patients Seen by the Eligible Clinician" Denominator

In the EHR Incentive Program, eligible professionals have the flexibility to define the denominator of "seen" patients within certain parameters (see CMS FAQ #3307). This particular flexibility, alongside the aforementioned exclusions from out-of-scope measures, enables radiologists to participate in MU. **The ACR believes CMS intends for the customizability outlined in FAQ #3307 to continue to apply to ACI denominators. We urge CMS to clarify explicitly in guidance that this is indeed the case.**

Delayed Release of Patient Facing Encounter Codes – Impact Mitigation

The delayed public release of the patient facing encounter codes used by CMS for the non-patient-facing determination means that any radiologists, pathologists, and anesthesiologists determined to be "patient-facing" have an unreasonably short timeframe to adopt and implement CEHRT prior to 2017 MIPS performance. **The ACR is deeply concerned about the lack of public notice-and-comment on the specific patient facing encounter codes prior to finalization as well as the late timing of this critical piece of MIPS compliance information.**

During the Medicare EHR Incentive Program, diagnostic radiologists, interventional radiologists, nuclear medicine physicians, pathologists, and anesthesiologists were automatically exempted by CMS from payment adjustments based on their provider enrollment, chain and ownership system (PECOS) specialty code data. **We urge CMS to temporarily and automatically reweight ACI to zero for all diagnostic radiologists (30), interventional radiologists (94) and nuclear medicine physicians (36) for the 2017 transition/2019 payment year.** This would ensure that all who are determined at the last minute to be "patient-facing" would not be unfairly required—on unreasonably short notice—to adopt/implement CEHRT and participate in ACI.

As an alternative to the above, we would urge CMS to summarily approve all applications to reweight ACI to zero submitted by "patient-facing" radiologists, pathologists, and anesthesiologists due to "extreme and uncontrollable circumstances."

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1891 Preston White Dr
Reston, VA 20191
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We believe that insufficient lead-time for CEHRT implementation and ACI participation caused by the late public release of the patient-facing encounter codes qualifies as both extreme and uncontrollable.

VIRTUAL GROUPS

CMS seeks comments on a number of aspects of virtual group implementation, including: development of minimum standards, effective use of data by virtual groups for meaningful improvement, virtual group piloting, parameters to ensure flexibility of virtual group composition, collective applicability of performance categories, interoperability of CEHRT across virtual group members, timeframe for virtual groups to implement a collective system, and lastly ideas for virtual group identifiers.

The ACR appreciates CMS' thoughtful consideration of the benefits of the virtual group provision as well as the complexities around meaningful and fair implementation of the concept. **We reiterate our belief that the primary benefit of the virtual group option is better recognition of the realities of modern-day medical practice than current quality programs allow.** For example, a common convention in radiology is the use of multiple different tax identification numbers (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, identified by their national provider identifiers (NPIs), work across all of these TINs. The proposed requirements of reporting MIPS or becoming a qualified professional (QP) 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. 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 concept of the virtual group would provide the opportunity to identify quality and value of multiple specialists as well as primary care clinicians within multispecialty groups in various settings such as academic faculty practices, multispecialty clinic model practices, HMO type practices or hospital-employed groups. There is a growing concern of surgical and medical subspecialties within practices reporting primary care metrics under one TIN. Allowing a virtual group to form to support the broader purpose of engaging specialists in the quality and performance improvement enterprise would benefit optimal patient care. **The ACR appreciates CMS consideration of this vision moving forward.**

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1891 Preston White Dr
Reston, VA 20191
(703) 648-8900

Government Relations
505 9th Street NW, Suite 910
Washington, DC 20004
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Clinical Research
1818 Market St, Suite 1600
Philadelphia, PA 19103
(215) 574-3150

MIPS APMs

APM Scoring Standard for MIPS Eligible Clinicians Participating in MIPS APMs

In the proposed rule, CMS established 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 CMS finalizing this proposal in order to minimize reporting burden and duplication of submitting data. **However, the ACR remains concerned by the restrictive definition of MIPS APMs, of which CMS finalized ten models from CMS' portfolio designated as MIPS APMs, these include:**

- Comprehensive Primary Care Plus (CPC+);
- Next Generation ACO;
- Medicare Shared Savings Program (MSSP) Tracks 1, 2 and 3;
- Oncology Care Model one-sided risk arrangement;
- Oncology Care Model two-sided risk arrangement;
- Comprehensive End Stage Renal Disease Care (CEC) Large Dialysis Organization (LDO arrangement);
- Comprehensive End Stage Renal Disease Care (CEC) non- Large Dialysis Organization (non-LDO one-sided risk arrangement);
- Comprehensive End Stage Renal Disease Care (CEC) non- Large Dialysis Organization (non-LDO two-sided risk arrangement).

None of these models is episode-based, and only two are disease-based (End Stage Renal Disease and Oncology) leading to limited opportunities for non- primary care specialists.

In the proposed rule, CMS asserts the Bundled Payments for Care Improvement (BPCI) model currently lacks the CMS criterion to become a MIPS APM. We hope CMS will move forward with its plan to build on the BPCI initiative and consider, through the Innovation Center, new voluntary episode payment models for 2018 that could meet the criteria to become a MIPS APM or Advanced APM. **The ACR agrees with the approach described in the final rule and believes episode payment models will provide a multi-specialty episode-based payment vehicle for participation under MIPS and potentially to qualify as an Advanced APM.**

Advanced APMs

In the final rule, CMS finalized seven 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);
- Comprehensive End Stage Renal Disease Care (CEC) non- Large Dialysis Organization (non-LDO two-sided risk arrangement).

As is the case for MIPS APMs, none of these Advanced APM models are episode-based and only two are disease-based (End Stage Renal Disease and Oncology). As noted in our MACRA proposed rule comment letter, the lack of Advanced APMs is a barrier for specialist participation, especially to radiologists whom typically do not serve as treating physicians but nonetheless provide considerable value and services during episodes of care. The ACR remains disappointed that the BPCI and the Comprehensive Care for Joint Replacement (CJR) models did not qualify as Advanced APMs for 2017. **We hope that if CMS finalizes restructuring the CJR model in the EPM proposed rule to meet the Advanced APM criteria that it quickly updates its list of eligible Advanced APMs for 2017.**

The ACR appreciates and supports CMS' consideration in the final rule (and in the Advancing Care Coordination proposed rule) to create the ACO Track 1+, developing a new voluntary bundled payment model (patterned upon BPCI), amending the CJR model to include a CEHRT track that will qualify as an Advanced APM, and adopting CEHRT tracks for the episode payment models that will allow those models to become Advanced APMs for 2018. We believe that creating diverse new Advanced APMs will facilitate broader specialist participation, especially by radiologists and others who do not typically function as physician clinical team leaders but who nonetheless provide essential services during a wide array of episodes of care.

ADVANCED APM CRITERIA

CMS finalized with some modification, the requirements for meeting each of the three criteria that define an Advanced APM under MACRA. These include (1) Require participants to use certified EHR technology (CEHRT); (2) Require quality measures comparable to those used in the quality performance category of MIPS while linking payment to quality; (3) Bear more than a nominal amount of risk for monetary losses or be a Medical Home Model expanded under CMS Innovation Center Authority.

Require participants to use certified EHR technology (CEHRT)

CMS finalized for the 2017 QP performance year requirement that at least 50 percent of clinician participants in an Advanced APM entity use certified EHR technology

(CEHRT); however, CMS did not finalize raising the CEHRT threshold to 75 percent for performance year 2018. CMS asserts 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 provides each EC the flexibility to participate as a MIPS APM EC or an Advanced APM QP 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 supports aligning the APM and MIPS CEHRT definitions. **The ACR appreciates CMS' caution on raising the level of CEHRT participation required under the Advanced APM criteria, and advise further caution as the Advanced APM models become narrower in scope.**

Require Quality Measures Comparable to those used in the Quality Performance Category of MIPS

CMS finalized its decision that an advanced APM must base payment on quality measures that are evidence-based, reliable, and valid; and that at least one such measure must be an outcome measure unless there is not an applicable outcome measure on the MIPS quality measure list at the time the APM is developed. The required outcome measure does not have to be on the MIPS quality measure list. CMS also finalized the establishment of an internal Innovation Center quality measure review process for measures that are not NQF-endorsed or on the final MIPS measure list in order to assess whether the measures meet these criteria. **The ACR agrees and 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 and provides flexibility by 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

In the final rule, CMS acknowledged the complexity of the proposed nominal amount standard whose provisions had included: (1) the specific level of marginal risk must be at least 30 percent of losses in excess of expected expenditures: (2) a minimum loss rate, to the extent applicable, must be no greater than 4 percent of expected expenditures: and (3) total potential risk must be at least 4 percent of expected expenditures.

In its place, CMS finalized two ways an APM can meet the Advanced APM nominal amount standard. In the final rule, CMS states "an APM would meet the nominal amount standard if, under the terms of the APM, the total annual amount that an APM Entity potentially owes CMS or foregoes is equal to at least: (1) for QP Performance Periods in 2017 and 2018, 8 percent of the average estimated total Medicare Parts A and B revenues of participating APM Entities (the "revenue-based standard"); or (2) for all QP

Performance Periods, 3 percent of the expected expenditures for which an APM Entity is responsible under the APM (the "benchmark-based standard"). For episode payment models, expected expenditures means the target price for an episode." **The ACR agrees and appreciates CMS revising and finalizing the Advanced APM nominal amount standard by reducing the requisite total risk and not finalizing the marginal risk and minimum loss rate described in the MACRA proposed rule.** We believe the originally proposed nominal amount standard was too complex and could potentially subject some APM Entities to substantially more than nominal financial risk.

The ACR also supports keeping Other Payer APMs simple and as consistent as possible with Medicare Advanced APMs to make it easy for clinicians to participate in Other Payer APMs, especially those in specialties with relatively few Medicare APM options.

Physician-Focused Payment Models

The Roles of the Secretary, the PTAC, and CMS

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 have every opportunity to qualify as advanced APMs under MACRA. The ACR appreciates the flexibility CMS offers in this final rule in the development of PFPMs for those who, to date, have had limited or no opportunity to participate in APMs and Advanced APMs. Much work still 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 lower costs.

The ACR supports the development of radiology-appropriate PFPMs as a pathway to advanced 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. We appreciate that the initial PTAC three-person review team will include at least one physician. However, that physician cannot realistically have the diverse expertise necessary to evaluate the clinical aspects across each model. Therefore we concur there should be clinical experts available to the PTAC review team to assist with technical questions which arise. The ACR is aware that through the Office of the Assistant Secretary for Planning and Evaluation, expertise is available through contractual arrangements with the Perelman School of Medicine at the University of Pennsylvania

Medical School and the Urban Institute. However, we believe this to be inadequate and offer this alternate option.

The ACR recommends that the PTAC request submission of a list of clinical experts either with the PFPM letter of intent or with the PFPM completed application, whichever is optimal for PTAC operations.

The ACR has also submitted this comment to PTAC during its comment period for the Processes of Reviewing and Evaluating Proposed Physician-Focused Payment Models, which was due December 9, 2016.

Without being able to predict the volume, quality, or appropriateness of the proposed PFPMs on which the PTAC will make comments and recommendations, CMS feels that they are not in a position to commit to test all such models. We appreciate CMS' consideration to test as many of the models as possible. **We believe each model should be tested to demonstrate that the proposed Advanced APM will actually meet the basic criteria specified by statute and that the physicians can achieve a QP determination**.

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

CMS did not establish a process or timeline for its own review of recommended PFPMs or to provide additional information regarding such a process in this final rule. We agree that the submissions will vary in size, style and scope. We appreciate the PTAC's and CMS' resources to help guide physician specialties through the application process and consideration of special circumstances as we head into new this new territory. **We look forward to receiving more information from CMS outside of notice and comment rulemaking on its internal review of PTAC recommended PFPMs.**

The PTAC has announced that it will allow a 12 month process, to review and determine if CMS should accept an APM. **We agree that this timeframe is preferable to the 18 months that was initially proposed.**

The PTAC has also announced that if an APM submission does not meet their criteria, the submitter is not expected to start over. Rather, the submitter may resubmit and address specific PTAC or CMS comments/concerns. **The ACR agrees with this approach that there be an appeal process and opportunity for resubmission.**

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.

Headquarters
1891 Preston White Dr
Reston, VA 20191
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Government Relations
505 9th Street NW, Suite 910
Washington, DC 20004
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Clinical Research
1818 Market St, Suite 1600
Philadelphia, PA 19103
(215) 574-3150

DEFINITION OF PFPMs

Relationship between PFPMs and Advanced APMs

CMS finalized the definition of a PFPM to mean an APM: (1) in which Medicare is a payer; (2) in which eligible clinicians that are EPs are participants and play a core role in implementing the APM's payment methodology, and (3) which targets the quality and costs of services that eligible clinicians participating in the Alternative Payment Model provide, order, or can significantly influence.

The ACR had commented that, a physician should not be accountable for being part of an APM in which they do not have a role to contribute. In the final rule, CMS finalizes the definition of a PFPM to specify, "eligible clinicians must play a core role in implementing the APMs payment methodology and the PFPM must target the quality and costs of services that these eligible clinicians provide, order, or can significantly influence". **We agree that only physicians who meet this definition should be rewarded or penalized in APMs and appreciate this revision.**

FINALIZED PFPM CRITERIA

CMS Consideration of Models

CMS offers "supplemental information elements" stakeholders may include in their PFPM proposals to assist agency review. CMS does not require these elements as PFPM criteria but instead to increase transparency of the process. CMS defers to the PTAC on how it may approach requesting any supplemental information beyond that required to meet PFPM criteria. To that end, CMS finalized the quality and cost criteria in which a PFPM is expected to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost. The ACR understands that this is CMS' ultimate goal. However, CMS also acknowledges that applicants may not be able to analyze the full impact a proposed PFPM may have on quality of care and cost. We agree with this conclusion and believe there may be additional clinical considerations. For example, use of an imaging centered preventative service or better follow-up care on pertinent indeterminate findings found on imaging may increase volume, but also enhance early detection of cancers. Both of these scenarios may not result in immediate cost reductions, but instead reduce future costs by preventing unnecessary downstream tests and therapeutic interventions. The cost savings associated with early intervention and preventive services may take considerable time to quantify. **Therefore, the ACR agrees that the submission of supplemental information to explain such clinical circumstances would be useful, and may help an application move more successfully through the review and approval process.**

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In response to commenters that expressed concern about the role of non-physician clinicians and non-physician services, CMS modified the proposed definition of PFPMs to include models that include a broader group of clinicians and their services. CMS also declined to define PFPMs to be provider-led. The ACR agrees that MACRA encompasses the participation of all eligible clinicians in APMs. **However, the ACR cautions CMS and the PTAC to carefully review APMs submitted by non-physicians to ensure that the scope of the model does not infringe upon the role of the physician and the requirement that they treat patients in accordance with their required training and certification guidelines. In particular, state scope of practice laws should be respected. The ACR believes there is a role for all non-physician eligible clinicians in APMs but one, which compliments a physician's expertise and does not sacrifice quality of care.**

Impact on Small and Rural Practice

The ACR is concerned how the MIPS and APM requirements will affect small and rural practices. CMS indicated that in order to provide program education and maximize participation, $100 million in technical assistance would be available to MIPS eligible clinicians in small and rural practices through contracts with quality improvement organizations and other entities. This funding is allocated to help practices select appropriate quality measures and health IT, train clinicians about the new improvement activities and assist practices in evaluating their options for joining an Advanced APM. The ACR believes that this technical assistance is vital in ensuring the success of small and rural practices in this program. However, in the final rule, CMS does not go into the specifics of how CMS plans to roll out and implement the technical assistance. **The ACR believes that it is critical for CMS to have a specific plan in place and be able to reach as many small and rural practices as possible to let them know of the specific resources that are available.**

Definition of Small and Rural Practice

In the final rule, CMS defines small and rural practice as practice with 15 or fewer clinicians and practices in rural and health professional shortage areas. The ACR appreciates this clarification.

Measure Reporting for Improvement Activities

In the final rule, CMS decided to reduce the number of required activities to one high-weighted or two medium-weighted activities. **The ACR appreciates CMS revising the number of required improvement activities for small and rural practices.**

Headquarters
1891 Preston White Dr
Reston, VA 20191
(703) 648-8900

Government Relations
505 9th Street NW, Suite 910
Washington, DC 20004
(202) 223-1670

Clinical Research
1818 Market St, Suite 1600
Philadelphia, PA 19103
(215) 574-3150

Conclusion

The ACR appreciates the opportunity to comment on this important final rule as we move into implementation of these new payment systems. We look forward to continued cooperative work with CMS moving forward. If you have any questions, please do not hesitate to contact Pam Kassing at (800) 227-5463 x4544 or via email at pkassing@acr.org or Judy Burleson at x4787 or jburleson@acr.org.

Respectfully Submitted,

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

cc: Zeke Silva, MD, ACR
Gregory Nicola, MD, ACR
Geraldine McGinty, MD, ACR
Pamela Kassing, MS, ACR
Laura Pattie, MS, CNMT, RCC, CPC
Amy Bassano, MA, CMS
Molly MacHarris, CMS
James P. Sharp, JD, CMS

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Reston, VA 20191
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