August 21, 2017

Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-5522-P,  
7500 Security Boulevard,  
Baltimore, MD 21244-1850

Re: Medicare Program; CY 2018 Updates to the Quality Payment Program  
Proposed Rule; 82 CFR 414 (June, 30 2017)

Dear Administrator Verma:

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-5522-P) updating the Quality Payment Program. The ACR appreciates CMS’ overall effort to ease the burden on physicians, especially in the small and rural setting, as we attempt to transition into these new payment systems. In this comment letter, we address the following issues in an effort to help further refine how radiologists can transition into the QPP:

- Small Practice Eligibility Determination
- Rural Area and Health Professional Shortage Area (HPSA) Practices
- Small Practice Bonus
- Identifying MIPS Eligible Clinicians (EC)
  - Low-volume threshold
  - Patient-facing Code List
  - Non patient-facing
  - Exclusions- Low-Volume Threshold
  - Eligibility of Clinicians Providing Services at Independent Diagnostic Testing Facilities (IDTFs)
  - Virtual Groups
- Facility-based measurement
- Performance period
- MIPS: Quality Performance Category
  - Multiple Submission Mechanisms
- MIPS: Advancing Care Information (ACI) Performance Category
- MIPS: Cost Performance Category
- MIPS: Improvement Activity (IA) Performance Category
- Scoring Methodology
  - Scoring Improvement
MIPS: Third Party Data Submission
  o QCDR self-nomination process

Advanced Alternative Payment Models (AAPMs)
  o APM Criteria: Financial Risk
  o All-Payer Combination Option

Physician-Focused Payment Models (PFPMs)
  o Relationship Between PFPMs and Advanced APMS
  o PFPM Criteria

Small Practice Eligibility Determination

In the CY 2017 QPP final rule, CMS defined and codified at §414.1305 the term “small practice” as a practice consisting of 15 or fewer clinicians and solo practitioners, noting that the size of the group would be determined before exclusions are applied. The eligibility determination was based on practice attestation. In the CY 2018 proposed rule, CMS proposes to use the codified definition of a small practice, but instead of the practice attesting to size, CMS is proposing that small practice eligibility determinations for the 2018 and future performance periods will be based on a determination period. The small practice determination period would be a 12-month assessment period consisting of an analysis of claims data that spans from the last 4 months of a calendar year 2 years prior to the performance period followed by the first 8 months of the next calendar year and includes a 30-day claims run out. This would allow CMS to inform small practices of their status near the beginning of the performance period as it pertains to eligibility relating to technical assistance, applicable improvement activities criteria, the proposed hardship exception for small practices under the advancing care information performance category, and the proposed small practice bonus for the final score. CMS is soliciting comment on this proposal regarding how the Agency would determine small practice size.

The ACR appreciates CMS offering to notify small practices of their eligibility near the beginning of the performance period. This helps them to determine early on, how to qualify for other allowances and benefits afforded to small and rural practices under the Quality Payment Program. However, we are concerned that CMS continues to include all eligible clinicians versus only MIPS eligible clinicians in the count to determine group size. The statute simply defines small practices as “consisting of 15 or fewer professionals.” We believe this provides CMS with the authority to include only MIPS eligible clinicians to be the sole contributors to the threshold levels set for small practice size. A practice with more than 15 eligible clinicians may potentially have resources to devote to improvements and meeting requirements for MIPS. However, if 80 percent of the clinicians in the practice are excluded from MIPS (due to low-volume, having QP status or new to Medicare) the practice would be unlikely to invest heavily in a MIPS participation strategy for the 20 percent of clinicians needing to participate. The clinicians who make up that small percentage of the practice would still need assistance and support similar to any small practice. To alleviate this highly plausible scenario,
the ACR recommends that CMS use a count of MIPS eligible clinicians only to determine group size.

Rural Area and Health Professional Shortage Area (HPSA) Practices

CMS is proposing to create a threshold for identification of rural and HPSA designations. For performance periods occurring in 2018 and future years, CMS proposes that an individual MIPS eligible clinician, a group, or a virtual group with multiple practices under its TIN or TINs within a virtual group would be designated as a rural or HPSA practice if more than 75 percent of NPIs billing under the individual MIPS eligible clinician or group’s TIN or within a virtual group, as applicable, are designated in a ZIP code as a rural area or HPSA. CMS is soliciting comment on this proposal.

The ACR supports CMS’ proposal to determine rural area and HPSA practices by zip code. However, similar to our concern and recommendation for identification of a small practice, we recommend that CMS use a count of only MIPS eligible clinicians versus all eligible clinicians in the practice.

Small Practice Bonus

CMS is proposing to adjust the final score of any eligible clinician or group who is in a small practice (defined as 15 or fewer clinicians) by adding 5 points to the final score, as long as the eligible clinician or group submits data on at least one performance category in an applicable performance period. CMS is requesting comments on this proposal and whether the small practice bonus should also be given to those who practice in rural areas as well.

The ACR appreciates CMS proposing 5 added bonus points to the final score for those small practice or solo practitioners who submit data for at least one performance category in an applicable performance period. This will greatly help small practices as they begin the transition into MIPS. The ACR feels that the 5 additional bonus points should be given to rural practices as well. Rural practices continue to have ongoing issues related to EHR interoperability and adoption of technology that otherwise would ease their reporting burden.

Identifying MIPS Eligible Clinicians (EC)

Low-volume threshold

CMS proposes for Year 2 of the QPP to modify the low volume threshold to exclude individual eligible clinicians or groups from the program that have Medicare Part B allowed charges less than or equal to $90,000 OR that provide care for 200 or fewer Part B-enrolled Medicare beneficiaries. During the first transition year (2017), threshold limits were less than or equal to $30,000 OR providing care for 100 OR fewer Part B Medicare
beneficiaries. Increasing the dollar amount and beneficiary count of the low-volume threshold would increase the number of individual MIPS eligible clinicians and groups excluded from MIPS. In addition, low-volume threshold determinations would be made at the individual and group level, and not at the virtual group level. CMS projects if this policy is finalized for 2018, 37 percent of individual MIPS eligible clinicians and groups would be in MIPS based on the low-volume threshold exclusion (and the other exclusions). However, 65 percent of Medicare payments would still be captured under MIPS in 2018 compared to 72.2 percent of Medicare payments under the CY 2017 Quality Payment Program final rule.

The low-volume threshold also applies to MIPS eligible clinicians who practice in APMs under the APM scoring standard at the APM Entity level, in which APM Entities do not exceed the low-volume threshold. In such cases, the MIPS eligible clinicians participating in the MIPS APM Entity would be excluded from MIPS requirements for the applicable performance period and not subject to a MIPS payment adjustment for the applicable year.

While the ACR supports this increase in low-volume threshold, we strongly encourage CMS to consistently apply how individual eligible clinician thresholds are scaled to a group. **In the determination of low volume threshold for groups, we suggest that CMS use the same methodology as for a patient-facing group; that is, if 75 percent of eligible clinicians in a group meet the low-volume threshold criteria, then the group would be considered a low-volume threshold group and not MIPS eligible.** Changes in low-volume threshold will reduce the burden for solo practitioners and clinicians practicing in small practices. **In future rulemaking cycles, we support the proposal to allow clinicians and groups the ability to opt-in to MIPS if they meet or exceed one, but not all, of the low-volume threshold determinations, including as defined by dollar amount, beneficiary count or, if established, items and services.**

**Patient-facing Code List**

CMS defines a patient-facing encounter as an instance in which a MIPS eligible clinician billed for services such as general office visits, outpatient visits, and procedure codes under the Medicare Physician Fee Schedule. The list of patient-facing encounter codes for the 2017 performance period was published on CMS’ website on December 29 and is used to determine the non-patient facing status of MIPS eligible clinicians.

In the CY 2018 QPP proposed rule, CMS states that it intends to publish the list of patient-facing encounter codes by the end of 2017 in a similar fashion on the QPP website for the 2018 performance period. **It is unclear how CMS plans to update the patient-facing encounter code list for each performance year. Will CMS update new or revised codes or will CMS revisit pre-existing CPT codes that were not previously on the list and subsequently change the patient-facing status of such codes?**
The ACR urges CMS to clarify how it plans to update the patient-facing code list for subsequent performance years.

The ACR is concerned that CMS intends to release the patient-facing encounter codes in a similar manner as the 2017 MIPS performance year. We believe that stakeholders should have an opportunity to provide meaningful comments on the code list before its official implementation. Since the list of patient-facing encounter codes was implemented through guidance, rather than a formal regulation, the ACR remains concerned that declining to use formal notices of proposed rulemaking deprives stakeholders of an adequate, standardized opportunity to comment on relevant policies.

For certain specialists such as radiologists, understanding whether or not they are determined by CMS to be non-patient facing MIPS eligible clinicians for a given year is of central importance to MIPS compliance planning. The late release of the patient-facing code list and subsequent notifications of non-patient facing status may have limited the ability for well over 100,000 MIPS eligible clinicians to adequately plan for a full year’s compliance during the 2017 transition year and to most appropriately select the “Pick Your Pace” option for obtaining a positive payment adjustment. The ACR requests that in the spirit of transparency, CMS seek comments on the patient-facing encounter codes from clinicians and stakeholders through formal notice-and-comment rulemaking, rather than regulatory guidance and release the code list sooner than at the end of the year so that clinicians can adequately plan for compliance.

Non Patient-facing

In order to account for the formation of virtual groups starting in 2018, CMS proposes to modify the definition of a non-patient facing MIPS eligible clinician to: an individual MIPS eligible clinician that bills 100 or fewer patient-facing encounters (including Medicare telehealth services defined in section 1834(m) of the Act) during the non-patient facing determination period, and a group or virtual group provided that more than 75 percent of the NPIs billing under the group’s TIN or within a virtual group, as applicable, meet the definition of a non-patient facing individual MIPS eligible clinician during the determination period.

In the 2017 QPP final rule, CMS finalized that non-patient facing MIPS eligible clinicians are required to meet the otherwise applicable submission criteria that apply for all MIPS eligible clinicians for the quality performance category; this policy remains unchanged for 2018. CMS would initially identify individual MIPS eligible clinicians and groups who are considered non-patient facing MIPS eligible clinicians based on 12 months of data starting from September 1, 2016, to August 31, 2017. To account for the identification of additional individual MIPS eligible clinicians and groups, it would conduct another eligibility determination analysis based on 12 months of data starting from September 1, 2017, to August 31, 2018. Additionally, CMS would not change the non-patient facing status of any individual MIPS eligible clinician or group identified as
non-patient facing during the first eligibility determination analysis based on the second eligibility determination analysis. During the 2018 MIPS performance period, non-patient facing MIPS eligible clinicians, groups, and virtual groups would have reduced requirements for two performance categories. For improvement activities, non-patient facing MIPS eligible clinicians, groups, and virtual groups can report fewer activities (two medium or one high weighted activity) and achieve a maximum improvement activities performance score. For advancing care information, non-patient facing MIPS eligible clinicians, groups, and virtual groups qualify for the reweighting policy, which sets the performance category weight to zero and reallocates the points to other performance categories.

The ACR appreciates CMS reducing the administrative burden of participating in MIPS and we support changes to the non-patient facing determination period. We also strongly recommend as non-patient facing determinations are made, clinicians and groups be notified of their status before the start of the performance year. We suggest including this information in the MIPS eligibility notifications sent to providers.

Exclusions – Low-Volume Threshold

CMS solicits comments on methods of defining items and services furnished by clinicians for purpose of the low-volume threshold.

As finalized for performance year 2017, CMS determines whether an eligible clinician or group does not exceed the low volume threshold based on Part B allowed charges billed (< $30,000) or number of beneficiaries for whom care was provided (< 100). CMS has the authority to also use a minimum number of items and services (as determined by Secretary) furnished to Part B individuals for a performance period as a determinative factor for low volume threshold clinicians. CMS considered defining items and services by using the number of patient encounters or procedures associated with a clinician. Defining items and services by patient encounters would assess each patient per visit or encounter with the MIPS eligible clinician, which is a simple and straightforward approach, however it could also incentivize clinicians to focus on volume of services rather than the value of services provided to patients. Alternatively, defining items and services by procedure would tie a specific clinical procedure rendered to a patient to a clinician.

If CMS uses this method, would CMS continue to use items and services to determine low-volume in addition to billing and number of beneficiaries? The ACR is concerned that radiologists, who provide large numbers of services to Medicare beneficiaries but with limited control of actual utilization, could be penalized by this proposed addition to low-volume threshold determination. The ACR recommends not using the number of items and services furnished per number of patient encounters. This methodology adds more complexity to the program in Year 2 at a time when clinicians, staff and CMS are working towards implementation of currently finalized methods and
procedures, and potentially targets specialties with blunted control of resource utilization.

For the 2019 performance year, CMS proposes to allow low volume threshold clinicians the option to participate in MIPS if they meet or exceed one, but not all of the threshold determinations. The intention of this proposal is to expand options, but there is potential for additional complexity and the need to determine certain parameters of participation, such as required length of participation or certain reporting requirements. This will also impact the ability to create benchmarks and meet sample size requirements. For example, a small practice with low Part B beneficiary volume may not have adequate sample size to be scored on many measures. CMS seeks comment on this and any additional considerations/scenarios it should address when establishing this opt-in policy.

The ACR has concerns that low-volume threshold-excluded individuals or groups who choose to participate would do so based on a presumption of high performance in MIPS, thereby skewing results for that select group since they would be measured against other physicians for whom participation is not optional. The ACR recommends that CMS consider using separate benchmarks for excluded individuals or groups who choose the option to participate in MIPS.

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

In the proposed rule, CMS does not specifically address the MIPS eligibility status of clinicians providing Medicare Part B services under IDTFs. However, CMS does state “when Part B items or services are rendered by suppliers that are also MIPS eligible clinicians, there may be circumstances in which it is not operationally feasible for us to attribute those items or services to a MIPS eligible clinician at an NPI level in order to include them for purposes of applying the MIPS payment adjustment or making eligibility determinations”.

This statement is inconclusive, one could interpret that there are also circumstances in which it is operationally feasible to attribute a MIPS eligible clinician at an NPI level. Because of the various billing and coding practices for IDTFs, i.e., 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 Medicare Administrative Contractors (MACs), a statement such as “there may be circumstances” does not provide adequate guidance. Additionally, IDTFs administratively control billing processes for MIPS eligible clinicians who performs services for the IDTF and the eligible clinicians may not have the ability to influence IDTF claims administration processes.

As we previously noted in our comments for the CY2017 QPP rulemaking cycle, the ACR requests that CMS determine and clearly state eligibility status for these
Virtual Groups

Definition
In the CY 2018 QPP proposed rule, CMS addresses elements of MACRA that were not included in the first year of the program, this includes a new participation option: virtual groups. In the proposed rule, CMS establishes requirements for MIPS participation at the virtual group level, which is defined as a combination of two or more TINs composed of a solo practitioner or a group with 10 or fewer eligible clinicians under a TIN that elects to form a virtual group with at least one other such solo practitioner or group for a performance period for a year.

Additionally, CMS notes in the CY 2018 QPP proposed rule, Section 1848(q)(5)(I)(ii) of the Act requires the establishment and implementation of a process that allows an individual MIPS eligible clinician or a group consisting of not more than 10 MIPS eligible clinicians, to be a virtual group with at least one other such individual MIPS eligible clinician or group. CMS’ interpretation of the statute refers to a group as “consisting of not more than 10 MIPS eligible clinicians” in section 1848(q)(5)(I)(ii) of the Act to mean that a group with 10 or fewer “eligible clinicians” (as defined at §414.1305) would be eligible to form or join a virtual group.

The ACR urges CMS to provide more clarity on the rationale for the statute interpretation and to apply consistency in determining practice size across several aspects of MIPS implementation, such as small practice size and virtual group. As noted in the section above on small practice size determination, we are concerned that CMS continues to include all eligible clinicians versus only MIPS eligible clinicians in the count to determine group size. We have the same concern for virtual group eligibility determination. We recommend that CMS instead rely on the “not more than 10 MIPS eligible clinicians” definition, which would not only allow more groups to take advantage of this reporting option but would also focus more directly on the number of clinicians who are actually participating in and contributing to MIPS (rather than those who are excluded).

Virtual groups would be required to meet the reporting requirements for each measure and activity, and the virtual group would be responsible for ensuring that their measures and activities are aggregated across the virtual group (i.e., across their TINs). Virtual groups are treated like other groups and must report all of their measures and activities at the virtual group level for scoring. CMS also clarifies that while entire TINs participate in a virtual group, including each NPI under a TIN, and are assessed and scored collectively as a virtual group, only NPIs that meet the definition of a MIPS eligible clinician would be subject to the MIPS payment adjustment. The MIPS payment adjustment would not apply to NPIs who are excluded from MIPS...
(i.e., new to Medicare; QP; Partial QP who chooses not to participate in MIPS; and those who do not exceed the low-volume threshold).

Not only do we seek confirmation that the payment adjustment in this proposal will be applied to only MIPS eligible clinicians, but the ACR strongly encourages CMS to only consider MIPS eligible clinicians as part of a virtual group as written in the statute. The virtual group should not be required to report for low-volume, non-MIPS eligible clinicians. It is a regulatory burden, which requires the reporting and assessment of eligible clinicians who are exempt from the program.

Virtual Group Election Process

CMS proposes that a solo practitioner or a group of 10 or fewer eligible clinicians must make their virtual group election prior to the start of the applicable performance period and cannot change their election during the performance period. If for any reason, a clinician leaves a virtual group mid-year, the virtual group would still be required to have that clinician accounted for when determining the groups MIPS final score and payment adjustment. For the 2018 performance year and future years, CMS proposes that those electing to be in a virtual group must do so by December 1 of the calendar year preceding the applicable performance period. By September of each year prior to the applicable performance year, clinicians can inquire about virtual group participation and eligibility. CMS anticipates this election will occur via e-mail to the QPP Service Center using the following email address: MIPS_VirtualGroups@cms.hhs.gov. CMS intends to make technical assistance available to support clinicians who choose this option for 2018 and 2019.

CMS notes that qualifications as a virtual group for purposes of MIPS do not change the application of the physician self-referral law to a financial relationship between a physician and an entity furnishing designated health services, nor does it change the need for such a financial relationship to comply with the physician self-referral law.

The ACR understands and agrees with the concept that a virtual group should identify itself prior to the beginning of a performance period. However, it seems unlikely that will occur for the 2018 performance period, in that the final rule and implementation details of the virtual group option will not be known until just before the election deadline for 2018.

Virtual Group – Special Status Determination

Similar to the 75 percent threshold adopted in 2017 for determining whether a group is non-patient facing, CMS is proposing the same definition for virtual groups, where greater than 75 percent of NPIs within a virtual group during a performance period are considered non-patient facing. The ACR supports the creation of virtual groups allowing clinicians an option to decide how they will participate in MIPS.
Facility-based measurement

In Year 2, CMS proposes to implement an optional, voluntary MIPS scoring mechanism for facility-based clinicians based on the Hospital Value Based Purchasing Program. The Hospital Value-Based Purchasing (VBP) is an existing program under Medicare that provides adjustments to bundled payments based on facility-wide quality measures. There are currently 13 quality and efficiency measures defined under VBP; CMS proposes to include all the measures adopted for the FY 2019 Hospital VBP Program on the MIPS list of quality and cost measures except for measures used for hospital outpatient departments. CMS proposes that facility-based individual MIPS eligible clinicians or groups that are attributed to a hospital would be scored on all the measures on which the hospital is scored for the Hospital VBP. In addition, the proposed rule indicates there will be no data submission requirements for the facility-based measures used to assess performance in the quality and cost performance categories.

CMS proposes that a MIPS eligible clinician is eligible for facility-based measurements if they have at least 75 percent of their covered professional services supplied in the inpatient hospital setting or emergency department only; this does not include hospital outpatient departments. CMS considered adopting the definition of “hospital-based MIPS eligible clinician under §414.1305, which defines a hospital-based MIPS eligible clinician as one who furnishes 75 percent or more of their covered professional services in an inpatient hospital, on campus outpatient hospital or emergency room setting. CMS is concerned that this definition is too broad and could incorporate clinicians that have limited or no presence in the inpatient hospital setting.

CMS estimates that approximately 20 percent of eligible facility-based clinicians will participate in facility-based measures reporting. The 75 percent threshold is different from the “hospital-based” designation used in the ACI performance category. CMS proposes to allow MIPS eligible clinicians who are facility-based to use their institution’s performance in the quality and cost performance categories. Facility-based MIPS eligible clinicians are to be scored based on their facility’s performance. CMS estimates that approximately 20 percent of eligible facility-based clinicians will participate in facility-based measures reporting.

We support CMS’ proposal to include this option for facility-based clinicians. However, many of our MIPS eligible radiologists often perform more than 75 percent of their work in a facility but primarily in hospital outpatient departments. Because the proposed definition for facility-based clinician only includes inpatient and emergency department services and not outpatient services, these radiologists will not be considered facility based. They could not achieve the 75 percent threshold requirement for inpatient/emergency services when 25 percent or more of their services are performed in the outpatient facility setting. These MIPS eligible radiologists are still disadvantaged, as they require hospital resources for successful participation in MIPS.
Even CMS’ participation estimates for this option seems low; we believe that this is due in part to the 75 percent threshold requirement. ACR recommends lowering the 75 percent threshold to 50 percent so more radiologist could choose this option if they desire.

CMS also proposes that individual MIPS eligible clinicians or groups who wish to have their quality and cost performance category scores determined based on a facility’s performance must elect to do so. The proposal also states clinicians or groups who are eligible and wish to elect facility-based measurement would be required to submit their election during the data submission period as determined through the attestation submission mechanism established for the improvement activities and ACI performance categories. The ability to submit data using multiple submission mechanisms will not be allowed for scoring purposes. If technically feasible, CMS plans to notify MIPS eligible clinicians and groups if they are eligible for facility-based measurement prior to the submission period.

CMS proposes an alternative approach of not requiring an election process but instead automatically applying facility-based measurement to MIPS eligible clinicians and groups who are eligible for facility-based measurement, if technically feasible, if the facility-based measurement score is higher than the quality and cost performance category scores based on data submitted.

For physicians participating in MIPS and Hospital VBP, the ACR supports CMS’ alternative scoring approach to use the higher quality and cost performance score. While using this approach would require facility-based MIPS eligible clinicians to continue submitting physician level quality measure data to CMS, it provides the most flexibility.

Section 1848(q)(2)(C)(ii) of the Act provides that the Secretary may use measures used for payment systems other than for physicians, such as measures for inpatient hospitals, for purposes of the quality and cost performance categories. The Secretary may not use measures for hospital outpatient departments, except in the case of items and services furnished by emergency physicians, radiologists, and anesthesiologists. CMS considered, but did not propose, an option for facility-based measures scoring in the transition year. For the 2020 MIPS payment year and onward, CMS proposes to implement facility-based measures to add more flexibility for clinicians to be assessed in the context of the facilities at which they work. CMS believes that it is appropriate to implement this scoring option in a limited fashion in the first year by focusing on inpatient hospital measures in certain pay-for-performance (versus pay-for-reporting) programs.

In implementing the facility-based measurement option in future years, the ACR strongly recommends that CMS consider use of the quality measures in the Hospital Outpatient Quality Reporting (HOQR) program, in particular the HOQR Imaging Efficiency measures are relevant to radiology groups.
**Performance Period**

For the 2018 MIPS performance year (2020 payment year), CMS proposes a performance period for the quality and cost categories to be the full calendar year, January 1, 2018 through December 31, 2018. For the improvement activities and advancing care information performance categories, CMS proposes the performance period would be a minimum of a continuous 90-day period within CY 2018 and up to and including the full CY 2018.

CMS introduced the MIPS program in 2017 as a transition, “Pick Your Pace” year to allow MIPS eligible clinicians to become familiar with the program and to gear up their participation. To require a full calendar year participation in the quality performance category for performance year 2018 is a sharp increase in requirements.

The ACR believes that setting the quality performance category period to a minimum 90-day period, similar to the improvement activities and advancing care information categories, would support simplicity, reduce confusion and ease the transition from the 2017 MIPS “Pick Your Pace” performance year. However, we believe it is more important to ease the transition from 2018 to 2019 performance years by supporting the proposed full-year participation in the quality and cost performance categories, as well as the minimum continuous 90-day for the advancing care information and improvement activities performance categories for the performance period. Further easing of the transition between the 2017 MIPS “Pick Your Pace” performance year and the 2018 QPP year 2 performance year can be accomplished by lowering the proposed performance threshold as discussed in the subsequent section.

**MIPS: Quality Performance Category**

**Data Completeness Criteria**

CMS proposes for payment year 2020 to maintain the current data completeness thresholds for the quality category:

- Registry: 50% of all applicable patients, regardless of payer
- QCDR: 50% of all applicable patients, regardless of payer
- EHR: 50% of all applicable patients, regardless of payer
- Claims: 50% of all applicable Medicare Part B patients

For the 2021 payment year, CMS proposes the following data completeness thresholds for the quality category:

- Registry: 60% of all applicable patients, regardless of payer
- QCDR: 60% of all applicable patients, regardless of payer
- EHR: 60% of all applicable patients, regardless of payer
• Claims: 60% of all applicable Medicare Part B patients

CMS intends to increase these thresholds over time through future rulemaking and seeks comment on what data completeness threshold should be established for future years.

CMS states that it would like to provide an additional year for individual MIPS eligible clinicians and groups to gain experience with MIPS before increasing the data completeness thresholds for data submitted on quality measures. CMS is concerned that accelerating the data completeness threshold too quickly may jeopardize MIPS eligible clinicians’ ability to participate and perform well under MIPS, particularly clinicians less experienced with MIPS quality measure data submission. CMS continues to believe it is important to incorporate higher data completeness thresholds in future years to ensure a more accurate assessment of a MIPS eligible clinician’s performance on quality measures and to avoid any selection bias. CMS expects data submitted to be representative of an eligible clinician’s or group’s overall performance for a measure.

CMS states that the data completeness threshold of less than 100 percent is intended to reduce burden and accommodate operational issues that may arise during data collection during the initial years of the program. MIPS eligible clinicians should take note of CMS’ plans to increase the data completeness threshold and take the necessary steps to prepare for higher data completeness thresholds in future years.

The ACR very much appreciates that CMS has maintained and is proposing to maintain a data completeness requirement of 50 percent for quality data submission. We hope that CMS will not drastically raise the data completeness rate each year and consider stopping at 75 percent and not impose a 100 percent reporting rate. 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 impractical reporting burdens on clinicians. Increasing the requirement to 90 or 100 percent of all applicable patients (when registry reporting) could pose a large burden on hospital-based clinicians, who often face barriers gaining permission to access hospital data, clinicians who merge practices or take on a new hospital contract, as well as clinicians who practice at multiple sites because not all sites may be enrolled in a registry.

Radiologists rely heavily on the IT infrastructure purchased, maintained, and operated by our hospitals. Many hospitals are still just beginning to support data collection for facility based physicians; while shouldering burden of their own set of quality reporting requirements. We have mentioned in previous communications, 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. It takes time to merge governance, best practice, culture, and MIPS reporting; building the infrastructure
within the new TIN to meet requirements to satisfy a threshold of 75 percent or more would be very onerous to meet during one performance period.

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 percent of their total volume as to not fall below the 90 percent minimum. The 90 percent 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 percent reporting rate, a TIN in this situation may not need to report from all sites to meet the requirement. The ACR strongly supports CMS’ proposal to maintain the 50 percent data completeness requirement, and requests that CMS consider a gradual increase with a cap at 75 percent for any reporting mechanism.

Calculating the Final score – Redistributing Performance Category Weights

CMS proposes redistributions for the 2020 MIPS payment year as follows, assuming CMS’ proposal to weight the cost performance category at zero percent are finalized.

- If CMS assigns a weight of zero percent for the ACI performance category or for the improvement activities performance category for a MIPS eligible clinician, CMS proposes to continue its policy from the transition year and redistribute the weight of that category to the quality performance category (assuming the quality performance category does not qualify for reweighting).
- If a MIPS eligible clinician qualifies for reweighting of the quality performance category and the ACI or improvement activity performance categories, then CMS would set the final score at the performance threshold because the final score would be based on one category only, which would not be a composite of two or more performance category scores.
- If a MIPS eligible clinician qualifies for reweighting of the quality performance category, CMS proposes to continue the policy from the transition year and redistribute the 60 percent weight of the quality performance category so that the performance category weights are 50 percent for the advancing care information performance category and 50 percent for the improvement activities performance category (assuming these performance categories do not qualify for reweighting).

CMS proposes redistribution of performance category weights for the 2020 MIPS payment year as follows under the scenario that CMS does not finalize its proposal to weight the cost performance category at zero percent.
CMS proposes to not redistribute the weight of any other performance categories to the cost performance category.

- If a MIPS eligible clinician qualifies for reweighting of the quality performance category and the ACI performance category, then CMS would redistribute the weight of both categories to the improvement activities performance category and would not redistribute the weight to the cost performance category.
- If a MIPS eligible clinician does not receive a cost performance category percent score, CMS proposes to redistribute the weight of the cost performance category to the quality performance category.
- If a MIPS eligible clinician does not receive a quality performance category percent score or a cost performance category percent score, CMS proposes to redistribute the weight of the cost performance category equally to the remaining performance categories that are not reweighted.
- If the quality performance category is reweighted to zero, but the cost category weight is not zero percent, AND either the improvement activities or ACI performance category is reweighted to zero percent, then CMS would redistribute the weight of the quality performance category to the remaining performance category that is not weighted at zero percent. CMS would not redistribute the weight to the cost performance category.

CMS also considered an alternative approach for the 2020 MIPS payment year to redistribute the weight of the ACI performance category to the quality and improvement activities performance categories, to mitigate potential undue emphasis on the quality performance category. For this approach, CMS would redistribute 15 percent to the quality performance category to obtain a final weight of 75 percent (60% + 15% = 75%) and 10 percent to the improvement activities performance category to obtain a final weight of 25 percent (15% + 10% = 25%), redistributing the weights in increments of 5 points for simplicity. This alternative approach, assuming the cost performance category weight is zero percent, is detailed in Table 39. Should the cost performance category have available and applicable measures and the cost performance category weight is not finalized at zero percent and the quality performance category is reweighted to zero percent, then CMS would redistribute the weight of the advancing care information performance category to the improvement activities performance category.

CMS invites comments on the proposals for weighting the performance categories for the 2020 MIPS payment year and the alternative option for reweighting the performance categories.

The ACR support CMS’ alternative approach for the 2020 MIPS payment year to redistribute the weight of the advancing care information performance category to the quality and improvement activities performance categories, to mitigate potential undue emphasis on the quality performance category.
Incentives to Use Certified EHR technology (CEHRT) to Support Quality Performance Category Submissions

CMS does not propose any changes regarding incentives to use CEHRT under the quality performance category, such that the following policies remain in effect:

• CMS awards 1 bonus point for each quality measure submitted with end-to-end electronic reporting.
• CMS applies a cap on the number of bonus points available for electronic end-to-end reporting at 10 percent of the denominator of the quality performance category percent score, for the first 2 years of the program.
• CEHRT bonus points are available to all submission mechanisms except claims submissions.

However, CMS seeks comment on the use of health IT in quality measurement and how the Department of Health & Human Services (HHS) can encourage the use of certified EHR technology in quality measurement as established in the statute. What other incentives within this category for reporting in an end-to-end manner could be leveraged to incentivize more clinicians to report electronically? What format should these incentives take? For example, should clinicians who report all of their quality performance category data in an end-to-end manner receive additional bonus points than those who report only partial electronic data? Are there other ways that HHS should incentivize providers to report electronic quality data beyond what is currently employed? CMS welcomes public comment on these questions.

The ACR continues to have outstanding questions to CMS from the final rule last year. In response to CMS’ comment request above we reiterate our questions regarding use of CEHRT for quality submission and the “end to end” reporting bonus as below.

10 Percent End-to-End Reporting Bonus for Quality

Scenario
Most radiologists do not use CEHRT or certified health IT of any kind in their practices. ACR enables end-to-end reporting for our registry participants by bridging radiology-specific, standardized health IT solutions (RIS/PACS, etc.) to ACR’s QCDR using our TRIAD software, or by submitting data to us through web services API directly from the participants IT solution. None of the software used in this scenario is certified under ONC’s health IT certification program.

Questions
1. Is the above scenario adequate to be considered meeting end to end electronic reporting?
2. If not, what specifically needs to change?
   a. Potentially we could certify our proprietary TRIAD bridge software for 45 CFR 170.315(c)(1).
b. If so, would certification for that one criterion alone be sufficient (i.e., still without CEHRT being part of the equation)?

c. If certification of TRIAD for 45 CFR 170.315(c)(1) is indeed mandatory, does CMS know if ONC testing labs would be able to test a product’s capability to record all data necessary and successfully calculate previously untested (i.e., non-MU) CQMs?

d. If so, could our registry participants use TRIAD while we are in the testing/certification pipeline in ONC’s health IT certification program (like in MU), or would their performance period have to begin after TRIAD is successfully certified?

e. Would use of web services APIs to submit quality measure data directly from standardized, but not CEHRT, health IT solutions to the ACR registries from which data is submitted to CMS, all without a break in the electronic process meet the intent?

Additional Points for Treating Complex Patients

CMS proposes additional bonus points for physicians who demonstrate that they are treating patients whose conditions are highly complex as compared to the average patient. CMS will base the level of complexity on the average HCC risk score for an eligible clinician or group. If CMS determines that certain patients are high risk, they will add 3 bonus points to the average amount of an eligible clinician’s final score. The bonus cannot exceed 3 points. The eligible clinician must submit at least one measure of activity in a category during the 12 month performance period (September 2017 – August 2018) in order to receive the bonus. Alternatively, CMS proposes a methodology to use a ratio of patients who are dual eligible to determine an eligible clinician’s treatment of high-risk patients who may be eligible for the complex patient bonus.

The ACR supports the concept of rewarding bonus points to a MIPS eligible clinician’s final score for treating complex patients, and supports using the HCC methodology, however, the ACR would like to propose the maximum bonus point allotted should not exceed 5 points as compared to the proposed cannot exceed 3 points. Individuals, groups, or virtual groups treating complex patients are as disadvantaged in MIPS as small groups whom, as proposed, will receive 5 points toward their final score as proposed for meeting the small practice definition.

Quality Measures

New Measures

In Table A.7, CMS is proposing to include a new measure stewarded by the Society for Interventional Radiology:

The ACR supports inclusion of this measure in MIPS performance year 2018.

Specialty Specific Measure Sets

Measure Classifications:

In the Table B.20a. Diagnostic Radiology Subspecialty Set we note the following errors:

- **Measure 145 Radiology: Exposure Dose or Time Reported for Procedures Using Fluoroscopy**, is once again listed as a “registry only” measure. We made note of this in the CY2017 QPP rule cycle and CMS finalized submission through claims or registry. We request CMS indicate that it is reportable through both methods.
- Measure 145 is listed with a (!!), indicating that it is an appropriate use measure, but that designation really does not apply to this measure. It should be considered high priority/patient safety (!). We did not notice this in the 2017 QPP rule cycle.
- **Measure #405 Appropriate Follow-up Imaging for Incidental Abdominal Lesions** is not indicated as a high priority/appropriate use (!!) measure. We addressed this with CMS in the 2017 QPP rulemaking cycle, mentioning that Measure #406 Appropriate Follow-Up Imaging for Incidental Thyroid Nodules was identified as (!!) appropriate use and these two measures are identical in structure, rationale and logic. CMS made that change in the 2017 QPP Final Rule but in this proposed rule it is once again not shown as such.

Topped Out Measures

CMS seeks comments on a topped out measure removal timeline, specifically regarding the number of years before a topped out measure is identified and considered for removal, and under what circumstances it should remove topped out measures once they reach that point (i.e., should it be automatic removal or should CMS consider certain criteria?).

In the 2017 QPP final rule, CMS defined a topped out measure as one for which performance is so high and unvarying that meaningful distinctions and improvements in performance cannot be made. Additionally, CMS stated that it would remove topped out measures over time.

CMS proposes a 3-year timeline for identifying and proposing to remove topped out measures. After a measure has been identified as topped out for three consecutive years, CMS may propose to remove the measure through comment and rulemaking for the 4th
year. Thus, in the 4th year, if finalized through rulemaking, the measure would be removed and would no longer be available for reporting during the performance period. This proposal applies to MIPS quality measures. QCDR measures that consistently are identified as topped out according to this same timeline, would not be approved for use in year 4 during the QCDR self-nomination review process.

CMS proposes to phase in special scoring for measures identified as topped out in the published benchmarks for two consecutive performance periods, starting with the select set of highly topped out measures for the 2018 MIPS performance period.

For all other currently identified topped out measures, the timeline would apply starting with the benchmarks for the 2018 MIPS performance period. Thus, the first year any other topped out measure could be proposed for removal would be in rulemaking for the 2021 MIPS performance period, based on the benchmarks being topped out in the 2018, 2019, and 2020 MIPS performance periods.

If the measure benchmark is not topped out during one of the three MIPS performance periods, then the lifecycle would stop and start again at year 1 the next time the measure benchmark is topped out. In addition, if for some reason a measure benchmark is topped out for only one submission mechanism benchmark, then CMS would remove that measure from the submission mechanism, but not remove the measure from other submission mechanisms available for submitting that measure.

While the ACR acknowledges the importance of including measures only where there is an identified gap in care and opportunity for improvement, we encourage CMS to look at factors in addition to a high benchmark when considering removal of a measure. 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 measures in MIPS or in other quality programs. Additionally, CMS’ calculation for topped out status does not take into account the number of clinicians reporting a measure and the relativity of this, as well as how many could be reporting the measure. As such, habitually top performers may be self-selecting these measures, which might represent a small portion of all providers to whom the measure applies and this might not be an accurate assessment of topped out status.

We also suggest that CMS start the timeline for removal of topped out measures based on benchmarks derived from MIPS performance years rather than rely on data collected prior to MIPS because measure sets, reporting options, and overall incentives for participation were different in PQRS. For example, CMS has included Measure #359 (Optimizing Patient Exposure to Ionizing Radiation (OPEIR): Utilization of a Standardized Nomenclature for Computerized Tomography (CT) Imaging) in the set of highly topped out measures for the 2018 MIPS performance period. We recognize that the historical benchmark for this measure is 100 percent; however, this is based on measure participation in the 2015 PQRS reporting year. At that time, Measure #359 was
only reportable in the OPEIR measures group, for which reporters submitted 20 cases for the measure (and all other measures in the measures group). We do not have reporting data for the 2015 OPEIR measures, but for 2014 PQRS OPEIR participation, as included in the 2014 PQRS Trend Report Table A11, only 180 eligible professionals submitted the measures in that group, 0.7 percent of the EPs that were able to submit that data. The ACR does not think it is appropriate to begin the timeline for removal of this measure as topped out based on an historical benchmark from that level of 2015 PQRS participation data.

The percentage of eligible professionals submitting measure #359 is also valuable information in that it means a large number of clinicians for whom the measure could apply, did not submit, or potentially did not even perform this measure. Measures that could have significant impact on national quality initiatives, but are determined to be topped out by the proposed methodology, would then be removed from a national quality program even if only a small fraction of clinicians for whom the measures were designed, performed exceptionally well. The full potential of such measures in promoting quality may not be realized. Removal of measure # 359 is of particular concern as it promotes a fundamental step in creating a network of image sharing to reduce unnecessary or redundant exams or outcome comparison in that a universal nomenclature is an essential building block for such endeavors.

Identifying and Assigning Measure Achievement Points for Topped Out Measures

CMS requests comments on the proposal to score topped out measures differently by applying a 6-point cap, provided it is the second consecutive year the measure is identified as topped out. Specifically, CMS seeks feedback on whether 6 points is the appropriate cap or whether CMS should consider another value. CMS also seeks comment on other possible options for scoring topped out measures that would meet policy goals to encourage clinicians to begin to submit measures that are not topped out while also providing stability for MIPS eligible clinicians.

In the CY 2017 QPP final rule, CMS finalized that topped out measures would be scored in the same manner as other measures for the 2019 MIPS payment year for the first year that a measure has been identified as topped out, but that CMS would modify the benchmark methodology for topped out measures beginning with the 2020 MIPS payment year.

As part of the proposed measure lifecycle discussed above, CMS proposes a method to phase in special scoring for topped out measure benchmarks starting with the 2018 MIPS performance period, provided 2018 is the second consecutive year the measure benchmark is identified as topped out in the published benchmarks. These policies apply to scoring achievement and would not affect CMS’ policy for awarding measure bonus points for topped out measures. Given that numerous measure benchmarks are currently identified as topped out and special scoring for topped out measures could impact some
specialties more than others, CMS considered ways to phase in special scoring for topped out measures. To accomplish this, CMS proposes applying the special topped out scoring of a 6-point cap to the select set of highly topped out measures for the 2018 MIPS performance period and to apply that to all topped out measures starting with the 2019 performance period, provided it is the second (or more) consecutive year the measure is identified as topped out.

The ACR appreciates CMS’ intention to phase in over a three-year period determination as to whether a topped-out measure should be eventually removed from MIPS. However, we encourage CMS to more gradually phase in the reduction of potential points available for measures identified as topped out. We recommend either raising the initial cap to 8 points versus 6, or begin capping points the third year in which a measure is identified as topped out.

Multiple Submission Mechanisms

CMS proposes for the 2018 performance period and future years, to allow individual MIPS eligible clinicians and groups to submit data on measures and activities, as applicable, via multiple data submission mechanisms for a single performance category as necessary to meet the requirements of the quality, improvement activities or ACI performance categories. The only exception is if using CMS Web Interface. This is a change from the QPP 2017 final rule where MIPS eligible clinicians were required to use only one submission mechanism per performance category. Additionally, requirements for the performance categories remain the same, regardless of the number of submission mechanisms used. CMS clarifies that if an individual MIPS eligible clinician or group submits the same measure through two different mechanisms, each submission would be calculated and scored separately since CMS does not have the ability to aggregate data on the same measure across submission mechanisms. CMS would only count the submission that gives the clinician the higher score, thereby avoiding the double count.

For 2018, there are no changes to the types of submission mechanism available for each performance category; claims, qualified registry and qualified clinical data registry mechanisms are still available. For virtual groups, CMS proposes they would also be able to use a different submission mechanism for each performance category, and would be able to utilize multiple submission mechanisms for the quality performance category, beginning with performance periods occurring in 2018. However, virtual groups would be required to utilize the same submission mechanism for the improvement activities and the advancing care information performance categories.

The ACR supports CMS’ recommendation to allow multiple reporting mechanisms to satisfy MIPS requirements. This option is particularly helpful for clinicians and groups deciding to report via claims and a qualified clinical data registry to receive the maximum number of points under a performance category. Many of our members are
seeking out registry participation as opposed to traditional claims. This proposal would reduce the administrative burden on clinicians and groups from submitting the same quality measures and hoping for a favorable outcome after the reporting period has ended. Clinicians and groups will have the ability to select the measures most meaningful to them, regardless of the submission mechanism. **While the ACR heartily supports this proposal, we are concerned about how CMS will employ the eligible measure applicability process when an individual or group submits measures using multiple mechanisms.** Would a clinician or group be expected to look across ALL reporting mechanisms to find six measures, if six relevant measures are not available within one mechanism? For example, would a clinician reporting four measures via claims be expected to also invest in a registry if one of those reporting mechanisms offers two additional measures relevant to the clinician? Similarly, would an individual be expected to invest in two different registries simply to satisfy the six measure requirement? This would pose an unrealistic burden. Thus we strongly recommend that CMS not look across reporting mechanisms for purposes of accountability when applying measure validation because of additional program complexity and the unrealistic burden it would pose on clinicians.

**In addition, the ACR would like CMS to confirm that a MIPS eligible clinician would be allowed to submit data using multiple qualified clinical data registries under the same NPI/TIN or TIN.** Allowance of reporting via multiple QCDRs in single TIN could serve as a pathway forward for greater specialist participation within multispecialty groups.

**MIPS: Advancing Care Information (ACI) Performance Category**

**Hospital-Based MIPS Eligible Clinicians**

CMS proposes to add services furnished in the off-campus-outpatient hospital setting (POS 19) to the “hospital-based” determination beginning in 2018. **The ACR strongly supports the expansion of the hospital-based definition to include POS 19.** We believe this proposal would appropriately increase the number of radiologists in hospital facilities who will receive a hospital-based determination in the future.

Moreover, **the ACR recommends that CMS implement a more flexible hospital-based determination for groups/TINs that aligns with the group-level “non-patient-facing” determination.** Specifically, TINs with greater than 75 percent of MIPS eligible clinicians determined “hospital-based” should obtain the “hospital-based” special status as a group. We believe this reduction from 100 percent to 75 percent would help address scenarios where radiology practices based in hospital facilities could have one or more clinicians who are not determined hospital-based by CMS for a given MIPS performance year.
Reweighting ACI – New Significant Hardship Exceptions

CMS proposes to implement new reweighting/hardship exception options for the advancing care information performance category for small practices and users of electronic health record (EHR) technology products that have been decertified by the HHS Office of the National Coordinator for Health IT (ONC), among others. The ACR supports these, and the other new and existing options for reweighting ACI in performance year 2018, and we recommend that CMS make all new options retroactively available to MIPS eligible clinicians for the 2017 performance period as well. We especially agree that small radiology practices are significantly disadvantaged when it comes to adoption and implementation of certified EHR technology, and that these practices may not have the support, infrastructure, or resources to successfully participate in ACI.

Reweighting ACI – “Extreme and Uncontrollable Circumstances” Significant Hardship Exception

The ACR urges CMS to universally accept hardship applications from MIPS eligible clinicians under the “extreme and uncontrollable circumstances” category if they were determined “non-patient facing” or “hospital-based” in one performance year and then “patient-facing” or “not hospital-based” in the next performance year. This leniency would help address scenarios in which practices or individuals might be surprised by not receiving the special status determinations they received in the prior MIPS performance year due to a minor change in the nature of covered professional services performed. It would allow these groups or clinicians a more reasonable window of time to prepare for future ACI participation, which requires a substantial lead time due to the need for CEHRT adoption and implementation.

Redistribution of Reweighted ACI Points to Quality and Improvement Activities Performance Categories

CMS is collecting comments on a potential alternative option for reallocating ACI’s weight to other MIPS categories whereby 15 percent would go to quality and 10 percent would go to improvement activities (as opposed to all 25 percent reallocated to quality). The ACR supports the availability of this alternative methodology for MIPS eligible clinicians who reweight ACI. We believe the alternative proposal would appropriately share ACI’s weight across multiple categories, thereby reducing overemphasis on any single MIPS category.

Aggregation of Group Data for ACI Reporting

CMS clarified that MIPS eligible clinicians who may qualify for zero percent weighting of ACI should nonetheless be aggregated in the group’s data for group reporting of ACI. Instead of mandating this, the ACR recommends that groups/virtual groups have the option to include or to not include ACI participation data from non-patient facing and
hospital-based MIPS eligible clinicians in their aggregated ACI data. Many radiology groups are comprised of physicians with disparate subspecialty interests serving in a variety of practice locations and healthcare settings. Current ACI measures are not generally appropriate and relevant for radiologists who would otherwise be reweighted for ACI. Groups/virtual groups should not be forced to lessen their overall performance on percentage-based ACI measures because they were obligated to include their non-patient facing and hospital-based MIPS eligible clinicians’ data with the rest of the group/virtual group.

We also note that CMS’ clarification for ACI group data aggregation is in direct conflict with the proposed scoring standard for APMs, in which TINs with a mix of eligible clinician types would not be required to report ACI data from zero percent weight-qualifying MIPS eligible clinicians. For consistency, we recommend that the flexibility in the APM scoring standard be applied to standard group reporting of ACI (as described in the previous paragraph) so that groups could decide not to incorporate ACI participation data from non-patient facing and hospital-based MIPS eligible clinicians.

MIPS: Cost Performance Category

In the CY 2017 QPP final rule, CMS finalized a policy to weight the cost performance category at zero percent in the final score for the transition year and a weight of 10 percent for the 2020 MIPS payment year. For the 2021 MIPS payment year and beyond, the cost performance category will have a weight of 30 percent of the final score as required by statute.

CMS notes that clinicians expressed desire to down-weight the cost performance category for an additional year, therefore, CMS proposes to continue to weigh the cost performance category at zero percent of the final score for the 2020 MIPS payment year. CMS seeks comments on this proposal and the alternative option of 10 percent weighting for the cost performance category for the 2020 MIPS payment year.

In addition, CMS is proposing to adopt the total per capita costs for all attributed beneficiaries measure and the Medicare Spending per Beneficiary (MSPB) measure that were implemented for the 2017 MIPS performance period. CMS is also proposing not to use the 10 episode-based measures that were adopted for the 2017 MIPS performance period. Rather, CMS is in the process of developing new episode-based measures with significant clinician input and believes it would be more prudent to introduce these new cost measures over time. The ACR supports this proposal; however, we suggest that CMS apply a standard scaling for groups, to be consistent across all of the performance categories. For example, we believe the MSPB measure should not apply to groups as long as 75 percent or more of each NPI in a group (TIN) has less than the 35 attributed beneficiaries. This should also apply to virtual groups, which will make the virtual group concept more attractive.
The ACR appreciates CMS’ acknowledgment that clinicians do not fully understand cost measures and their role in reducing costs and the need for additional time to prepare for the implementation of the cost performance category. Moreover, clinicians need to understand the attribution and the scoring methodology and gain more familiarity with the measures through performance feedback so that they may be able to make the adjustments necessary to improve their performance. We also appreciate CMS working with clinicians and stakeholders with developing episode-based measures that will be used in the cost performance category.

We request CMS delay the implementation of reporting of patient-relationship codes on Medicare Claims for 2018 as many of our members are not educated on the statutory requirements of such codes, and will not have a chance to familiarize themselves on the appropriate utilization of such codes given that these codes have not been finalized yet.

We are in support of CMS’s proposal to continue weighting the cost performance category to zero percent for the 2020 MIPS payment year. We believe a slow ramp up of the cost performance category is sensible given the patient relationship codes have not been finalized and the complexity of the work involved with developing episode-based cost measures, which we have been active participants with the Acumen Episode-Based Cost Measures Clinical Committees and Subcommittees this past year. It will be a challenge to meet the statutory timeline given that CMS will not start collecting limited data until 2018, this will not allow enough time to inform cost measurement in performance year 2019.

Alternative Measures

The ACR made comments to CMS during the initial QPP 2017 rulemaking cycle regarding the use of alternative measures in the cost category. We would like to reiterate these comments this year because this category is important to radiology so we encourage use of actionable, meaningful measures for radiologists. We believe there are relevant, valid, alternative cost metrics for radiology. The ACR continues to encourage CMS to allow clinicians to receive credit in the cost category for quality measures considered appropriate use or efficiency.

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

- Appropriate imaging recommendations for “incidentalomas” (over-diagnosis) (too many, too often) such as MIPS Measures #405 and 406. The ACR continues to develop measures in this area.
- Use of prior images to avoid duplicative exams, such as MIPS 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 program.

The ACR appreciates that CMS is working with non-patient facing clinicians and specialty societies to propose alternative cost measures for non-patient facing MIPS eligible clinicians and groups under MIPS in future years. We request that CMS prioritize the development of alternative cost measures for non-patient facing clinicians. ACR leaders are actively engaged with the Acumen Episode-Based Cost Measures Clinical Committees and Subcommittees and welcome the opportunity to continue working collaboratively with CMS to develop cost measures that are applicable to non-patient facing clinicians.

MIPS: Improvement Activity (IA) Performance Category

Submission Criteria

CMS previously clarified that if one MIPS eligible clinician (NPI) in a group completed an improvement activity, the entire group (TIN) would receive credit for that activity. In addition, CMS specified that all MIPS eligible clinicians reporting as a group would receive the same score for the improvement activities performance category if at least one clinician within the group is performing the activity for a continuous 90 days in the performance period. CMS proposes to generally apply its previously finalized and proposed group policies to virtual groups. Also, CMS requests comment on whether in the future it should establish a minimum threshold (for example, 50 percent) of the clinicians (NPIs) that must complete an improvement activity in order for the entire group (TIN) to receive credit in the improvement activities performance category. In addition, CMS requests comments on recommended minimum threshold percentages and whether it should establish different thresholds based on the size of the group. CMS requests comments on how to set this threshold while maintaining the goal of promoting greater participation in an improvement activity.

The ACR believes CMS should not alter its current policy in allowing only one MIPS eligible clinician in a group to complete an improvement activity, and applying that credit to the entire group. Many of the improvement activities are representative of group-level involvement whether one or all the members are directly participating (such as many of the QCDR related activities). Perhaps CMS could define which activities could be eligible for group credit, but performed at the MIPS eligible clinician individual level, as opposed to creating threshold criteria for group credit in improvement activities.
Required Time Period for Performing an Activity

CMS does not propose any changes to the required period of time for performing an activity for the improvement activities performance category in this proposed rule.

*The ACR supports CMS’ decision to maintain the performance period requirement as it is currently.*

Application to Non patient-facing MIPS Eligible Clinicians

CMS does not propose any changes to the application of improvement activities to non-patient facing individual MIPS eligible clinicians and groups for the improvement activities performance category in this proposed rule.

*The ACR supports CMS decision to maintain the current application of IA requirements to non-patient facing eligible clinicians.*

Newly Proposed Improvement Activities

CMS has proposed several new improvement activities including the following in the Patient Safety and Practice Assessment sub-category:

IA: Consulting AUC using clinical decision support when ordering advanced diagnostic imaging

Description: A MIPS eligible clinician would attest that they are consulting specified applicable appropriate use criteria (AUC) through a qualified clinical decision support mechanism for all advanced diagnostic imaging services ordered. This activity is for clinicians that are early adopters of the Medicare AUC program (e.g., 2018 performance year) and for clinicians that begin the program in future years as will be required by CFR §414.94 (authorized by the Protecting Access to Medicare Act of 2014). Qualified Mechanisms will be able to provide a report to the ordering clinician that can be used to assess patterns of image-ordering and improve upon those patterns to ensure that patients are receiving the most appropriate imaging for their individual condition.

This activity has a high weighting and is eligible for the advancing care information bonus.

*The ACR appreciates the inclusion of this activity as we strongly support the AUC provisions of the Protecting Access to Medicare Act (PAMA) and encourage the implementation of these. We also strongly encourage CMS to reword this improvement activity so that radiologists can obtain credit for supporting their referring clinicians in the implementation of AUC through qualified clinical decision support mechanisms such as the following:*
• A MIPS eligible clinician would attest that they are consulting specified or providing radiological consultative services in association with appropriate use criteria for advanced diagnostic imaging.

This additional language and qualification is consistent with what CMS allows for RSCAN participants under the transforming clinical practice initiative (TCPI).

AUC Clinical Decision Support Mechanisms (CDSMs) Integration With Certified Health IT Products

Referring clinicians should have ready access to qCDSMs seamlessly incorporated into their clinical workflows via their preferred EHR solutions. The ACR recommends that CMS communicate the need for the Office of the National Coordinator for Health IT (ONC) to initiate a rulemaking to revise the 2015 Edition EHR health IT certification criteria regulations in such a way that integration with, or linking to, one or more AUC qCDSMs is required functionality for health IT solutions seeking certification for either the CDS criterion (45 CFR 170.315(a)(9)) or the CPOE of diagnostic imaging criterion (45 CFR 170.315(a)(3)). Health IT solutions already tested and certified for the specific 2015 Edition certification criteria in question should also be required to demonstrate satisfaction of the modified requirements to maintain certification.

Proposed Changes to Existing Improvement Activities

CMS has proposed modifying the weight of IA_CC_4 TCPI Participation from high to medium. In describing rationale for the change, CMS states that MIPS eligible clinicians who participate in the CMS’ TCPI, which is an APM (as defined in section 1833(z)(3)(C) of the Act), will automatically earn a minimum score of one-half of the highest potential score for this performance category, as required by section 1848(q)(5)(C)(ii) of the Act. In addition, CMS anticipates that most MIPS eligible clinicians that are fully active TCPI participants will participate in additional practice improvement activities and will be able to select additional improvement activities to achieve the improvement activities highest score.

The ACR believes this is incorrectly stated. The TCPI program is not an APM. It is funded under CMMI, but it is a care model not an alternative payment model. Clinicians who are in an APM are not eligible to participate in TCPI Practice Transformation Networks (PTNs). One main intention and goal of the Transforming Clinical Practice Initiative is to transform practices to an alternative payment model. CMS states earlier in the body of the rule (pg. 398) “activities that require performance of multiple actions, such as participation in the Transforming Clinical Practice Initiative (TCPI), participation in a MIPS eligible clinician’s state Medicaid program, or an activity identified as a public health priority (such as emphasis on anticoagulation management or utilization of prescription drug monitoring programs) are justifiably weighted as high (81 FR 77311 through 77312).”
The ACR strongly recommends that CMS review its stated rationale for reweighting this improvement activity and keep it at a high weight.

Scoring Methodology

Performance Threshold

CMS invites public comments on the proposal to set the performance threshold at 15 points, and seeks comment on setting the performance threshold at the alternative of 6 points or at 33 points for the 2020 MIPS payment year. CMS also seeks public comments on principles and considerations for setting the performance threshold beginning with the 2021 MIPS payment year, which will be the mean or median of the final scores for all MIPS eligible clinicians from a prior period.

As required by statute, CMS must compute a performance threshold with which to compare MIPS eligible clinicians’ scores for purposes of determining the MIPS payment adjustment factors, using either the mean or median of the final scores for all MIPS eligible clinicians for a prior period. However, CMS has flexibility to set the performance threshold for the first two years of MIPS. Using this flexibility, CMS finalized a performance threshold of 3 points for the transition year. In the 2017 QPP rule, CMS stated its intent to increase the performance threshold in the 2020 MIPS payment year (based on 2018 performance period), and that, beginning in the 2021 MIPS payment year, CMS would use the mean or median final score from a prior period as required by law.

CMS states that for payment year 2021, CMS is required by statute to use a performance threshold based on mean or median scores for all MIPS eligible clinicians for a prior period. CMS is concerned that keeping the performance threshold score too low in payment year 2020 will not sufficiently incentivize MIPS eligible clinicians to participate meaningfully in 2018 and prepare adequately for the following year. Thus, CMS sees the need to adjust the threshold for 2020 payment year from the low level, transition year threshold of 3 points for the 2019 MIPS payment year so that the shift to the mean/median-based threshold in the 2021 payment year will not be such a drastic change.

With an aim to strike a balance, CMS proposes for the 2020 MIPS payment year to set the performance threshold at 15 points. CMS states that by the 2021 MIPS payment year a MIPS eligible clinician would likely need to submit “most of the required information and perform well on measures and activities to receive a positive payment adjustment.” Setting a threshold lower than 15 points for the 2020 payment year may significantly increase the threshold eligible clinicians would need to meet in the 2021 payment year and could provide a smaller total amount of negative payment adjustments resulting in smaller positive adjustments because of budget neutrality. A threshold higher than 15 may be too challenging particularly for small practices but would allow for higher positive payment adjustments.
Thus, CMS considered an alternative of setting a performance threshold of 6 points that an eligible clinician could meet by submitting two quality measures with required data completeness or one high-weighted improvement activity. CMS also considered an alternative of setting the performance threshold at 33 points, which would require full participation both in improvement activities and in the quality performance category (either for a small group or for a large group that meets data completeness standards) to meet the performance threshold. As we referenced above in the Performance Period section, the ACR recommends that CMS implement the 6 point performance threshold for MIPS performance year 2018 to help ease the transition between the 2017 MIPS “Pick Your Pace” performance year and the 2018 QPP year 2 performance year.

Additional Performance Threshold for Exceptional Performance

CMS seeks comments on its proposal to keep the additional performance threshold for exceptional performance at the 2019 payment threshold of 70 points. CMS also would like feedback on whether it should raise this threshold for the 2020 payment year.

By statute, CMS must compute, for each year of MIPS, an additional performance threshold for purposes of determining the additional MIPS payment adjustment factors for exceptional performance. In determining the additional performance threshold, CMS must apply either of the following methods: (1) the threshold shall be the score that is equal to the 25th percentile of the range of possible final scores above the performance threshold; or (2) the threshold shall be the score that is equal to the 25th percentile of the actual final scores for MIPS eligible clinicians with final scores at or above the performance threshold for a prior period.

As allowed by a special rule for the first two years of MIPS, for the transition year, CMS established the additional performance threshold at 70 points, decoupling it from the performance threshold as a basis. Because CMS does not have MIPS final scores for a prior performance period yet, CMS would have to set the additional performance threshold at the 25th percentile of possible final scores above the performance threshold if not decoupling the additional performance threshold from the performance threshold. With a performance threshold set at 15 points, the range of total possible points above the performance threshold is 16 to 100 points. The 25th percentile of that range is 36.25 points, which is barely more than one third of the possible 100 points in the MIPS final score. CMS does not believe that a score of 36.25 points indicates exceptional performance.

CMS conducted analysis of data available and modeled to estimate final scores for the 2020 MIPS payment year. Based on this, CMS believes that the additional performance threshold at 70 points maintains the incentive for excellent performance while keeping the focus on quality performance and states that raising it above 70 points would in many instances require the use of an EHR for those to whom the ACI performance category
requirements would apply. The ACR agrees that CMS should maintain the decoupled 70-point additional performance threshold for exceptional performance in the 2020 MIPS payment year.

CMS also seeks public comment on which method CMS should use to compute the additional performance threshold beginning with the 2021 MIPS payment year: (1) the threshold as the score that is equal to the 25th percentile of the range of possible final scores above the performance threshold; or (2) the threshold shall be the score that is equal to the 25th percentile of the actual final scores for MIPS eligible clinicians with final scores at or above the performance threshold for a prior period. Should CMS use the lower of the two options, which would result in more MIPS eligible clinicians receiving an additional MIPS payment adjustment for exceptional performance? Alternatively, should CMS use the higher of the options, which would restrict the additional MIPS payment adjustment for exceptional performance to those with the higher final scores? Since a fixed amount is available for a year to fund the additional MIPS payment adjustments, the more clinicians that receive an additional MIPS payment adjustment, the lower the average clinician’s additional MIPS payment adjustment will be.

The ACR recommends that CMS use the lower of the two options so that a higher number of eligible clinicians may receive it, since it is likely that in the first year of using final scores there will be fewer eligible clinicians earning it.

Baseline Period/Benchmarks

CMS is not proposing any changes to benchmarking policies as finalized for CY 2017 but is clarifying that performance period benchmarks are created in the same manner as historical benchmarks. That is, using decile categories based on a percentile distribution, each benchmark must have a minimum of 20 individual clinicians or groups who reported on the measure meeting the data completeness requirement and case minimum case size criteria and performance greater than zero.

The ACR appreciates this clarification on use of “same year” performance period benchmarks for scoring when a historical benchmark is not available.

Scoring Quality Performance Category – Achievement

Case Minimum Requirements and Measure Reliability and Validity

CMS does not propose any changes to its case minimum policies that require at least 20 cases for all quality measures except the all-cause hospital readmission measure, which requires at least 200 cases and only applies to groups of 16 or more clinicians that meet the case minimum requirement.

For the 2019 MIPS payment year, CMS finalized two classes of measures:
• Class 1 measures that can be scored based on performance because they have a benchmark, meet the case minimum requirement, and meet the data completeness standard. These measures can receive scores of 3 to 10 based on performance compared to the benchmark.  
• Class 2 measures that cannot be scored based on performance because they do not have a benchmark, do not have at least 20 cases, or have not met data completeness criteria. These measures receive 3 points for the 2019 MIPS payment year.

CMS proposes to revise Class 2 measures to include only measures that cannot be scored based on performance because they do not have a benchmark or do not have at least 20 cases. Revised Class 2 measure would continue to receive 3 points. CMS also proposes to create Class 3 measures, which are measures that do not meet the data completeness requirement, in order to encourage complete reporting and to recognize that data completion is within the direct control of the MIPS eligible clinician. Proposed Class 3 measures would receive 1 point; however, if the measure is submitted by a small practice with 15 or fewer clinicians, the Class 3 measure would receive 3 points given concerns that data completeness may be harder to achieve for small practices with smaller case sizes.

The ACR agrees with the proposed revised definition of Class 2 measures as those that have met data completeness requirements but do not have a benchmark or do not have at least 20 cases reported, and agree that these measures should receive 3 points. However, we believe that measures in their first three years of inclusion in the MIPS should be an exception to this definition.

While the use of performance period benchmarks to some extent supports uptake of new measures into the MIPS quality performance category, it is not preferable to do so. If there is no historical or performance year benchmark then measures cannot be scored, thus resulting in an award of only 3 points for a new measure. Thus, MIPS eligible clinicians are hesitant to use new measures. The performance period benchmark is by no means a complete solution for this issue, since an eligible clinician would not know what results to expect in terms of scoring from submission of a new measure. We strongly recommend that CMS score new Class 2 measures without historical benchmarks at 5 points to encourage MIPS eligible clinicians to report such measures in order to build reliable historical benchmarks.

The ACR believes that the development of Class 3 measures seems reasonable. This is consistent with what practices have experienced when participating in PQRS. The ACR supports this proposal and recommends using a full performance year of participation. 

Scoring Improvement for the MIPS Quality Performance Category Percent Score

CMS proposes to define an improvement percent score to mean the score that represents improvement for the purposes of calculating the quality performance category percent.
score. CMS also proposes that an improvement percent score would be assessed at the quality performance category level (versus individual measure level). CMS proposes to add the improvement percent score to an existing achievement percent score. Consistent with bonuses available in the quality performance category, CMS proposes that the improvement percent score may not total more than 10 percentage points. **CMS invites public comments on these proposals.**

To qualify for an improvement percent score, CMS proposes the following requirements.

- **Data sufficiency.** CMS would measure improvement when there is a comparable quality performance category achievement percent score for the MIPS performance period immediately prior to the current MIPS performance period. **CMS also solicits comment on whether to require some level of year-to-year consistency when scoring improvement.**

- CMS proposes to compare results from an identifier when CMS receives submissions with that same identifier either TIN/NPI for individual, or TIN for group, APM entity, or virtual group identifier for two consecutive performance periods. CMS proposes that “comparability” of quality performance category achievement percent scores would be established by looking first at the submitter of the data, as detailed below.

  - Where CMS does not have the same identifier for two consecutive performance periods, CMS proposes to identify a comparable score for individual submissions or calculate a comparable score for group, virtual group, and APM entity submissions.
  - For individual submissions, if CMS does not have a quality performance category achievement score for the same individual identifier in the immediately prior period, then CMS proposes to apply the hierarchy logic (described under “Final Score Used in Payment Adjustment Calculation”) to identify the quality performance category achievement score associated with the final score that would be applied to the TIN/NPI for payment purposes.
  - For group submissions, when CMS does not have a comparable TIN group, virtual group, or APM Entity score, CMS proposes to calculate a score by taking the average of the individual quality performance category achievement scores for the MIPS eligible clinicians that were in the group for the current performance period.

**CMS also seeks comment on an alternative to this proposal, CMS would like to know if it should restrict improvement to those who submit quality performance data using the same identifier for two consecutive MIPS performance periods.** CMS believes this option would be simpler to apply, communicate and understand than what is proposed, however this alternative could have the unintended consequences of not
allowing improvement scoring for certain MIPS eligible clinicians, groups, virtual groups and APM entities.

**CMS is also proposing that MIPS eligible clinicians must fully participate in the current performance year to receive an improvement score**

To calculate improvement percent score, CMS proposes the following:

- **Prior year floor.** Given the 3-point floor for any scored measure that would have led to an achievement score of at least 30 percent for individuals who fully participated in the transition year, CMS proposes that if a MIPS eligible clinician has a previous year quality performance category score less than or equal to 30 percent, CMS would compare 2018 performance to an assumed 2017 quality performance category achievement percent score of 30 percent.

- **Focus on achievement performance.** CMS proposes to focus on improvement based on achievement performance and would not consider measure bonus points in the improvement algorithm. Therefore, to measure improvement at the quality performance category level, CMS will use the quality performance category achievement percent score excluding measure bonus points and excluding any improvement score for the applicable years.

- **Calculation of “Improvement Percent Score.”** To calculate an improvement percent score, CMS will compare the current MIPS performance period quality performance category achievement percent score to the previous score. If the current score is higher, the MIPS eligible clinician may qualify for an improvement percent score to be added into the quality performance category percent score for the current performance year.

CMS provides the formula as follows: Improvement percent score = (increase in quality performance category achievement percent score from prior performance period to current performance period / prior year quality performance category achievement percent score)*10%. CMS explains that this would mean a 20 percent rate of improvement for achievement (for example) would be worth a 2-percentage point increase to the quality performance category achievement percent score.

CMS also proposes that the improvement percent score cannot be negative (that is, lower than zero percentage points).

*The ACR supports scoring improvement for the quality performance category as proposed in the above section including limiting scoring improvement for individuals, groups, or virtual groups who use the same consecutive identifiers. We would also like to propose CMS restrict scoring improvement to those who use the same mechanism or mechanisms of reporting (QCDR, EHR, QR, Claims, etc.) from year-to-year to not*
allow an individual, group or virtual group to take advantage of differences in reporting mechanism measure benchmarks as their sole means of improvement

Alternatives for measuring improvement

CMS considered an alternative to measuring the rate of improvement, which would use band levels to determine the improvement points. Under this alternative, a MIPS eligible clinician’s improvement points would be determined by an improvement in the quality performance category achievement percent score from one year to the next year to determine improvement in the same manner as set forth in the rate of improvement methodology.

CMS considered another alternative that would adopt the improvement scoring methodology of the Shared Savings Program for CMS Web Interface submissions in the quality performance category. Under the Shared Savings Program approach, eligible clinicians and groups that submit through the CMS Web Interface would have been required to submit on the same set of quality measures, and CMS would have awarded improvement for all eligible clinicians or groups who submitted complete data in the prior year. As Shared Savings Program and Next Generation ACOs report using the CMS Web Interface, using the same improvement score approach would align MIPS with these other programs.

CMS invites public comments on the proposal to calculate improvement scoring using a methodology that awards improvement points based on the rate of improvement and, alternatively, on rewarding improvement at the band level or using the Shared Saving Program approach for CMS Web Interface submissions.

The ACR is not in favor of scoring improvement in quality using band-level or Medicare shared savings methodology given their inherent complexities, and prefers the simpler approach of scoring improvement as originally proposed.

Scoring Cost Performance Category

CMS proposes to add improvement scoring to the cost performance category scoring methodology starting with the 2020 MIPS payment year, where improvement would be assessed at the measure level. CMS does not propose any changes to the methodology for scoring achievement in the cost performance category for the 2020 MIPS payment year other than as described under “Facility-Based Measures Scoring Option for the 2020 MIPS Payment Year.” CMS also proposes a change in terminology to refer to the “cost performance category percent score” in order to be consistent with the terminology used in the quality performance category.
Measuring Improvement for the Cost Performance Category

For the cost performance category, CMS proposes that improvement scoring is available to MIPS eligible clinicians and groups that demonstrate improvement in performance in the current MIPS performance period compared to their performance in the immediate preceding MIPS performance period, and that improvement will be measured at the measure level. CMS believes that it would have data sufficient to measure improvement when it can measure performance in the current performance period compared to the prior performance period.

**CMS proposes a different data sufficiency standard for the cost performance category than for the quality performance category.** First, for data sufficiency to measure improvement to be available for the cost performance category, the same cost measure(s) would need to be specified for the cost performance category for 2 consecutive performance periods. Additionally, for a measure to be scored in either performance period, a MIPS eligible clinician would need to have a sufficient number of attributed cases to meet or exceed the case minimum for the measure. Moreover, a clinician would have to report for MIPS using the same identifier (TIN/NPI combination for individuals, TIN for groups, or virtual group identifiers for virtual groups) and be scored on the same measure(s) for 2 consecutive performance periods. If the cost improvement score cannot be calculated because sufficient data is not available, CMS proposes to assign a cost improvement score of zero percentage points. For MIPS payment year 2020, the total available cost improvement score would be limited to the 2 cost measures that would be available in both the first and second performance periods of the program (total per capita cost and Medicare Spending Per Beneficiary). MIPS eligible clinicians would be able to review their performance feedback and make improvements compared to the score in their previous feedback. **CMS invites public comments on these proposals.**

Since MIPS is still in its beginning years, and because CMS has proposed the cost performance category to be weighted at zero percent, CMS believes that clinicians should focus on achievement as opposed to improvement. **Therefore, CMS proposes that although improvement would be measured according to the method described above, the maximum cost improvement score for the 2020 MIPS payment year would be zero percentage points;** thus, the cost improvement score would not contribute to the cost performance category percent score calculated for the 2020 MIPS payment year. CMS proposes that if CMS maintains a weight of 10 percent for the cost performance category for the 2020 MIPS payment year, the maximum cost improvement score available in the cost performance category would be 1 percentage point out of 100 percentage points available for the cost performance category percent score. **CMS invites comments on these proposals as well as alternative ways to measure changes in statistical significance for the cost measure.**

*The ACR supports scoring of the cost performance category and scoring of*
improvement in the cost performance category as proposed.

**MIPS: Third Party Data Submission**

**QCDR Self-Nomination Process**

In the 2017 QPP final rule, CMS finalized the self-nomination period for the 2018 performance period and for future years of the program to be from September 1 of the year prior to the applicable performance period until November 1 of the same year (i.e., September 1, 2017 through November 1, 2017 for the 2018 performance period).

In the CY 2018 proposed rule, CMS proposed several changes to the QCDR self-nomination process, such as changing the terminology for specialty society measures developed for the QCDR from “non-MIPS” to “QCDR” measures. *The ACR agrees and supports using the term “QCDR” measures; the non-MIPS terminology is confusing to members looking to maximize participation in QPP.*

CMS has also proposed a multi-year approval for QCDR’s in good standing to be approved for a 2-year increment. *The ACR supports the alternative policy.* We have been a QCDR since its inception and have remained in good standing, but the self-nomination process did not reflect this when seeking approval status for the upcoming performance year. Many of the requirements for the 2017 self-nomination process were burdensome and required several months of preparation even though we were not applying as a new QCDR vendor. *The ACR supports a multi-year approval allowing for a more streamlined approach for QCDR vendors that have minimal measure changes. In addition, we recommend that CMS include in this multi-year approval process the ability to identify measures to be dropped from a QCDR with a year advance notice, unless the measure has proven to have unintended consequences. When notification of QCDR approval, along with the associated measures, is not received until mid-year of the performance period, it handicaps physicians and groups who previously used the dropped measures or who planned to use the measure at the beginning of the performance year; advance notice of a year would alleviate this issue.*

Earlier this year, the ACR provided specific feedback to the CMS contractor handling the self-nomination applications. We would like to offer our feedback again here.

*The ACR appreciates the opportunity to provide feedback on the QCDR self-nomination process. We have been a QCDR since 2014 and over the years we continue to see improved efficiencies and enhance communication between CMS and vendors on development, adoption and implementation of these registries and the quality data captured. With any quality program, there are always opportunities for improvement. We have identified a few suggestions below for CMS’ consideration as CMS plans to launch the 2018 self-nomination process:*
**JIRA Functionality**
- Process for selecting existing QPP measures is easy and straightforward
- Enhance submission process for entering non-MIPS measures
- Allow JIRA form to pre-populate measure details for existing non-MIPS measures; pre-populated fields should be customizable
- Online JIRA questions should mimic required information from QCDR self-nomination factsheet i.e., data capture methods, method for calculating performance rates across all MIPS categories Quality, IA and ACI
- Add questions to online form to capture measure details for calculating performance rates i.e., inverse, proportional vs. continuous, exceptions/exclusions etc.
- Allow a comment feature for attached documents to ensure contractor feedback is captured
- There was an issue with numbering quality measures; allow vendor to apply measure quality IDs using JIRA
- Overall JIRA ticketing system is easy to navigate and results can be exported to a PDF file

**CMS Education and Resources**
- Modify JIRA user guide to include detailed instructions on entering existing non-MIPS measures as new measures if this approach is preferred
- Publish full timeline of QCDR activities in the factsheet; the preferred format is a toolkit vs. a condensed factsheet
- If possible, release list of approved QCDRs and QRs at the same time as the requirements overlap between these distinct registry types
- Publish a QCDR Participation Made Simple for MIPS
- Process to review qualified posting needs to be improved if content cannot be changed after posting to QPP; CMS allows 2 versions of these postings which led to some confusion
- Continue offering vendor support calls and allow for vendors to present implementation strategies
- Provide JIRA tutorial on vendor support calls and have this as a standing action item during the self-nomination period

**Overall**
- QCDR training guide or toolkit is needed for new vendors similar to 2015 and 2016 reporting years
- Contractor should provide all comments and request for information via JIRA instead of email to simplify tracking
- All contacts indicated on the self-nomination application should be contacted when there is a question on measures or the self-nomination application i.e., clinical, program, technical and submitter contacts have unique perspectives and can add to the discussion
- More transparency from contractor during the clinical review period. Measure status (approved, provisionally approved and/or rejected) must be communicated more frequently
- Allow more time for vendors to respond to measure edits that require substantial changes
- Supporting documentation attached to JIRA for non-MIPS measures must be viewed by contractor or clinical team and allow for comments to be captured

Lastly, we would like to provide feedback on activity that occurred prior to the self-nomination process. In fall of 2016, CMS launched a project to streamline the non-PQRS measures in preparation for MIPS program. Many of the vendors including ACR were asked to consolidate measures into a single quality action. While, we support the request to allow for performance measurement across a broader cross-section of clinicians for MIPS we disagree on the time allotted to make these changes. Vendors were given less than a month to comply or the measure would be removed from the QCDR supported measures list for the following reporting year. CMS developed the QCDR to allow specialty societies to create measures that are more applicable and appropriate. Measure development is not an easy process; in most cases clinical input or coordination across multiple organizations are required. In the future, we request more time to respond to requests that require substantial changes to measure specifications. It would be beneficial to all stakeholders if measure consolidation requests and inclusion criteria are more transparent. We appreciate the opportunity to provide feedback on all aspects of the self-nomination process as we seek to support our registry participants and providers through this reporting mechanism.

Advanced Alternative Payment Models

APM Criteria: Financial Risk

Nominal Amount of Risk

For the 2019 and 2020 Medicare QP performance periods, CMS proposes to continue with the Advanced APM generally applicable revenue-based standard at 8 percent of the average estimated total Medicare Parts A and B revenues of all providers and suppliers in participating APM entities. CMS believes maintaining the 8 percent standard through 2020 will provide stability for clinicians and APM entities. CMS will address the standard for 2021 and thereafter through future rulemaking.

The ACR supports CMS’ proposal to keep the revenue-based nominal amount standard at 8 percent for 2019 and 2020. It is too early in the program to know if physicians could meet a higher threshold of risk. The ACR supports setting a lower standard for small and/or rural practices for 2019 and 2020 that are APM participants or who join larger APM Entities to participate. It is much more difficult for small and rural practices to take on the same amount of financial risk since they have less resources than larger
practices to outweigh any potential losses. The ACR supports the same revenue-based nominal amount standard for the All-Payer Combination Option. Consistency among all-payer agreements would ease regulatory burden.

All-Payer Combination Option

QP Determinations at the Individual Eligible Clinician Level

For payment years 2019 and 2020, an eligible clinician may become a QP only through participation in Advanced APMs (Medicare Option). For payment year 2021 and beyond, QP status may also be reached based upon combined Advanced APM and Other Payer Advanced APM participation (All-Payer Combination Option). For each clinician, CMS will assess QP status first under the Medicare Option (by both payment and patient count methods) then under the All-Payer Option (by both methods). CMS will apply the most advantageous of the calculation results for each clinician.

While CMS will continue to make Medicare Option QP determinations at the APM Entity level, CMS instead proposes to make All-Payer QP determinations at the individual eligible clinician level. CMS believes that clinicians participating in an Advanced APM Entity are likely to share a high level of involvement in the entity’s cost and quality initiatives, but is concerned that clinician involvement and shared accountability in Other Payer Advanced APM Entities are more variable. Another concern is that clinicians may participate in multiple Other Payer entities whose memberships are not likely to overlap consistently. Group data from Other Payer Advanced APMs are therefore less likely to capture most clinicians’ participation accurately. CMS seeks comment on the extent to which Other Payer APM entity participants could be accurately assessed as a group; the degree of variability in participation by clinicians in Other Payer APM entities; and, any situations wherein All-Payer determinations should be made at the group level. CMS also anticipates obstacles to obtaining information needed to make group-level All-Payer QP determinations; and patient data plus entity Participation Lists would be needed. Where CMS is to make group-level Other Payer QP determinations, CMS proposes that Affiliated Practitioner List clinicians would still be assessed at the individual level, but the agency seeks comment on alternative approaches.

For payment year 2021 and beyond, radiologists will need to participate in multiple APMs in order to meet the percent of revenue or patient thresholds under the All-Payer Combination Option in order to become qualifying APM participants (QPs). Given that a major portion of radiologists are considered non-patient facing, the patient attribution threshold often cannot be met at the group or individual level. It also may be difficult for individual radiologists to meet the Other Payer revenue threshold, in addition to Medicare’s APM entity thresholds, in order to achieve QP status. Like many other specialties, radiologists benefit from being evaluated as a group because the members can
collectively meet the thresholds to obtain QP status. We envision that radiologists will need this kind of group determination also for the All-Payer Combination Option.

Although the ACR realizes that CMS may face significant challenges in obtaining information necessary at the APM Entity group level under the All-Payer Combination option, the ACR would appreciate CMS finding a way to overcome these operational problems instead of evaluating all physicians at the individual level. The ACR recommends that CMS make QP determinations at the APM Entity (or group) level by asking the APM entity to attest that there is a high level of engagement by all providers on their participation list.

Physician-Focused Payment Models (PFPMs)

Section 101 (e)(1) of MACRA created the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to make comments and recommendations to the Secretary of the Department of Health and Human Services on proposals for Physician-Focused Payment Models (PFPMs) submitted by individuals and stakeholders. The Secretary is required by MACRA to establish criteria for PFPMs and to review the comments and recommendations on proposed PFPMs and to post a detailed response to those comments and recommendations on the CMS website.

In the proposed rule, CMS seeks comments on broadening the definition of PFPMs to include payment arrangements that involve Medicare, Medicaid or the Children’s Health Insurance Program (CHIP) (or some combination of these) as a payer. CMS believes that broadening the definition of PFPMs would complement the All-Payer Combination Option and could provide an opportunity for stakeholders to propose PFPMs to the PTAC that could be Other Payer Advanced APMs. Additionally, participation in Other Payer Advanced APMs would contribute to an eligible clinician’s ability to become a Qualified Participant (QP) through the All-Payer Combination Option.

The ACR supports broadening the definition of PFPMs to include payment arrangements that involve Medicare, Medicaid or the Children’s Health Insurance Program (CHIP) or some combination of these as a payer. We agree that broadening the definition of PFPMs would complement the All-Payer Combination Option and could provide an opportunity for stakeholders to propose PFPMs to the PTAC that could be Other Payer Advanced APMs. Expanding models to include Medicaid or CHIP as a payer would be consistent with the CMMI demonstrations that include Medicaid and CHIP programs and would also complement the All-Payer option. However, we believe Advanced APMs for Medicare should be a priority since there is currently a shortage of opportunities for specialists, including radiologists, to participate in Advanced APMs, which limits their ability to attain QP status in the early years of the program.
Relationship Between PFPMs and Advanced APMs

Section 1868(c) of MACRA does not require PFPMs to meet the criteria to be an Advanced APM for purposes of the incentives for participation in Advanced APMs under section 1833(z) of the Act, and CMS did not define PFPMs solely as Advanced APMs. Stakeholders may propose as PFPMs either Advanced APMs or Medical Home Models, or other APMs. CMS recognizes that both stakeholders and the PTAC may want to discuss whether a proposed PFPM would be an Advanced APM in their proposals, comments, and recommendations.

The ACR acknowledges that not all PFPMs will qualify as Advanced APMs. Most radiologists provide services for patients across diverse disease processes and care pathways, thus participation in multiple models will likely be necessary to achieve the threshold requirements as defined for QPs in Advanced APMs. The ACR strongly believes that radiologists should be able to participate in as many PFPMs/APMs as possible, in keeping with the goal of MACRA to encourage movement of physicians from traditional fee-for-service to value-based reimbursement models.

The ACR encourages the Secretary to act swiftly on PTAC recommendations so that additional models become available for participation as quickly as possible given that the Advanced APM Incentive Payment is time-limited.

Physician-Focused Payment Models (PFPMs) Criteria

In the proposed rule, CMS is seeking comments on the Secretary’s criteria and whether the criteria are appropriate for evaluating PFPM proposals and are clearly articulated. In addition, CMS is seeking feedback on stakeholders’ needs in developing PFPM proposals that meet the Secretary’s criteria. In particular, CMS would like to know whether stakeholders believe there is sufficient guidance available on what constitutes a PFPM, the relationship between PFPMs, APMs, Advanced APMs, and how to access data, or how to gather supporting evidence for a PFPM proposal.

We reviewed the Secretary’s criteria and find most to be appropriate and clearly articulated.

Medical specialty societies have been working to develop PFPMs, a process that requires considerable time from model development to testing and implementation. In order to provide the necessary support for the development of PFPMs, CMS should make data readily available upfront to help in modeling impacts.

As we previously noted, 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 believe there should be clinical experts available to the PTAC review team to assist with technical questions that 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 an 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 acknowledges the amount of work required for the Preliminary Review Team (PRT) and PTAC to thoroughly review each PFPM submission. We have concerns that the PTAC may have insufficient resources to evaluate models in a timely manner, particularly with anticipated increase in submissions as familiarity with the program progresses. The ACR encourages CMS to consider mechanisms for managing an influx of proposals without creating significant delay in the evaluation process. We believe a clinical expert panel would improve the efficiency of the PTAC.

In the CY 2017 QPP final rule, CMS did not establish a process or timeline for its own review of recommended PFPMs from the PTAC or provide additional information regarding such a process. We understand that proposal submissions will vary in size, style and scope, and we look forward to receiving more information from CMS on its internal review timeline and review process of PTAC recommended PFPMs.

Conclusion

The ACR appreciates this opportunity to comment on the CY 2018 proposed updates to the Quality Payment Program. The ACR stands ready to assist CMS in helping the radiology community continue the transition to the Quality Payment Program. Please feel free to contact us any time through Judy Burleson at jburleson@acr.org, Pam Kassing at pkassing@acr.org or Laura Pattie at lpattie@acr.org with questions or requests.

Respectfully Submitted,

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