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The mission of the American College of Cardiology and the American College of Cardiology Foundation is to transform cardiovascular care and improve heart health.

August 21, 2017

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

RE: Medicare Program; CY 2018 Updates to the Quality Payment Program (CMS-5522-P)

Dear Administrator Verma:

The American College of Cardiology (ACC) appreciates the opportunity to comment on proposed 2018 updates to the Medicare Quality Payment Program (QPP) as published in the Federal Register on June 30, 2017.

The ACC is the professional home for the entire cardiovascular care team. The mission of the College and its more than 52,000 members is to transform cardiovascular care and to improve heart health. The ACC leads in the formation of health policy, standards and guidelines. The College operates national registries to measure and improve care, offers cardiovascular accreditation to hospitals and institutions, provides professional medical education, disseminates cardiovascular research and bestows credentials upon cardiovascular specialists who meet stringent qualifications.

For the second year of the QPP, the ACC provides recommendations that balance the goal of moving clinicians forward in a value-based payment system while providing a stable environment in which this practice transformation can occur. Developing comprehensive policy recommendations and improvements to the QPP is a challenging endeavor as clinician performance under the first year will still be unknown until the end of 2018. Despite this limitation, CMS has provided thorough recommendations for Year 2 and future years of the QPP in this proposed rule. In response to this proposed rule, the ACC specifically addresses the following areas:

- **Merit-Based Incentive Payment System (MIPS)**
  - Support of virtual group reporting with consideration of the assistance practices may need in order to implement this new option;
  - Continued flexibility for small practices and low-volume clinicians and groups;
  - Updates to the Quality, Cost, Advancing Care Information (ACI), and Improvement Activities (IA) categories of MIPS;
  - Support of streamlined scoring for MIPS Alternative Payment Model (MIPS APM) participants;
  - Support of reporting MIPS categories using multiple submission mechanisms;
  - Cautious support of facility-based scoring for clinicians using the Hospital Value-Based Payment Program (HVBP) score;
  - Support of bonus points for treating complex patients with comments on the dual-eligible versus Hierarchical Condition Category (HCC) methodologies;
  - Discussion of proposed changes to MIPS scoring, including a transition to a mean or median approach in Year 3 of the QPP;
  - Concern with potential unintended consequences of publicly reporting Year 1 performance data on Physician Compare; and
  - Concern with the current qualified clinical data registry (QCDR) self-nomination process.

- **Advanced Alternative Payment Models (Advanced APMs)**
  - Cautious support of the All-Payer Combination Option concept overall, with opposition to the proposal to measure risk at the individual eligible clinician level;
  - Support maintaining the current nominal risk standard for the 2019 and 2020 performance years, along with additional flexibility for small and rural practices; and
  - Support of expanding the scope of Physician-Focused Payment Models (PFPMs) to consider Medicaid and Children's Health Insurance Plan (CHIP) arrangements.

As actual performance data or newly modeled data becomes available, the ACC requests that CMS share this with practicing clinicians, medical societies and other stakeholders to continue the productive discussion and collaboration on concrete and meaningful improvements to the QPP.

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

The ACC commends CMS for maintaining the position that that MIPS participation is not a one size fits all process for all clinicians and groups. The College appreciates continuation of flexible participation options for small practices, low-volume, and non-patient facing clinicians as well as the implementation of new options such as virtual group reporting that may be beneficial to small practices and solo practitioners. In addition to this flexibility, we support CMS' proposals to maintain overall consistency in the reporting weights, thresholds and requirements for the MIPS categories of Quality, Cost, Advancing Care Information, and Improvement Activities in Year 2 of the program.

Virtual Groups

The ACC supports implementation of virtual group reporting for the 2018 performance year with the offer of technical support to those practices that elect to report via this option. The

College also supports CMS' proposal not to enforce geographic or specialty limitations on the clinicians who can form a virtual group in the initial years of implementation as this option may provide most value to those clinicians who are the only representative of their specialty in a particular region. Virtual groups will provide the opportunity for solo practitioners and small practices to report MIPS performance together, which will also encourage collaborative approaches to care and quality improvement.

However, the timeline proposed for 2018 performance period virtual group election period is too tight. CMS proposes a two-stage election process that requires an eligibility determination and formation of the virtual group, including execution of a written and formal agreement between each member of the virtual group. This process must be completed by December 1 prior to the start of the performance year. With the timing of the final rule, groups would only have one or two months to navigate and execute this process; it is expected that for the initial performance year, groups may need additional time to understand the virtual group structure and requirements and to discuss this option with their colleagues before electing. CMS should begin releasing guidance on virtual group reporting as early as possible so groups and solo clinicians have ample time to make an informed decision about this option and consult with those who will be part of their group.

CMS should also consider if an election deadline of later than December 1 is appropriate at least for the 2018 reporting period. The ACC recognizes the value of confirming a virtual group's reporting status prior to the start of the performance period; however, with the continuation of 90-day reporting periods for Improvement Activities and Advancing Care Information, there are still ways for virtual groups to elect at the beginning of 2018 and still achieve enough points to avoid a MIPS penalty.

Low-Volume Threshold

The ACC supports continuation of the low-volume threshold exempting clinicians from MIPS participation based on their Medicare Part B charges or Part B beneficiary count. The College agrees that this will decrease the reporting burden for clinicians who treat few Medicare beneficiaries, especially small practices and solo practitioners.

CMS proposes to increase the threshold from $30,000 or less in Part B allowed charges or fewer than 100 beneficiaries to $90,000 or less in Part B allowed charges or fewer than 200 beneficiaries. The ACC recognizes this is a substantial increase, but supports the change in order to ensure that all clinicians who are truly low-volume are eligible for the exemption.

The ACC encourages CMS to continue reviewing the threshold annually. As part of this annual review, CMS should consider maintaining a threshold that preserves stability. CMS should prevent a scenario where many practices are shifting between the low-volume exemption and MIPS participation from year to year.

Part B Threshold

CMS should provide greater communication around what is included under "Part B allowed charges" for calculating the low-volume threshold and application of MIPS bonuses and penalties. To predict their low-volume eligibility, many clinicians considered only their Part B

professional component charges under the Physician Fee Schedule (PFS). CMS later clarified that the MACRA statute applies to all Part B allowed charges, including the professional and technical component under the PFS as well as drugs and supplies billed and administered under Part B. This guidance will help clinicians and groups better understand the applicability of QPP policies to their Part B payments and assist with determining status eligibility.

However, the ACC is concerned by the impact that the application of any MIPS bonuses or penalties to the payment of Part B drugs and supplies may have on patient access. One unintended consequence is that the application of a MIPS penalty on top of the rising costs of drugs may limit the ability for clinicians to continue administering these therapies. Conversely, it also seems inappropriate for a clinician to receive a bonus on the cost of a Part B drug, which is not based on the value of the clinician's service. The College asks CMS to consider these issues and to watch for unintended consequences; however, recognizes that CMS' ability to change this policy may be limited by statute.

Option to Participate in MIPS

The ACC supports the ability for clinicians and groups who would otherwise be excluded from MIPS participation due to the low-volume threshold to opt-in to MIPS participation. This would promote CMS' goal of ultimately tying all Medicare payments to a value-based payment program while preserving access to care for Medicare beneficiaries. The College also believes that there may be some clinicians and groups who have invested in meaningful practice transformation and want to be rewarded for their efforts regardless of the MIPS exemption. CMS states that due to infrastructure limitations, clinicians and groups exempt under the low-volume threshold would be required to sit out of the program in Year 2 but may be able to opt-in as early as the 2019 performance period. The College encourages CMS to make this option available in Year 3 of the QPP.

Small Practices

The ACC greatly appreciates CMS' continued attention to supporting small practices for success under MIPS. Moving to a value-based payment system requires that practices invest in infrastructure and staff to understand and report their data and to identify and champion areas for maintaining or improving patient care. The ACC continues to express concern that some solo practitioners and practices, particularly small and rural, may feel as if they are forced to integrate with larger groups or even close their practices because the administrative burdens of participation are too great. This may be detrimental to patient access to care in areas dominated by small practices and solo practitioners. **To address this issue, the ACC supports implementation of new concepts such as the virtual group reporting option, as well as continued policies such as reduced point thresholds for Improvement Activity participation full credit.**

The ACC also supports the proposal to award solo practitioners and groups an automatic five points on the MIPS composite performance score. CMS should reconsider this amount annually to ensure that it accomplishes the goal of creating an even playing field among MIPS clinicians and groups regardless of practice size. For future years, CMS should consider whether it is feasible to transition many of the scoring bonuses and flexibilities applied on a measure by measure or individual MIPS category basis to the overall MIPS composite score as CMS does with this proposal. While the College greatly appreciates the scoring flexibility that CMS has provided, many

of the practices that these policies are intended to help may not actually have the staff or resources to help them create a robust strategy on an individual measure basis. **The ACC is willing to work with CMS and other stakeholders to determine how to maintain flexible scoring and bonuses within a simplified scoring system for future years.**

Quality

Data Completeness Threshold

CMS proposes to increase the data completeness threshold for the Quality category to 12 months of measure data for Year 2. Based on the historical success of cardiologists reporting measures for a full performance year under the Physician Quality Reporting System (PQRS), the ACC believes that this will be manageable for many cardiologists. However, the College recognizes that there will be some clinicians and groups testing quality reporting for the first time in 2017; increasing to a full calendar year may be challenging. Additionally, several clinicians have stated that a shorter reporting period such as 90 days or up to 9 months provides practices with the time needed to update their EHR and administrative systems with the necessary measure specifications and data elements. **While the ACC encourages clinicians and groups to strive to full year performance, we recommend that CMS consider a mandatory shorter reporting period for data completeness. Those who do report for a full year should be rewarded for doing so with additional points on the Quality score.**

Topped Out Measures

The ACC supports the multi-year notice and comment period proposed for topped out measures , as this provides ample time and notice for measure stewards to provide input on the value of the measures, and also provides clinicians and practices with time to determine whether or not to continue reporting the measures. However, the ACC recommends that CMS consider scoring options for topped out measures rather than complete removal of these measures from MIPS.

The College continues to oppose the removal of topped out measures from the program. Many topped out measures promote evidence-based best practices in patient care; clinicians and groups should be recognized for maintaining these practices that have a clear connection to high-quality care. Furthermore, removal of these measures would be misaligned with CMS' goal of implementing more outcome measures, as it would be impossible to develop robust outcome measures without an understanding of the processes that contribute to the outcome.

Rather than removing topped out measures or measures that cannot be benchmarked, CMS should keep these measures available for MIPS reporting unless removal is determined to be appropriate by the measure steward. It would be reasonable for CMS to cap the possible score on topped out measures at 6 points or a similar median score if performance improvement cannot be statistically measured. The College recognizes that this places a responsibility on the clinician or group to seek additional MIPS points through other quality measures or MIPS categories; however, this compromise is more acceptable than complete elimination of topped out measures. CMS' priority should be to ensure all measures included in the program represent the most meaningful core elements of high-quality care, regardless of their baseline performance benchmarks.

Quality Measures Determined to be Outcome Measures

The ACC supports the use of the measure steward's designation and the National Quality Forum (NQF) designation, if applicable, to determine whether a quality measure is an outcome measure. **In addition to applying these two standards, the College strongly recommends that CMS continue to consider intermediate outcome measures as outcome measures for the purpose of MIPS requirements and bonus point scoring.**

Quality Measures for 2018 and Future Years

The ACC strongly supports CMS' decision not to propose *Fixed-dose Combination of Hydralazine and Isosorbide Dinitrate Therapy for Self- Identified Black or African American Patients with Heart Failure and LVEF < on ACEI or ARB and Beta-blocker Therapy (MUC 16-74)* as a MIPS Quality category measure for the 2018 performance period as it contradicts the recommendations of the 2013 American College of Cardiology Foundation/American Heart Association (ACCF/AHA) Guideline for the Management of Heart Failure and raises several concerns regarding patient access to medication and pharmaceutical costs. The ACC/AHA guideline recommendation states:

> *"The combination of hydralazine and isosorbide dinitrate is recommended to reduce morbidity and mortality for patients self-described as African Americans with NYHA class III–IV HFrEF receiving optimal therapy with ACE inhibitors and beta blockers, unless contraindicated)." (Class I, Level of Evidence: A)*[1]

The guideline further notes "if the fixed-dose combination is available, the initial dose should be 1 tablet containing 37.5 mg of hydralazine hydrochloride and 20 mg of isosorbide dinitrate 3 times daily. The dose can be increased to 2 tablets 3 times daily for a total daily dose of 225 mg of hydralazine hydrochloride and 120 mg of isosorbide dinitrate. When the 2 drugs are used separately, both pills should be administered at least 3 times daily. Initial low doses of the drugs given separately may be progressively increased to a goal similar to that achieved in the fixed-dose combination trial. Thus, the guideline explicitly notes that either the fixed dose combination or the two component agents are considered equivalent from the perspective of the guideline.

The ACCF/AHA guideline writing committee had the option to limit this recommendation to only fixed dose combination hydralazine and isosorbide dinitrate therapy. However, the writing committee explicitly decided to allow as equivalent the use of the individual components to ensure that patients have adequate flexibility in terms of drug availability or cost. Note that the brand name fixed-dose combination is proprietary and costs on average at locations of a large national pharmacy, $307.77 per 90 tablets compared with $37.51 for isosorbide dinitrate (90 tablets) and $20.68 for hydralazine (90 tablets) as the individual generic components. Although some patients may be able to obtain assistance from the manufacturer for the fixed-dose combination, such assistance is not guaranteed to all patients. The measure as constructed by the National Minority Quality Forum does not create exceptions, exclusions, nor acknowledged patient refusal for any reason such as cost or religion; it only takes into account medical reasons.

[1] Yancy, Clyde W. et al "2013 ACCF/AHA Guideline for the Management of Heart Failure." *Journal of the American College of Cardiology* 62.16 (2013): e147-e239. Web. 17 Aug. 2017. (Available at: http://www.onlinejacc.org/content/62/16/e147)

The ACC strongly believes that creating a performance measure that permits only the use of the brand name fixed-dose combination of hydralazine and nitrates for African-American patients with systolic heart failure, would penalize clinicians who, in using generic agents, are providing guideline-concordant, high-value care. While this alone is adequate reason to deny implementation of this measure, the ACC also believes that by discouraging the use of a permissible approach a guideline-recommended therapy—particularly one that is substantially less expensive—the measure could have the paradoxical effect of denying this important therapy to many patients. ACC has concerns about the financial burden fixed-dose combination treatment would place on many patients increasing the likelihood of medical non-compliance. In addition, use of this measure in MIPS would run counter to the goals of achieving high-value care based on quality and cost. **The College appreciates CMS' decision not to include this measure in MIPS for the 2018 performance year and requests the Agency maintain this position for future years of the program.**

Advancing Care Information (ACI)

All-or-Nothing Approach

Under the federal EHR Incentive Program, there was little flexibility for physicians who struggled to meet the requirements, particularly when implementing new EHRs. For years, the College, the American Medical Association and many other medical specialty societies called for increased flexibility in the federal EHR Incentive Program. CMS responded with a program in QPP Year 1 that contains two prongs – a base component and a performance component. While the new structure partially addresses concerns, it continues to include components of the previous all-or-nothing approach that interferes with well-intentioned efforts to implement EHRs in a manner that reflects the program's goal: improved patient care. The Agency takes steps in this direction by providing bonus points to those who use their EHRs to perform certain quality improvement activities, but there remain opportunities for improvement. The ACC continues to harbor concerns regarding this approach and urges CMS to develop an EHR program that truly rewards clinicians for their efforts to adopt health IT.

Registry Reporting

The ACC is a strong supporter of registry reporting and critical data collection efforts. That said, the College largely agrees with the Agency's proposal to tread carefully with respect to public health and clinical data registry reporting requirements for the 2017 and 2018 performance years.

Immunization Registry Reporting

Without question, ensuring patients are appropriately immunized is critical. That said, the administration of routine immunizations is not the primary role of most cardiologists. The ACC appreciates CMS' recognition that reporting options be available to clinicians who do not routinely provide vaccinations and those who do not have access to immunization registries, ensuring that these clinicians are treated fairly. The current proposal would allow clinicians to substitute reporting to an immunization registry with syndromic surveillance reporting, electronic case reporting, public health registry reporting or clinical data registry reporting.

The College appreciates the provision of alternative methods for achieving the full performance score; however, the ACC urges CMS to clarify that the exclusion will still be available to those who do not routinely provide vaccinations. Cardiovascular specialists typically do not offer vaccinations and could be forced to choose for which measure their clinical data registry reporting would be counted, given the limited number of appropriate registries for cardiovascular clinical data registry reporting.

Clinical Data Registry Reporting

Reporting to clinical data registries remains challenging for some and could prevent success in the ACI performance category, given the technological barriers that remain outside of clinicians' control, such as the lack of interoperability. Additionally, mandating participation could cause an unprecedented surge in registry enrollment, which, on the surface, seems like a good problem to have. However, the time it takes to move through the steps necessary for achieving active engagement, is not insubstantial. In fact, it can take many months to finalize agreements, map out the relevant data elements, test the mapping and move into production. Clinical data registries will also need time to adapt to this influx. **Given these concerns, the College supports not mandating clinical data registry reporting at this time. The ACC however, agrees that those clinicians reporting data to clinical data registries should be rewarded for such activities.** Providing the option of earning bonus points under the ACI category would appear to be an appropriate mechanism for doing so.

While the College is a strong supporter population and public health activities, the ACC believes expanding the ACI requirements to include reporting to public health registries, for syndromic surveillance, or of electronic cases would be premature. **As such, the College supports the use of the bonus concept for rewarding those who are able to participate but not penalizing those who are not, regardless of the reason.**

Use of EHRs for Improvement Activities

The College strongly supports rewarding clinicians who use certified EHR technology to perform Improvement Activities (IAs). The purpose of converting from paper records to electronic ones is to improve the quality of care provided to patients. Using bonuses to reward clinicians for using their EHRs to perform IAs will help to further that goal, while not precluding them from participating in IAs that are unrelated to health IT. The College particularly supports rewarding clinicians and groups with ACI credit for engaging in IA activities that promote patient engagement and communication across practices because this two-way engagement has been difficult for some clinicians to achieve, the result of the continued lack of interoperability.

Reporting Period

CMS proposes to maintain the 90-day reporting period for the ACI component of the MIPS program. **The College supports continuing this policy to ensure clinicians have time to acclimate to the new program.** Additionally, allowing for a 90-day reporting period will allow those who are able to implement 2015 CEHRT to do so without it affecting their ability to fully participate.

2015 CEHRT Requirement

The ACC is pleased that CMS has recognized the concerns expressed by the AMA, the College and many other physician groups regarding the low availability of 2015 CEHRT, as well as the lengthy implementation timeline required. **Continuing to delay required use of 2015 CEHRT is the correct decision, and the College strongly urges CMS to adopt this proposal for the 2018 performance period.**

Hardship Exceptions: Five-year Cap

CMS proposes to eliminate the five-year limitation for hardship exceptions for the ACI component of the MIPS program based on concerns that the significant hardships justifying the original exception may extend beyond five years. **The College agrees that the five-year limit is arbitrary and should be eliminated, particularly for hardships well beyond the control of clinicians, such as local availability of internet access.**

Hardship Exceptions: Decertified EHR Technology Exception

The College strongly supports the implementation of the 21st Century Cures Act requirement that CMS promulgate an exception to the ACI performance category for clinicians whose EHRs have been decertified. The ACC is pleased that CMS recognizes the difficulties inherent in transitioning from a decertified EHR to a certified system. Implementing a new EHR is not as simple as purchasing a new computer. It requires time to conduct a needs assessment, gain an understanding of the certified products on the market, ascertain the most appropriate product for a particular practice, negotiate and sign a contract, implement a new EHR and train clinicians and staff to use the new EHR, time to transition from the old EHR to the new one, including migrating the data from the old one to the new one. A two-year transition is reasonable, given all of the steps required for the transition to be complete.

Hospital-based Clinicians

Clinicians in hospital outpatient departments are employees with little authority regarding purchasing, similar to those who perform the majority of their services in hospitals. As such, including services provided with the Place of Service (POS) code 19 (off-campus outpatient hospital) within the calculation for determining facility-based clinicians is entirely logical for the ACI category. While this may not hold true for the other MIPS categories, the ability of clinicians to participate in ACI is predicated entirely upon the decision of the parent entity to purchase appropriate CEHRT for the outpatient department. **The College supports CMS' proposal to include POS 19 in its definition of hospital-based MIPS eligible clinician in future performance periods.**

Advanced Practice Professionals

Advanced practice professionals (APPs) have traditionally been excluded from participation in quality reporting programs for at least the early years of the programs. As such, there is little information available regarding the appropriateness of existing measures as indicators of APP performance. Additionally, APPs are more often than not employees of medical practices or

facilities with little influence over their organizations' decision to purchase and implement CEHRT. **Given the lack of data available regarding the performance of APPs with respect to ACI measures, as well as their relative inability to influence purchasing decisions for physician practices and other entities, the College supports providing APPs the flexibility to determine whether it is appropriate for them to participate in the ACI at this time.** Once CMS has identified appropriate EHR-related measures for APPs, the ACC would support requirements for APPs similar to those imposed on physicians.

Improvement Activities (IAs)

Proposed Improvement Activities for 2018

The ACC supports the addition of new IAs for 2018 as well as proposed revisions to current activities that help clarify specific initiatives that would qualify for credit. In particular, the ACC appreciates inclusion of the PCI Bleeding Campaign as a new activity beginning in 2018 and recognition of the NCDR Clinical Quality Coach as an MOC Part IV recognized activity.
The ACC supports the proposal to include "Completion of an Accredited Safety or Quality Improvement Program Activity" as a new IA for 2018. This will encourage clinicians to engage in quality improvement focused continuing medical education (CME), which will in turn have a positive impact on patient care.

Recognition of the Appropriate Use Criteria (AUC) Program

The ACC strongly supports participation in the Appropriate Use Criteria (AUC) Program for advanced imaging services created under the Protecting Access to Medicare Act of 2014 (PAMA) as a high weight IA for 2018. The ACC sees significant value in AUC consultation over prior authorization to reduce the ordering of potentially inappropriate services. The College appreciates the credit awarded to early adopters of the program as several practices and facilities have already taken steps to implement AUC and clinical decision support (CDS) consultation in anticipation of a January 1, 2018 start date. This program will require many ordering clinicians to consult with AUC and CDS mechanisms for the first time and will promote a new level of care coordination between clinicians ordering and furnishing advanced imaging services.

CMS should maintain participation in the AUC program as a high weight activity not only for the 2018 performance period, but also for future years. In addition, the College looks forward to working with CMS to determine how the goals of the AUC Program can further align across all MIPS categories and alternative payment models under the QPP.

Removal of Improvement Activities: Million Hearts Risk Reduction Model

The ACC opposes removal of participation in the Million Hearts Risk Reduction Model from the Improvement Activities list for the 2018 performance period. Many clinicians are participating in this model with the understanding that they will receive credit for the initiatives that they are taking to manage populations at high-risk for cardiovascular disease.

CMS should maintain IA status for the Million Hearts model for all five years of the program or at a minimum, one additional year. Overall, the Agency should consider implementing a consistent,

multi-year process for phasing out IAs. Like many IAs, the Million Hearts model encourages clinicians and groups to dedicate time and resources to the implementation of novel practices to improve patient care. In particular, the Million Hearts model requires participants to do this over a five-year period. Implementing a phase-out period would allow practices to better prepare for changes in IAs from year to year.

Future Year Group Threshold

CMS proposes that in future years, at least 50 percent of the clinicians in a practice would have to successfully participate in an IA in order for the practice to receive credit for the activity under group reporting. Under current policies, only one clinician in a group needs to successfully participate in the IA in order for the group to receive credit. While it is appropriate to raise the requirement beyond the current threshold in order to promote participation in IAs by all clinicians in a practice, the ACC is concerned that the proposed threshold of 50 percent may limit the ability for clinicians to report those IAs most meaningful to their practice.

Many IAs are designed to improve care for a particular patient population or clinical condition. In a multi-specialty practice, cardiologists and cardiovascular team members may account for less than 50 percent of the group. The proposed threshold may interfere with their ability to report participation in an IA that may be unique to their specialty group. **The ACC recommends that CMS consider implementing a threshold lower than 50 percent of clinicians for group-level reported IAs to maintain a balance of increasing participation in efforts to improve care while not limiting the ability to receive MIPS credit.**

Cost

Cost Category Weight for 2018

The ACC strongly supports CMS' proposal to maintain the Cost category weight at zero percent for the 2018 performance/2020 payment period. The College appreciates CMS' recognition of the current episode-based measure development process and the need to test these new measures before implementing them for scoring. Any measures that appear to be flawed after this test period should not be implemented for scoring.

CMS must use the 2018 performance year to educate clinicians on these new measures as well as use of the patient relationship modifiers to ensure that these measures are appropriately capturing costs attributable to clinicians. As part of this learning process, CMS should provide clinicians and groups with feedback reports on their Cost performance so they can understand how they are being scored and clearly identify any areas for improvement. CMS must be transparent with what costs are considered as part of a clinician-level score.

Future Years of the Cost Category

The ACC recognizes that maintaining the Cost category at zero percent for another year may impact the ability for CMS to gradually phase this category into the performance score, as the MACRA statute currently requires that 30 percent of the final MIPS score be based on Cost in the third and future years of the QPP. While not ideal, CMS can help prepare clinicians for this coming change by

ensuring that the cost measures are proven to be valid and reliable through real-world testing in the current performance period and by prioritizing education on the Cost category in 2018 to prepare for future years. This education should ensure that clinicians understand concepts such as: what items and services are measured under the cost category, how costs are attributed to clinicians, what measures are used under the cost category, and how episode-based measures operate. This education should provide clinicians with the ability to read their feedback reports from CMS and clearly understand the actions they can take to improve their performance in this category.

The ACC remains interested in other ways CMS may be able to phase in Cost performance to the statutory requirement while maintaining a stable program for clinicians. Other options could include incorporating Cost performance at 30 percent in the third year of the program but allowing clinicians to voluntarily elect performance tiering for one year, similar to the approach of the Value-based Payment Modifier. The ACC is open to working with CMS to explore options, but maintains that informative clinician feedback and education will be the best ways to prepare clinicians for the implementation of this category.

Claims-based Measures Proposed for the MIPS Cost Performance Category

In addition to the episode-based measures, CMS proposes to utilize the total per capita cost measure and the Medicare Spending Per Beneficiary (MSPB) measure for Cost measurement for the 2018 performance period. **The ACC continues to believe that there are significant issues with use of the total per capita cost measure and the MSPB measure.** The total per capita cost measure simply adds together all costs for attributed beneficiaries, regardless of whether the clinician or practice in question had any relation to or control over the costs that were incurred. Particularly for specialist clinicians, this measure may be suboptimal for helping to drive meaningful improvements in care efficiency. The MSPB is designed to measure cost at the hospital level, and has not been adequately tested, validated, or NQF-endorsed for use at the clinician level. Additionally, neither the total per capita cost measure nor the MSPB adequately account for social risk factors which have previously been shown to be associated with higher costs of care, such as poverty. As a result, some clinicians may be held responsible for care and conditions that are outside of their control.
The ACC recommends elimination of the total per capita cost measure and the MSPB measure for Cost performance and encourages the development of new measures that are designed for practice-level measurement that adequately account for differences in patient conditions and complexity.

Episode-based Measures

The ACC supports the use of episode-based measures for Cost performance as long as these measures are evidence-based and validated. The College greatly appreciates the work of its members who are currently working with CMS and its contractor to develop cardiovascular-specific episode definitions and measures. The perspective of these practicing clinicians is crucial to ensuring that these measures reflect real-world patient encounters.
The College strongly urges CMS to proceed cautiously with the implementation of new episode-based measures for scoring. No episode-based measures should be implemented for performance determinations until they have been tested and reviewed for accuracy. CMS should also ensure that the new patient relationship category coding that will be implemented to improve attribution of episode-based measures is properly utilized. Implementing episodes for scoring

without conducting this review may result in clinicians being unfairly penalized for treating high-risk patients due to flaws in the episode's procedure and diagnosis coding, attribution, and risk adjustment methodology. The ACC supports CMS' intent to provide clinicians and groups with information on their performance on these measures prior to Year 3 of the program to solidify their understanding of this category.

Facility-Based MIPS Scoring

The ACC cautiously supports efforts to implement facility-based scoring for clinicians who provide their care primarily in the hospital. As with all policies, CMS should watch for unintended consequences with facility-based scoring and educate clinicians on how this option affects their MIPS reporting requirements and score.

The College supports the requirement that clinicians opt into facility-based scoring for their MIPS Quality and Cost performance. There is an administrative burden to reporting data for pay-for-performance programs. It may be easier for hospitals to default to the use of their HVBP score for their clinicians as it would eliminate the need to report both clinician-level and hospital-level data. While this may be a benefit for some, other clinicians may not want to be bound to their hospital's performance or may want to be scored against self-selected measures. CMS should inform hospital-based clinicians of their ability to elect facility-based scoring as early as possible prior to or during the performance period along with the choice to opt-in. As part of this feedback, CMS should include their hospital's most recent HVBP score and how that is translated into the MIPS score, along with the clinician's prior year MIPS performance to support an informed decision.

Under the proposed rule, clinicians electing to use their HVBP score for Quality will automatically have a base score of 30 points as this is the floor performance rate for hospitals currently participating under the HVBP. This may provide an unfair advantage to clinicians who cannot elect this option and must strive for higher performance to create an even playing field, despite other available bonuses. CMS should consider whether it is appropriate to directly crosswalk the HVBP score to the MIPS score or if an alternative methodology needs to be developed.

Starting with the HVBP score provides CMS with a starting point for implementing facility-based scoring in MIPS. The ACC is aware that CMS is developing a technical expert panel (TEP) to develop principles for applying inpatient-level quality measures to clinician-level measurement. The ACC looks forward to the work of this TEP and hopes that CMS will use the feedback of this group to determine how hospital-level measures such as those collected through clinical data registries may be used for MIPS measurement in future years of the program.

Hospital-Based Clinician Threshold

CMS proposes to determine that a clinician or group is hospital-based and eligible for facility-level Quality and Cost scoring if 75 percent or more of services are provided in a hospital or emergency department setting. As part of this calculation, CMS proposes to include services provided with the Place of Service (POS) code 19 (off-campus outpatient hospital). The ACC believes it is appropriate to include these services for calculating an exemption from ACI reporting; however, it may have a different effect when it comes to facility-based reporting as proposed. Many of the services provided in the off-campus outpatient hospital setting include clinic visits, diagnostic services, and therapeutic

services. **CMS should consider whether the majority of outpatient services have direct impact on the HVBP measures of cost and quality in determining whether to include POS 19 services in the threshold calculation for facility-based cost and quality measurement.**

Complex Patient Bonus

The ACC strongly supports bonus points on the final MIPS score for complex patients for Year 2 and future years. A pay-for-performance system such as MIPS carries an unintended risk of penalizing clinicians and groups who care for the most vulnerable patient populations. Under the Cost category alone, the treatment of complex patients places clinicians and groups at a disadvantage because the resource needs of these patients often does not reflect the typical patient episode. As CMS continues to move toward value-based payment programs that incorporate outcome and cost measures, the complex patient bonus will be necessary to offset disincentives for caring for the most vulnerable populations, and to ensure that the performance of clinicians treating these patients is appropriately rewarded and access to care is maintained.

Complex Patient Bonus Methodology

The ACC appreciates consideration of the dual-eligible ratio and Hierarchical Condition Category (HCC) methodologies; however, there are additional benefits and limitations to each methodology that should be considered. The dual-eligible methodology offers a straightforward way of encouraging high-quality care for a patient population that is known to be medically complex and have a high burden of related social risk factors that have a significant impact on health. For example, research continues to show that dually-eligible patients have higher readmission rates, higher preventable admission rates, and higher costs of care both for hospital episodes and overall. [2] However, CMS should not assume that a clinician treating fewer or no dual-eligible patients sees no complex patients. In this instance, the Hierarchical Condition Category (HCC) methodology may do a better job of capturing complex patients since it is based on the patient's documented medical conditions rather than socioeconomic status. CMS could consider a two-pronged threshold similar to the low-volume threshold and Advanced APM qualifying participant status determinations that awards points based on meeting either a dual-eligible risk score or HCC risk score threshold.

Medical and social complexity are two distinct – but often overlapping – constructs. Some practices may serve highly medically complex patients with an average level of social risk, while others may serve a highly socially complex group with an average level of medical risk. Both of these types of practices may struggle under MIPS if risk adjustment does not adequately account for these differences. Further, both of these types of patients are precisely the ones that could face difficulties with access to care if incentives are put in place that penalize practices that disproportionately serve them. Understanding the needs of complex patients and how to best measure quality of care for this population in a pay-for-performance environment continues to be a challenge for the College.

Socioeconomic status should be considered as part of risk adjustment and patient complexity, but it should never replace measures of actual patient illness and medical severity. Improving risk-adjustment and scoring methodologies such that social and medical complexity are adequately

[2] Doll JA, Hellkamp AS, Goyal A, Sutton NR, Peterson ED, Wang TY. Treatment, Outcomes, and Adherence to Medication Regimens Among Dual Medicare-Medicaid–Eligible Adults With Myocardial Infarction. JAMA Cardiol. 2016;1(7):787–794. doi:10.1001/jamacardio.2016.2724

accounted for, along with issues such as functional status and frailty, is critical to the future of value-based payment programs. The College ask that timely access to data on the medically complex and dual eligible population so researchers can continue to better explore methods for measuring care for complex patients.

Increases to the Performance Threshold

The ACC cautiously supports CMS' proposal to increase the base MIPS 2018 composite performance score threshold from 3 points to 15 points in order to avoid a penalty in the 2020 payment year. The College agrees with CMS in that there should be a threshold increase in order to move clinicians and groups from merely testing MIPS to prepare them for greater participation in Year 2 and future years. At first, increasing the point threshold by five times seems like an unreasonable increase. **The College continues to caution against significant increases in requirements or scoring thresholds on a yearly basis.**

CMS states that clinicians can still attain 15 points through a variety of participation options similar to the "pick your pace" options in Year 1. This includes the ability to achieve the performance threshold by successfully participating in just one of the MIPS categories. Based on this opportunity for clinicians and groups to continue phasing into full performance in Year 2, the ACC finds the threshold of 15 to be reasonable, subject to the concerns expressed in the following section related to mean or median scoring. CMS must educate clinicians and groups on the various ways that MIPS performance can be met to achieve this threshold.

Transition to a Mean or Median Scoring Approach

The MACRA statute requires that the Secretary base the MIPS performance threshold on either the mean or median of final MIPS composite scores starting with the 2021 payment year. The ACC appreciates CMS voicing concern that maintaining a low performance threshold in Year 2 of the program may help clinicians in the short term transition, but may ultimately create a steep learning curve if the mean or median approaches result in the eventual need to meet much higher performance thresholds.

Without an understanding of how performance scores will be distributed under MIPS, it is difficult for the College to provide meaningful input as to whether CMS should implement a mean or median scoring methodology starting in QPP Year 3. It is also difficult to assess whether a performance threshold of 15 points is a fair compromise that supports a continued transition to MIPS participation with the eventual transition to mean or median scoring. If possible, CMS should use historical quality program data along with the data from Year 1 of MIPS to develop models that can be shared with stakeholders to provide a better understanding of the two approaches and the impact on scoring thresholds.

Improvement Scoring

The ACC continues to support recognition for those who demonstrate meaningful improvement from year to year. The College appreciates CMS' thorough consideration of improvement scoring for the MIPS Quality and Cost categories starting in Year 2.

While rewarding improvement on an individual quality measure basis is ideal, the ACC recognizes that this would require clinicians and groups to report the same quality measures each year using the same reporting mechanism. This would limit the ability to freely select measures based on clinical relevance rather than opportunities for performance points. **Based on this, the ACC supports CMS' proposal to award performance improvement points based on the overall Quality category score rather than on individual measures.**

For the Cost performance category, CMS proposes to score improvement at the measure level. The ACC believes this is appropriate as the claims-based cost measures alone capture such a broad beneficiary population that it would be impossible to identify improvement and opportunities for improvement based on the category composite. Additionally, with the implementation of episode-based cost measures, measure level performance scoring will help clinicians and groups better target those patient populations where improvements to resource use can be explored. The ACC supports CMS' proposal to provide feedback on Cost performance and improvement starting with the 2018 performance year to help clinicians and groups understand this category even though performance will not impact the MIPS score until future years.

The proposed methodologies for measuring Quality and Cost performance improvement are undoubtedly complex. Again, the College appreciates the depth of consideration CMS has given to this topic, including the impact that changes to ICD-10 coding updates may have in the comparability of measures from one performance period to another. CMS should ensure that these methodologies can be translated into clear and actionable feedback in the performance reports so clinicians and groups can easily understand how to earn points on improvement. As with any new policies, CMS should review the impact of these proposals after the first year of implementation and refine them as necessary to ensure that they achieve the intended goal of rewarding improvement.

MIPS Alternative Payment Model Scoring (MIPS APMs)

The ACC supports continued scoring flexibility for MIPS eligible clinicians and groups participating in APMs. This policy reduces the potential for duplicative reporting across MIPS and these models, which are focused on the same value-driven care goals as MIPS.

For the 2017 performance period, the ACC opposed the finalized MIPS APM scoring which weighted the performance categories differently depending on participation in a Medicare Shared Savings Program Accountable Care Organization (MSSP ACO), Next Generation ACO, or other Medicare APM. **The ACC is pleased that CMS proposes to simplify scoring for the 2018 performance/2020 payment periods by implementing one adjusted weighting scale across all APMs.**

The ACC supports the proposed weights for all MIPS APM participants in Year 2 at 50 percent Quality, 0 percent Cost, 20 percent Improvement Activities, and 30 percent Advancing Care Information. This proposal does place a greater weight on the Quality category for MIPS APM participants compared to all other MIPS participants; however, the College finds this preferable to placing greater weight on the ACI category which accounts for up to 75 percent of the MIPS APM score in Year 1 of the program.

Performance Feedback

Providing clinicians and groups with timely and actionable performance feedback is critical to understanding how to provide high-value patient care under MIPS. Under Medicare's legacy programs, many clinicians found feedback to be difficult to access and once obtained, difficult to interpret. The ACC is pleased that CMS continues to collect input from practicing clinicians to inform the development of these feedback reports and looks forward to providing input on future concepts. The College also encourages CMS to work with QCDRs and other reporting mechanism providers on the development of feedback reports to ensure that the resources provided by both CMS and these vendors are consistent rather than contradictory.

Public Reporting and Physician Compare

The College is interested in further understanding how CMS intends to report performance under Physician Compare, particularly in light of the flexibility offered in the first years of the QPP. Because of the "pick your pace" options, some clinicians and groups may only be reporting a minimum amount of data to test the program. Their performance data, when applied to the five-star scoring system, may show that they met the minimum performance threshold; however, this does not necessary correlate to the assumption that they provided a lower level of care than a clinician or group reporting a full year or across all MIPS categories.

CMS should consider how to best reconcile the value of public reporting with the risk of releasing data that can be misinterpreted. **For this reason, the ACC strongly supports the proposal to provide clinicians and groups with a 30-day window for previewing their Physician Compare data and provide them with the opportunity to opt out of having their first-year performance data publicly reported.**

Multiple Submission Mechanisms

The ACC supports the proposal to allow clinicians and groups to report data on measures and activities using multiple submission mechanisms for a single MIPS category. However, the ACC recognizes that this policy is one instance where welcomed flexibility may lead to complexity in implementation. CMS should create educational programs to help clinicians and groups understand this option. For example, the proposed rule states that the CMS Web Interface is not permitted as a multiple submission mechanism. This may create confusion, as the ACC understands that groups under one "split TIN" are allowed to submit under other submission mechanisms where some clinicians are participating in the Web Interface as part of an accountable care organization and others are reporting via another mechanism for MIPS.

The ACC recognizes that for the 2018 performance period/2020 payment period, CMS is only allowing split TINs in situations where some clinicians in a group are participating in a MIPS APM or Advanced APM and others are participating under MIPS. The College encourages CMS to consider whether split TINs among full MIPS participating groups can be feasible in future years of the program. The multiple submission method provides value in allowing specialists within a multi-specialty setting to report their own measures; however, some clinicians may find that their practice or facility does not want to manage multiple mechanisms. The alternative solution would be for each specialty within a group to create their own TINs and report as subgroups; however, it is not easy to

create new TINs due to their connection to the billing and financial operations of a group. Allowing all MIPS eligible groups to report unique sets of measures via a single mechanism or multiple mechanisms promotes the ability for all clinicians to have a meaningful impact on overall MIPS performance. The ACC recognizes that this split TIN approach will undoubtedly create challenges with the current MIPS group scoring methodology, but offers to work with CMS to develop a solution.

Measure Applicability Validation

The ACC has concerns with the quality measure validation process proposed with regard to multiple submissions. CMS proposes that if a MIPS eligible clinician or group reports fewer than the six required measures via claims or a qualified registry, CMS will apply the validation process to determine if other measures were available for reporting across those mechanisms. The College interprets this to mean that the validation process may determine that a clinician who reports via claims should have also reported via a qualified registry, or that a clinician who reported via a qualified registry should have also reported via another qualified registry in order to reach six measures. This poses an additional administrative burden on clinicians as well as a potential cost burden, as the qualified registries carry enrollment fees per clinician. **Rather than conducting measure application validation across mechanisms, the ACC recommends that in cases of claims reporting, CMS limit validation to measures applicable to claims reporting only. For clinicians or groups reporting via qualified registry, CMS should limit validation only to the measures available through the qualified registry used.**

While the ACC supports exemptions from this process for EHR and QCDR reporting, the College is concerned that this proposal as written poses a potential burden, especially to smaller practices still reporting via claims, and should be revised.

Qualified Clinical Data Registry Reporting

The ACC supports continued recognition of qualified clinical data registries (QCDRs) as accepted reporting mechanisms for MIPS reporting. QCDRs have a direct impact on quality improvement as they allow clinicians to report specialty-specific quality measures outside of the MIPS measure set and support participation in several IAs. For the development of policies related to QCDRs for 2018 and future years, the ACC asks that CMS provide the same policy stability requested for clinicians.

QCDR Self-Nomination Criteria and Process

The ACC supports the proposal to streamline the self-nomination application process for QCDRs in good standing. While this is a small step in the right direction, CMS must consider other ways to simplify and standardize the process for QCDR self-nomination.
The ACC recommends that CMS de-couple the QCDR self-nomination and measure selection processes. CMS should dedicate an initial window to the self-nomination process which approves a QCDR's data capture methods, validation processes, and methods for calculating data. This process will be supported by the proposed streamlined process. CMS should award QCDR status for a period of 3-5 years based on the information collected.
Measure selection should occur under a different timeline that provides QCDR vendors with additional time to engage with CMS and contractors in discussions on the measures that will be

offered for MIPS reporting. As part of this conversation, CMS should not only provide direction on what they expect of measures for the upcoming performance period, but also provide QCDRs with a sense of what they plan to prioritize in future years so societies can align their long-term measure development and implementation goals with those of the QPP.

QCDR Timeline Issues

The ACC National Cardiovascular Data Registry (NCDR) found the 2017 self-nomination process to be burdensome and is aware that several QCDRs and medical specialty societies encountered the same issues. The ACC asks that CMS be more transparent in identifying the contractors it is working with so QCDRs are aware of who is reaching out to them and why.

For example, NCDR staff received requests from various contractors over the past few months related to QCDR measure approval outside of the normal JIRA process. It was unclear what information NCDR needed to provide to CMS and this contractor in order to resolve issues such as duplicative measures. The intent of this process was also not immediately apparent. In some cases, the ACC is aware of circumstances where these conversations resulted in identical measures being approved for some QCDRs but rejected for others. The ACC asks that CMS work with its contractors to provide QCDRs with an advance timeline of requests to expect from these various contractors so staffing and resources can be allocated to address these requests in a timely manner. In addition, CMS should exercise oversight over the information provided by its contractors to ensure that it is consistent across vendors.

The final QCDR list for 2017 was not publicly posted until July 13, 2017, more than halfway through the performance year. Prior to this, CMS provided clinicians with thorough education on the MIPS program, yet none of it could include references to the specific QCDRs and measures available for reporting since final approval was not announced until the summer.

Despite the public posting of QCDRs, the College still continues to face hurdles in preparing to report 2017 performance data for clinicians. For the 2017 performance year, CMS has undertaken a large scale overhaul of the technical infrastructure used by the QCDRs to submit data. The College is concerned as this was done without input from the societies operating these registries and without concern for feasibility. The College recognizes that CMS is trying to develop efficiencies in the reporting process; however, without knowing the business processes and resource allocations of the organizations that operate QCDRs, CMS should not make these decisions without input from stakeholders.

The ACC requests that for the 2018 performance year and future years, CMS dedicate more resources for developers to understand technology and infrastructure changes earlier in the year; that CMS include technical information in the rule; and that consideration is taken by CMS to understanding technical challenges faced by specialty societies looking to submit data on behalf of their clinicians.

ADVANCED ALTERNATIVE PAYMENT MODELS (ADVANCED APMs)

The ACC acknowledges CMS' interest in moving toward Advanced APMs that encourage clinicians to coordinate care for a population under a two-sided risk model. Year 1 of the QPP provided few opportunities for participation in this pathway through specialty-focused models. The College is encouraged by CMS' approach in this proposed rule to implement policies that make qualifying participation under the Advanced APM pathway more accessible to cardiologists.

All-Payer Combination Option

The ACC supports implementation of the All-Payer Combination option for determining Advanced APM qualifying participant (QP) status. This may provide the opportunity for more clinicians to participate in the Advanced APM pathway, particularly specialists who may find it difficult to meet the payment/attributed patient thresholds through Medicare models alone.

CMS proposes to make QP determinations under the All-Payer Combination Option at the individual eligible clinician level rather than that of the APM entity. Measuring risk at the individual eligible clinician level could be a barrier to entry to participating in APMs as this puts the onus on an individual to meet high QP thresholds that are already challenging for APM entities as a whole to meet. **The College strongly disagrees with the proposal to measure risk at the individual eligible clinician level and urges CMS to maintain measuring risk at the level of the APM entity.**

The College recommends that CMS take a cautious approach to implementation as the Agency acknowledges that there are limitations to this option. For example, CMS would not maintain the participation list or affiliated practitioner list for other payer APMs. The College is concerned that this will limit the ability to provide clinicians with accurate notice of their QP status unless CMS is able to coordinate this information across payers in a timely manner. CMS should address these infrastructure limitations prior to full implementation.

Medical Home Model

The College supports incentives to encourage participation of specialists in the medical home model. The ACC is encouraged by continued efforts to recognize specialty-focused medical homes as historically the focus of this model has been mainly targeted at primary care clinicians. Participation in this model also requires a large up-front investment and commitment by practices. In addition to incentivizing participation in the medical home model, CMS should also continue to consider other Advanced APM opportunities for specialists.

Nominal Risk Standard

CMS proposes to maintain the generally applicable revenue-based nominal amount standard at eight percent of the average estimated total Medicare Parts A and B revenue of providers and suppliers in participating APM Entities for the 2019 and 2020 Medicare QP performance periods. **The College supports this proposal to maintain the current generally applicable revenue-based nominal amount standard rather than increasing the standard for the 2019 and 2020 Medicare QP performance periods.** Maintaining the current standard will provide clinicians additional time to

adjust to performing within the current standard. The ACC encourages CMS to maintain similar stability as it reconsiders this standard in future years.

Small and Rural Practice Nominal Risk

For the 2019 and 2020 QP performance periods, CMS seeks comment on a lower revenue-based nominal amount standard for small practices, how to define rural practices, and whether the lower standard should apply to small or rural practices that are either participants in APMs or that join larger APM entities to participate in APMs. The ACC appreciates CMS' recognition that participation in Advanced APMs may be more difficult for small and rural practices that do not have the resources to invest in the infrastructure required of Advanced APMs or the ability to comfortably engage in a two-sided risk model.

The College strongly supports the proposal to lower the revenue-based nominal amount standard for small and rural practices to allow small practices and clinicians practicing in rural areas to enter into Advanced APMs if desired. For small and rural practices, one of the greatest barriers to participating in Advanced APMs is the nominal risk amount standard. Unlike their larger counterparts in urban areas, small and rural practices often do not have sufficient financial resources to build care coordination infrastructure and lack the patient volume necessary to offset this resource drain and remain viable.

Advanced APMs Starting or Ending during a Medicare QP Performance Period

CMS should calculate threshold scores for Advanced APMs that are actively tested continuously for a minimum of 90 rather than 60 days. While 60 days is the shortest period between two snapshot dates (June 30th – August 31st), 90 days is the shortest possible length of time CMS would use to make QP determinations; therefore, a 90-day active testing period is sensible. A 90-day active testing period is also more appropriate as it provides additional time to meet the volume requirements to reach the QP threshold. It is challenging for cardiologists to meet the QP thresholds. A 90-day active testing period would provide a greater window of time to gain the volume of patients or revenue to meet the QP threshold requirements.

For eligible clinicians whose individual Medicare threshold scores are less than the APM entity threshold, CMS proposes to apply a weighted methodology using the group level Medicare threshold score to either the individual clinician payment amount or patient count method and weighted for individual provider Medicare volume. This proposal creates a moving target for participation that could lead to consequences such as QP status of eligible clinicians changing within the year. Unless CMS bases participation on volume from the prior year, as payment changes, the QP status of eligible clinicians may also change during the year. For example, an eligible clinician may not know whether he/she is a QP until the last day of the year. The ACC opposes any policy that creates this level of uncertainty.

Physician Focused Payment Models (PFPMs)

The ACC remains engaged in the work conducted by the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to identify PFPMs for testing and potential implementation.

The College is pleased to see that CMS has proposed changes that will allow for a broader definition of PFPMs under the QPP.

The College supports expanding the definition of PFPMs to include payment arrangements with Medicaid and CHIP as this will allow for the development of broader models that address the needs of various populations. Greater uniformity in defining acceptable for proposals by various types of payers, within reason, is preferable. However, the ACC reminds CMS that for certain disease states, guidelines of care through Medicaid and CHIP are less developed than those in Medicare and this may present challenges in the development of new models.

Ideally, clinical guidelines and performance against benchmarks should serve to standardize appropriate care between institutions and guide payment. Often, for older adults, care guidelines exist for many disease states to guide performance and reimbursement because the standard is known and clear expectations exist based on the large Medicare population. In pediatrics, guidelines exist for certain disease states such as diabetes, asthma, and to an extent, oncology but not for others, such as cardiology. For pediatric cardiology in particular, the cardiovascular care community as a whole is still working towards a standard and may lack consensus on specific guidelines for inpatient or outpatient management of many disease states. It would certainly help to have physicians at the table for the discussion of CHIP reauthorization and Medicaid reimbursement but with the acknowledgment that reimbursement for maintaining guidelines/standards within the pediatric arena may not be as far along in development.

CLOSING

The ACC looks forward to ongoing discussion and collaboration with CMS to develop policies that support the ability for clinicians to focus on the delivery of high-quality patient care under an evolving value-based payment environment. The College is encouraged to see that in addition to the Year 2 QPP proposals presented in this rule, CMS is already thinking ahead to how these policies may impact Year 3 participation.

The ACC appreciates the Agency's consideration of the comments presented in this letter. If you have any questions or would like additional information regarding any recommendations, please contact Christine Perez, Associate Director, Medicare Quality and Payment Policy, at (202) 375-6630 or cperez@acc.org.

Sincerely,

Mary Norine Walsh, MD, FACC
President