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June 27, 2016

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

Re: Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed Rule (CMS-5517-P)

Dear Acting Administrator Slavitt:

On behalf of the members of the American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM), we appreciate the opportunity to provide comments in response to the Notice of Proposed Rulemaking for the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models. We appreciate the outreach by the Centers for Medicare & Medicaid Services (CMS) to the physician community during this comment period and we hope that this open dialogue will continue in order to ensure the successful and effective implementation of MACRA.

The AANEM is comprised of nearly 4000 neurologists, physical medicine and rehabilitation (PMR) physicians, technologists, and other collaborators interested in neuromuscular diseases. Our physician members diagnose and treat patients with disorders of the muscle and nerve, such as carpal tunnel syndrome, cervical and lumbar radiculopathies, Guillan-Barre syndrome, Lou Gehrig's disease (ALS), diabetic and other forms of peripheral neuropathy, myasthenia gravis and muscular dystrophy. Many of these are considered rare disorders, e.g., myasthenia gravis.

Many of our physicians subspecialize in neuromuscular medicine, electrodiagnostic medicine, or neurophysiology. These physicians see a very select subset of patients and, in some cases, such as electrodiagnostic testing, only see the patient once for an electrodiagnostic evaluation with the follow-up care provided by the referring physician. As a result, our members have experienced great difficulty in finding applicable quality measures under Medicare's current value-based/quality programs. This will become even more difficult with the general trend away from process measures to outcome-based measures. Additionally, many of our members have had trouble finding any APMs that work in their specialized practices. For these reasons and more, we have carefully reviewed the proposed rule and made specific suggestions for modifications that we believe will improve the new proposed payment programs for eligible clinicians, patient

care, and CMS.

While we believe that the proposed rule represents progress over the three quality/value-based programs currently in place, we have serious concerns over the implementation of the program and certain aspects of the program's design. First, we are very concerned about the extremely short timeframe between the publication and the implementation of the final rule. We respectfully request that CMS allow a minimum of 6 months between the release and implementation of the final rule so as to allow the eligible clinicians enough time to learn about the new requirements and to make the necessary changes to their practices to bring them into compliance with the new rule. We also believe that this extra time will be helpful for vendors, registries, and others to update their systems to ensure they are in compliance with the new program requirements. For example, to date, there are no 2015 certified EHR products available and most believe that physicians will not have this updated technology by January 2017. Alternatively, we ask that CMS issue an interim final rule as its next step to allow for continued improvement and refinement of the concepts in the proposed rule. We note that the statutory language for the MIPS and APM categories does not require the use of a full calendar year reporting period, so the first reporting period could begin July 1, 2017.

A second concern we have with the proposed rule is the full calendar year reporting period for both the MIPS and APM programs. Such a requirement can create a significant administrative burden without improving the validity of the data, especially in categories that are not automatically calculated by CMS. We propose that CMS permit eligible clinicians to select a shorter reporting period if they believe it is more appropriate for their practice.

Third, the intent of MACRA was not only to integrate the current incentive programs into MIPS but to improve and simplify these programs into a single more unified approach. In this regard, we encourage CMS to better align the different components of MIPS so that it operates as a single program rather than four separate parts, such as creating a common definition for small practices. Also, we suggest that CMS simplify the reporting burdens and improve the chances of success by creating more opportunities for partial credit and fewer required measures within MIPS.

Fourth, we have some general concerns (as well as more specific concerns discussed later) about the impact of the proposed rule on small, rural, and Health Professional Shortage Areas (HSPAs). We have two general recommendations:

(1) Lower the reporting burdens for these practices by incorporating specific accommodations into each of the four MIPS categories and ensuring there are free or low cost reporting options within each category.

(2) Where possible, compare practices to their peers rather than to larger, more advanced/sophisticated entities.

(3) Increase the low-volume threshold (this suggestion is discussed in greater detail below).

Finally, we noted the lack of non-MIPS options, in general, given the extremely narrow definition of "Advanced APMs" and the overall dearth of options for specialists even within the MIPS program itself.

The following paragraphs contain comments related to specific sections of the proposed rule. Occasionally, specific page numbers of the proposed rule are cited – these page numbers are based on the PDF version available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-10032.pdf.

Merit-Based Incentive Payment System (MIPS)

General Comments

We appreciate CMS's efforts to consolidate the existing quality/value programs into a single, cohesive payment program. We also commend CMS for removing, in general, the all-or-nothing reporting requirements under MIPS. However, we have several general concerns with the MIPS program, as well as specific concerns in the individual categories. One major concern is the potential impact of MIPS on solo and small physician practices. In an attempt to address this, CMS has proposed a low-volume threshold that would exempt physicians with less than or equal to $10,000 in billing charges and fewer than 100 unique part-B enrolled Medicare patients from MIPS. According to an AMA analysis of the 2014 "Medicare Provider Utilization and Payment Data: Physician and Other Supplier," only 10% of physicians and 16% of all MIPS eligible clinicians would be exempt under this proposal and that these clinicians account for less than 1% of total Medicare allowed charges for Physician Fee Schedule services. We support that AMA's suggestion of raising the threshold to $30,000 in Medicare allowed charges and changing the "and" in the current proposal to "or" with regards to the number of unique part-B enrolled Medicare patients. We propose the following definition for low-volume: physicians with less than or equal to $30,000 in billing charges OR fewer than 100 unique part-B enrolled Medicare According to the AMA's analysis, this would exclude approximately one quarter of physicians while still subjecting more than 95% of allowed spending to MIPS. Additionally, by maintaining the patient threshold, it would exempt physicians who may provide very complex, high-cost treatments to a small number of Medicare patients.

Additionally, while we appreciate the time and effort it takes to provide clinicians with performance feedback, such feedback is necessary to educate clinicians and allow them to make the necessary changes. The proposed rule suggests such feedback would only be provided on an annual basis. This would not allow the clinician to use the information to make changes in the performance year for which the feedback is based. Therefore, we strongly suggest that CMS make every possible effort to provide performance feedback at least twice a year. Relatedly, we also noted that while eligible clinicians are able to request a targeted review of their MIPS reporting, it is entirely up to CMS's discretion as to whether such a request is granted. Such discretion should not be permitted, especially

since, according to the proposed rule, if an eligible clinician or group is found to have submitted inaccurate data, CMS would reopen, revise, and recoup any resulting overpayment. There is no mention of an appeals process for the eligible clinician or group. This should be added to the final rule.

Finally, we note that under the proposed rule, CMS intends to publicly report MIPS scoring for individual clinicians via the Physician Compare website. While we understand the desire to provide the public with information to help educate them and, potentially, guide them in their selection of clinicians, we believe it is of the utmost importance that the measurements reported accurately reflect the performance of the physician. With the short timeframe from the release of the final rule and its implementation, there will be a very steep learning curve for the physicians. Therefore, we believe that delaying the public reporting of MIPS scores by 2 years is reasonable and will allow enough time for physicians to become fully acquainted with the requirements of MIPS.

Clinical Practice Improvement Activities (CPIA) Category

We commend CMS for reducing the required timeframe for the performance of relevant activities in the CPIA category from the initial proposed 1 year to 90 days. AANEM currently has two "Performance in Practice" modules (PIPs) available that qualify under Part IV MOC. The required timeline (i.e., how long the physician must perform the activities in the module for) on these PIPs is currently 30 days but it would far more be feasible for us to extend that time frame to 90 days than 1 year. Relatedly, it is unclear from Table H in the proposed rule what, if any, requirements there are for a project under Part IV MOC to meet in order to qualify under the CPIA category. We respectfully request that CMS clarify that PIPs that meet part IV of MOC and are 90 days would meet the CPIA requirements

In addition to including part IV MOC activities in this category, we encourage CMS to look at including Continuing Medical Education (CME) as a qualifying CPIA. "Section 1848(q)(2)(C)(v)(III) of the Act defines a CPIA as an activity that relevant eligible clinicians organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes." (p. 81) Learning through CME is integrally related to and a necessary component of improvement clinical practice. Furthermore, there are already mechanisms in place to ensure that accredited/certified CME activities are: (1) relevant to practice-related learning needs and practice gaps, (2) evaluated to measure the educational and clinical impact of those activities, and (3) created and provided independent from commercial influence. The PARS Reporting System could be augmented to assist CMS in tracking compliance. Approved CME activities could meet the 90-day requirement in the proposed rule by utilizing a 90-day survey or evaluation period within the program.

AANEM would like to propose the usage of its electrodiagnostic (EDX) laboratory

accreditation program as a CPIA. The AANEM EDX Laboratory Accreditation program is a voluntary, peer-review process that identifies and acknowledges EDX laboratories for achieving and maintaining the highest level of quality, performance, and integrity based on professional standards developed by AANEM and cited by Medicare Local Coverage Determinations across the country. The accreditation program provides laboratories specializing in EDX medicine with a structured mechanism to assess, evaluate, and improve the quality of care provided to their patients. There is a peer review component of the accreditation process that provides feedback to the laboratories on how to improve their practices. The program is granted to practices for a 5-year period and is open to all types and sizes of practices. The program requires annual reporting, as well as a full renewal every 5 years. We believe that, at a minimum, the initial application and renewal processes should count as a CPIA. More information on this program can be found on our website: http://www.aanem.org/Practice/EDX-Laboratory-Accreditation.

The proposed rule lacks clarity on the CPIA criteria. It does not appear that there is a formal process in the proposed rule for suggesting additional CPIAs than those stated in the proposed rule. We respectfully request that information be included in the final rule on the process for proposing a new CPIA and what criteria will be used to evaluate whether a CPIAs will be accepted or rejected.

Finally, we suggest that the number of required CPIAs be reduced to require either two high-weighted (20 points) or four medium-weighted (10 points) CPIAs, or some combination, for a total of 40 points. Under the proposed rule, a physician could be required to report on as many as six different activities which would be extremely resource-intensive. This is especially unfair in light of the fact that the CPIA category will only account for 15% of the overall MIPS composite score. Relatedly, we also suggest that participants in an APM receive *full* credit for the CPIA category.

Resource Use Category

While we understand the need to measure resource use in order to accurately measure quality, we have several concerns and questions related to the measurements in this category.

First, the Per Capita and Medicare Spending Per Beneficiary (MSPB) measures should be removed. It is inappropriate to use such broad measures to evaluate the resource use of individual physicians as the QRURs consistently show that the services delivered by an individual physician represent a tiny fraction of the total cost of care for their patients. However, if CMS chooses to retain these measures, we request additional information as to how any "adjustments" to these measurements will be made. For example, the proposed rule states that, "a specialty adjustment would be applied to the total per capita cost measure," but it provides no explanation as to how this would be calculated. (p. 131). We would appreciate further details on precisely what CMS means by this statement. For example, many of our subspecialized physicians see more complex cases and, as a result, often provide more testing and other services. While the proposed rule

also includes an adjustment for the "health status" of the patients, it is not clear that this factor would apply to a patient who is referred for a suspected disease but, after testing, shows a simpler (or no) diagnosis. We would respectfully request that CMS provide additional details on how it intends to apply such adjustments and, where necessary, to work with affected specialty and subspecialty physicians and organizations that represent these physicians in the creation of criteria for these adjustments.

Second, we note that per section 1848(r)(3) of the Act, there will be patient relationship categories and codes that "define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service." (p. 134). The proposed rule goes on to explain that, "These categories shall include different relationships of the clinician to the patient and reflect various types of responsibility for and frequency of furnishing care." (p. 134). While we commend CMS for recognizing the importance of taking into consideration the physician's relationship with the patient when calculating resource use, we request additional information on what impact such codes will have on the resource use determination. As discussed earlier in this letter, many of our physicians only see patients via referral and, oftentimes, that referral comes with a suspected diagnosis that the physician may need to rule out and which may involve additional testing. Alternatively, in the event that the referral does not come with any suspected diagnosis, sometimes additional testing is required to rule out several possible diagnoses. The creation of these types of codes should reflect these types of situations in order to accurately account for the varying types of relationships and responsibilities of the physician to the patient in many specialties and subspecialties.

Third, the resource use category allows for the use of episode-based measures. We applaud CMS's inclusion of such measures as we feel these measures could provide for a much more meaningful measurement of a clinician's performance in this category, but, unfortunately, there are no measures that currently apply to the vast majority of the neuromuscular disorders our members diagnose (there is a measure for Parkinson's disease which would apply to a subset of our membership). The proposed rule states that CMS intends to continue to engage stakeholders in the development of additional episode-based measures, but it does not contain any information on how clinicians or other groups can participate in the process. We respectfully request that CMS provide detailed information on how to participate in the development process of episode-based measures.

Finally, MACRA states that if there are not sufficient applicable measures, the Secretary shall assign "different scoring weights (including a weight of zero)." The law permits but does not require a score of zero. Therefore, we believe that the most appropriate action in such an instance would be to score the physician as "meets resource use standard." The default assumption in MIPS should be that physicians are practicing efficiently unless the data shows otherwise.

Quality Performance Category

While the proposed quality category attempts to simplify the reporting requirements, it also creates additional complications. In order to achieve the goal of simplifying the process, we believe several key changes should be made. In particular, we suggest that CMS should reduce the number of required measures to four to allow clinicians to focus on the most pertinent ones and eliminate the outcome/high priority and cost-cutting measure requirements, instead counting these measures only as bonus points.

According to the proposed rule, part of one of the primary goals of the Quality Performance category is to use a patient-centered approach to program development, which includes "Measuring performance on measures that are relevant and meaningful." (p. 91). We agree that the quality measures must be "relevant and meaningful" in order for them to be of any use to both the eligible clinician and CMS. Part of the problem with the current Medicare value-based/quality programs is that there are not enough meaningful measures for many specialties and, in particular, subspecialties like electrodiagnostic and neuromuscular medicine. Current programs have required physicians to report on as many measures as they possibly can, without regard to the meaningfulness to his/her practice. Often, this has resulted in physicians having to undertake additional administrative burden to ask patient questions and document responses to questions that have no relevance to that physician's treatment of the patient (and measures that the particular physicians has absolutely no control over). We appreciate that CMS has included language that the measures used should be "relevant and meaningful" but we seek clarification on what standards CMS intends to use in order to determine whether or not a measure is "relevant and meaningful" to a particular physician's practice. Additionally, the proposed rule states, "If fewer than six measures apply to the individual MIPS eligible clinician or group, then we propose the MIPS eligible clinician or group would be required to report on each measure that is applicable." (p. 97) Again, we ask for clarification on how CMS proposes to define "applicable."

We do appreciate the efforts of CMS to create specialty-specific measure sets in Table E. This will simplify the task of many general specialists in identifying applicable measures. We also appreciate that CMS has proposed allowing those specialists who elect to report their specialty-specific measure sets which have fewer than 6 measures to only report on the total number of measures in that set. However, there are no measure sets for subspecialists. Many subspecialists will find it difficult to find "applicable" or "relevant and meaningful" measures within the general specialty measure sets. We propose that CMS work with subspecialist physicians and organizations that represent these physicians to create meaningful sub-specialty measure sets, such as measures for common conditions like carpal tunnel syndrome or more complex, but less common, conditions like ALS. As CMS is no doubt aware, the creation of new measures is very time and resource-intensive so we would request that CMS provide these groups of physicians and the organizations that represent them with additional financial and administrative support in the development and testing of such measures.

We understand that per Section 1848(q)(2)(C)(iv) of the Act, CMS is not permitted to exempt eligible clinicians from the performance category entirely. Therefore, we hope that CMS will work with the affected specialist and subspecialist physicians to identify applicable measures and re-weight this category as necessary.

We also suggest that CMS reduce the reporting threshold under this category to 50%, as opposed to 80%, for claims reporting and 90% for EHR, clinical registry, or web-interface that is currently required. The proposed changes constitute an almost two-fold increase in data completeness as compared to the current PQRS requirements. Additionally, setting such high thresholds is unrealistic and does not account for administrative problems that physicians may run into, especially in the first couple of years. A 50% threshold still requires the reporting on a majority of patients.

Finally, with regards to the removal of "topped out" measures, we suggest that CMS adopt a three-year phase out period to allow for the submission of new measures within the current Call for Measures timeframe. As discussed above, there is a dearth of measures for many specialists (and especially subspecialists) so the removal of any measures that are presently applicable to them should be phased out to allow for new, relevant measures to be created and implemented. Furthermore, CMS requires a measure developer to submit measures nearly two years prior to the start of the program year; therefore, giving affected groups a three year head-up provides them with at least a full year to undertake the development of a new measure.

Advancing Care Information (ACI) Category

We commend CMS for its efforts to provide greater flexibility in its scoring methodology as compared to the current Electronic Health Record (EHR) Meaningful Use (MU) program, but we are concerned that it remains a pass-fail program and retains the same prescriptive measures. We are also troubled by the complexity of the ACI category and the seemingly compliance-driven measure, as opposed to physician and patient-centric, nature of the measures. In addition to these concerns, we request clarification on a few sections in the proposed rule related to this category and have a few recommendations.

First, in the proposed rule, the base score carries over the problematic all-or-nothing structure of the current MU program in that if a physician fails to report/attest to just one requirement, the physician earns a zero for not only the base category, but the *entire* ACI category, regardless of whether that physician successfully reported 100% on every other ACI requirement. We recommend that CMS award credit for each measure reported under the base score and clarify that a physician will not fail the entire ACI category if they fail to report on all base measures.

Second, scoring in this category should include a physician's improvement from year to year. As it is currently written, the scoring pits physician practices of varying size, resources, and manpower to compete against one another for percentage points. Instead, it should focus individual improvement from year to year. If a physician achieves a

minimum 1% increase in their adoption of a performance measures, they should be awarded the full ten points for that measure.

Third, performance in this category should be measured from a majority (50%) of patients rather than the total patient population. This takes into account many valid reasons as to why a patient or physician may not perform an ACI measure. For example, a patient may prefer to not have their health information shared on a patient portal for privacy concerns.

Fourth, the proposed rule requires a 1 year reporting period. For the 2014 and 2015 reporting periods, MU operated on a 90-day reporting period. We believe that a 90-day reporting period is sufficient and allows time for clinicians to make necessary technology updates and/or accounts for system downtime. However, if CMS chooses to retain the 1 year performance period, we request clarification as to the meaning of the statement on page 197: "MIPS eligible clinicians that only have data for a portion of the year can still submit data, be assessed and scored for the advancing care information performance category." We request clarification as to whether a physician who only has data for a portion of the year and reports that data will be eligible for all possible points under this category or if they will be penalized.

Fifth, in the Stage 2 Final Rule (77 FR 54099), CMS noted that eligible professionals who lack face-to-face interaction with patients or lack the need to provide follow-up care with patients faced challenges with EHR measures. However, the proposed rule goes on to provide an exemption (without the need for an application) from this category only for non-patient facing physicians but makes no mention of the physicians who lack the need to provide follow-up care with patients. We respectfully request that CMS clarify the reasons for not including physicians not providing follow up care, such as physicians who perform electrodiagnostic studies solely on referrals and do not ever see the patient for follow-up care, and further request details on how or if CMS proposes to administer the application for exemption for these physicians. For example, the subspecialist may identify the patient has ALS but then a different team of physicians, therapists, etc. manage the future care of that patient.

Finally, CMS should allow clinicians to continue to use the 2014 edition technology until it confirms that 2015 edition technology is readily available. Currently, there is no certified software that has met the 2015 edition criteria so it is not realistic to mandate clinicians use 2015 technology beginning in 2018.

MIPS Composite Performance Score

The proposed calculation method is very confusing and it is unlikely that the majority of physicians will understand the various point systems, how they relate to each other and, ultimately, the implications of the final score on their Medicare reimbursement. Therefore, we suggest that the scoring focus on a single total score rather than four different subcomponent scores.

Additionally, MACRA allows a fair amount of latitude for the Secretary to reweight MIPS categories if there are not sufficient measures or activities applicable to a participant. However, the proposed rule focuses primarily on shifting any missing category into the weight of the quality performance category. Given that the performance category is already worth 50%, we believe this puts too much emphasis on this category, essentially negating the remaining categories. Instead, we suggest that CMS work with affected physicians and physician organizations to determine the best method of reweighting to accommodate the unique needs of various practices.

MIPS Auditing

With regards to reviews and audits under the MIPS program, we have two suggestions. First, we suggest that CMS broaden the timelines. Specifically, CMS should not limit the request for a targeted review to within 60 days after the close of the data submission period. Most physicians will not know if they should request a review of the MIPS adjustment factor until they receive information from CMS about whether they have earned a MIPS incentive or penalty. We recommend CMS allow at least 90 days for a targeted review after a physician is notified of their performance in MIPS. Second, CMS should publish clear guidance on what documentation must be maintained to comply with a MIPS audit.

Alternative Payment Models (APMs)

Section 101(e)(2) of MACRA provides for an incentive payment of 5% to eligible clinicians (and excludes them from having to participate in MIPS) who meet the definition of "Qualifying APM Participants" (QPs) for participation in eligible alternative payment models (referred to as "Advanced APMs" in the proposed rule). The proposed rule also provides for favorable MIPS scoring for physicians who participate in APMs that do not qualify as an Advanced APM.

At the present time, there are very few APMs and even fewer Advanced APMs that neuromuscular/electrodiagnostic physicians would be able to utilize. While we are currently in the early stages of researching the development of an APM(s) that may be applicable, we note that such an endeavor is extremely resource-intensive, especially for a smaller organization, such as AANEM. Therefore, we respectfully request that CMS provide additional resources targeting smaller groups to aid in the development of new APMs.

Advanced APMs

We appreciate and agree with the flexibility proposed for Advanced APMs to select their own approach to measuring quality so long as the measures selected are comparable to MIPS quality measures. We also agree with the proposed requirement that 50% of QPs use certified EHRs to document and/or communicate with their patients or other health care providers but we would urge CMS not to increase the percentage in subsequent

years.

The proposed rule sets the revenue threshold to meet the definition of a QP at 25% in 2019 but increases it to 75% for 2023. We note that, according to the proposed rule, very few APMs will qualify as Advanced APMs and we believe that if part of the goal of MACRA is to encourage participation in Advanced APMs, CMS should be more flexible in its qualification process, lowering the initial threshold to 20% of patients receiving care through the APM for 2019, increasing to 50% by 2023. Many APMs are designed for a specific subset of patients based on a specific condition or disease and many physicians participating in these APMs will have difficulty obtaining enough of their revenue (75% by 2023) to ever qualify as a QP. Furthermore, the focus should be on the percentage of patients as opposed to total revenue as some rarer conditions seen by the eligible clinician may account for a large portion of the total revenue but it would be unrealistic to create APMs specific to these rare conditions.

Additionally we have serious concerns related to the requirement that the Advanced APM undertake "more than nominal risk." First, the definition is complicated and confusing with multiple components including total risk, marginal risk, and minimum loss rate. The definition should be simplified to make it easier for physicians to understand the financial risks and to avoid losses. Second, the risk requirements should be based on professional service revenues, not expenditures under the APM, as physicians should not be held responsible for expenses outside of their control. Third, the proposed rule defines "more than nominal" as 4% of total costs – this amount is in excess of CMS's long-used definition of "significant" impact of 3% of physician revenue according to the Regulatory Impact Analysis notes. Fourth, physician's uncompensated costs (e.g., care coordinators, data analysis, and other nonbillable services) should be counted as financial losses. Fifth, similar to the standards for medical homes, the loss of guaranteed payments should be counted as losses for all APMs. All APM participants should be able to treat repayment of performance-based payments as financial risk.

Additionally, we appreciate CMS's acknowledgement that many specialty-focused or disease-specific APMs utilize attribution methodologies that are not based on evaluation and management services and, therefore, targeted exceptions will be necessary. While the use of targeted exceptions, as opposed to the creation of more general standards, will complicate the process of defining the standards for approval of an APM, we agree with CMS that this approach is more appropriate and equitable given the complexities involved with the design of APMs. However, we hope that CMS will provide developers of APMs with additional guidance on how to apply for such an exception and what information will be required in the application. We are also hopeful that CMS will work with APM developers early in the process in order to facilitate any changes deemed necessary before significant resources are invested in the project.

Finally, we believe that a formal review process should be established through which other APMs could be modified so that they can qualify as Advanced APMs. This review process would make more feasible the eventual development of Advanced APMs from the new APMs developed by stakeholders, especially models for specialists/subspecialists

and those recommended by the Physician-Focused Payment Model Technical Advisory Committee (PTAC). Comments from some CMS officials have indicated that stakeholder models proposed by the PTAC will then have to go through a full CMS model review process before being approved, suggesting that it would take years before such models would become available.

MIPS APMs

We appreciate CMS's proposal to allow for at least some incentives for participants in APMs that do not qualify as Advanced APMs. We support granting certified medical home participants with full CPIA credit, but we believe that participation in any MIPS APM should qualify the eligible clinician for full CPIA (not just the half credit currently proposed). By participating in a MIPS APM, eligible clinicians are essentially doubling down on their risk – facing both the potential penalties under MIPS and the potential financial loss under the APM. MACRA clearly intended to encourage broad APM participation and we believe that the potential benefits of participation must be sufficient enough (such as full CPIA credit) to make the time and effort required by participation in an APM worthwhile.

Physicians-Focused Payment Models (PFPM)

Physician-Focused Payment Models (PFPM) are defined in proposed rule as, "An Alternative Payment Model wherein Medicare is a payer, which includes physician group practices (PGPs) or individual physicians as APM Entities and targets the quality and costs of physician services….[These] may address such elements as physician behavior or clinical decision-making." (p. 608) We believe that our Electrodiagnostic Laboratory Accreditation program would potentially qualify under this definition. AANEM's accreditation program meets at least the first two criteria laid out in the proposed rule: (1) the program defines specific standards for electrodiagnostic practices that ensures only high-value care is provided to patients and (2) the program protects patient safety and improves overall care delivery through additional standards. The third and final criteria, enhancement of information via health information technology, is currently outside of the scope of the program but we believe that with further clarification of what, specifically, is considered under this criteria, it may be possible to adapt the program. We look forward to working with the PTAC in the development of an applicable PFPM.

We would like to echo our concern with regards to the timeline from application to approval by the PTAC. We would also like clarification as to what, if any, impact participation in a PFPM has on a physician's participation in MIPS.

Conclusion

We thank you for your consideration of our recommendations. We hope that this letter will serve as part of a continuing and collaborative discussion with CMS as the regulations are finalized and implemented. We would also like to strongly encourage CMS to consider delaying the implementation of the final rule until July 1, 2017, to allow for all parties to familiarize themselves with the new requirements and make the appropriate changes to ensure compliance. We would welcome meeting with CMS to answer questions related to any of our suggestions.

Sincerely,

Vern Juel, MD, AANEM President