COLLEGE of AMERICAN PATHOLOGISTS

November 17, 2015

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Attention: CMS-3321-NC

Subject: Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models

Sent via Electronic Submission to http://www.regulations.gov

Dear Acting Administrator Slavitt:

The College of American Pathologists (CAP) appreciates the opportunity to comment on the Request for Information CMS-3321-NC entitled "Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models" (RFI). The CAP is a national medical specialty society representing 18,000 physicians who practice anatomic and/or clinical pathology. CAP members practice their specialty in clinical laboratories, academic medical centers, research laboratories, community hospitals and federal and state health facilities.

The CAP is looking forward to working with CMS to determine how to design the Merit-Based Incentive Payment System (MIPS) to measure appropriately providers who typically do not furnish services that involve face-to-face interaction with patients, including pathologists. The CAP believes considerable accommodations or alternate measures will be necessary to meet this clause[1] in the Medicare Access and CHIP Reauthorization Act (MACRA). Currently, pathologists are not accounted

[1] In carrying out this paragraph, with respect to measures and activities specified in subparagraph (B) for performance categories described in subparagraph (A), the Secretary—
''(I) shall give consideration to the circumstances of professional types (or subcategories of those types determined by practice characteristics) who typically furnish services that do not involve face-to-face interaction with a patient; and
''(II) may, to the extent feasible and appropriate, take into account such circumstances and apply under this subsection with respect to MIPS eligible professionals of such professional types or subcategories, alternative measures or activities that fulfill the goals of the applicable performance category.
In carrying out the previous sentence, the Secretary shall consult with professionals of such professional types or subcategories.

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for in two of the four MIPS categories (pathologists are currently exempt from Meaningful Use (MU), and not accounted for under Resource Use because they do not provide primary care services.) In addition, MACRA outlines six types of activities that would meet the definition of Clinical Practice Improvement Activities. Several of those categories may not be applicable to non-patient facing specialties (e.g. expanded practice access, such as same day appointments). Though we could not answer every question in the RFI due to both the short comment period and a lack of context, the CAP offers specific suggestions below and looks forward to further conversations with CMS prior to release of the proposed regulations for the implementation of MACRA on both the MIPS and alternative payment fronts.

A. The Merit-Based Incentive Payment System (MIPS)

1) MIPS Eligible Provider (EP) Identifier and Exclusions

Should we use a MIPS EP's TIN, NPI or a combination thereof? Should we create a distinct MIPS Identifier?

The CAP believes that it would be appropriate for CMS to allow for selection of group or individual reporting option as is currently available. This means CMS should continue to assess quality performance as it does currently via the Tax Identification Number (TIN) and the National Provider Identifier (NPI) under the Physician Quality Reporting System (PQRS) for individual reporting and at the TIN level for the PQRS Group Practice Reporting Option (GPRO). Additionally, we suggest that the group reporting option be extended to all MIPS categories. Due to the diversity of pathology practices, CMS should maintain flexibility and multiple ways of participating in MIPS.

2) Quality Performance Category

Should we maintain the same or similar reporting criteria under MIPS as under the PQRS?

The CAP urges CMS to maintain the current mechanisms available to report data to CMS as an individual EP and as a group practice participating in the PQRS GPRO. We specifically ask that CMS maintain the claims-based reporting option as that is the most viable option for pathologists to report quality measures. We would also urge CMS to continue exclusion of pathologists from selection as focal providers about whom the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey asks. Since pathologists do not have an appointment-based practice and are generally non-patient facing providers, it is appropriate that they not be included in the CAHPS requirement.

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The reporting criteria should be as simple as possible. CMS should eliminate many of the existing criteria, including reporting on cross-cutting measures, reporting on three National Quality Domains. These and other criteria unnecessarily complicate the program and do not provide any additional assurance of quality.

What is the appropriate number of measures on which a MIPS EP's performance should be based?

Should we require that certain types of measures be reported? For example, should a minimum number of measures be outcomes-based? Should more weight be assigned to outcomes-based measures?

There should not be an absolute minimum number of measures, outcomes-based or otherwise, that EPs have to report. The current measures list is insufficient to cover all practice types, and the challenge of participating will only be exacerbated by imposing a minimum number of measures, particularly outcomes measures. If CMS does decide to change the current minimum of nine measures, the minimum should be reduced not raised. In addition, if a minimum number of measures is established on which an EP's performance is based, EPs who are unable to report on the minimum should not be penalized if they do not have applicable measures. The measure development process is difficult and requires numerous resources that many specialties do not have readily available. In addition, the turnover of measures due to either high performance rates or changing guidelines adds to the challenge of maintaining a selection of appropriate measures that may be used by the many specialties and sub-specialties. Further, the current definitions of outcomes do not address outcomes for diagnostic specialties. Since outcome measures as currently defined are elusive for non-patient facing diagnostic physicians who do not mange patients either before or after rendering a diagnosis, we believe that such physicians should be excluded from any outcome measure requirements, if they are established. We recommend that an EP continue to be able to report on only measures that are applicable to his/her practice.

Should we require that reporting mechanisms include the ability to stratify the data by demographic characteristics such as race, ethnicity, and gender?

CMS should not require that reporting mechanisms include the ability to stratify data by demographic characteristics. While reporting of quality data, stratified by race, ethnicity, sex, primary language, and disability status is important, the CAP urges CMS to exempt non-patient facing providers, such as pathologists, from this requirement. This information is not readily available or accessible to non-patient facing EPs, such as pathologists, and it would therefore be inappropriate for CMS to require it. The CAP also requests that CMS clarify how the information will be used.

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3) Resource Use Performance Category

Value-Based Modifier (VBM): Currently under the VBM, we use the following cost measures: (1) Total Per Capita Costs for All Attributed Beneficiaries measure; (2) Total Per Capita Costs for Beneficiaries with Specific Conditions (Diabetes, Coronary artery disease, Chronic obstructive pulmonary disease, and Heart failure); and (3) Medicare Spending per Beneficiary (MSPB) measure. CMS seeks comment on the following questions:

Apart from the cost measures noted above, are there additional cost or resource use measures (such as measures associated with services that are potentially harmful or over-used, including those identified by the Choosing Wisely initiative) that should be considered?

The current VBM program is designed for primary care specialties and generally does not measure the value that pathologists provide to their patients. For example, none of the cost measures or outcomes measures applies to pathologists and the attribution mechanism has been designed for primary care specialties. While pathologists routinely contribute to team-based care, it is difficult to account for their resource use under the current system. We hope that CMS takes this into consideration as it develops the resource use performance category of MIPS. The CAP has previously recommended alternatives but due to the short response time and the limited details on the implementation of MIPS for this RFI, we feel further discussion of an alternative methodology is not appropriate. However, we ask for further discussions between the CMS and the CAP prior to the issuance of a proposed rule on MIPS.

4) Clinical Practice Improvement Activities Performance Category

The CAP believes that a menu of Clinical Practice Improvement Activities will be needed to accommodate the differences in practices between specialties and the sub-specialties. For example, participation in tumor boards is a significant clinical practice improvement activity, but may not be applicable to pathologists in small practices or sub-specialties. The CAP offers the following examples of activities that could qualify for the proposed Clinical Practice Improvement Activities subcategories:

- Population management, such as monitoring health conditions of individuals to provide timely health care or participation in a qualified clinical data registry;
  - *Participation in Blood Product Utilization Management Committee*
  - *Participation in Clinical Laboratory Services Utilization Management Committee*
- Care coordination, such as timely communication of test results (including critical values), timely exchange of clinical information to patients and other providers, and use of remote monitoring or telehealth;

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- *Participation in Multidisciplinary Tumor Boards*

o Patient safety and practice assessment, such as thorough use of clinical or surgical checklists and practice assessments related to maintaining certification; and
  - *Patient Safety checklist use*
  - *Proficiency Testing (PT) surveys on Clinical Laboratory Improvement Amendments (CLIA) laboratory performed tests*
  - *Participation in Practice level assessments (e.g. Q Probes, Q tracks – though Sub-Committee does not recommend naming them explicitly unless we include non-CAP Programs.)*

o Participation in an alternative payment model (APM). *Credit for participation in APM if EP falls below threshold for exclusion from MIPS.*

What information should be reported and what quality checks and/or data validation should occur to ensure successful completion of these activities?

The CAP recommends that CMS use attestation to determine if an EP has met the requirements for this category. CMS could allow EPs to propose their own activities (with third party verification e.g. The Joint Commission (TJC) or the American Board of Pathology (ABP)) or accept activities that are part of Maintenance of Certification.

How often providers should report or attest that they have met the required activities?

The CAP suggests that providers attest annually, for example once per incentive period.

What threshold or quantity of activities should be established under the clinical practice improvement activities performance category? For example, should performance in this category be based on completion of a specific number of clinical practice improvement activities, or, for some categories, a specific number of hours?

We urge the CMS to keep requirements simple for the clinical practice improvements performance category. As MIPS will be a new program for EPs, we believe it is important for the CMS to ensure that participation is not overly burdensome.

5) Meaningful Use of Certified EHR Technology (CEHRT) Performance Category

What alternate methodologies should CMS consider for this performance category?

How should hardship exemptions be treated?

The current MU program is not applicable to pathology practice and many of the program requirements are impossible for pathologists to meet. Thus, the CAP appreciates the continuation of the hardship exception that was finalized in the CMS final rule for MU Stage

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2, which grants automatic relief for pathologists based on their Provider Enrollment, Chain and Ownership System (PECOS) specialty code. We believe that pathologists should not be penalized for failing to meet the requirements of a program designed for office-based physicians. Therefore, all efforts to align the current MU program to MIPS must account for specialty practice differences in clinical information systems used and the nature of the typical patient relationship (e.g. non-patient facing). The CAP requests that hardship exemption for pathologists continue until an appropriate alternative for MU that is applicable to Laboratory Information Systems (LIS) is developed.

6) Other Measures

The CAP believes that system level and population based measures should be applicable to EPs, such as pathologists, who typically furnish services that do not involve face-to-face interaction with patients. Activities like blood utilization, infection control and test utilization committee participation should be credited to the whole group. We urge CMS to be flexible and not to focus exclusively on measures and activities that involve face-to-face encounters as these would have an unfair and negative impact the MIPS composite performance scores of pathologists and other non-patient facing specialties.

7) Flexibility in Weighting Performance Categories

How do we apply the quality performance category to MIPS EPs that are in specialties that may not have enough measures to meet our defined criteria? Should we maintain a Measure-Applicability Verification Process?

The CAP recommends that CMS not reweight the MIPS categories if sufficient measure and activities are not applicable or available to an EP. We believe that a MIPS composite performance score based on fewer than four categories would not be comparable to scores based on four categories. For example using only two categories for non-patient-facing specialists versus four categories for other specialties would disadvantage the non-patient facing EP compared to other specialties and therefore is inherently unfair. The CAP is continuing to explore alternatives for MU and Resource Utilization for pathologists but due to the short response time for this RFI and the limited details on the implementation of MIPS for this RFI, we cannot provide an alternative mechanism at this time, but ask for further discussions between the CMS and the CAP prior to the issuance of a proposed Rule on MIPS. The CAP suggests that as the MIPS program is implemented, that CMS takes steps to assure that appropriate measures in each category exist

What minimum case size thresholds should be utilized? For example, should we leverage all data that is reported even if the denominators are small? Or should we employ a minimum patient threshold, such as a minimum of 20 patients, for each measure?

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The CAP believes that CMS should employ a minimum patient threshold of 20 patients for each measure.

8) Public Reporting

As the CAP has stated in prior comments to CMS, we believe that all EPs should have an opportunity to review their personal information that will be included on the CMS Physician Compare website prior to posting. Prior review by physicians will give physicians the opportunity to improve their processes when deficiencies are identified; and is aligned with the stated program goals of improving health care quality. As CMS moves forward with implementation of MIPS, we ask that the current 30 day preview period be extended to 60 days to give physicians adequate time to review any potential inaccuracies they may find during the review process and that CMS provide a specific methodology through which physicians can correct any inaccuracies prior to CMS publicly posting the information. Anecdotally, we found many entries for the CAP members were inaccurate. For example, some entries failed to note participation in the PQRS when the member had participated and received an incentive payment, and the opposite was also true, physicians who had not participated had notations that they were noted as having done so. Accuracy of information should be the first and highest priority before any additional information is considered for the site.

The CAP reiterates its comments from previous years that encourage CMS to develop educational tools for patients viewing the Physician Compare website, especially with implementation of MIPS. The CAP believes it will be important to note when a physician could not participate in a specific performance category listed due to circumstances beyond his/her control, (e.g. PQRS due to lack of applicable measures or electronic prescribing (eRx) because they do not meet minimum criteria set by CMS or write prescriptions as part of their medical practice.) The absence of this explanatory information is potentially misleading and could imply a lack of interest in quality when the issue is actually lack of applicability of the program to that physician. The CAP reiterates the need to indicate clearly on the website when a program does not apply to a particular physician.

CMS seeks comment on including individual EP and group practice-level quality measure data stratified by race, ethnicity, and gender in public reporting, if statistically appropriate. While this data may be helpful, we seek clarification as to its utilization. Additionally, the CAP has concerns as this information is not typically available to pathologists or a LIS and therefore, making it inappropriate for CMS to require it. Though the data is often not readily accessible as it is not routinely provided with every specimen, pathologists do seek that

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information when necessary for interpretation; however, this would be burdensome to do for all cases. We hope that CMS engages with the CAP before making specific proposals related to measure stratification.

9) Feedback Reports

The current QRURs are not actionable for pathologists. The only measures in the reports that are applicable to pathologists are the PQRS pathology measures. Pathologists rarely have any patients attributed to them, and when they do it is difficult to understand how this can be correct, since they do not provide primary care services. As noted in previous comments, the feedback reports distributed to CAP members showed performance on measures in practice areas that pathologists cannot affect and that were completely unrelated to the services pathologists provide. QRURs received by pathologists to date still do not meet CMS stated principle of providing meaningful and actionable information. The CAP urges CMS to provide more timely and appropriate feedback as it pertains to pathologists.

B. Alternative Payment Models

1) Payment Incentive for APM Participation

How should CMS define "services furnished under this part through an eligible alternative payment model (EAPM) entity."

CMS should define services furnished through an EAPM to encompass services (a) provided to beneficiaries who are assigned to an EAPM regardless of whether the services are provided by a participating or non-participating EAPM provider or (b) otherwise received from EAPM providers. Defining the phrase in such a fashion increases the focus on coordination, population management and individual services rendered to members enrolled in eligible alternative payment models and incentivizes practitioners such as pathologists who by virtue of their capabilities, roles, and training coordinate care and execute many of the objectives that are encouraged under MACRA by recognizing their contributions to beneficiaries who receive services through EAPMs.

What policies should the Secretary consider for calculating incentive payments for APM participation when prior period payments were made to an EAPM entity rather than directly to a QP, for example, if payments were made to a physician group or an accountable care organization (ACO)? What are the advantages and disadvantages of those policies? What are the effects of those policies on different types of EPs (that is, those in physician-focused

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APMs versus hospital-focused APMs, etc.)? How should CMS consider payments made to EPs who participate in more than one APM?

To continue to encourage the provision of services through APMs/EAPMs by individual practitioners, CMS should ensure it considers prior period payments made directly to a qualifying APM participant (QP) in addition to those made to a physician group or ACO for purposes of determining EP status. To handle this in any other way could serve to penalize a provider who was indeed providing services that benefited the physician group/ACO and its patients, but for whom payments would not be accounted. While this information may be difficult to capture, even if through self-reporting by the payer or recipient, its being considered for purposes of determining EP status is critical.

The distinction in the effect of such an approach on different types of EPs (physician-focused versus hospital-focused) should be minimal. Similarly, payments made to EPs participating in more than one APM should be combined and considered for purposes of threshold and eligibility determination. The goal of increased coordination and provision of services to patients through APMs is furthered through such an approach. In addition, this is consistent with the direction taken under the MSSP that specialists generally (unless they have otherwise attributed patients under current MSSP methodology) are permitted to participate with more than a single ACO.

What types of data and information can EPs submit to CMS for purposes of determining whether they meet the non-Medicare share of the Combination All-Payer and Medicare Payment Threshold, and how can they be securely shared with the federal government?

Submission by EPs of information CMS does not receive directly under the MSSP or other qualifying APM would need to be through a secure and confidential means so that the specific terms of the arrangements from each of the payers that contribute to achieving the All-Payer Threshold could not be discerned. In addition, only the minimum necessary information for purposes of determining the Combination All-Payer and Medicare Payment Threshold should be required. While the confidentiality of information submitted would need to be maintained, the process for submission must also not be administratively burdensome nor otherwise deter those who truly have transitioned or are transitioning to alternative payment models from fulfilling the Combination All-Payer and Medicare Payment Threshold for administrative reasons.

2) Patient Approach

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What are examples of methodologies for attributing and counting patients in lieu of using payments to determine whether an EP is a QP or partial QP?

The CAP is not providing specific examples, but underscoring the importance of ensuring any methodology adopted by the agency recognizes the contribution of quality health care provided by pathologists and other specialties that are either hospital-based or not predominantly patient-facing and as such would not be able to have patients attributed or "counted." The CAP concurs that determining whether an EP is a QP or partial QP should not turn solely on payments so as not to deter participation. While pathology spending alone does not represent a large portion of episode or alternative payment model spend nor are pathologists responsible for much of the total cost of care, the extensive influence of laboratory testing on clinical decision making uniquely positions pathologists to assist in achieving the goals of these models, particularly in minimizing waste and inefficiencies in innovative evidence-based ways beyond actual payments made to pathologists. In short, the cost of the pathology services themselves pales in comparison to the effect of pathologists' interventions on downstream cost avoidance. Failure to take this into account into determining whether an EP is a QP or partial QP fails to mobilize these significant contributions to the overall success of the APM.

3) Regarding EAPM Entity Requirements

What entities should be considered EAPM entities?

While CAP was quick to recognize and explore pathologists' roles in coordinated care models even prior to the launch of the MSSP, it has not to date identified a model that could be considered a stand-alone pathology EAPM. Practically speaking, pathologists are likely members of EAPMs rather operating than their own pathology EAPM. In these instances, EAPMs should be required to ensure the adequacy of their networks and the scope of services (either in or outside their network) they provide to the population for which they are responsible. Determining and ensuring adequacy for specialties such as pathology and other diagnostic and facility-based specialties has presented unique challenges as historic adequacy measures based on distance or drive time are not applicable nor do they ensure reasonable access to services through an EAPM entity.

What criteria should be considered when determining "comparability" to MIPS of quality measures required by a non-Medicare payer to qualify for the Combination All-Payer and Medicare Payment Threshold? Please provide specific examples for measures, measure types, (for example, structure, process, outcome, and other types (recommended data

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sources for measures (for example, patients/caregivers, medical records, billing claims, etc.), measure domains, and comparable methodology.

Comparability to MIPS of quality measures required by a non-Medicare payer to qualify would for the Combination All-Payer and Medicare Payment Threshold would need to be based on meaningful performance measurement that reflects and recognizes not only practitioner contributions, but also potentially the level of integration of the applicable health system.

Pathologists' activities provide the infrastructure and foundation for effective and appropriate care. Pathologists, by virtue of their capabilities and roles already coordinate care and execute many of the objective under MACRA and other efforts targeted at increasing integration to improve patient care and the patient care experience overall.

CAP welcomes the opportunity to work with CMS and with other clinicians, as applicable to develop measures that reward the activities pathologists can and in many instances, already do undertake in alternative payment models for appropriate inclusion in determining comparability. While pathologists advise on patterns of utilization and ordering practices, collaborate with other clinicians on diagnostic and prognostic care of patients, and play a key role in harm reduction and infection control, the current Medicare performance measurement system has made it difficult to develop pathology measures that fit its program design and truly capture pathologists' contributions. CAP is optimistic performance measurement for purposes of determining comparability could more effectively lend themselves to pathologists' interventions and activities in an alternative payment environment, and recognize contributions that are so important to aligned and coordinated team-based care, population health, and health care systems.

4) Use of Certified EHR Technology

What components of certified EHR technology as defined in section 1848(o)(4) of the Act should APM participants be required to use? Should APM participants be required to use the same certified EHR technology currently required for the Medicare and Medicaid EHR Incentive Programs or should CMS other consider requirements around certified health IT capabilities?

While not related specifically to certified technology components, the CAP notes that pathologists and their laboratories have long utilized computerized LIS to support their work of analyzing patient specimens and generating test results. Through these LIS, EHRs or enterprise-wide clinical information systems exchange laboratory and pathology data. The

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CAP has heard from several pathologist members about renewal fees they were charged by EHR vendors that rise to the level of price gouging to maintain the interface that is the lifeblood of health information flow to and from the laboratory and ordering physicians. The CAP was therefore very pleased to see the Health and Human Services Office of Inspector General (OIG) issue an alert on October 6, 2015 reminding vendors and providers that information blocking practices through EHR donation arrangements may adversely affect protection under the anti-kickback statute safe harbor. In that communication, the OIG warned against any action taken by a company to limit the use of donated items by charging fees to deter non-recipient providers and the donor's competitors from interfacing with the donated system. OIG indicated these arrangements would pose legitimate concerns the parties were improperly locking in data. While an APM theoretically should thwart such information blocking, the reality of marketplace dynamics that exist beyond the APM may in practical terms produce a different result of which HHS should remain mindful.

5) Definition of Physician-Focused Payment Models

How should "physician-focused payment model" (PFPM) be defined?

At a minimum, these models should be defined so as not to exclude models that move physicians toward true coordinated care and alternative payment models with measurable goals.

Are there additional or different criteria that the Committee should use for assessing PFPMs that are specialist models? What criteria would promote development of new specialist models?

We are pleased to see the scope of EP participants for the model including information about what specialty or specialties EP participants would fall under the model. Ensuring this criterion or additional clarifying criteria are flexible enough to permit single specialty PFPMs or multiple specialties, and if the latter, that the PFPM's network as applicable, is adequate in that it includes diagnostic and hospital based physicians, will be important considerations.

6) Required Information on Context of Model Within Delivery System Reform

We are considering that proposed PFPMs should primarily be focused on the inclusion of participants in their design who have not had the opportunity to participate in another PFPM with CMS because such model has not been designed to include their specialty?

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We applaud and encourage inclusion of participants who have not had the opportunity to participate in another PFPM with CMS because a model has not been designed to include their specialty. We concur that specialists should not be excluded simply because a model has not been designed to include their specialty. To encourage physician participation in alternative payment models such artificial impediments must be removed to avoid penalizing physicians for lack of fit given the complexities or specifics of their specialties that to date have not lent to an existing model. In the case of pathologists, while some have been able to integrate into an APM, others have struggled at this point of APM maturity in their marketplaces to gain meaningful recognition for their significant contributions through no fault of their own. For PFPMs not to afford them opportunities would be detrimental to the expansion of APMs under MACRA. Your approach of affording the opportunity to those specialties for which there has not historically been an applicable design reflects a welcome mindset and is positive step toward addressing the full continuum of care to the benefit of beneficiaries. Not recognizing successful contributions of specialties for which there is no current design will merely reinforce current exclusionary practices and detract from the motivation for ongoing contributions.

7) Technical Assistance to Small Practices and Practices in Health Professional Shortage Areas

What should CMS consider when organizing a program of technical assistance to support clinical practices as they prepare for effective participation in the MIPS and APMs?

CMS should consider a host of concise user-friendly tools including educational sessions, webinars, frequently asked questions, how to guides and the like, in a variety of formats (video, audio, printable) to reach the broadest possible number of clinical practices. The College keeps its members informed through a variety of means including electronic newsletter, webinars, sections of our website on value based-care, performance measurement, and health care reform. These communications often include public information from CMS and other regulators, so their reach would be exponentially greater than CMS direct distribution, and would also be self-reinforcing.

What kind of support should CMS offer in helping providers understand the requirements of MIPS?

We would suggest that the CMS provide clear, specific examples and instructions that specialty societies, such as the CAP, can use to educate their members. Other examples of CMS support could include web-based tutorials, FAQs, discussion sessions at major professional meetings led by CMS representatives, newsletters, vignettes demonstrating

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how different specialties can successfully meet requirements, templates analogous to the Office of the Inspector General (OIG) Model Compliance Plan for clinical laboratories as a guide, and re-educating EPs on resources that are available.

The CAP appreciates the opportunity to comment on this important RFI. Please direct questions on these comments to:

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- Sharon West for APMs. (202) 354-7112 / swest@cap.org

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