June 27, 2016

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Mr. Slavitt:

AMGA welcomes the opportunity to comment on the "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician Focused Payment Models" (CMS–5517–P) proposed rule. AMGA, founded in 1950, represents more than 450 multi-specialty medical groups and integrated delivery systems representing about 177,000 physicians who care for one-in-three Americans. Beyond fee for service and Medicare Advantage (MA), our member medical groups also participate, or will participate, in all six of the APM models identified. Therefore, AMGA has a strong interest in how Title I of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is implemented and moreover achieving the triple aim of improving the experience of care, improving the health of populations, and reducing spending or the per capita costs of healthcare.

AMGA's comments are organized under the MIPS formula and APM pathway; however, we begin with two overarching comments.

MACRA Implementation or Start Date

The MACRA final rule is not anticipated until on or about November 1. If the rule is finalized until then, AMGA proposes CMS define the 2017 performance year as less than the full calendar year, for example, beginning July 1. Among other reasons, AMGA is concerned eligible clinicians and clinician groups will not have sufficient time to review and select appropriate quality measures and make the necessary Health Information Technology (HIT) changes to succeed under MIPS particularly since CMS proposes, in some instances, to substantially increase measure reporting thresholds.

The Need to Measure for Value under MACRA

The intent of MACRA Title I is to improve care quality and reward value. Tying an increasing percent of Medicare fee for service payments to quality or value through alternative payment models such as Accountable Care Organizations (ACOs) is also Department of Health and Human Services Secretary Sylvia Burwell's goal. However, in the proposed MACRA rule CMS will measure and score quality and resource use or spending separately. CMS will not measure outcomes in relation to spending. CMS will not measure for value. If value is left unaddressed in the final rule, it will be difficult at best for the agency to meet MACRA and the Secretary's overarching goals. CMS also cannot reasonably

expect providers or eligible clinicians to continue to enter into, and succeed under, risk based or APM contacts if they do not know if they are incrementally improving quality or outcomes relative to spending.

The need to measure for value is well recognized. In the Medicare Payment Advisory Commission's (MedPAC's) June 2014 report to the Congress, the commissioners stated bluntly, "Medicare's current quality measurement approach has gone off the tracks." With an overemphasis on process measures, providers were left with, the commissioners stated, "fewer resources" to "improve the outcomes of care, such as reducing avoidably hospital admissions." MedPAC's comment echoed Michael Porter. In a 2010 New England Journal of Medicine essay, Porter argued, "The failures to adopt value as the central goal in health care and to measure value are arguably the most serious failures of the medical community." This, he said, has among other things, "resulted in ill-advised cost containment, and encouraged micromanagement of physician practices which imposes significant costs of its own." Per this latter point, a recent study published in Health Affairs by Lawrence C. Casalino and others found physician practices in four common specialties spent more than 15 hours per physician per week reporting external quality measures. This time translated to an estimated $15.4 billion in total costs.

CMS has an opportunity in the final MACRA rule to begin to measure for value. Among other opportunities, MACRA funds $15 million annually between 2015 and 2019 to identify gaps in MIPS quality measures. These funds could be used to develop new measures that align with the Department's National Quality Strategy's "efficiency and cost reduction" priority area or, per the proposed rule, "measures that reflect efforts to lower costs and significantly improve outcomes." CMS could look to and work with the International Consortium for Health Outcomes Measurement (ICHOM) to both exploit and develop additional and much needed outcome measures. Working with ICHOM also provides an opportunity to compare Medicare program performance internationally. CMS could also create a minimum resource use threshold. For example, California's Integrated Healthcare Association's (IHA) value based pay for performance program imposes both quality and spending thresholds. If both thresholds are not met, the provider or provider group's performance score is reduced. As MedPAC suggested in its June 15 MACRA comment letter, CMS could identify and measure comparative performance or performance for all providers via claims data. CMS could then condition resource use scores based on spending in comparable performance categories. (Andrew M. Ryan and others recently published in Medical Care Research and Review a review of seven methodological approaches that combine quality and spending to measure for efficiency.) Measuring for value could also be forwarded via how the agency builds out MACRA required care episode and patient condition group codes that are intended to improve resource use measurement.

Lastly, in the proposed rule CMS does not define the agency's bundled payment demonstrations as APMs. The agency could find a way to include bundled payment arrangements such as the Bundled Payments for Care Improvement (BPCI) and Comprehensive Care for Joint Replacement (CJR) demonstrations since they are designed to improve value or outcomes achieved over spending.

Performance improvement or innovation in healthcare cannot ultimately be achieved via the same conventional thinking that measures quality and spending separately or not simultaneously. Achieving one without the other and/or defining quality as, or a proxy for, value will produce "ill-advised cost containment." If CMS expects providers to continue to buy into and succeed in a pay for value, or a foregone revenue, world, they need to measure and make known the causal relationship between outcomes and spending. The foremost MIPS and APM goal ought to be measuring and rewarding value.

Merit-based Incentive Payment System

Telehealth and Remote Monitoring

The proposed rule makes very limited mention of telehealth and remote monitoring. CMS does propose to include telehealth services in the definition of patient-facing encounters. The proposed rule also identifies two telehealth-related Clinical Practice Improvement Activity (CPIA) measures. AMGA proposes CMS increase the agency's emphasis on provider use of telehealth and remote monitoring to drive access and quality and improve spending efficiency by, for example, identifying additional telehealth-related CPIA and Advancing Care Information (ACI) performance measures.

Non-Patient Facing Thresholds

CMS proposes to define non-patient facing MIPS eligible clinicians as those that bill for 25 or fewer patient-facing encounters during the performance period. This determination appears arbitrary. AMGA proposes CMS justify in the final rule how the agency arrived at this number. With such a low patient encounter threshold it may be unreasonable for CMS to expect eligible clinicians will be able to meet the minimum number of cases with 26 patient-facing encounters to receive a MIPS quality score.

The Low-Volume Threshold

CMS proposes to exclude clinicians that have annual Medicare billing charges less than or equal to $10,000 and provide care to 100 or fewer Part B beneficiaries. This determination also appears arbitrary. AMGA proposes CMS justify in the final rule how the agency arrived at these amounts. Does, again, the agency reasonably expect eligible clinicians with $10,001 in billing charges and 101 beneficiaries to meet the minimum number of clinical cases to receive a MIPS quality score? Clinicians should not be burdened with reporting if it is more likely than not they will not meet the minimum number of clinical cases to receive a MIPS score.

Quality Measurement

On balance, AMGA is in agreement with MedPAC's comment that MIPS, in sum, be designed to determine "aggregate population-based outcome measures across providers in a local area sharing the same hospitals and clinicians." In addition, AMGA proposes CMS make known to MIPS participants average MIPS component scores by provider category, i.e., by MIPS eligible clinicians, by MIPS APM participants, by MIPS participating partially qualifying advanced APMs and cross tab comparative advanced APM performance.

CMS proposes for CMS Web Interface (GPRO) reporting, providers report on the first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module/measure. If less than 248, the group will be required to report on 100% of assigned beneficiaries. AMGA believes the 100% requirement may be administratively or technically unattainable. Since CMS recently reduced the GPRO reporting requirement for ACOs to 248 from 411, CMS could revert back to a higher number. More preferably, CMS can identify a minimum number based on the number of eligible clinicians in the group.

For individual clinicians using Qualified Clinical Data Registries (QCDRs), qualified registries or via Electronic Health Records (EHRs), CMS proposes to increase from 50% to 80% for claims reported data and to 90% measures reported via EHR, clinical registry and QCDR or web interface. AMGA believes these percent increases are unnecessary and unrealistic for several administrative reasons, including the assumption that practices will be ready to report measures on day one, or January 1, 2017. In addition, these thresholds may actually cause eligible clinicians to avoid selecting otherwise

appropriate measures because of the increased reporting burden. Principally for these reasons, AMGA proposes CMS continue to use the 50% reporting threshold.

AMGA supports the voluntary, not mandatory, reporting of Consumer Assessment of Health Plans (CAHPS) measures for all sized practices since CAHPS instruments can have low response rates. Also, patient satisfaction does not always or necessarily correlate with desired clinical outcomes since it is based on patient bias. In addition, AMGA proposes CMS consider moving the CAPHS measure to the CPIA category.

For measures reported via the CMS Web Interface or GPRO, CMS proposes to use ACO 2017 quality benchmark scores to determine MIPS ACO quality scores. For scoring under the 30th percent, for which the ACO program does not score or scores at zero, CMS will assign a value of two points. AMGA questions the logic of scoring ACO quality performance twice. MIPS ACO shared savings determinations for 2017 would be scored, in part, on 2017 quality performance and MIPS ACO 2017 quality performance would again be reflected in the MIPS 2019 payment year. CMS has a policy of not scoring performance twice. Following this logic, and since non-ACO APMs are excluded from MIPS quality scoring, AMGA proposes CMS exempt ACOs from the MIPS quality scoring.

AMGA strongly recommends CMS work to develop and prioritize behavioral health measures. In addition, CMS could add the Medicaid Adult Core Set to MIPS to better account for the care of dual eligible beneficiaries.

Concerning the proposed three global or population measures, since these measures can tend to have limited statistical reliability/validity for individual clinicians, AMGA proposes they be applied, at least initially, to only eligible clinician groups.

Topped Out Measures

Based on 2014 Physician Quality Reporting System (PQRS) data, CMS notes approximately half of the MIPS quality measures proposed are topped out. CMS proposes for topped out measures to award no more than 8.5 out of 10 maximum points. Alternatively, CMS proposes to use flat percentages, as in the ACO program, such that high scores can earn maximum or near maximum quality points while allowing room for year over year improvement. AMGA supports the proposal to use flat percentages for topped out measures. AMGA proposes CMS revisit removing, or phasing out over a multi-year period, topped out measures as well as duplicate measures and the limited number of measures related to children and adolescents. AMGA also proposes CMS not limit the number of topped out measures an eligible clinician can report since not all specialties have a robust number of quality measures from which to choose.

Resource Use Performance Category

As noted above, AMGA recommends CMS begin to consider together or correlate resource use and quality performance or begin to measure for value.

AMGA questions the validity of using a resource use total per capita cost measure and the Medicare Spending Per Beneficiary (MSPB) measure. Because the vast majority of Medicare beneficiaries have multiple chronic conditions their care is not entirely attributable to one clinician. Therefore, a beneficiary's total cost of care should not be attributed to one clinician. This approach also perpetuates the Value-Based Modifier Program (VM) problem where those physicians and hospitals that treat comparatively more complex patients are penalized, particularly when CMS has yet to address how the

agency will risk adjust for sociodemographic or socioeconomic factors. AMGA proposes CMS would more accurately measure resource use by episodes of care, however, it is uncertain to AMGA whether or not the episode-based measures listed in Table 4 and 5 are sufficiently developed to be applied in the near term. AMGA also is concerned the MSPB and episode measures may overlap and as a result eligible clinicians would be scored twice for ostensibly the same performance. AMGA encourages CMS to fully develop care episode groups, patient condition groups and patient relationship categories before being applied to measuring resource use.

CMS proposes to reduce from 125 to 20 the case minimum for each resource use measure (as well as for eligible clinician's quality measures) including the MSPB measure. CMS states this is, "the same case minimum that is being used for the VM," and, "an analysis in the CY 2016 PFS final rule (80 FR 71282) confirms that this [20 case] measure has high average reliability for solo practitioners (0.74) as well as for groups with more than 10 professionals." AMGA questions the reliability and generalizability of 20 cases, in part, since CMS just increased from 20 to 125 the number of cases for the MSPB measure in last year's physician fee schedule rule. In addition, the use of 20 cases presents two inter-related problems. Because half of current measures are topped out and because clinicians likely will opt to report on only high performing measures, there will be limited, if no ability, for eligible clinicians or clinician groups to demonstrate comparative superior performance. The result, as MedPAC stated in its comment letter, is "MIPS will likely score clinicians and adjust their payments based on small gradations of performance on measures that are unlikely to capture true value."

CMS proposes to average all resource use measures. That is all resource measures will be weighted equally. AMGA encourages CMS to re-examine this assumption in light of the above comments concerning value. Again, resource use or dollars consumed should have some relationship to quality or outcomes achieved. CMS also assumes in the proposed rule, "lower costs [spending] represents better performance." Again, this assumption is at least questionable since, for example, the data show all avoided 30 day hospital re-admissions do not constitute improved quality. Also, under the Hospital Value-Based Purchasing program, hospitals receive bonuses for spending efficiency despite having substantially lower quality scores.

CMS proposes no minimum number of measures will be required to receive a score under this category. AMGA proposes CMS apply the least number of measures that, in sum, capture a meaningful percent of the eligible clinician's or clinician group's practice performance.

CMS proposes the agency may use in addition to Part A and B, Part D charges "if the Secretary determines appropriate" and states further, "we intend to consider how best to incorporate Part D costs into the resource use performance category." AMGA supports CMS work to operationally design and integrate Part D measures with Part A and B care in MIPS, particularly as the agency evolves its ACO and other pay for performance models. However, we do not believe the resource use category is sufficiently evolved to add Part D spending in the near term.

CMS proposes for 2017 the agency will not score ACOs under MIPS resource use. CMS states this is because ACOs are already subject to cost and utilization performance assessment under the MSSP. AMGA proposes either ACOs not be assessed as well in subsequent performance years, or alternatively offer MIPS ACOs the choice to be assessed under resource use. Similarly, AMGA also supports allowing Next Generation ACOs to choose to be scored under the MIPS resource use category.

AMGA supports the proposal to exempt in 2017 clinicians participating in MIPS APMs not using the

CMS Web Interface from submitting MIPS quality data until 2018.

AMGA proposes CMS develop CPIA measures related to social service supports.

AMGA echoes MedPAC's comment that the agency not apply a specialty adjustment to the per capita cost measure and any other resource measure. That is CMS should not adjust away spending difference correlated with differences in the supply of specialists.

Finally, CMS proposes to determine resource use scores based on the performance period rather than a prior baseline period. Because resource use scores will be based on claims data, AMGA proposes CMS develop a resource use baseline or benchmark scores as the agency proposes for quality measurement.

Clinical Practice Improvement Activities

AMGA supports the proposal to allow ACOs the ability to choose whether they are scored under CPIA at the ACO level or at the ACO TIN level. Alternatively, AMGA proposes ACOs, like qualifying PCMH's, be given full, not half, credit under the CPIA. To reduce reporting burden, AMGA proposes CMS identify more, or increase the number of, high (or 20 point) measures.

Advancing Care Information

Generally, the ACI measure still emphasizes the simple use of health information technology, i.e., competency in sending health care information electronically. The ultimate goal of the ACI measure is to improve care outcomes via measures that incent a business rationale for Certified Electronic Health Record Technology (CEHRT). CMS should evolve the ACI measure to reach this goal.

The base score still includes Meaningful Use's pass/fail methodology. AMGA proposes CMS award points for each base score measure reported. AMGA also proposes CMS gradually reduce the ACI base score weight and increase the performance score weight. It appears some 2018 Stage 3 Meaningful Use requirements will be required in 2017. Therefore, AMGA proposes eligible clinicians be given more time to meet these requirements. AMGA proposes ACI performance scores also should include an eligible clinician's year over year improvement. AMGA proposes CMS continue to use or apply previous meaningful use exclusions and hardships under MIPS ACI. AMGA also encourages CMS to align in the final rule ACI measures with the forthcoming Office of the National Coordinator's (ONC's) interoperability recommendations.

Risk Adjustment for Socioeconomic Status

AGMA strongly encourages CMS to work to continually improve risk adjustment methodology throughout MIPS and the APM pathway. As the agency is aware, the science of risk adjustment is still largely unevolved. For example, the New York State Cardiac Surgery Reporting System (CSRS), arguably the gold standard for hospital and physician quality, cannot distinguish performance among the vast majority of hospital and doctors. Recent data shows only 2% of physicians scored above the statewide average and only 8% of hospitals had risk adjusted mortality rates above the state average.

Performance Feedback

AMGA remains concerned CMS does not provide performance feedback in a timely manner. AMGA encourages CMS to evolve MIPS measurement such that reporting becomes a more iterative process where eligible clinicians and vendors provide performance data more routinely and CMS responds as frequently as monthly with composite score performance, particularly resource use performance since

it's derived from claims data.

MIPS Primary Care Medical Homes
AMGA proposes CMS increase the recognized accreditation entities for medical homes beyond NCQA to include, for example, Blue Cross Blue Shield accreditation.

MIPS and Small Practice Performance
CMS generally defines small practices as 15 or fewer clinicians with, it appears, the exception for the all-cause hospital readmission measure that accounts for 10 clinicians or fewer. AMGA proposes CMS use one, consistent definition. Beyond a consistent definition, per the agency's proposed rule impact table, nearly one-third of practices have nine or fewer eligible clinicians. This suggests the small practice definition is too lax. AMGA proposes CMS significantly tighten this definition to, for example, practices with five or fewer eligible clinicians.

Qualifying Participant Option to Report Under MIPS
CMS proposes to allow partially qualifying participants to opt out of MIPS reporting. CMS also seeks comments on ways to reduce MIPS data submission requirements "to enable MIPS eligible clinicians participating in Advanced APMs to maximize their focus on care delivery redesign necessary to succeed." AMGA proposes this opt out option be extended to Track 1 ACOs.

Virtual Groups
CMS proposes not to implement this provision until 2018, however, the agency seeks comments on factors to consider regarding the establishment and implementation of virtual groups. If CMS finalizes the non-patient facing and MIPS exclusion thresholds, virtual groups should be established for the explicit purpose of better enabling eligible clinicians to meet the clinical case reporting thresholds under MIPS scoring.

Year Over Year Improvement
CMS proposes not to score year over year improvement for 2017 but seeks comments on how best to incorporate improvement scoring for all categories. Since CMS will use existing measures or measures previously reported under PQRS, if eligible clinicians select measures for which they were scored in 2016, AMGA propose CMS award in 2019 year over year improvement for 2017 performance.

MIPS Performance Threshold
It appears CMS will use a single numerical threshold to determine MIPS adjustments. It may be likely eligible clinician performance may concentrate around a mean or median. Therefore, AMGA proposes CMS identify a threshold range score, at least for 2017 scoring, such that eligible clinicians falling within the range would be held harmless.

Alternative Payment Models

Bearing Financial Risk for Monetary Losses/Nominal Amount Standard
CMS defines financial risk beyond a nominal amount at 4% of total Part A and B spending. However, the 4% is in actuality substantially higher for physician practices that receive only Part B reimbursement. Since CMS references the maximum penalty under MIPS, AMGA proposes CMS define beyond nominal risk similarly, or beginning with 4% of Part B professional services revenue in performance year 2017. Alternatively or more specifically still, AMGA proposes CMS define nominal risk as total Part B cost of care delivered by the APM eligible clinician or clinician group.

Since the proposed rule identifies the six APMs, and since APM participation requires providers or provider groups be in a contractual relationship with CMS, it is unclear when or where the beyond nominal risk definition (30% marginal risk, 4% minimum loss rate and the 4% of expected expenditures) applies. It is unclear whether all APMs going forward must meet these criteria and if all payer APMs also will be required to meet this definition.

Since the definition of nominal risk is based in part on the MSSP, AMGA proposes the definition include a stop-loss provision. The proposed rule does mention stop loss on page 28307 and in Table 29 on page 28309, but it does not appear CMS actually is proposing to include this provision.

CMS seeks comment on page 28307 on "a tiered nominal risk structure." AMGA proposes CMS allow marginal risk to be adjusted upward or downward depending on total amount of expected expenditures. This would mean marginal risk at 30% would be applied to only APMs in the highest expected expenditure category. That is, the marginal risk percentages are tiered. The marginal risk percentage increases as expected expenditures increase. The percent of marginal risk and expected expenditures should correlate as expected expenditure amounts will vary widely, i.e., the ability to make repayment successfully is related to total expected expenditures or the financial size of the organization.

On page 28307, the proposed rule states, "we would not include any payments the APM Entity or its eligible clinicians would make to CMS under the APM if actual expenditures exactly matched expected expenditures. In other words, payments made to CMS outside the risk arrangement related to expenditures would not count toward the nominal risk standard." AMGA requests CMS provide a specific example.

Finally, AMGA is well aware of the considerable concern within the Track 1 ACO provider community about the agency's proposal to exclude Track 1 ACO from advanced APM bonuses. In previous MSSP related proposed rules, AMGA supported recognition of Track 1 startup and participation costs by, for example, including startup costs in a Track 1's established benchmark. AMGA recognizes awarding advanced APM bonuses to all current (and future) Track 1 participants would have significant Medicare financing implications and discourage or delay providers from progressing to either Track 2 or Track 3, the MSSP's ultimate goal. AMGA also recognizes providers have been reluctant to sign Track 2 or 3 agreements or accept financial downside risk.

There are several solutions CMS ought to consider to address these inter-related problems or concerns. As AMGA argued in its proposed ACO benchmark rule comment letter earlier this year, CMS could allow Track 1 ACOs in any performance year to move to Track 2 or Track 3. CMS could alternatively allow a subset of Track 1 TINs in any performance year to sign a Track 2 or 3 agreement. CMS could define Track 1 ACOs in their second agreement period as eligible for the advanced APM bonus since these ACOs would have accumulated or absorbed significant administrative costs over four years that would be in excess of a nominal amount. This policy would also encourage providers that did not earn shared savings during their first agreement period, which at present represent approximately 75% of all Track 1 ACOs, to remain in the MSSP.

There also is another alternative. Researchers, for example Harvard's Dr. J. Michael McWilliams, have repeatedly argued the Track 1 model does not provide sufficient financial incentives. CMS is well aware approximately one-third of 2012-2013 ACOs did not sign in 2015 a second agreement period contract largely for this reason. Therefore, for those Track 1 ACOs that earn shared savings in an

amount less than 5% of their total Part B reimbursements, CMS should award the ACO the difference. This approach would provide additional financial incentive and address the fact that total ACO shared savings paid are highly concentrated among a very few number of successful ACOs. This approach would, also and again, incent providers to participate and persist in the MSSP. Another way to address insufficient financial incentives would be to allow willing MIPS ACOs, including Next Generation ACOs, to fully participate or compete in all four MIPS categories. The assumption here is ACOs would likely be competitively advantaged.

Patient Centered Medical Home (PCMH) Risk Criteria

Among other related provisions, AMGA supports the proposed "not necessarily worse off" provision. Under this provision a PCMH would meet its risk threshold if it lost the right to otherwise guaranteed payment, such as a per member per month payment.

AMGA offers several proposals related to the definition of a PCMH as an advanced APM. Since PCMH criteria do not apply until 2018, AMGA proposes the "owe or forego" percentages begin in 2018 and not 2017. The 2017 2.5% risk threshold should be moved to 2018. AMGA also proposes the 2.5% to 5% ramp up over four-years begin only after the provider begins performance as a PCMH APM. Based on its experience with the MSSP, CMS is well aware providers improve APM performance incrementally year over year.

The proposal to limit the organization in which the PCMH is performing to 50 or fewer clinicians "in the organization through which the APM entity is owned and operated" appears to be both arbitrary and a proxy for the organization's financial resources and capacity. Since the 2.5% risk threshold is based on the organization's limited ability to manage financial risk at 4%, AMGA proposes there would be greater accuracy in identifying a minimum threshold amount of Medicare reimbursement or expected expenditures that are necessary for a PCMH to reasonably assume downside risk. Alternatively, AMGA proposes a limitation on the number of PCMH clinicians rather than in the entity's overarching organization. For example, as CMS suggests, the PCMH cannot exceed some percent of total organization clinicians. AMGA does support the proposal that size limitation would be determined prospectively if it was based on a maximum number of clinicians. AMGA also supports the proposal that if the PCMH's overarching organization is managing 4% of risk the number of clinicians is moot.

Federally Qualified Health Centers

CMS proposes FQHC's that participate in an ACO be counted towards Qualifying Participant (QP) determination under the patient count but not the payment amount threshold calculation. CMS is excluding the payment amount threshold because FQHCs are not reimbursed under the Medicare Part B physician fee schedule. AMGA supports this proposal.

Qualifying Participant (QP) Status

There is considerable concern among AMGA members that, as proposed, participants in APMs will not know if they are a QP participating in an advanced APM until after the performance year. AMGA proposes CMS consider making QP determinations for the 2017 performance year in 2016. Doing so would, in part, relieve their burden of APMs also having to report under MIPS in 2017. This policy would also apply going forward.

AMGA supports the proposal to total an eligible clinician's performance in multiple APMs such that the eligible clinician can more readily achieve QP status or do so when none of the APMs in which they participate achieves QP status. AMGA also proposes CMS allow for QP status either at the TIN or

NPI level.

CMS proposes the requirement that eligible clinicians would have to be listed on the last day of the performance period, or December 31, in order to be included as an advanced APM participant. AMGA encourages CMS to reconsider this proposed definition. In the final rule, AMGA also encourages CMS to explain how the agency will account for clinicians that join an APM during the performance year. AMGA proposes they be included in the QP calculation.

AMGA proposes CMS not limit QP determinations for Next Generation ACOs to providers identified on the TIN-NPI list that is used for alignment purposes and submitted in June or July of the preceding year. This list is produced too early in the year to include all of a TIN's NPIs who are actively billing that year. Also, because it is created specifically for alignment purposes, this list generally will be limited to primary care providers. This is particularly problematic for the lists submitted in 2016, as they were submitted before entities had a full understanding of MACRA's implications. Next Generation 2017 applicants were required to submit their TIN-NPI list June 3. To include an NPI on the list, the Next Generation applicant was required to notify that provider 14 days prior, or by May 20. This gave Next Generation applicants just a few weeks to understand MACRA's implications in context of who is included on the TIN-NPI list. For these reasons, AMGA requests CMS create a process for QP determination that is not limited to the TIN-NPI list submitted for ACO alignment purposes and that the process include all NPIs billing under the TIN as of December 31 of the year preceding the performance year.

Advanced APM Determination

CMS proposes to release an initial set of advanced APM determinations no later than January 1, 2017. If CMS finalizes this proposal, AMGA recommends CMS provide the advanced APM detailed threshold information such that the advanced APM knows to what extent it meets or exceeds both qualifying thresholds.

AMGA recognizes CMS policy has been to adjust Part B payments two years after the performance year. AMGA proposes CMS work to reduce the lag to one year. For example, the payment year for the 2017 performance year would be 2018, not 2019. Since CMS proposes to award advanced APM performance as late as December 31 of the payment year, the agency has approximately nine months, which is sufficient time to calculate the two advanced APM thresholds. Such a policy would incent greater provider participation in APM models.

Advanced APM HIT Requirements

CMS proposes non-hospital advanced APMs have at least 50% of its eligible clinicians use of CEHRT in 2017. This would increase to 75% in 2018. If this assumes the percent usage is for the entire performance year and if the final MACRA rule is published on or around November 1, this leaves insufficient time for HIT vendors to make related software program updates such as dashboards. A November final rule also makes is difficult to make changes in response to MIPS CPIA data collection and reporting. If the final rule is published after October 15, AMGA proposes these percentages be met over some time period less than the full performance year period. In AMGA's May 2015 Meaningful Use Stage 3 comment letter, we recommended a 90 day reporting period for new and current participants since coordinating vendors and third-party interoperability partners takes time.

Advanced APM Thresholds

AMGA supports several proposed threshold-related provisions. These include the beneficiary

threshold where the numerator is assigned beneficiaries and the denominator is assignable beneficiaries in the performance year. Similarly, under the payment threshold the numerator is all Part B covered professional services for attributed beneficiaries and the denominator is all attribution eligible for the performance period. AMGA supports the proposal of not double counting beneficiaries for any single advanced APM and the proposal whereby an advanced APM must elect during the performance year whether to report MIPS in the event it is determined after the performance year to be a partially qualifying QP and can change its decision during the performance year. AMGA also supports the proposal that reporting MIPS can be made at the TIN level in instances where an ACO comprises multiple TINS. AMGA supports the proposal CMS, beginning in 2021, will apply the threshold criteria sequentially, first using the Medicare option and next using the all-payer combination option. AMGA supports the proposal that if an APM entity participates in multiple APMs and one is an episode payment APM, CMS would add the number of numerator beneficiaries in the episode APM to the numerator of the non-episode APM, for the purpose of supporting participation in multiple APMs. Finally, AMGA supports the criteria that under the all-payer combination similar CEHRT and quality measures be used and providers bear more than nominal risk.

However, in the proposed rule CMS does not explain the agency's reasoning for selecting the qualifying and partially qualifying beneficiary and payment percent thresholds. These appear arbitrary. In the final rule AMGA proposes CMS explain the rationale the agency used in selecting these thresholds.

MIPS APMs

AMGA recognizes regulatory implementation of MACRA Title I is complicated. AMGA proposes CMS simplify implementation by requiring no additional reporting requirements for APMs to receive a MIPS score. Among other benefits this would increase MIPS competition between and among eligible clinicians.

CMS proposes MIPS APMs that are ACOs, including Next Generation ACOs, be exempt from resource use scoring and other APMs be exempt from both quality and resource use scoring. AMGA recommends MIPS APMs be given the choice of whether or not to be exempt from these MIPS component scores. ACOs and other APM participants should not be precluded from competing fully under MIPS.

Partially Qualifying APMs

CMS proposes partially qualifying APMs have a choice to participate in MIPS. AMGA supports this policy.

Medicare Advantage (MA) Plans Under the All Payer Advanced APM Threshold

The proposed rule states, "We believe it is important to note that APMs may involve Medicare Advantage plans and payers other than Medicare." CMS states further, "We propose to evaluate payment arrangements between eligible clinicians, APMs Entities and MA plans as Other Payer APMs," however CMS states further, "we would not consider an arrangement where the MA plan meets the CEHRT and quality measures criteria outlined in this proposed rule, but pays the APM Entity on a fee-for-service basis, to be an Other Payer Advanced APM because there is no risk connected to actual cost of care exceeding projected cost of care." AMGA supports the proposal to consider MA plans under the advanced APM all payer threshold beginning in performance year 2019. AMGA believes CMS should consider developing incentives for MA plan participation within the all payer category.

Comprehensive Care for Joint Replacement (CJR) Demonstration

CMS seeks comments on how the CJR model could qualify as an advanced APM. AMGA proposes including the CJR demonstration as an advanced APM by requiring CJR participants meet similar MIPS quality and ACI measures. Among quality measures, CMS should require a patient-reported functionality measures and use of the Unique Device Identifier (UDI).

Advanced APM Bonus Payments

AMGA supports the proposals that bonuses will be based on all covered professional services under Part B for the full prior calendar year across all billing TINS associated with the qualifying participant's NPI. AMGA also supports the proposal that the amount will be calculated at the qualifying participant level by their TIN/NIP combination. AMGA also supports the proposal to preclude APM incentive payments for the purposes of determining future APM financial benchmarks.

CMS proposes to make bonus payments no later than one year from the end of the incentive payment base period. For example, that means December 31 for payment year 2019. AMGA proposes CMS identify a payment date that is earlier than the last day of the payment year. AMGA proposes CMS align the uses of advanced APM bonus payments with those of ACO shared savings payments and include the ability of advanced APMs to share bonus payments with beneficiaries.

Physician Focused Payment Models (PFPMs)

AMGA supports several of the agency's proposed PFPM submission criteria. AMGA supports the proposal that PFPMs can include non-Medicare payers, that a PFPM can include additional types of entities and services beyond physician practices and their services, and that a PFPM does not have to meet advanced APM criteria. AMGA supports the reasoning PFPM proposals include information regarding quality measurement, cost reduction, how payment would be different from current Medicare methodologies, or how a PFPM can improve existing methodologies, and have evaluable goals.

That said, AMGA is concerned the proposed criteria is overly burdensome. Among other things, CMS proposes the submission criteria will need to explain whether the PFPM fits within current Medicare portfolio, explain the scope of impact, explain the likelihood of success, explain how many practices and beneficiaries will be impacted, explain potential outcomes, explain whether the model can be expanded, explain morbidity and mortality rates, explain how attractive the model will be to participants, and the feasibility in implementing the model. Added to these, the agency proposes providers identify existing barriers to improve care and reducing costs while precluding providers from recommending CMS pay for "high-value services" for which agency does not currently reimburse. This provision runs counter to the agency's desired move toward capitated payment. The proposed rule also states the agency will not set any schedule or deadlines in response to PFPM submissions and the PFPM Technical Advisory Committee's (PTAC's) work or its recommendations. This effectively allows the agency to have no responsibility in evaluating PFPMs. AMGA proposes at minimum, CMS be required to review all PTAC submitted proposals via identified criteria and deadlines the agency will use or meet in evaluating PTAC-recommended PFPMs.

Thank you for offering AMGA an opportunity to comment. We look forward to continuing to work with CMS to evolve further MACRA implementation. If you have any questions please do not hesitate to contact David Introcaso, Ph.D., Senior Director for Regulatory and Public Policy, at dintrocaso@amga.org.

Thank you.

Donald W. Fisher
President and CEO