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Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Verma:

On behalf of the AMGA, we appreciate the opportunity to comment on the “Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program” (CMS-1693-P).

Founded in 1950, AMGA represents more than 450 multi-specialty medical groups and integrated delivery systems representing approximately 177,000 physicians who care for one-in-three Americans. Our member medical groups work diligently to provide innovative, high quality patient-centered medical care in a spending efficient manner. Many of our medical groups already participate in the Accountable Care Organization (ACO) or the Medicare Shared Savings Program (MSSP) and in the Next Generation ACO and in the Comprehensive Primary Care + and in other Pay For Performance (P4P) demonstrations. AMGA has a strong interest in seeing improvements made to the Part B program, the MSSP and the Medicare Access and CHIP Reauthorization Act's (MACRA's) Quality Payment Program (QPP).

In order, our comments address the Physician Fee Schedule (PFS), the MSSP, or the Accountable Care Organization (ACO) program, and the QPP.

We begin with a brief summary of our comments.

- AMGA supports CMS' proposed E/M documentation changes, but argues the agency is confounding two separate issues by proposing to collapse Level two through five codes. Documentation requirements are unrelated to the complexity of a beneficiary's care needs represented by a billing code.
- AMGA generally supports the agency's proposal to add a “virtual check-in,” a remote evaluation, and to allow for inter-professional internet consultations.
- We support changes to the MSSP quality measure set and make five recommendations to improve ACO quality reporting and scoring.
- AMGA remains opposed to the high Merit-Based Incentive Payment System (MIPS) exclusion thresholds CMS proposes to retain for performance year 2019. Because the

agency proposes to exclude roughly half of providers from MIPS, we oppose a proposed Composite Performance Score (CPS) threshold of 30 points.

- We are generally in agreement with CMS concerning proposed changes to the MIPS quality measure set, improvement activities, and promoting interoperability components. We have concerns regarding including eight episode cost measures in the MIPS cost component.
- We recommend CMS do far more to make MIPS virtual groups a viable option for MIPS providers.
- Concerning APMs, AMGA is concerned the agency has failed to expand its APM portfolio, effectively denying providers an adequate opportunity to evolve their practices into pay for performance.

PFS Comments

Proposed Changes to Evaluation & Management (E/M) Documentation and Reimbursement

In its proposed 2018 PFS rule, CMS noted the agency's interest in simplifying E/M documentation in order to reduce clinical burden, improve care coordination and provider work flow. The agency sought specific changes to reduce documentation, specifically concerning changes to beneficiary history and physical exam guidelines.

In our response to the proposed 2018 rule, we noted evaluation and management (E/M) visits, particularly complex patient visits, involve a substantial amount of required documentation (as demonstrated, in part, by the fact Medicare Learning Network's "Evaluation and Management Services" guide is 90 pages). Frequently, however, the level of documentation is not commensurate with delivering care that is both high quality and time efficient. For example, if a Medicare beneficiary presents with new onset diabetes, which warrants a level 5 visit, the provider is still required to document the examination of unrelated organ systems that do not contribute to treating and stabilizing the diabetic beneficiary. In addition, this level of documentation increasingly is unjustified as the Medicare program moves to value-based payments – under which the provider is no longer incented to drive utilization to maximize fee-for-service (FFS) reimbursement but instead improve quality and reduce spending. Documentation requirements should align and support reimbursement. That is, documentation requirements under value based arrangements should provide only the necessary information to allow the primary provider and all other cross covering providers to treat the patient longitudinally.

In the current 2019 proposed rule, CMS notes the agency has been concerned E/M codes have been mis-valued at least since formally discussing the topic in its proposed 2012 PFS rule. CMS notes the use of E/M codes (00201-5 and 99211-5) remains administratively burdensome and outdated, too complex, ambiguous, and fail to meaningfully distinguish differences among code levels. CMS also notes they have not been updated to reflect changes in technology, especially Electronic Health Records (EHRs). In addition, the 2016 21st Century Cures Act requires reducing regulatory burden related to EHRs. Reducing the number of E/M codes potentially would avoid Medicare Administrative Contractors (MACs) misinterpreting their use. Finally, CMS notes any changes in E/M documentation would require changes to E/M reimbursement since these two variables are, CMS states, "intrinsically related."

CMS makes several proposed E/M documentation and reimbursement changes. These include:

- CMS proposes to collapse or combine office and outpatient E/M Level two through five codes into one composite code, or code two.
- Though providers would still identify a code two through five, CMS proposes to allow providers to select how they document the E/M visit by: choice of time; medical decision making (MDM); or, use of the current 1995 & 1997 documentation frameworks. CMS is soliciting comments on use of other criteria to document E/M visits, for example, the agency cites Marshfield Clinic's "point system."
- CMS is proposing three supplemental or HCPCS add-on G codes: primary care; complexity; and, prolonged visit. A primary care services G code, GPC1X, would be used for an established patient that can be used by any specialty. G code GCGOX would be a complexity code for certain specialists, i.e., endocrinologists, rheumatologists, hematologists/oncologists, urologists, neurologists, obstetrics/gynecologists, allergy/immunologists, otolaryngologists, cardiologists, & interventional pain providers. CMS is also proposing a prolonged visit G code, GPRO1, for prolonged evaluation that requires direct patient contact beyond 30 minutes.
- CMS proposes to reimburse E/M code two payments at \$135 for new patients and \$93 for established patients (excluding add-on payments for the three, proposed supplemental codes).
- CMS proposes two new codes for podiatry services.
- Regarding use of E/M codes, included in global procedural codes, CMS proposes to reduce payment by about 50% for the least expensive procedure or visit that the same physician or physician in the same group furnishes on the same day as a separately identified E/M visit.
- CMS proposes eliminating the extra documentation for furnishing an E/M visit in the home rather than the office and eliminating the prohibition on billing same day visits by practitioners in same group and specialty.
- CMS is seeking general comments or input on the best number of E/M visit codes and how best to achieve a balance between the number of E/M codes and documentation rules. CMS also is interested in learning about potential use of patient relationship codes/modifiers to differentiate resources provided in E/M visits or used as an alternative to G codes.

Consistent with our comments in response to the proposed 2018 PFS rule, AMGA remains supportive of simplifying E/M documentation requirements. Specifically, simplifying documentation requirements, as CMS recognizes, is inherently advantageous. AMGA is neither persuaded nor convinced that, as CMS states, "documentation changes for E/M visits are intrinsically related to our proposal to alter PFS payment for E/M visits." CMS is confounding two separate issues. Documentation requirements are unrelated to the complexity of the beneficiary's care needs as represented by a billing code. A Medicare beneficiary's health neither improves nor deteriorates based on how accurately or not a provider documents health status. For many years MedPAC, among others, has observed that the Medicare program suffers from prioritizing the care setting and/or payment first and the beneficiary's care needs second. The proposed regulatory change perpetuates this problem. The proposed rule would only make sense if the agency was paying a population health capitated rate. AMGA finds itself largely in agreement with Bob Berenson's critique in his August 15 Health Affairs essay that the metaphor most apt in characterizing the proposed is "the tail wagging the dog."

Since the proposed rule was published on July 27, many observers have commented that consolidating four codes into one likely may lead to numerous unintended negative consequences. Among other behavioral responses, providers potentially would be incented to abbreviate or limit their care, require more complex patients to make multiple visits, refer such patients to specialists, and/or to more acute care settings. Or, they may simply stop seeing Medicare beneficiaries or at least new Medicare beneficiaries. In total, the proposed changes have the potential to increase the volume of services, cause more care fragmentation, and undermine care coordination and comprehensiveness, which would all increase patient burden. Others have expressed concern the proposed would cause less complex patients to face higher cost sharing than they would otherwise pay under existing E/M policies. The policy also potentially would worsen the already existing shortage of primary care physicians and mid-level professionals. We agree. AMGA members also are concerned that finalizing the proposed rule with a January 1, 2019 start date also would cause disruption in providing timely provider education. For example, providers would need to learn new documentation requirements to code for the proposed three supplemental or add-on G codes and also would need to update their EHR software programs. In addition, since Medicare serves as the so-called market maker, providers also would have to assume other payers would soon adopt these payment changes further disrupting provider practices.

We believe CMS can and should go forward and finalize reforms to E/M documentation requirements. As proposed, giving providers the choice of documenting E/M visits either by choice of time, MDM, or via use of the current 1995 & 1997 documentation frameworks should provide, at least initially, sufficient flexibility and constitute marked progress. Should the provider community recommend additional or other documentation techniques, we encourage CMS to substantively evaluate these.

Concerning the agency's proposal to collapse office visit codes using five levels to one, we agree there are potential benefits. For example, CMS notes doing so would eliminate need to audit provider groups against four visit coding levels. Regardless, we believe it would be best for the beneficiary and the provider - and adhere to statutory requirements - for CMS to work further to improve current coding by re-evaluating resource intensity in differentiating between and among a defined set of E/M codes. This work could lead to CMS to conclude fewer than four codes are needed. Conversely, it could be determined that more than four codes are appropriate. By proposing the supplemental G codes CMS effectively admits that its plan to collapse the number of E/M codes is flawed. To begin, CMS could work to integrate the criteria CMS developed in fashioning these supplement codes into the CPT E/M codes. Moreover, we note CMS increasingly is recognizing time or time thresholds as a, or *the*, discriminator in defining payment codes. (MedPAC in its September 4 comment letter noted, "time accounts for between 75 and 80 percent of the variation in work RVUs in the fee schedule.") For example, in the agency's recent effort to create a "virtual check-in" that is substantially defined as five to 10 minutes. We encourage CMS to use time differentials to define levels of office E/M codes.

Finally, among related proposed E/M changes, AMGA supports the agency's proposal to eliminate the prohibition on billing same day visits by practitioners of the same group. Obviously, the change would reduce beneficiary inconvenience and provider administrative burden. Concerning CMS' proposal to create two new G codes for podiatry (GPD0X and GPD1X), our members are concerned that creating unique codes amounts to differential payment for the

same E/M services. We are concerned that creating varying payment or reimbursement under the PFS based on physician specialty is prohibited by Section 1848 of the Social Security Act. We also are concerned the proposed valuation for added complexity G code for certain specialties is substantially higher than the proposed valuation for the add on primary care G code in large part because ambulatory E/M primary care reimbursement is already comparatively underpriced. Concerning the prolonged services G code, CMS should consider defining a prolonged visit as one that simply exceeds 30 minutes total, rather than defining the visit as one that as at least half of the 30 minutes, or an additional 16 minutes.

Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services

CMS is proposing two new physician services using communication technology to assess whether the patient's condition necessitates an office visit. CMS is proposing a brief communication technology-based service, code GVCI1, which it terms a "virtual check-in." The service would be for established patients only and not be billable if it fell within seven days of a previous E/M visit or led to an E/M service or procedure within the next 24 hours. CMS also is proposing to pay for, via code GRAS1, a remote evaluation of a patient's condition via the use of pre-recorded patient video, images, or store and forward or asynchronous communication technology. This service would not be reimbursed if the information led to an in-person visit with the same physician. Instead, it would be bundled into the office visit if the service was related to a related E/M visit within the previous seven days. Again, the use of either service may be used to determine whether or not an office visit or other service is warranted. CMS also is proposing to pay for inter-professional internet consultations via six CPT codes. These codes would apply when a physician requests an opinion or treatment advice of a consulting physician with specific specialty expertise. CMS also proposes that the treating practitioner obtain and document verbal beneficiary consent that includes the beneficiary's awareness of cost sharing, in advance of these services.

On balance, AMGA supports implementing these new codes. We encourage CMS to clearly define who is an "established" patient and explain why the agency prices a virtual check-in at \$15. The agency should, at least initially, limit virtual check-ins and asynchronous evaluations to established patients and avoid imposing a frequency limit on the use of these codes by the same practitioner with the same patient - though we recognize this service could drive excess utilization. We also encourage CMS to explain how these new service will interact or dovetail with the agency's chronic care management codes. We support the use of virtual check-ins in the treatment of opioid use disorders and other substance use disorders in order to better enable Medication Assisted Therapy protocols. Concerning inter-professional internet consultations, specifically ensuring these services are billed appropriately and program integrity is maintained, medical record documentation also should include narrative explaining why the consultation was reasonable and necessary.

Medicare Shared Saving Program

CMS is proposing to reduce the number of MSSP or ACO quality measures for 2019 from 31 to 24. Specifically, CMS is proposing to begin scoring two Consumer Assessment of Health Plan Survey (CAHPS) Summary Survey Measures (SSMs) in the current ACO quality measure set: Courteous and Helpful Office Staff; and, Care Coordination. These measures would be scored as pay for reporting for 2019 and 2020 before becoming pay for performance for ACOs in their first agreement period beginning in 2021. CMS is also seeking comment on converting the CAHPS

SSM Health and Functional Status measure from pay for reporting to pay for performance. With appropriately an increasing emphasis on patient reported outcomes, we agree these CAHPS measures should move to pay for reporting.

CMS is proposing to retire four claims based measures in the current ACO set the agency argues have a high degree of overlap with other measures in the ACO set. These are: skilled nursing 30 day all cause readmission; all cause unplanned admissions for patients with diabetes; all cause unplanned admission for patients with heart failure; and, use of imaging studies for low back pain. We agree however only if CMS, as it notes in the proposed rule, continues to provide ACOs feedback on their performance on these measures and if CMS, also as it also notes, works to include the Skilled Nursing Facility Quality Reporting Program (SNFQRP) measure: potentially preventable 30 day post-discharge readmission measure for skilled nursing facilities. Beyond the four measures noted, CMS also is proposing to eliminate six current ACO measures in order to align with the QPP program, i.e., ACO measures 12, 13, 15, 16, 30 and 41. Regarding measure 41, CMS proposes to keep one of its two components, i.e., diabetes hemoglobin A1c poor control, and proposes to add one new measures, ACO-47 or falls: screening, risk assessment, and plan of care to prevent future falls.

Though it is beyond the scope of what is discussed in this proposed, we have five comments related to the ACO quality measure set and benchmarking ACO quality performance. First, as AMGA has noted in numerous previous MSSP, PFS, MACRA and other comment letters, CMS should work to calculate for value, that is, correlate quality and spending or outcomes achieved relative to spending. Absent doing so the agency finds itself perversely awarding earned shared savings to ACOs that have comparatively worse quality than the worse performing ACOs or those falling below their negative medical loss ratio. This is also true for CMS' Hospital Value-Based Purchasing (HVP) program, where comparatively spending efficient hospitals are awarded bonuses despite having comparatively significantly worse quality. Second, despite near universal agreement that quality measures and performance benchmarking need to become more outcome based, there appear to be none in the 2019 measure set. Third, to the CMS' credit, the agency has been moving to adopt Patient Reported Outcome Measures (PROMs). We encourage CMS to consider adding these to the ACO set beyond ACO-7, the CAHPS: Health Status/Functional Status measure. Fourth, as noted in our previous letters, we see no reason why the MSSP and the Medicare Advantage program's quality measures are different. Among the 24 MSSP 2019 measures, by our count less than half, or 10, also appear in the MA star ratings program.

We also would note that NORC's recently published Next Generation ACO (NGACO) demonstration evaluation found 37% of Medicare spending for 2016 NGACO-aligned beneficiaries occurred exclusively with providers outside the NGACO network and 47% was a mix of in and out of network providers. That is, 84% of care was partially or completely beyond the control of the NGACO. This amount of so called leakage creates difficulties for ACO providers to improve care quality and outcomes. This calls into question the fairness of holding ACO providers accountable for quality performance, undermines the benefit of prospective assignment, and ultimately hinders an ACO's ability to earn shared savings.

Appropriate Use Criteria

CMS should exempt physicians who are participating in the QPP via APMs as these models are not subject to the same concerns that AUC is intended to address, namely inappropriate use of

advanced imaging services. We reiterate our comments provided in our 2018 comment letter, i.e., AUC criteria in connection to the QPP becomes moot under value-based arrangements including MIPS APMs.

The QPP Program

The MIPS Low Volume Threshold

CMS is again proposing high MIPS exclusion thresholds. Beyond again excluding those Eligible Clinicians (ECs) with allowed charges less than or equal to \$90,000 and those ECs whom provide covered professional services to 200 or fewer Part B enrollees, CMS is proposing to add a third criteria, i.e., those ECs whom provide 200 or fewer covered professional services to Part B enrollees. CMS estimates in Table 96 that in 2019 the agency will exclude approximately half, or 571,000 ECs, from the MIPS program. This is roughly the same percent of ECs CMS excluded last year. As we did in our August 2017 comments in response to the 2018 proposed QPP rule and in our December 2016 comments in response to the 2017 final QPP rule, we continue to believe CMS needs to fully implement MIPS, soon to be in its third program year.

As we discussed in our comment letter last year and an August 3, 2017 Health Affairs essay, excluding roughly half of ECs denies them the opportunity to participate and succeed under MIPS. For this reason, last year AMGA recommended CMS allow individual ECs or groups that fall below the exclusion thresholds to voluntarily participate and be scored under MIPS. To the agency's credit the 2019 proposed rule includes an opt-in provision whereby individuals and groups can voluntarily participate and be scored for their performance. The provider community too recognizes the importance of participation which explains why CMS estimates 42,000 ECs will voluntarily participate in MIPS in 2019. As a related aside, we also support and credit the agency for proposing to add physical therapists, occupational therapists, clinical social workers, and clinical psychologists to the list of MIPS ECs.

This improvement aside, excluding providers from earning a MIPS score incents complacency. Comparative lower reimbursement also lessens excluded clinicians' ability to improve care delivery, ironically producing the opposite effect of what MACRA intends. Because scores will be publicly reported at the National Provider Identifier (NPI) or individual clinician level, exclusion may also cause non-participating clinicians to not only be less competitive but less employable as well. Selective participation will reinforce or legitimize already existing complaints about MACRA accelerating industry consolidation. Finally, excluding half of MIPS participants again in 2019 undermines MACRA's intent. Implementing the program such that it is "least burdensome" is not the same as altogether exempting a high percentage of ECs.

For ECs having to participate in MIPS, excluding a high percentage of ECs has a measurable negative effect on those ECs required to participate in MIPS. Because MIPS is spending neutral, eliminating a substantial percent of MIPS participants collapses the range of positive and negative Composite Performance Scores (CPS), which in turn causes a substantial decline in update payment amounts. To note further, because of the high exclusion thresholds CMS estimates more than 618,000 ECs will receive a positive payment adjustment for 2019 performance with only 32,000 receiving a negative payment adjustment. While the maximum payment update for performance year 2019, or payment year 2021, is 7%, CMS estimates the aggregate positive adjustment dollars for performance year 2019 would equal \$372 million, less the \$500 million in exceptional performance bonus moneys. As we noted last year, as a percent

of estimated total Part B spending in 2019, \$872 million (\$372 million plus \$500 million) is a little more than one percent of total Part B annual spending. CMS estimates percentage updates in Part B reimbursements for payment year 2021 would be between 1.9% for practice sizes one to 15 to 2.5% for practice sizes of more than 100 for a mean update of 2.0%. These percentages are obviously far below the maximum update percentage. We have heard from several AMGA members that with updates artificially compromised by the high exclusion thresholds, MIPS participating AMGA ECs spent more money in various clinical practice improvements in performance year 2017 than they will receive in payment updates in 2019. With such small payment adjustments, it becomes an open question if ECs will fully engage in the program over time or if will MIPS will become a check-the-box compliance exercise for those required to participate. The high exclusion problem only becomes worse the longer CMS excludes a significant percent of ECs from MIPS participation because the annual payment rate adjustments accumulate year-over-year. Lastly, MIPS is intended to help or incent ECs to provide higher quality care that is more spending efficient. If you exclude a significant percent of providers this also has a negative effect on the tens of millions of Medicare's fee-for-service beneficiaries.

Delaying or denying MIPS participation for roughly half of ECs is a step backward. The Physician Quality Reporting System (PQRS) program, again MIPS's predecessor, did not have an exemption for clinicians with a low volume of Medicare patients or allowed charges. Nor did the Meaningful Use (MU) and Value-Based Modifier (VM) programs. Delay and deny for however long full MIPS participation will ultimately leave excluded clinicians unable to compete for several years. As with ACOs, other Medicare pay for performance providers and a long list of commercial plan providers, for example those participating in the closely observed Alternative Quality Contracts, have learned improving quality and reducing spending growth takes years of effort or experience. Improving quality and spending efficiency is not, as is frequently stated, akin to flipping a switch. Implementing the MACRA program is already compromised by CMS' proposal to again delay for another year fully implementing the MIPS cost component, which is designed to constrain service volume growth. In addition, the program is handicapped by inadequate risk adjustment and the fact lower performers, moreover those with comparatively more beneficiaries suffering socio-economic disadvantages, cannot be rewarded for improvement. If MACRA is ever to be a catalyst for change, the proposal to largely retain the exclusion thresholds runs completely counter to that goal.

For these reasons and because CMS noted in its 2017 final rule, "we anticipate that more clinicians will be determined to be eligible to participate in the program in future years," AMGA opposes the agency's proposal to retain the high exclusion thresholds.

Composite Performance Score

CMS is proposing to raise the CPS from 15 points in 2018 to 30 points in 2019. It also proposes to raise the exceptional performance threshold score from 70 to 80 point. We support the latter change. Originally under the MACRA statute for performance year 2019, the Secretary was to select either a mean or median score of prior scores for all MIPS ECs. However, the Bipartisan Budget Act of 2018 allows the Secretary to increase the CPS for program years three through five to, as the proposed rule states, "ensure a gradual and incremental transition" to a mean or median score. CMS selected 30 points because the agency states it "would provide a gradual and incremental transition to the performance threshold we would establish for the 2024 MIPS payment year" which they currently estimate at between 63.5 and 69 points.

In last year's proposed rule, CMS floated the idea of a 33 point CPS for 2018. In our comment letter in response to that rule we encouraged CMS to finalize the 2018 CPS threshold score at 33 points. We are surprised the proposed CPS for 2019 is lower. Moreover, as suggested in our exclusion threshold comments above, another low or modest payment neutral CPS score allows for only an estimated five percent of ECs to receive a negative payment adjustment for performance 2019. This, again, significantly compromises the ability of all other MIPS ECs to earn a percent update that approximates the maximum, which is set at 7% for performance year 2019. The exclusion thresholds and the CPS forces AMGA to conclude the MIPS program will neither challenge nor fully engage the medical community. In turn, this means the intended effect of MACRA legislation, to drive quality improvement and reduce spending growth, will not be achieved.

MIPS Quality Measures

AMGA supports the agency's proposal to add seven high priority measures, four patient reported outcome measures (and that they be risk adjusted), as well as the proposed removal of 34 measures. In general, we agree with CMS' goal to over time reduce the number of process measures within the MIPS quality measure set. As the agency notes, in 2018 102 of the 275 MIPS quality measures are process measures that are not considered high priority.

CMS is proposing to accelerate the removal of so called topped out measures. With the exception of QCDR measures, if a measure reaches a mean performance score within the 98th and 100th percentage range, CMS may choose to remove the measure in the next rule making cycle. That is, CMS may opt to forgo the four year time line it previously finalized to remove such measures. We agree the value added of such measures does not offset the reporting burden.

CMS is also proposing to begin to categorize measures by value. CMS states "not all measures are created equal." Therefore, the agency seeks comments on "implementing a system where measures are classified as a particular value (gold, silver and bronze) and points are awarded based on the value of the measures." High value measures, gold measures, are those that measure for an outcome, are a composite measure, a CAPHS measure, or one that addresses an agency high priority. Low value or bronze measures are, for example, ones that are standard of care process measures or are a topped out process measure. We are encouraged CMS introduces the concept of value into quality measurement, as AMGA has argued for several years the agency needs to begin to measure for value or outcomes achieved relative to spending. As we have noted on several occasions previously, both the MSSP and the Hospital Value-Based Purchasing (HVP) program award financial bonuses to comparatively more spending efficient providers regardless of their comparative quality scores or where their quality scores are comparatively worse. While we encourage CMS to explore this approach and offer our assistance in doing so, we believe the agency should also work to correlate the MIPS quality and cost component scores that currently are calculated separately.

MIPS Cost Measures

CMS is proposing to increase the cost component score weight from 10% in 2018 to 15% in 2019 and anticipates raising the weight by five percent annually until it reaches 30 percent in 2022. MACRA required the cost component weight to increase to 30% in 2019 but the Bipartisan Budget Act of 2018 gave CMS authority to delay weighing the cost component at 30 percent until performance year 2021. CMS is also proposing to add to the two cost component measures: total cost per beneficiary; and, Medicare spending per beneficiary, eight episode-

based cost measures. CMS is also proposing to potentially raise the cost performance measurement period to two years and is proposing a new attribution method for three of the new cost measures, while also maintaining the minimum reliability threshold at 0.4%.

Our concerns include the use of setting a minimum reliability rate of 0.4 percent, a case minimum thresholds of 10 individual episodes for the procedural measures and 20 episodes for an inpatient condition measure. AMGA is concerned whether a two year performance period would assume the same reliability threshold. We have concerns regarding the proposed change to episode attribution from the individual provider to the TIN level and what effect performance on these cost measures will have on specific types of provider practices. We are also concerned attributing a proposed acute inpatient medical condition episode to an EC who provides 30 percent of E/M care during the episode may be too low of a threshold. For these reasons and others including the fact the agency is still working on developing or finalizing underlying episode groupers, we believe it would be more appropriate, or strike a better balance, if CMS raised the cost component weight to 15 percent but did not calculate episode based cost measures until at least another year. Performance in 2019 on the episode based measures should, however, be reported to MIPS ECs.

In addition, as we did last year, AMGA again recommends the agency factor in functional status limitations or Activities of Daily Living (ADLs) in developing episode based measures. As we noted previously, this recommendation was made in part based on Harriet L. Komisar and Judy Feder's 2011 Georgetown paper, "Transforming Care for Medicare Beneficiaries with Chronic Conditions and Long-Term Care Needs: Coordinating Care Across All Services." Komisar and Feder found Medicare beneficiaries with any number of chronic conditions along with functional status limitations consume substantially more services - and costs - than similar beneficiaries who do not have functional status limitations. More specifically, the findings indicated average spending is nearly twice as much for beneficiaries with chronic conditions and functional limitations as for those with three or more chronic conditions only. The problem of course is how to identify beneficiaries with functional limitations. We recommended this data could be at least initially collected via "welcome to Medicare" visits. We understand this data is collected in PACE records, which suggests the PACE process could be duplicated. Also, as the Bipartisan Policy Center noted in an April 2017 paper titled, "Improving Care for High-Need, High-Cost Medicare Patients," there is opportunity to factor functional limits in risk adjustment.

Finally, as we noted above and as well in our March 2016 response to the proposed Quality Measurement Development Plan, in our May 2016 comments to the Health Care Plan Learning and Action Network's (HCPLAN's) Performance Measurement White Paper, and in other comment letters, we recommended the agency begin work to correlate quality or outcomes achieved relative to spending so that we can begin to measure for value.

Improvement Activities and Promoting Interoperability

We support the agency's proposal to add six new improvement activities (IAs) including "relationship-centered communication" and other related changes to the MIPS component. Concerning the agency's proposal to delay nominated new or modified IAs by one year, or make nomination and inclusion a two year process. As others have argued, if IA additions and modifications are relevant and important they should be made in a timely or expedient manner.

AMGA is generally in agreement with the proposed changes to the MIPS' Promoting

Interoperability scoring component (previously termed Advancing Care Information, or ACI). We agree with the agency's proposal to adopt a new scoring methodology based on four objectives: e-prescribing; health information exchange; provider and patient exchange; and, public health and clinical data exchange. AMGA therefore supports CMS' proposal to eliminate several measures from the current ACI list. We agree with retaining the 90 day reporting period for this category and AMGA supports the use of 2015 edition of Certified Electronic Health Record Technology (CEHRT). Concerning patient access and availability, we agree ECs or providers be only held accountable for providing beneficiaries with access to their health information whether or how they are using the information.

Virtual Groups

AMGA continues to support the virtual group provision. However, AMGA remains concerned that, as structured, the MIPS option is largely not viable. For example, again for performance year 2019, CMS estimates there will only be 16 virtual groups participating in MIPS. The essential question of how individual and small group ECs will be able to identify appropriate virtual group partners remains unclear. The agency provides no direction or assistance in answering this practical and essential question. Recognizing the importance of "how" virtual groups are created, in May 2017 AMGA hosted a conference call with CMS' virtual group lead, Ms. Lisa Marie Gomez, to propose how the agency could use historical claims, quality metrics, and other data to inform and motivate practices to form or join a virtual group. Our discussion was later outlined in an essay that provided a brief description of how CMS can activate or stimulate the creation of virtual groups by helping groups identify other solo and small practices eligible to participate and helping them determine if they have a reasonable or statistically probable chance of attaining a MIPS score that would be higher than they could attain independently.

Conceptually, the solution we proposed is a neural network-based learning algorithm that combines or exploits multiple data sources to create score maximizing virtual groups. Effectively, CMS would create a network based learning algorithm that would include relevant claims data, historical Physician Quality Reporting System (PQRS), Value Modifier (VM) and Meaningful Use (MU) program data, related quality data and data from other sources available to CMS. The algorithm would attempt to predict quality and other measurement performance. The resulting data would be used to create scorecards for CMS, or CMS vendors, to share with practices. The data could also be used to enhance CMS' Quality Performance Payment (QPP) website to provide increasingly more targeted information to solo and small groups and/or can be exported to other data systems.

The algorithm would attempt to enable CMS to identify solo and small group providers that would be collectively advantaged by forming a virtual group. In statistical terms this essentially is the challenge of creating a hybrid regression analysis model. CMS, or a CMS vendor, would then contact the identified solo and small group providers that the algorithm demonstrates would be advantaged. Those contacted would then be free to choose to participate in or to form a virtual group. For those that choose to do so, CMS, or a CMS vendor, would provide technical assistance or education and support. The immediate advantage a matchmaking model presents is it helps solo and group practices to avoid having to wait an extended period of time to learn if their virtual group proved successful, i.e., it lowers their risk of attaining a suboptimal score. This is because the time between forming a virtual group or participating in one and receiving a virtual group score can be delayed for as long as three years.

With the program primed, CMS would continue to exploit and evolve the algorithm. This means the agency would conduct on-going analysis to identify other or new solo and small group practices to join existing virtual groups and to identify year-over-year solo and small group practices that should align with other virtual groups based on their MIPS performance strengths and weaknesses. For example, virtual group A, B, and C could be advantaged in the subsequent performance year by adding solo or small group practice D. Similarly, solo or small group participant A could be further advantaged in the subsequent performance year by joining virtual group X, Y, and Z. Because MIPS participants, component measures and MIPS scoring will change year-over-year, continuing to work the algorithm is in the best interest of CMS and both virtual group participants and aspirants.

CMS has repeatedly stated the agency's goal is to reduce MIPS reporting burden. This motivation largely explains why CMS is proposing to again exempt roughly half of ECs from MIPS participation in 2018. However, a more aggressive virtual group approach would likely yield numerous benefits. Among others, an effective virtual group program would allow the agency to reduce the low volume exclusion thresholds. This would allow for a far greater number of solo and small group providers to participate in MIPS. Greater participation would make the MIPS program, intended moreover to improve care quality and reduce spending growth, more effective. Higher participation also means more opportunity for greater financial reward. More solo and small group practices with more MIPS experience and greater financial reward also means more ECs will be able to migrate to the MACRA APM pathway – the ultimate goal of MACRA legislation. We strongly encourage CMS in the final 2018 MACRA rule or via other mechanisms to partner with MIPS stakeholders to develop a virtual group matchmaking model.

Alternative Payment Models (APMs)

AMGA supports the agency's proposal to retain the no-more-than eight percent revenue-based financial risk requirement for Advanced APMs and its proposal to leave unchanged this financial risk threshold through performance year 2022. CMS has noted publicly its goal is to increasingly promulgate multi-year rules for the MIPS and APM programs. AMGA strongly encourage this approach not only for these programs but for the MSSP and other Medicare silos.

AMGA also supports CMS' proposals to add flexibility in meeting the Advanced APM Medicare and Other Payer thresholds, specifically by using patient count for one threshold and payment for the other threshold. We support a third option in meeting the All Payer threshold or at the APM entity level, the individual EC level, or at the TIN level. We support reducing the minimum financial risk level from four to three percent for Other Payer APMs. AMGA is on record for supporting the Medicare Advantage APM demonstration and supports the proposal to waive MIPS reporting requirements for MA-participating physicians. Finally, the AMGA encourages CMS to move to a multi-year APM determination process instead of its current policy of single year determinations.

AMGA remains concerned CMS has not produced, or has not fielded, any new Advanced APMs in the recent past with the possible exception of continuing the Bundled Payment for Care Improvement (BPCI) demonstration under BPCI Advanced beginning this fall. The agency did field a Direct Provider Contracting demonstration RFI earlier this year but its future is uncertain at this date. As CMS is well aware participation in, for example, the Oncology Care, Comprehensive End-Stage Renal Disease and the MA Value-Based Insurance Design

demonstrations is limited. While participation in the MSSP has been considerable only a small percent have to date participated in an at-risk or Advanced APM qualifying track. However, this may change should the current proposed MSSP rule be finalized. The stakeholder community is also well aware the Department has not selected any Physician-Focused Payment Model Technical Advisory Committee (PTAC)-recommended models for testing. We strongly encourage the agency to accelerate its efforts to develop a far more robust Advanced APM portfolio.

We thank CMS for consideration of our comments. Should you have questions please do not hesitate to contact AMGA's David Introcaso, Ph.D., Senior Director of Public Policy at (703) 842.0774 or at dintrocaso@amga.org.

Sincerely,

A handwritten signature in cursive script that reads "Jerry Penso".

Jerry Penso, MD, MBA
President and Chief Executive Officer