



American Medical Group Association®

November 17, 2015

Mr. Andrew M. Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS 3321-NC
P.O. Box 8013
Baltimore, MD 21244

Submitted Electronically

Re: 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, File Code CMS-3321-NC

Dear Acting Administrator Slavitt:

The American Medical Group Association (AMGA) appreciates the opportunity to respond to the Centers for Medicare and Medicaid Services (CMS) Request for Information (RFI) on the implementation of the Merit-Based Incentive Payment System (MIPS) and alternative payment models (APMs) established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). AMGA represents 450 large, multi-specialty medical groups and other organized systems of healthcare delivery, with 170,000 physicians caring for approximately one in three Americans.

Many AMGA member medical groups have been early adopters of electronic health records (EHRs) and quality improvement activities. We therefore have a strong interest in the transformation of the healthcare delivery system to one that reimburses appropriately for high-value healthcare and moves the payment system towards pay-for-value, rather than the volume of services delivered. CMS has a tremendous opportunity to build upon what works well in the current environment, while streamlining quality measurement and improving healthcare delivery through the MIPS and APMs, and we offer comments on several aspects of the RFI in support of these goals.

AMGA appreciates the extension of the comment deadline provided on October 20, along with the list of priority categories for response, and our comments reflect areas of broad consensus among our members, in the order found in the extension notice.

Priority Category One

This priority category asks for stakeholder input on how to implement the MIPS. Since the MIPS will consolidate the existing Medicare EHR Incentive Program, the Physician Quality Reporting System (PQRS), and the Value-Based Modifier (VM), there is an opportunity to retain aspects of these three programs that are working well, while addressing opportunities for improvement. As a general principle, we would urge CMS to lessen complexity wherever possible, and ensure that the MIPS framework is easily understandable and achievable. In the early years, this will entail building upon existing program structures, while making incremental changes that will allow healthcare providers, patients, and the health information technology industry to adjust to the new regulatory framework.

MIPS Eligible Professional (EP) Identifier: CMS is asking for stakeholders to provide input into the advantages and disadvantages of using the currently available identifiers, and the advantages and disadvantages of creating a distinct MIPS identifier, and we offer input concerning both approaches. Using the current Tax Identification/National Provider Identifier (TIN/NPI) combination would not require additional action on behalf of healthcare providers or CMS, and would arguably be the simplest approach. This would be helpful to both CMS and healthcare providers with managing the other changes inherent in MIPS implementation, and could lessen administrative burdens on both sides.

However, a MIPS-specific identifier could offer certain advantages. EPs could have the autonomy to create units of MIPS accountability of their choosing when applying for the identifier, and could unify multiple TINs into a single unit of accountability if they choose. CMS would need to conduct immediate provider education and outreach on the application and registration process for the distinct MIPS identifier, however, if this path is chosen.

Given the advantages of each identifier type, we recommend that physicians and medical groups have the ability to choose which approach would work best for them.

Quality Performance Category: AMGA believes that quality measurement should continue to be used for more appropriate payment, patient engagement, and public education. Moreover, the quality measures themselves should create incentives for continuous quality improvement, while providing appropriate mechanisms for determining whether medical groups and healthcare delivery systems are improving the health of their patient populations. Accordingly, AMGA supports an approach to measuring quality performance in the MIPS that would greatly reduce the number of quality measures, with an emphasis on those that have been proven to improve outcomes, rather than simply measure processes that provide little insight into the quality of care being provided. Several of our members have told us that in the current environment, they are reporting on 100, or more, quality measures to satisfy the requirements of the federal government, their state, and private payers, and that it can be very challenging to focus on what is truly important with so many boxes to check. In the MIPS, CMS has the opportunity to streamline, harmonize, and refocus quality measurement and reporting. Dramatically reducing the number of required quality measures, while retaining group-level reporting options would be a way to accomplish this goal.

We suggest that CMS build on the existing infrastructure of the PQRS in selecting measures for this category, and work with physicians to identify measures that have been associated with better outcomes (both performance and process), are not burdensome to report, and include measures that are cross-cutting across multiple specialties. Quality measures meeting these criteria could include blood pressure control, admissions for ambulatory sensitive conditions, and postoperative infections. Quality reporting could be further simplified to include a mix of claims-based reporting, along with necessary self-reporting such as Consumer Assessment of Healthcare Providers and Systems, if used; blood pressure control; Hgb A1c >9 for diabetes; and body mass index assessment. Performance measurement for some types of quality measures could also be determined through data in EHRs, rather than chart search, and we encourage CMS to expand the reporting opportunities that could use this approach. We believe there should continue to be multiple reporting methods available at present, since medical groups have diverse capabilities and are in different places along the path to quality improvement and reporting. Going forward there should be greater emphasis on medical record-generated and clinical quality data registries, however.

Moreover, we recommend establishing a scoring methodology for measures that includes both measuring year-to-year improvement, which would reward those making progress toward a high level of performance, and sustaining excellence, which would reward those who already achieve a high level of performance. CMS should not disadvantage high-performing providers because they cannot demonstrate increased performance above an already very high performance level on a particular measure. The appropriate emphasis should be to maintain this high level of performance in such cases.

The RFI asks whether CMS should require reporting mechanisms to include the ability to stratify data by demographic characteristics such as race, ethnicity, and gender. AMGA members agree with this approach because it helps them identify gaps in care and account for risk more precisely, resulting in a more accurate understanding of the variables that effect performance and patient outcomes.

Resource Use Performance Category: The RFI seems to suggest that CMS will retain the current VM cost measures and expand upon them, however, providers should not be penalized if there are no resource use measures that apply to them, which is the case for some providers, such as specialists who conduct consults, because their opinion may, or may not, be acted upon. Radiologists and pathologists are in similar situations. Their opinions clearly have an impact on downstream events, but only in the sense of identifying a condition to be treated, and they should not be held accountable for treatment decisions that they have no influence upon. Data also suggests that the current VM cost and outcomes measures may discriminate against physicians who have more patients with multiple chronic conditions or higher disease acuity. It is critically important that CMS resolve these issues and work to improve the current attribution process, risk adjustment process, and the episode-based measures, in order for MIPS to be equitable and successful. Improving these areas will require a significant investment of resources, and time, so in the interim, CMS should not penalize healthcare providers for existing program limitations as improvements are made.

In this category of questioning, the RFI asks about how Medicare Part D data can be included in the Resource Use Performance Category. Given the current price volatility in the prescription drug market, AMGA recommends that Medicare Part D data not be included in this category, since drug pricing is outside the control of medical groups. Moreover, using pharmacy data is particularly challenging, given that patients have increasing opportunities to purchase generic medications at pharmacies outside of their own insurance plans and medical groups, at very reasonable prices. Many patients take advantage of these opportunities, and this can lead to providers, and insurers, inaccurately thinking that a patient is noncompliant.

Clinical Practice Improvement Activities Performance Category: AMGA member medical groups in most cases have adopted, and support, clinical practice improvement activities that include expanded access to appointments, including urgent care and same-day appointments; population health management to target specific high-cost, high-volume disease states; care coordination; patient engagement through shared decision-making; and patient safety activities that allow them to continuously improve. We agree that these activities are foundational in the MIPS assessment for this performance category, and support them as currently defined. AMGA member medical groups have been at the forefront of clinical practice improvement for many years, and AMGA's Acclaim Award honorees and recipients provide rich examples of how these clinical practice improvement activities improve healthcare delivery in their medical groups¹.

We also support the use of Patient-Centered Medical Home (PCMH) certification as a way to meet the Clinical Practice Improvement Activity Performance Category requirements. We are also pleased that a PCMH is considered an APM in the context of MACRA.

Priority Category Two

Feedback Reports: The current Quality and Resource Use Feedback Reports (QRURs) help medical groups gauge the success of clinical practice measures in transforming care, however, AMGA has suggestions that would make them easier to access and to interpret. Our members have told us that the composite scoring algorithm is not transparent, and they would prefer to have access to a document that outlines the entire algorithm, including standardized standard deviations. Also, CMS could provide additional context around the supplemental exhibits, in addition to high-level indicators on where performance could be improved, as compared to the performance of peers. This would help providers readily identify any gaps that may be present and make needed corrections and improvements more quickly.

CMS could also improve the ability to access supporting documentation of the QRUR reports. The supporting documentation is currently located in several areas of the website. It would be far more efficient to have one central website that would house links to all of the

¹ The Acclaim Award: Past Recipients and Honorees:
http://www.amga.org/wcm/PI/AcclaimAward/wcm/PI/Acclaim/past_acclaim.aspx

methodologies that are used for each QRUR section. This would be very helpful to providers as they analyze their QRUR reports and supporting documentation.

Alternative Payment Models

The MACRA legislation provides a strong incentive to medical groups and health systems to participate in APMs through a 5% bonus on covered Medicare professional services, but also requires APMs to report on quality measures comparable to those in the MIPS, and bear financial risk for monetary losses under the APM that are in excess of a nominal amount.

The legislation defines APMs as models under the Center for Medicare and Medicaid Innovation (CMMI), the Medicare Shared Savings Program (MSSP), the Health Care Quality Demonstration Program, and other demonstrations required by federal law. AMGA has continuing concerns about the existing framework in the MSSP that include the need for a prospective patient attribution process that includes patient election, the need for better and more timely data exchange with CMS, an improved and more transparent benchmarking process, effective patient engagement strategies, a more accurate risk-adjustment methodology, and waivers from certain Medicare policies that would help MSSP participants better coordinate patient care and reduce costs. Several of these challenges are outstanding and will need to be effectively addressed in order for future APM models, which will share these features, to be successful, and for healthcare providers to be willing to assume more than nominal risk. We fear that without substantive improvements in these areas, APMs will not provide a sound enough foundation upon which healthcare providers can feel secure participating in the models.

For further insight on the tools healthcare providers will need to be successful in a risk-taking environment, we would direct CMS to a recent AMGA white paper entitled: *Taking Risk: Where Healthcare Financing Is Going and How to Get There*², which is based on the survey responses from 115 healthcare executives at 101 AMGA member medical organizations. Impediments identified by the survey respondents include ineffective patient attribution methodologies, a lack of transparent cost/quality data feedback, and a lack of access to full administrative claims data.

Assuming that CMS can resolve these outstanding issues and apply the improvements to future APMs, we believe that these models have the potential to improve healthcare and reduce the costs of that care, while providing effective incentives for providers to choose the APM path. To that end, we would urge CMS to work toward providing viable APM options to all providers.

² *Taking Risk: Where Healthcare Financing Is Going and How to Get There*. Chester Speed, Nikita Stempniewicz, Grant Couch, 2015. <http://www.amga.org/wcm/Advocacy/Tools/wpRiskTaking.pdf>

The RFI also asks for comment on how to define services furnished through an eligible APM entity. Part of the definition should include participation in Medicare Advantage (MA), since these plans can provide capitated payments that provide financial stability, while encouraging providers to innovate within the model to improve patient outcomes. If a provider or provider group receives capitation payments from a MA plan, then those dollars should count as APM dollars. MA plans continue to grow in popularity among both patients and healthcare providers, with approximately one in three Medicare beneficiaries enrolled in a MA plan. While we recognize that the MACRA legislation may not consider MA to be an eligible APM program, we believe there is merit in doing so, and would urge CMS to use its considerable administrative discretion to categorize certain MA plans as APMs. The agency must also clarify the role of MA in 2021, and beyond, when the combination all-payer and Medicare payment threshold option begins.

CMS is also seeking stakeholder input on what certified electronic health record information technology (CEHRT) should look like in an APM environment. CMS must focus on standardization and reasonable measurement, while promoting true interoperability of EHRs. It is imperative that CMS work to create standards that will make EHRs more user-friendly for providers, and will support the activities that will be essential to successful participation in an APM such as data aggregation, registry development, risk stratification, data analytics, and care protocols. Without these needed changes, healthcare providers will have difficulty participating in APM models.

In defining risk “in excess of a nominal amount” as the MACRA law requires, AMGA would like to emphasize that the financial risk inherent in establishing an APM, such as EHR infrastructure costs that enable care coordination and quality improvement, the hiring of care managers and staff training, to name a few, can be considerable. The start-up costs borne by APM participants should therefore be included in the calculation of financial risk. Many AMGA members have willingly incurred such expenses in their facilities because it is the right thing for their patients and for the healthcare delivery system as a whole, and these investments should be acknowledged as part of the financial risk required for APM participation. There are other examples of financial risk that CMS can draw upon in Medicare payment programs, such as in the MSSP.

Concerning the increasing payment thresholds over time for revenue as they relate to MSSP Accountable Care Organizations (ACOs), CMS should determine thresholds based on a percent of revenue for patients attributed to the ACO itself, not on the total revenue of the ACO, since many ACOs (multi-specialty groups and large systems) have a preponderance of specialists that account for much of the revenue, and care for patients not attributed to the ACO.

Although the MACRA legislation is very prescriptive regarding certain aspects of MIPS and the APMs, with APM participation requiring increasing Medicare payment thresholds between 2019 and 2023 forward, we would urge CMS rulemaking to reflect the realities of the healthcare marketplace. Several members contend that the sharply increasing Medicare payment threshold percentages outlined in the MACRA law are unrealistic as they relate to

APM participation. We recognize the inherent tension between moving toward a value-based payment system, and the current obstacles to a successful transition to such a system, and we respectfully request that CMS grant the maximum flexibility to providers as they manage this increasing complexity in healthcare delivery.

As CMS implements the APM program, we encourage the agency to develop several types of models that will provide multiple options for providers to choose from, while reducing barriers to entry and creating an environment that will promote provider confidence as they take on greater financial risk.

Conclusion

AMGA appreciates the opportunity to provide comments to help guide the MACRA implementation process. Great care must be taken as CMS begins to implement the law so that physicians have a smooth glide path toward value-based payment. We well appreciate the complexity of the task at hand, and would like to be a resource to CMS as MACRA is implemented. Should you have questions or concerns, please contact Karen Ferguson, Senior Director of Public Policy, at kferguson@amga.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Donald W. Fisher".

Donald W. Fisher, Ph.D.
President and CEO