



One Prince Street
Alexandria, VA 22314-3318
☎ 703.838.0033
✉ 703.548.1890

August 21, 2016

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

Dear Ms. Verma:

On behalf of AMGA, we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS') proposed "CY 2018 Updates to the Quality Payment Program" rule (CMS-5522-P). 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. Our member medical groups strongly support full implementation of Medicare Access and CHIP Reauthorization Act (MACRA) Merit-based Incentive Payment System (MIPS) program and have equal interest in participating in, and succeeding under, the MACRA Alternative Payment Model (APM) pathway. This letter is consistent with AMGA's comments submitted last December 19 in response to the agency's 2017 MACRA final rule with comment and with AMGA's June 27, 2016 comments in response to the 2017 MACRA proposed rule.

MIPS Comments

The Exclusion Threshold

CMS proposes to substantially increase the MIPS exclusion thresholds in 2017 from eligible clinicians (ECs) with less than or equal to \$30,000 in Part B allowable charges or less than or equal to 100 Part B beneficiaries served in 2017 to \$90,000 in Part B allowable charges or less than or equal to 200 Part B of beneficiaries served in 2018. This past May CMS informed more than 807,000 ECs, or approximately two-thirds of Medicare Part B clinicians, that they would be exempt from MIPS this year. The proposed 2018 rule would again exempt two-thirds of clinicians, or more than 900,000. This percent and number would be substantially higher if CMS did not estimate clinicians participating under the APM pathway would double between 2017 and 2018, or from an estimated 70,000 to 120,000 to 180,000 to 245,000. CMS proposes to exclude the vast majority of ECs because the agency states it seeks to "move the program further in the least burdensome manner."

In AMGA's December 19 letter we stated "AMGA hopes CMS will fully implement the MIPS program in performance year 2018." We based this comment in part on the agency noting in its 2017 final rule that "we anticipate that more clinicians will be determined to be eligible to participate in the program in future years."

This point aside, AMGA believes substantially increasing the exclusion thresholds is counterproductive for numerous reasons, as AMGA's David Introcaso outlined in an August 3 [Health Affairs](#) blog post. As noted in [Health Affairs](#), ECs excluded are denied an opportunity to participate and succeed. CMS will not score an EC or group that falls below one of the exclusion thresholds even if they voluntarily report under MIPS. ECs that would be successful under MIPS are therefore forced to leave higher reimbursement rates on the table; these could be considerable over time. One estimate shows MIPS can cause up to a 46 percent spread in Part B payment rates over the next five years. AMGA recommends at minimum the agency allow individual ECs or groups that fall below either or both exclusion threshold to voluntarily participate and be scored under MIPS.

Among other problems, excluding ECs and small groups 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 two-thirds of MIPS participants again in 2018 undermines MACRA's intent. Implementing the program such that it is "least burdensome" is not the same as altogether exempting two-thirds of ECs.

Excluding two-thirds of ECs has a measurable negative effect on those eligible clinicians required to participate in MIPS. In last year's proposed MACRA rule, CMS estimated aggregate positive adjustment dollars would equal \$1.333 billion (including \$500 million for exception performance bonus payments) in payment year 2019. In the current proposed rule for the payment year 2020, this amount under standard participation assumptions is now approximately 50 percent less, or estimated at \$673 million (again including the \$500 million for exception performance). It is true the number of participating eligible clinicians is estimated to decline between 2017 and 2018, but by only eight to 14 percent.

Because MIPS is a zero sum game, exempting two-thirds of MIPS eligible clinicians effectively collapses the MIPS Composite Performance Score (CPS) distribution curve. The effect of this is made apparent in Table 86 of the proposed rule. In payment year 2020, where payment adjustment scores will range from -5 percent to +5 percent, CMS estimates no MIPS participating provider will receive a positive payment adjustment (that includes exceptional performance payments) of more than 1.7 percent. The average adjustment will be 0.9 percent. As a percent of estimated total Part B spending in 2018, the MIPS positive payment adjustment, again \$673 million, is estimated to equal 1.16 percent of CMS' estimated allowable Part B charges of \$58 billion. If no moneys are paid in exceptional bonus payments, MIPS payments at \$173 million will equal 0.3 percent of allowable charges.

The effect of eliminating of two-thirds of eligible clinicians from the MIPS formula is to financially undermine participating clinicians. They effectively lose by winning, particularly when considering MIPS-scored APMS, for example Track 1 ACOs, have made infrastructure investments with the reasonable expectation they would be competitive under MIPS. This problem becomes substantially worse the longer CMS excludes a significant percent of eligible clinicians from MIPS participation because the annual payment rate adjustments accumulate year-over-year. In addition, with such small payment adjustments, it is an open question if ECs will fully engage in the program or if MIPS will become a check-the-box compliance exercise for those required to participate.

Delaying or denying MIPS participation for two-thirds of eligible clinicians 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. Continued delays of full MIPS participation may 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, providers have learned that improving quality and reducing spending growth takes years of effort. 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 implementing the MIPS cost component, designed to constrain service volume growth, for another year, inadequate risk adjustment, and the fact lower performers cannot be rewarded for improvement. If MACRA is ever to be a catalyst for change, the proposal to increase the exclusion thresholds needs to be significantly limited.

For these reasons, AMGA opposes the agency's proposal to significantly increase the exclusion thresholds. If anything, CMS should reduce the current threshold criteria, particularly because CMS is proposing to slightly increase the CPS payment neutral performance threshold from three to 15 point and is proposing to reward small practices, or those with 15 or fewer ECs, five CPS bonus points.

The MIPS Quality Component Score

Generally, CMS states the agency is "not proposing any changes to the submission criteria for quality measures in this proposed rule." This point aside, AMGA remains concerned with well more than 250 quality measures from which to choose, with a significant percent of measures that are both process oriented and topped out, MIPS ECs will be measured on non-comparable data. It will be difficult if not possible for CMS to credibly delineate high from low MIPS performers. This is particularly true when you consider a mere five measures accounted for about one-third of PQRS reporting in 2015. These five measures were: documentation of current medication in the medical record; preventive care screening for tobacco use and cessation, body mass index and high blood pressure; and, pain assessment. As MedPAC and numerous others have recommended, including AMGA, CMS over time should work to define the MIPS quality component using a far more limited number of outcome measures that preferably are claims-based, such as preventable hospital admissions and emergency department visits.

Beyond non-comparability, current MIPS quality reporting also suffers from the well-documented financial burden that reporting quality measures imposes. (As we have cited in previous comment letters, see again, for example, Lawrence P. Casalino's related March 2016

Health Affairs article.) We found it telling that the proposed rule estimates the total estimated burden of record keeping and data submission resulting from the 2018 proposed rule's provisions at 9.4 million hours with a total labor cost of \$857 million, or \$184 million more than the estimated total 2018 MIPS bonus payment at \$673 million. Also, CMS notes the agency is “not proposing to change our policies related to stratifying benchmarks by practice size for the 2020 MIPS payment year.” However, because CMS calculates quality performance benchmarks by reporting mechanism, scoring by decile can and does vary significantly. For example, a perfect breast screening score varies from a score of 73.23 under the Electronic Health Record (EHR) submission method, to a score of 87.97 under the registry/Qualified Clinical Data Registry (QCDR) submission method, to a score of 100 under the CMS web interface submission method. This creates gaming opportunities we believe the agency would want to avoid.

Use of Multiple Submission Mechanisms to Report Quality Measures

CMS is proposing in 2018 to allow individual ECs or groups to report quality, Improvement Activities (IA), and Advancing Care Information (ACI) measures via as many mechanisms as necessary to meet the requirements of each component. CMS is making this proposal to expand the options available to clinicians to select the measures most meaningful to them, regardless of the submission mechanism. If an EC submits the same measure through two different mechanisms, CMS proposes to count the submission that gives the EC the higher score. Virtual groups would be able to use multiple mechanisms for quality reporting but would have to use the same submission mechanism for the IA and ACI performance categories.

AMGA supports this proposed MIPS reporting change.

Topped Out Measures

CMS proposes in 2018 to limit topped out measures to a maximum of six out of 10 points, with the exception of Web Interface measures, and identifies six measures for special topped out measure scoring for 2018. CMS also proposes a three year time line for identifying and removing topped out measures. CMS recognizes that 45 percent of measures currently are topped out, however, the percent ranges from 10 percent of Electronic Health Record (EHR) measures to 70 percent of claims measures.

AMGA generally supports this approach. We agree continuing to report and score consistently high quality performance indefinitely year-over-year neither provides evidence of quality improvement nor justifies the expense in reporting. CMS also should work to include a policy to also retire topped out Web Interface measures. In addition, because there already is a significant percent of measures that are topped out, in retiring measures the agency should also work to replace measures, preferably outcomes measures, at a pace that allows ECs to continue to have an adequate and appropriate list of measures from which to choose.

Public Reporting Quality

MACRA requires MIPS performance to be published on CMS' Physician Compare website. This includes, for example, final MIPS scores and performance under each of the MIPS four component categories. Since we support this policy and since the Medicare Advantage (MA) program will be included under MACRA in the near future, we recommend that MA quality information be added to the Physician Compare website. If the intent of Physician Compare is to better inform the Medicare beneficiary they should also have easy access to similar MA data, particularly since the MA program now accounts for one-third of all Medicare beneficiaries.

Facility Based Reporting

Generally, CMS is proposing a new scoring option that would allow facility-based MIPS ECs to participate in MIPS by being scored based on their facility's performance. CMS proposes to begin by using the Hospital Value Based Program (VBP). Specifically, CMS proposes for the 2020 payment year to include or add all the measures adopted for the 2019 Hospital VBP on the MIPS list of quality and cost measures. There would be not additional data submission requirements for these participants.

AMGA supports this proposal. Again, AMGA believes as many ECs should participate in the MIPS program as is practically possible.

MIPS Cost Component

CMS is proposing to change the weight of the cost performance category from 10 percent to zero percent for the 2018 performance year. CMS is also seeking comment on keeping the weight at 10 percent for performance year 2018. CMS is proposing the delay in part to afford the agency time to develop more episode-based measures. The agency does note it finalized in 2017 the Medicare Spending Per Beneficiary (MSPB) measure, the total per capita cost measure, and ten episode-based measures. However, the agency further states it will continue to evaluate these measures. They could be removed or others added as cost measure development continues. As CMS notes, MACRA requires the agency to assign cost a weight of 30 percent of the MIPS final score beginning in the 2019 performance year.

AMGA is not surprised the agency is proposing to delay the cost component. We well recognize the challenge in developing episode cost measures having, in part, attended Dr. Pierre Yong's related presentation this past April 3 at the AMA. (We also commented this past April 24 on the agency's December 23, 2016 white paper, "Episode-Based Cost Measure Development for the Quality Payment Program.") Based in part on Dr. Yong's April 3 presentation, we recommended to Dr. Yong in late April that he consider factoring in functional status limitations or Activities of Daily Living (ADLs) in developing episode based measures. 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 than similar beneficiaries with no 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 be duplicated. Also, as the Bipartisan Policy Center noted in an April paper titled, "Improving Care for High-Need, High-Cost Medicare Patients," there is opportunity to factor functional limits in risk adjustment. (<http://bipartisanpolicy.org/wp-content/uploads/2017/04/BPC-Health-Improving-Care-for-High-Need-High-Cost-Medicare-Patients.pdf>)

Again, AMGA recognizes the difficulty in developing accurate and meaningful cost measures. Therefore, we understand CMS' hesitancy to weight the cost component in 2018. That said,

AMGA members are concerned that a zero weight in 2018 will mean the cost component, as required by law, will go from zero to 30 percent in one year. Therefore, on balance we believe it would likely be more productive to weight cost at 10 percent in 2018 primarily for two reasons. First, the downside risk from a 10 percent cost weight is substantially mitigated by the modest 15 point CPS score CMS is proposing. Second, because the cost component weight must be 30 percent in 2019 if CMS is interested in gradually implementing MIPS this does not achieve that goal. If CMS chooses to make final a zero weight in 2018 we strongly encourage the agency to provide MIPS ECs with Medicare Spending Per Beneficiary (MSPB), per capita cost data and as well episode based measure data as soon as possible and as frequently as possible so that MIPS ECs are prepared for the 30 percent cost weight in the 2019 performance year.

Finally, as we noted in our MACRA comments last year, in our comments in March 2016 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 or begin to measure for value.

Improvement Activities

CMS is requesting comment on whether the agency should establish a minimum threshold of ECs that must complete an Improvement Activity (IA) in order for the entire TIN to receive credit, for example, 50 percent of ECs. CMS also notes the agency intends in future years to score IA based on performance and improvement rather than simple attestation as is currently the case.

AMGA supports the agency's intent both to require a minimal critical mass of ECs within a group to report on an IA and also supports the agency's interest in moving to measuring actual performance instead of whether simply the IA was performed or not.

Advancing Care Information

CMS is proposing to allow ECs to use either 2014 or 2015 Edition Certified Electronic Health Record Technology (CEHRT) in performance year 2018. We do not object. We will note, however, that many AMGA members have invested in 2015 CEHRT because of the apparent advantages this next generation of information technology presents. This leads us to welcome the proposal to grant a one-time 10 percent bonus for exclusive use of 2015 CEHRT in 2018. Among other advantages, the 2015 edition software will offer greater interoperability, improved privacy and security, improved data exporting, and application programming interface (API) capabilities that will substantially improve the user experience.

Virtual Groups

CMS is proposing implement the MACRA virtual group provision in performance year 2018. The agency has proposed to make virtual group participation to those in groups with 10 or fewer ECs if they do not fall below either exclusion threshold. Individuals or groups must select to participate in a virtual group before the start of the performance year and cannot change their election during the performance period. Virtual groups, CMS also proposes, will consist of a combination of an unlimited number of Tax Identification Numbers (TINS) with no geographic or specialty restrictions and must operate under a written agreement.

In theory, AMGA supports the proposed virtual group provisions. In practice, AMGA is less concerned with how a virtual group is constructed than how individual and small group ECs will

be able to identify appropriate virtual group partners. The agency provides no direction or assistance in answering this practical and essential question. This likely explains largely why CMS in the proposed rule estimates that only 16 virtual groups will be formed in 2018, accounting for only one percent of all MIPS ECs. Recognizing the importance of “how” virtual groups are created, this past May 5 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. We believe CMS should proactively work to find solutions to the “how” question if it expects a reasonable number of individuals and small groups to identify similar practices and create synergy. We make this recommendation also because it has the potential to make MIPS participation “less burdensome” for individual and small group ECs, as well as provide rationale for lowering the exclusion threshold criteria.

Year-Over-Year Improvement

Per MACRA, CMS is proposing to score year-over-year improvement along with achievement in quality performance. CMS is proposing two possible methodologies: taking the higher of the achievement or improvement score, as is done in the hospital Value Based Performance (VBP) program; or, add to achievement an improvement score as in the Medicare Shared Savings or Accountable Care Organization (ACO) program. Via either formula CMS proposes to limit the improvement score to no more than 10 percentage points. AMGA believes MIPS improvement scoring should be comparable to other Medicare programs. As a significant percent of MIPS ECs that migrate to the APM pathway will choose an ACO track, AMGA recommends, such that MIPS participants gain a familiarity with the Medicare Shared Savings program, MIPS improvement scoring mirror ACO improvement scoring.

The Small Group Bonus

CMS is proposing to award five CPS bonus points to small practices, virtual groups, and APM entities with 15 or fewer clinicians for payment year 2020 only. (CMS is proposing exclude practices in rural areas.) CMS states the bonus “is intended to be a short term strategy go help small practices transition to MIPS.” CMS justifies the bonus payment using the same logic in proposing to significantly increase the exclusion thresholds. Namely, based on historical data, presumably, PQRS data, small practices would be less competitive or score comparatively worse under MIPS, CMS believes, than larger practices.

CMS estimates practices one to 15 providers in size are actually less likely to receive a negative payment adjustment than practices 16 to 24 in size, or 10 percent compared to 10.9 percent. As for positive adjustments, CMS estimates that in payment year 2020 aggregate positive adjustments for groups with one to fifteen clinicians will be \$288 million compared to \$258 million for practices with 100 or more clinicians. It is estimated that one-to-15-sized clinician groups will have approximately 30 percent more in allowed Part B charges but this is offset by their being 25 percent less likely to receive an exceptional payment adjustment.

The data CMS presents does not support the agency's proposed bonus. In addition, awarding five bonus points would allow small practices, CMS admits, to avoid reporting any quality measurements in order to receive the bonus. AMGA cannot support the proposed bonus absent evidence justifying it. If small practices, as CMS states, “have a lower combined impact performance than larger practices,” there are other opportunities for them to be competitive, for example, by participating in a virtual group and reporting more quality measures than the

minimum number.

The Complex Patient Bonus

CMS initially is proposing to a one-year bonus paid to MIPS ECs that care for a comparatively higher percent of complex patients. CMS considered defining the complexity bonus based on either Hierarchical Condition Category (HCC) risk scores or through the proportion of patients with dual eligible status. As CMS notes, HCC scores have been used in the Value Modifier (VM) program, for dual eligibility status in the Medicare Advantage (MA) five star quality performance measurement methodology, and for the Hospital Readmissions Reduction Program. CMS specifically is proposing to calculate or define the bonus payment using HCC scores since these are familiar to ECs because of their familiarity with this design via the Value-based Modifier (VM) program. CMS is proposing the bonus not exceed three points.

AMGA supports this proposal in concept in part because MIPS quality performance benchmarks generally do not adjust for socio-demographic characteristics. Because AMGA has previously argued Medicare programs should compete on a level playing field, we recommend that for MIPS APMS, CMS mirror the Medicare Advantage program and calculate the MIPS APM bonus using dual eligible and disabled status.

The Composite Performance Score (CPS)

For performance year 2018, CMS is proposing a 15 point MIPS performance threshold. CMS argues, “we set the performance threshold at a low number to provide MIPS eligible clinicians an opportunity to achieve a minimum level of success under the program, while gaining experience with reporting on the measures and activities.” CMS also argues the agency is proposing a 15 point threshold because “it represents a meaningful increase in performance threshold, compared to 3 points in the transition year [2017].” CMS seeks comment on 15 points as well as comments on lower or higher threshold scores. CMS specifically requests comment on alternative scores of 6 or 33 points.

The combination of higher MIPS exclusions thresholds and an admittedly low CPS threshold score is reflected in the proposed rule's impact tables. Because approximately two-thirds of ECs will be excluded in 2018 and because the CPS threshold score is “a low number,” Table 87 shows 94 percent of ECs will, CMS estimates, receive either a positive or neutral payment adjustment and only 5.7 percent will receive a negative payment adjustment. Because MIPS is revenue neutral, this means in 2020 the net payment adjustment will be only slightly higher than zero percent, or CMS predicts 0.9 percent. CMS estimates under its “alternative assumptions” that this will equal \$283 million in positive payment adjustments in 2020. Assuming all \$500 million of exceptional performance moneys are paid out the grand total is \$783 million, or 1.36 percent of allowable Part B charges of \$57.5 billion.

If all 94 percent of the 555,000 participating ECs, or 517,000 ECs, received a positive adjustment the mean dollar amount would equal \$1,500. It is worthwhile to note the \$783 million in 2020 rate increase moneys is \$74 million less than the agency's estimate of the \$857 million ECs will incur in MIPS record keeping and satisfying submission requirements.

The combination of an increased exclusion threshold combined with a low CPS threshold, which CMS admits could be obtained, for example, by reporting no quality measures, forces AMGA to conclude a MIPS program that does not challenge or engage the medical community will not

approach the desired quality improvement and spending reduction goals MACRA intends. The legislation already suffers from several inherent problems made perhaps most recently outlined by J. Michael McWilliams in his May Annals of Internal Medicine essay, “MACRA: Big Fix or Big Problem?” For principally these reasons AMGA recommends CMS, at minimum, finalize a 33 point CPS threshold score.

APM Comments

QP Determinations at the Eligible Clinician Level

CMS is proposing to make QP determinations under the All-Payer Combination Option at the individual EC level only. CMS makes this proposal based on the belief that “in many instances the eligible clinicians in the APM Entity group we would identify and use to make QP determinations under the Medicare Option would likely have little, if any, common group level participation in the Other Payer Advanced APMs. The eligible clinicians in the same APM Entity group would not necessarily have agreed to share risks and rewards for Other Payer Advanced APM participation as an APM Entity group, particularly when eligible clinicians may participate in Other Payer Advanced APMs at different rates within an APM Entity group (or not at all).” CMS states, “Specifically, we are concerned that if we were to make All-Payer Combination Option QP determinations at the APM Entity level, the denominator in QP threshold calculations could include all other payments and patients from eligible clinicians who had no, or limited, Other Payer Advanced APM participation, thereby disadvantaging those eligible clinicians who did have significant Other Payer Advanced APM participation.” CMS also explains it is making this proposal because “we anticipate that there could be significant challenges in obtaining the information necessary at the APM Entity group level under the All-Payer Combination Option.”

AMGA does not support the proposal. AMGA fails to understand the assumption that an EC participating under the Medicare Option “would likely have little, if any common group level participation in the Other Payer Advanced APM.” CMS should provide evidence supporting this assumption should the agency finalize this proposal. In theory, we recognize there could be a resultant “denominator” problem. However, this is based on the agency's assumption, that we again question, that commonly there are ECs in a group participating under the Medicare Option but not that group's “Other Payer Advanced APM/s. We recognize “there could be significant challenges in obtaining the necessary information . . . under the All-Payer Combination Option,” but this problem or the adequacy or inadequacy of addressing it is not less difficult than addressing it at the group level.

This proposal, if finalized, exacerbates an already well recognized problem that care is already too silo-ed and uncoordinated, i.e., we fail to see how this proposal, intentionally or not, will not compound this problem. AMGA members provide team-based, coordinated care that is designed to ensure patients have their needs met by the most appropriate provider. The model removes barriers and care fragmentation. This proposal, however, would hinder these efforts. We note as well that if finalized, CMS will not have a justification for providing a group score to individual MIPS ECs. AMGA does not support the proposal.

Other and All Payer Combination Options

This past May 31, AMGA along with nine other stakeholder groups including Premier, American Essential Hospitals, and the American Medical Association (AMA), forwarded a letter to the CMS Administrator arguing the agency has the regulatory authority to allow Medicare Advantage

(MA) providers to participate under the “Other” and “All Payer” APM categories before performance year 2019.

In brief, we argued CMS has the authority to permit eligible professionals to become qualifying participants within Advanced APMs under the beneficiary count alternative under section 1833(z)(2)(D) of the Social Security Act. We noted the statute does not include language requiring CMS to consider only Medicare Fee for Service (FFS) patients. It refers in general terms to “counts of patients.” Had Congress intended restrict countable patients to FFS Medicare beneficiaries, it would have had to so specify. Since the statute does not include limiting language requiring CMS to only count FFS patients, the agency has the latitude to interpret this provision to include MA enrollees in the patient count methodology beginning in 2019. In addition, Section 1833(z)(2)(D) does not dictate specific years for the implementation of certain policies or create distinctions between payer types. Rather, it allows the Secretary to do as he/she deems “appropriate.” This provides CMS with flexibility in terms of how it structures the beneficiary count test. In fact, CMS has already used this authority to set the beneficiary count thresholds lower than the revenue test. CMS has the authority to allow MA contracts to be included in 2019 and beyond as part of the beneficiary count alternative. Our letter went on to discuss specifics concerning related issues including how to count MA beneficiary lives in the beneficiary threshold test and aligning financial risk standards across all advanced APMs.

In the proposed rule, CMS states the agency is seeking comments to include MA providers for participation in advanced APMs via, “uses of our waiver and demonstration authorities.” Earlier this year CMS launched its Medicare Advantage Value-Based Insurance Design Model (MA VBID) demonstration and late last year the agency announced it planned to expand the demonstration to add three additional states and two chronic conditions to the initial seven states and diseases. Like fee for service MACRA APMs, the MA demonstration attempts to improve quality and outcomes and reduce spending growth via financial incentives. In this instance through four approaches that reduce or eliminate beneficiary cost sharing and provide targeted MA beneficiaries additional benefits. We see no reason why CMS could not expand the MA VBID model by adding a fifth approach that provides a bonus to MA providers in an attempt to meet the Center for Medicare and Medicaid Innovation (CMMI) test of reducing spending without reductions in quality or an improving quality without increased spending.

Beyond expanding the MA VBID demonstration CMS could use its demonstration authority to create a stand-alone voluntary MA APM demonstration that would exempt ECs from MIPS and qualify them for the APM pathway bonus. That is, the MA APM demonstration would become a qualifying APM model. We recommend CMS also consider developing this option for the 2018 performance year. As CMS has already outlined in the proposed rule, here, to qualify them as an advanced APM, ECs would use the proposed submission option to provide details on their MA risk contract, along with other relevant information including MA revenue, beneficiary count information, requisite quality measurement and CEHRT information and TIN-NPI information by EC. As discussed above, we believe threshold performance be, again, calculated at the group level. The bonus payment of course would remain based on EC Part B billing.

As we stated in our May 31 letter, one-third of Medicare beneficiaries currently are enrolled in an MA plans and enrollment is expected to reach 40 percent within the next few years. Despite this, MA providers who take risk will not get credit for their efforts under MACRA until 2021. Either via beneficiary count and/or via expanded use of CMMI's current MA VBID demo or another demo, CMS has an opportunity to realize MACRA's intent. We also note that aligning fee for service and MA creates synergies that will accelerate population-based strategies and translate into higher quality and more efficient care throughout the Medicare program.

Revenue Threshold Cliff

CMS has established both revenue and beneficiary thresholds for APM participants to qualify for the advanced APM five percent bonus. For example, the payment threshold for payment years 2019 and 2020 is 25 percent. This means that if ECs in a qualifying APM receive 24.9 percent of allowable Medicare reimbursement under the qualifying APM they will fail to qualify for the five percent advanced APM bonus. We believe this is too severe a test. We recommend CMS consider MedPAC's proposal that instead of a threshold or cliff, qualifying APM ECs receive a five percent bonus on the revenue derived via their advanced APM. This would allow for the elimination of any threshold and incent ECs to participate in qualifying APMs to a maximum extent. MACRA's goal is, after all, to move an ever-increasing number of ECs away from strictly FFS reimbursement to FFS-based APMs.

Eight Percent Revenue-Based Standard

CMS is proposing for 2019 and 2020 to maintain the revenue-based nominal amount standard at eight percent of average estimated total Part A and B revenues of all providers in the APM. We question the rationale for an A and B revenue formula, since this may or will disadvantage physicians employed by a hospital and/or discourage a physician-based organization from adding a hospital to its APM participation list because the addition of Part A spending will significantly increase the APM's risk exposure. Instead of improving care coordination and the continuum of care the policy may produce the opposite effect by retarding collaboration between physician groups and hospitals.

Limiting the Number of Medical Home APM ECs

Last year CMS finalized a rule to limit, beginning in 2018, the number of APM medical home ECs to 50 at the ownership or parent company level. However, for performance year 2018 only, CMS would not impose this regulation for those entities participating in the first round of the Comprehensive Primary Care Plus (CPC+) demonstration. We believe the ownership level size criterion will preclude many organizations from participating in CPC+ going forward. We believe a more productive approach would be to apply the size criteria at the medical home level, not the ownership or parent company level.

Thank you for your consideration of AMGA's comments. If you have any questions please do not hesitate to contact David Introcaso, Ph.D., Senior Director of Regulatory and Public Policy, at dintrocaso@amga.org or at 703.842.0774.

Sincerely,

A handwritten signature in black ink that reads "Ryan O'Connor". The signature is written in a cursive style with a large initial "R" and "O".

Ryan O'Connor
Interim President and Chief Executive Officer
AMGA