



Advancing High Performance Health

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

Dear Mr. Slavitt:

The AMGA appreciates the opportunity to provide input to the Centers for Medicare & Medicaid Services (CMS) on the provisions open for comment in Medicare Program: Merit-Based Incentive Payment System and Alternate Payment Model Incentive under the Medicare Physician Fee Schedule Final Rule with Comment Period (CMS-5517-FC), which implements the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). AMGA, founded in 1950, represents more than 450 multi-specialty medical groups and integrated delivery systems representing about 177,000 physicians who care for one-in-three Americans. Beyond fee for service and Medicare Advantage (MA), our member medical groups also participate in every current Alternative Payment Model (APM) model. Therefore, AMGA has a strong interest in how Title I of MACRA is implemented and moreover in achieving the triple aim of improving the experience of care, the health of populations, and reducing spending or the per capita costs of healthcare.

Generally, AMGA strongly supports MACRA's move to paying eligible clinicians under value-based arrangements that emphasis quality improvement, efficient spending, clinical practice improvement, and meaningful use of certified EHR technology under the Medicare Incentive Payment System (MIPS). AMGA equally supports MACRA's Alternate Payment Model (APM) pathway that will allow eligible clinicians to benefit from participating in either Advanced APMs or MIPS APMs.

2017 as a "Transition Year"

In the final rule CMS chose to define the first MACRA performance year or 2017 as a transition "or pick your pace" year. This means eligible clinicians can in 2017 choose "test," "partial" or "full" MIPS participation. More specifically, eligible clinicians can choose to report on one quality, improvement or advancing care information measure to avoid a negative payment adjustment in payment year 2019. CMS chose this approach to lessen or reduce the potential negative payment adjustment impact in the first MACRA payment year. In the final rule, CMS estimated 10% of solo practices and practices with two to nine eligible clinicians would receive a negative MIPS payment adjustment. In the proposed MACRA rule, CMS estimated 87% of solo clinicians and 70% of practices with two to nine eligible clinicians would receive a negative MIPS payment adjustment. CMS also estimated in the final rule 10% or less of eligible clinicians in groups 10-24, 25-99, and 100 or more will receive a negative MIPS payment adjustment. In the

proposed rule, CMS estimated 49% for groups with 10-24 eligible clinicians, 45% for groups with 25 to 99 eligible clinicians and 18% for groups with 100 or more eligible clinicians would receive a negative MIPS payment adjustment. By implementing a “pick your pace” approach, CMS has substantially reduced the likelihood of a negative payment adjustment in 2019. By allowing for fewer negative MIPS payment adjustments, or by substantially compressing the MIPS scoring distribution curve, CMS has largely disallowed eligible clinicians to compete fully for a maximum positive MIPS payment adjustment of +4% in 2019. In the proposed rule impact table CMS estimated the aggregate positive MIPS adjustment at \$1.333 billion. In the final rule impact table the estimate is \$699 million. For groups with 100 or more clinicians for example, CMS has cut by nearly 50% the aggregate positive MIPS payment adjustment from \$539 million to \$274 million.

AMGA members over the past several years have made substantial investments in health information technology (HIT), clinical practice improvement activities, including care coordination and better integration of behavioral and mental health services, and are participating in various pay for performance models, such as the Medicare Shared Savings Program (MSSP), or Track 1 of the Accountable Care Organization (ACO) model. This work was done, in part, to perform or compete successfully under MACRA's precursor programs: the Physician Quality Reporting System (PQRS); the Value-Based Payment Modifier (VM); and, the agency's HIT Meaningful Use (MU) programs. The agency's decision to define 2017 as a “transition year” is a step backward as it penalizes providers that have taken steps to improve care and population health and reduce spending growth in order to effectively subsidize providers that have not yet to date chosen to do so. AMGA hopes CMS will fully implement the MIPS program in performance year 2018.

Proposed ACO Track 1 +

AMGA strongly supports the agency's intention to create a new two-sided ACO track that allows for lower financial risk or provides a better risk on ramp or glide path for Track 1 providers, which currently account for 95% of all MSSP participants and interested but hesitant ACO program participants. If appropriately structured, AMGA is hopeful 1+ will sustain and grow ACO program participation and contribute to reducing Medicare spending growth.

In a letter in support of Track 1+ that AMGA signed along with, among others, the Association of American Medical Colleges (AAMC), the American College of Physicians (ACP), the American Medical Association (AMA) and Premier Healthcare Alliance, we argued, in part, Track 1+ should be designed such that:

- Track 1+ is available to all current ACO participants;
- allows for all current ACO program and ACO demo participants the ability to participate in Track 1+ in any performance year;
- allows for indefinite participation or participation beyond six years or two three-year agreement periods;
- employs regional financial benchmarking;
- offers greater incentives or a higher earned shared savings percent than Track 1;
- allows for either preliminary prospective or prospective beneficiary assignment and allows Track 1+ participants MSR/MLR flexibility;
- allows for beneficiary attestation;

- allows for risk adjustment for health status for the continuously assigned; and,
- offers participants the ability to apply for payment waivers including home health, skilled nursing and telehealth.

AMGA supports these recommendations primarily because the MSSP and the Medicare Advantage programs need to be on a level playing field. As MedPAC argued in chapters one through three in its June 2014 report to Congress, “a major issue is that Medicare’s payment rules and quality improvement incentives are different and inconsistent across the three payment models,” or across FFS, MA and MSSP. We note particularly the disparity in how CMS rewards quality between MA and ACOs. MA plans are rewarded bonuses for high quality. ACOs are not.

Concerning Track 1+, meeting the definition of an advanced APM or meeting advanced APM financial risk requirements, CMS states on page 77426 of the final rule, “we caution that a revenue-based standard is not easily applied to most current APMs, which tend to base risk arrangements on expenditure benchmarks that are unrelated to a particular APM Entity’s revenue.” (CMS will define the revenue-based standard for performance years 2017 and 2018 as 8% of the ACO’s average estimated total Medicare Parts A and B revenues.) If the Track 1+ is defined as an ACO model, for it to succeed, it would make sense for the 1+ model to limit risk to something less than financial risk posed under Track 2. This would mean something less than financial risk that is limited to 5% of the total updated benchmark expenditures in the first performance year, 7.5% in the second performance year and 10% in the third performance year. Therefore, AMGA proposes these stop loss percents be lower for Track 1+ and, like Track 2, ramp up over the initial three-year agreement period.

Advanced APM Revenue-Based Nominal Amount Standard

CMS seeks comment for future consideration regarding the amount and structure of the revenue-based nominal amount standard for performance period 2019 and beyond. “For instance,” CMS states it is, “considering setting the revenue-based standard at up to 15 percent of revenue or setting the revenue-based standard at 10 percent so long as risk is at least equal to 1.5 percent of expected expenditures for which an APM Entity is responsible under an APM.”

AMGA supports the option of a revenue-based standard to meet the nominal risk criteria. Whether it is limited to up to 15% of revenue or some other percent, based on AGMA member experience to date with the ACO program and demonstrations, we believe revenue risk should be accompanied with a stop loss provision as is currently the case in the ACO benchmark-based standard. This would make the revenue-based option comparable to the ACO benchmark-based standard. Since CMS appears committed to a ramp up approach, AMGA also recommends that providers be allowed to ramp up their financial risk exposure whenever or whatever year they begin participation under an APM agreement, including participation in an advanced APM medical home.

CMS is proposing, in cases where an APM entity is a part of a larger health care organization, the larger organization serve as the basis for meeting the revenue-based nominal amount standard. AMGA does not support this proposal. Many AMGA members are organizations that include provider groups with widely varying organizational capacities that serve widely varying populations in widely varying geographic regions. Effectively, provider groups within an organization vary widely in their ability to accept financial risk beyond a nominal amount. Based

on our member's experience locally-based care should not be evaluated for APM financial risk standards on, or in conjunction with, other providers in dissimilar environments simply because they share the same brand or logo - particularly in a rapidly consolidating industry.

Medical Home Model Financial Risk Criteria

AMGA supports the agency's risk criteria for medical home models to qualify as an advanced APM entity. Specifically, the organization would potentially owe or forego at least 2.5% of total Medicare Part A and B revenue in 2017, 3% in 2018, 4% in 2019 and 5% in 2020. AMGA agrees medical homes, unlike other APM entities have less capacity to manage "substantial disruptions in revenue." As CMS notes, "nominal" depends on the situation in which it is applied."

As we noted above and in our June 27 comment letter in response to the proposed MACRA rule, AMGA recommends medical home participants be able to start at 2.5% in their first APM performance year, regardless of what calendar year that is. "We consider the incremental increases," CMS states in the final rule, "in the standard over several years from 2.5 percent to 5 percent to be a recognition that the earliest adopters of risk in the Medical Home Model context might initially consider any losses to be substantial while acclimating to bearing risk, but with successive year of experience, gain comfort and confidence in assuming higher risk levels." This logic applies equally to the "earliest adopters" as it does to subsequent adopters, as every provider regardless of when they agree to participate as an advanced APM medical home will experience an initial three years of performance.

Information Submission Requirements Under the All Payer Option

CMS is seeking comments on "the process for submitting information" regarding payment arrangement information between the payer and provider or information on financial risk arrangements, use of certified Electronic Health Record (EHR) and payment tied to quality measures. CMS also seeks related information on amounts of payments and the relevant number of patients. This information CMS states is necessary for the Secretary "to determine whether a payment arrangement is an Other Payer Advanced APM and to determine the eligible clinician's Threshold Score." While CMS recognizes the importance of maintaining business practice confidentiality, CMS questions whether the process could be appropriately and more easily forwarded by obtaining All Payer related information directly from individual eligible clinicians.

AMGA does not believe individual eligible clinicians should be responsible for submitting All Payer information. While CMS states, "we would maintain the confidentiality of certain information that the APM Entities and /or eligible clinicians submit regarding Other Payer Advanced APM status, AMGA strongly believes if individual eligible clinicians were required to submit All Payer information it would assuredly compromise their ability, or violate their obligation, to keep confidential contractual insurance plan information.

Stratifying MIPS Quality Measure Benchmarks By Practice Size

CMS states the agency is "not stratifying [quality measure] benchmarks by other practice characteristics such as practice size" but is seeking "comment on any rationales for or against stratifying by practice size." For individual eligible clinicians there are five mechanisms by which clinicians can report MIPS quality measures. For groups there are six. CMS has reduced data completeness criteria to 50% in 2017 for claims, registry, QCDR and EHR submission mechanisms. CMS will also establish and publish separate quality measure benchmarks for each

of these submission mechanisms. AMGA is particularly concerned with this approach for largely four inter-related reasons. First, we fail to see the rationale or logic for assigning mean or benchmark scores by submission mechanism. Second, varying benchmark scores by submission mechanisms presents gaming opportunities. Providers may choose to report quality measure data based on the mechanism with the lowest benchmark or select their quality measures based on the mechanism with the lowest benchmarks. Third, the 50% data completeness threshold is not comparable to the GPRO requirement of 248 consecutively ranked and assigned beneficiaries. Fourth, quality should be measured and rewarded on its own merits. For example, evidence suggests Track 1 ACO quality measurement scores, reported via GPRO, are or would be comparatively higher. This would skew GPRO benchmarks making it more difficult for ACOs, which are required to report their measures under GPRO, to be competitive under MIPS. For these reasons, AMGA recommends CMS work to stratify quality measures benchmarks by practice size, not by submission mechanism.

MIPS Topped Out Quality Measures

CMS seeks comments “on whether, for the second year [beginning in 2018] a [quality] measure is topped out, to use a mid-cluster scoring approach, flat rate percentage approach or to remove the topped out measures at this time.” AMGA recognizes the benefits of continuing to offer topped out measures. For example, as CMS states, “it would possibly make it difficult for some specialties to have enough applicable measures to report.” For a measure that is topped out for a second year, CMS has proposed, beginning in 2018, to use one of these three approaches to score the measure. Per our comment above concerning program uniformity, it appears the sensible solution, as CMS offers, is to “apply a flat percentage in building the benchmarks for topped measures, similar to the Shared Savings [ACO] Program.” To prevent gaming, if after monitoring and evaluating the use of topped out measures, CMS may want to consider, as the agency suggests, to “limit how many topped out measures could be reported through future rulemaking.” AMGA also recommends before CMS removes a topped out measure the agency identify a comparable or replacement measure.

MIPS Virtual Groups

In the final rule CMS identifies four sets of questions for comment concerning implementation of virtual groups. These question sets concern provisions and elements such as minimum standards, related to virtual group requirements, technical and operational elements, technological infrastructure and group identification, or creating a new identifier for virtual groups.

As provided for in MACRA virtual groups of eligible clinicians or group practices consisting of not more than 10 MIPS eligible professionals can elect to be a virtual group for the purposes of collective reporting. The provision is presumably based on allowing solo practitioners and small group practices to share resources thereby lessening the individual's or small group's burden of MIPS reporting. AMGA strongly supports the virtual group provision. AMGA strongly supports the agency's recommendation to pilot virtual groups before 2018 implementation. AMGA also supports that at least initially CMS not establish “minimum standards” such that virtual groups are not inhibited in how they organize and design their MIPS reporting protocols. This would also allow the greatest opportunity for peer-to-peer learning. Similarly, we do not believe CMS should initially develop “types of requirements that could be established” to promote care coordination nor have to meet “a timeframe . . . in order to build a system or coordinate a systematic infrastructure that allows for a collective, streamlined capturing of measure data.”

Virtual groups should, as CMS notes, “have the flexibility to form any composition of virtual group permissible under the Act while accounting for virtual groups reporting on measures across the four [MIPS] performance categories.” Concerning a new identifier for virtual groups, our preliminary sense is groups can be constituted by NPIs and/or TINs. However CMS chooses to regulate virtual groups, providers and other stakeholders should be given ample time to comment.

MIPS Scoring for Year-Over-Year Improvement

CMS notes the agency is seeking comments “on how best to incorporate improvement scoring for all [MIPS] performance categories.” Again, for purposes of consistency, AMGA recommends CMS adopt measuring an eligible clinician’s or group’s own year-over-year improvement similarly to how the agency measures and rewards year-over-year improvement in the ACO program. That is, as of last year, CMS began rewarding ACOs for quality improvement by adding additional points to their domain scores. ACOs can earn up to four points in each domain if they demonstrate statistically significant quality improvement year-over-year.

Thank you for your consideration of our 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,

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