The Voice of Accountable Physician Groups

August 8, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-5522-P: Medicare Program; CY 2018 Updates to the Quality Payment Program (QPP)

Dear Administrator Verma:

We appreciate the opportunity to comment on the Medicare Access and CHIP Reauthorization Act (MACRA) CY 2018 updates to the QPP proposed rule.

CAPG represents nearly 300 physician organizations across 44 states, Washington, DC and Puerto Rico. Our members participate in alternative payment models (APMs) across Medicare Advantage (MMA) and traditional Medicare. CAPG members have successfully operated under risk contracts for over three decades and play an important role in advancing the value movement.

To summarize our feedback on the proposed rule:

- We call on the Centers for Medicare & Medicaid Services (CMS) to design a demonstration project to test risk contracts between health plans and physician groups in MA as a qualifying MACRA advanced APM;
- We applaud CMS for its continued commitment to the value movement and encourage the agency to stay the course with proposals that would continue the on ramps to pay-for-performance and advanced APMs.

The MACRA statute was intended to provide incentives and encouragement through a variety of mechanisms for physicians and physician groups to move into advanced APMs. Perhaps most notable is the five percent bonus for physicians that take risk in certain qualifying models. However, it is also notable that MACRA include 0.5 percent updates to the Medicare Part B Physician Fee Schedule followed by five years with zero percent updates. These updates clearly

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fail to keep up with inflation and create financial challenges for clinicians in Medicare. We believe that this will present additional incentives for clinicians to move into advanced APMs -- provided that attractive models are available -- as the main way to offset the impact of flat payment updates.

The Proposed Rule would implement several policies that we believe will continue to press physicians and physician groups toward advanced APMs. As discussed below, we believe that the proposed expanded exclusions from MIPS will continue to push those groups that remain in MIPS into advanced APMs. Further, we believe that the flat update included in the MACRA statute will encourage even those exempted from MIPS to seek advanced APM status.

Given all of the policy pressure toward advanced APMS, it is now more critical than ever that CMS offer robust options for participation in advanced APMs. The quickest, simplest way to enhance the APM portfolio for physicians and physician groups is to count qualifying risk contracts between plans and physician groups in MA as advanced APMs.

Our specific comments and proposals are set out below.

I. The CAPG member model is essential for a cost effective, high quality healthcare system

Our members' preferred advanced APM is prepaid capitation. This model best aligns the incentives for physicians to provide high quality, coordinated care. Under this model, the payment amount does not fluctuate based on the volume of services provided. Instead, the physician organization is paid a set amount per member, per month.

Our physician organizations have the flexibility to tailor payments to their individual contracted or employed physicians (paying a salary, sub-capitation, or fee-for-service). In addition to Stars and many other external quality programs, our members hold their employed and contracted physicians to robust internal performance standards with a portion of the physician's payment often depending on performance metrics across several areas.

Capitated payment allows our members to deploy proven techniques and innovative approaches to patient care. The model incentivizes a team-based approach, whereby healthcare professionals such as care managers, nurses, social workers, care navigators, pharmacists and others are deployed as part of a physician-led care team. Each member of the team is encouraged to practice to the top of his or her license. The primary care-led team approach improves care outcomes.

These arrangements also incentivize physicians to provide the right care, at the right time, in the most effective setting. For example, patients are treated safely in lower cost settings, such as the patient's home, when appropriate. Our extensive experience has demonstrated that this approach is better aligned with patient and physician preferences.

While this model of capitated, coordinated care exists in pockets across the country today, there is clearly more for CMS and the industry to do to proliferate the model. MACRA provides the potential to spread capitation and coordination at a more rapid clip, however modifications must be made to implementation to accelerate this movement to value.

II. CMS should create a MA advanced APM demonstration project that enables clinicians in MA to qualify for the MACRA five percent bonus

a. CMS has clear legal authority to create an MA APM demonstration project.

Under MACRA, certain qualifying models can become eligible for advanced APM status. The statute defines bonus-eligible advanced APMs to include Center for Medicare & Medicaid Innovation (Innovation Center) demonstration projects, Medicare Shared Savings Program (MSSP) accountable care organizations (ACOs), and demonstrations required by federal law. In addition, advanced APMs must participate in a quality program comparable to MIPS; use certified electronic health records technology (CEHRT); and bear more than nominal financial risk or be a qualifying medical home.

To qualify for the five percent advanced APM bonus, APMs must have a certain threshold of their Part B revenue or patients in the advanced APM. For the first two years of MACRA implementation, that threshold has been spelled out to in include 25 percent of Part B payments or 20 percent of Part B patients. In later years, the Medicare Part B threshold increases to 50 percent and then 75 percent.[1]

Under current regulations and sub-regulatory guidance, only a handful of models qualify as advanced APMs. The majority of these models are Innovation Center demonstrations. The existing models, all built upon Part B, show promise, but have thus far exhibited mixed results and modest success. Currently, no MA arrangements count as advanced APMs and MA risk does not count toward an organization's Medicare risk threshold.

In response to the agency's request in the proposed rule, CAPG is proposing that CMS use its demonstration authority to create a voluntary MA APM that would qualify its participating clinicians for the five percent MACRA bonus and exempt those clinicians from MIPS. Specifically, CMS has the legal authority to use Section 1115A of the Social Security Act to test new models with the potential to lower costs and maintain or improve quality of care offered to patients.[2] CMS should use this legal authority to design a demonstration project to compare the cost and

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[1] Beginning with the 2021 payment year, advanced APMs may count "all payer" revenue in addition to 25 percent of their Medicare Part B revenue to reach the thresholds to qualify as an advanced APM. We note that in all years of the MACRA APM bonus, CMS has proposed to require participation in Medicare Part B payment models.

[2] Memorandum from Akin Gump to CAPG re: CMS has legal authority to make incentive payments to participants in Medicare Advantage alternative payment models (April 7, 2017).

quality of care delivered in risk contracts between MA plans and physician organizations to the cost and quality of care delivered in traditional Medicare.

This MA APM option would then become a "qualifying model" under the MACRA statute by virtue of being an Innovation Center demonstration. Furthermore, once within the Innovation Center, CMS can use waiver authority to modify the existing Medicare Part B revenue test to include MA revenue, creating a modified revenue threshold that includes Medicare risk revenue from Part B and MA risk revenue. In addition, or in the alternative, CMS could use the patient count threshold without a waiver as the language for that category is broader and permits the inclusion of MA patients as currently written.[3]

As mentioned above, for the Innovation Center to test a model, models are to be expected to lower costs and improve or maintain the quality of care. An existing body of evidence proves that risk contracting between plans and providers in MA satisfies both tests.

On the quality component, a recent study in the American Journal of Managed Care compared quality of care between two physician groups: one where an MA plan paid fee-for-service downstream to physicians and one where the MA plan paid capitation to the physician group (an advanced APM). The advanced APM group's patients had a six percent better survival rate than the FFS group. Further, the advanced APM group achieved 11 percent lower emergency department utilization and nearly 12 percent lower inpatient utilization when compared to the FFS group.[4] In sum, the quality benefits of the model we describe are clear.

Furthermore, a recent study by the Integrated Healthcare Association (IHA) shows that, in California, statewide averages for emergency department visits, all-cause readmissions, and inpatient bed days are all between 50 percent and 75 percent higher than the statewide averages for MA (567 vs. 373 emergency department visits per thousand member years, 18.4 percent vs. 11.2% readmissions, and 1,363 vs. 789 bed days per thousand member years).[5] The differences are compelling in terms of the quality available in a coordinated care system like MA, versus a fragmented FFS system. Advanced APMs have the potential to align incentives for physicians and produce better quality care for patients.

Second, there is compelling evidence that this demonstration will save money as compared to traditional Medicare. Research dating back to the 1990s has showed that as the penetration of managed care increases, traditional Medicare spending is reduced. Recent research has

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[3] Memorandum from Akin Gump to CAPG re: CMS has legal authority to make incentive payments to participants in Medicare Advantage alternative payment models (April 7, 2017).
[4] Mandal et al., Value-Based Contracting in Medicare Advantage Healthcare Delivery and Improved Survival, Am. J. Manag. Care 2017:23(2).
[5] Integrated Healthcare Association, Benchmarking California Health Care Quality and Cost Performance (2016), available at http://www.iha.org/sites/default/files/resources/issue-brief-cost-atlas-2016.pdf (accessed December 15, 2016).

similarly shown that greater MA market penetration is associated with reduced costs in traditional Medicare and slowed growth in traditional Medicare spending.[6]

In addition, the Medicare Payment Advisory Committee (MedPAC) has published findings showing that enrollment-weighted bids in MA averaged 94 percent of FFS spending in 2016. MedPAC estimates that HMOs bid an average of 90 percent of FFS spending. These numbers suggest that HMOs can provide the same services for less than FFS in the areas where they bid.[7]

Creating incentives for physicians to participate in risk-bearing relationships in MA (where today there may be barriers to doing so across the country) will be one step forward in accelerating the spread of MA risk contracts. We believe that this policy will help continue to rapid growth of MA across the country, thereby controlling costs and lowering fee-for-service spend.

b. CMS should adopt a model design that facilitates physician group and independent practice association participation.

Below is a detailed description of the model we are suggesting. We note that this model builds off of, but makes modifications, to what CMS itself has proposed for the all-payer calculation that is required to begin in the 2019 payment year. We urge CMS to adopt this demonstration project in 2018. Not only will that benefit clinicians by allowing them to participate in the advanced APM track of MACRA should they desire to do so, but it will give the agency crucial experience with a significant component of the advanced APM all-payer option prior to the nationwide rollout of that option.

First, as CMS describes in the proposed rule, we would use the eligible clinician submission option to allow medical groups and IPAs to submit MA risk contract information to CMS for consideration as an advanced APM. Leveraging off of the organized administrative systems of the groups and IPAs will bring efficiency and accuracy to the program.

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[6] M. Chernew, et al., Managed care and medical expenditures of Medicare beneficiaries, Journal of Health Economics (2008), available at http://www.sciencedirect.com/science/article/pii/S016762960800101X?via%3Dihub; C. Afendulis et al., The Effect of Medicare Advantage on Hospital Admissions and Mortality, National Bureau of Economic Research (2013), available at http://www.nber.org/papers/w19101; K. Baicker, et al., Medicare Payments and System-Level Health-Care Use: The Spillover Effects of Medicare Managed Care, American Journal of Health Economics (2015), available at http://www.mitpressjournals.org/doi/abs/10.1162/AJHE_a_00024#.V7Q3MmCEB1R; Johnson G., et al., Recent Growth in Medicare Advantage Enrollment Associated with Decreased Fee-for-Service Spending in Certain US Counties, Health Affairs (2016), available at http://content.healthaffairs.org/content/35/9/1707.abstract.

[7] Medicare Payment Advisory Commission, Data Book June 2016, available at http://www.medpac.gov/docs/default-source/data-book/june-2016-data-book-section-9-medicare-advantage.pdf?sfvrsn=0 (accessed Aug. 4, 2017).

The medical group or IPA would submit a summary of relevant contract terms[8] from the health plan–group contract to CMS for approval as an advanced APM qualifying model. The medical group or IPA would also submit a list of clinicians participating in the risk contract, including the TIN-NPI combination for each clinician.[9] The medical group or IPA will attest to its MA revenue and MA patient count information. CMS will calculate the traditional Medicare information for the medical group or affiliated IPA doctors, just as it currently does for traditional Medicare advanced APM participants.

CMS will use the reported TIN-NPI combinations to identify the individual clinicians and tally the Part B revenue for participating clinicians for purposes of calculating the amount of the bonus CMS will pay. This step is identical to the process CMS uses for advanced APMs under current regulation.

Note, unlike the CMS proposal for implementing the all-payer thresholds, we propose that CMS calculate the risk and patient count threshold performance at the group or IPA level, not at the individual clinician level. Once that risk level is achieved by the APM entity, CMS should use the traditional Medicare revenue information to pay the bonus to the participating clinicians' Medicare Part B billing TINs. This is consistent with current CMS practice in traditional Medicare.

We believe that assessing risk at the individual clinician level is unworkable. The key reason is that risk contracts in MA tend to exist between the group or IPA (APM entity) and the plan and not between individual clinicians and the health plan. Instead, individual clinicians may contract for a subcapitated payment, salary, or other form of compensation from the physician group. We believe that a standard that requires individual clinicians to report all of their income from different sources and determine risk at the individual level will be unworkable, burdensome, and will not necessarily give CMS the information it needs about the underlying contract between the MA plan and the group. Furthermore, the individual clinician assessment does not align to what is required in traditional Medicare, where, in general, risk is assessed at the group level. Creating a different standard in MA adds unnecessary complexity to the implementation of the QPP.

Below we provide additional detail on how the model would work. Because we see key differences in how medical groups and IPAs would participate, we have separated out detailed processes for each organization type.

Detailed Process between CMS and Staff/employed model Medical Group

1. Physician group submits a summary of the relevant terms of its MA risk contracts to CMS for review. These terms align to the MACRA definition of an advanced APM (quality measurement, CEHRT, and more than nominal risk). The group will also need to

[8] Relevant contract terms should be limited to those that have a direct bearing on MACRA APM status: quality, CEHRT and risk. CMS should minimize the required disclosures to reduce burden on physicians and groups and streamline data collection.

[9] In the case of an IPA, the clinician list would be limited to those with "meaningful participation" in the IPA's MA risk contract. This concept is described in greater detail below.

submit a list of clinicians participating under the arrangement. [Appendix A]. The physician group will need to do this for each MA contract with multiple MA plans that may qualify as an advanced APM.

   a. Name of arrangement
   b. Geography covered
   c. Term of arrangement (contract start and end dates)
   d. Describe accountability for 5 star quality measures[10]
   e. Describe requirements that more than 50 percent of clinicians use certified electronic health records technology (CEHRT).
   f. Describe "more than nominal risk" provision (including capitation) for the physician group.
   g. List individual clinicians participating in the arrangement (include TIN-NPI combination for each clinician).

2. CMS reviews the submission and determines whether the contract between the health plan and the group meets the MACRA criteria as an advanced APM. If so, CMS lists the name of the arrangement as an advanced APM on the CMS website.
3. Physician group submits its total MA revenue and MA patient count information to CMS to support the calculation of the MA revenue and patient count thresholds [Appendix B].
4. Physician group must attest to or certify the accuracy of all information submitted to CMS. CMS retains the right to audit this information.
5. If the physician group meets one of the two thresholds (revenue or patient count) based on a threshold that combines its reported MA information plus CMS-calculated traditional Medicare information, CMS will pay a bonus to the Part B billing TIN equal to five percent of the **traditional Medicare** revenue.

Detailed Process between CMS and IPAs

1. CAPG proposes that IPAs function like medical groups for purposes of the MA APM.
2. The IPA submits a summary of the relevant terms of its MA risk contracts to CMS for review. These terms align to the MACRA definition of an advanced APM (quality measurement, CEHRT, and more than nominal risk). The IPA will need to submit a list of clinicians participating under the arrangement [Appendix A].[11] The IPA will need to do this for each MA contract with multiple MA plans that may qualify as an advanced APM.
   a. Name of arrangement
   b. Geography covered

[10] CMS should deem the 5 star ratings program quality measurement to be equivalent to what is required under MIPS, sufficient to meet the MACRA requirements for quality.

[11] In IPA relationships, some clinicians are "non-exclusive" meaning that they participate with multiple IPAs. We believe that defining "meaningful participation" in an IPA will address the participation of these clinicians. However, there may be instances where a clinician has less than meaningful participation with multiple IPAs and his or her total practice revenue exceeds the thresholds. As the agency has done for traditional Medicare participants in multiple APMs, CMS should design an "exception" for these clinicians as well.

    c. Term of arrangement (contract start and end dates)
    d. Describe accountability for quality measures.
    e. Describe contractual requirement that more than 50 percent of clinicians use certified electronic health records technology (CEHRT).
    f. Describe "more than nominal risk" provision (including capitation) for the physician group.
    g. List individual clinicians with "meaningful participation"[12] in the arrangement (include TIN-NPI combination for each clinician).
3. CMS reviews the submission and determines whether the contract meets the MACRA criteria as an advanced APM. If so, CMS lists the name of the arrangement as an advanced APM on the CMS website.
4. The IPA submits its total MA revenue and MA patient count information to CMS to support the calculation for the revenue and patient count thresholds for its MA population. [Appendix B].
5. IPA must attest to the accuracy of all information it submits to CMS regarding the IPA's MA contracts and revenue. CMS retains the right to audit for accuracy.
6. CMS will calculate the traditional Medicare revenue and patient count information for the clinicians listed in step 2 above.
7. CMS will determine if the IPA meets one of the two thresholds (revenue or patient count) based on a threshold that combines the IPA's reported MA information plus CMS-calculated traditional Medicare information. Again, the revenue and patient count tests would be modified to reflect a combined MA and traditional Medicare revenue/patient count (rather than only Part B as is current practice). IPAs, like medical groups, should remain free to participate in both a Part B APM and an MA APM.
8. If the IPA meets the patient count or revenue threshold, CMS will calculate the bonus payment amount based on information CMS collects related to Part B payments to clinicians on the IPA's list.
9. Bonuses will be paid to the Medicare Part B billing TIN for the participating clinician, just as is done in traditional Medicare advanced APMs today.
10. The IPA will notify its clinicians that it is submitting their names on a list that may allow them to qualify for a bonus and escape MIPS. The IPA will collect acknowledgements in writing from its contracted clinicians that the IPA is submitting this information on the clinician's behalf. [Appendix C and D].

Today, CMS uses only Part B revenue to calculate the risk and patient count thresholds. We are proposing, for both IPAs and medical groups, a combined Medicare threshold that would aggregate Part B and Part C revenue or patient counts for a single threshold calculation. Our intent is that physicians with MA risk will qualify. Those that already qualify by having a Medicare ACO or other qualified entity using their Part B revenue should have the option to

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[12] For purposes of IPA arrangements, we recommend that CMS develop a volume test to ensure that clinicians participating in the IPA and benefitting from the bonus payment are strongly tied into a coordinated care model. We suggest that CMS may want to mirror the low-volume threshold set out for MIPS: $90,000 or less in Part C payments or 200 or fewer Part C patients with the IPA.

participate in both the Part B qualifying model and the MA APM model described above. This would enable physicians and physician groups to combine their Medicare risk revenue to meet the escalating risk thresholds in later years (50 percent and 75 percent). As an example, a group participating as a Next Gen ACO could also qualify as an MA APM and could use both risk arrangements to meet the new Medicare threshold.

c. Additional considerations.

A few additional considerations to highlight for CMS. First, any process CMS adopts for the MA APM demonstration should minimize reporting burdens on physicians and physician groups. Self-reporting, attestation, and auditing should be sufficient to protect the trust funds from fraud and abuse.

Second, the model we outlined above would apply a five percent bonus to the clinicians' part B revenue only, not the Part C revenue. In prior comments, CAPG has outlined a recommended solution to apply a bonus to MA revenue to encourage the adoption of risk contracting in MA. We are hopeful that in forthcoming rulemaking and guidance on the MA program, CMS will continue to explore how it can encourage the proliferation of capitated coordinated care downstream from health plans in MA.

Third, the Innovation Center may need to deploy additional waiver authority to address Stark Law concerns, as it has done with the traditional Medicare models.

Finally, we note that the timing of this demonstration is critical. We call on CMS to implement the above demonstration beginning in December 2017, just as it has proposed for the creation of virtual groups. While we know that CMS and the PTAC are working to bring new models online, we fear that the pace will not be fast enough to allow our risk-bearing clinicians to access the advanced APM pathway and will leave these sophisticated players in MIPS. Rapid introduction of MA APM options will facilitate a faster transition to value across the country and will provide clinicians with valuable new options to advance their risk-bearing capabilities.

III. CAPG comments on the agency's advanced APM proposals

Below are CAPG's comments on the specific proposals on advanced APMs contained in the proposed rule.

a. CAPG supports the eligible clinician submission option for all-payer APMs.

The MACRA statute created an option for advanced APMs to meet the revenue or patient count thresholds by adding their all-payer revenue (commercial, MA and Medicaid) to their Medicare Part B risk threshold beginning in the 2021 payment year. In this proposed rule, CMS provides additional details on how the all-payer threshold could be met.

We applaud CMS's proposal to have both a payer-initiated process and an APM entity or clinician-initiated process to become an advanced APM.[13] Under the proposed rule, CMS would allow either the plan or the APM entity or clinician to submit a form describing an all-payer advanced APM arrangement. The APM entity submission pathway will be critical to the successful implementation of all-payer models, particularly because under MACRA the bonus is paid directly to the clinicians and not to health plans or other payers. We believe that the incentive to submit information and applications lies within the physician organization and we support this proposal.

As part of the submission, CMS indicates in the proposed rule that it would also like to collect supporting documentation, including copies of contracts and other underlying materials. We recommend that CMS limit its requests for information to that information that supports the model's qualifications as an advanced APM (quality, CEHRT, and risk). We do not think that full contract disclosure is necessary and believe that requiring additional, unnecessary documentation will serve as a barrier to participation.

b. CAPG opposes assessment of risk at the individual clinician level for all-payer advanced APMs.

CMS proposes that QP determinations under the all-payer combination option would be performed at the individual eligible clinician level only (not at the physician group or APM entity level). CMS says that there will be significant challenges in making these determinations at the group level.[14]

Furthermore, in order to determine whether the individual clinician is a QP under the all-payer combination option, CMS suggests that it would need to receive all of the payment amount and patient count information attributable to the clinician through every other payment advanced APM and for all payments or patients (except excluded payer types) made or attributed to the clinician in the performance period.[15] CMS further indicates that its determinations about all-payer APM status would remain in place for only one year.

CAPG has significant concerns with this proposal. Requiring individual clinicians to submit all of their payment information every year creates significant burden for clinicians. Although CMS has stated that groups could report on behalf of their individual clinicians, we still think that requiring this information on behalf of each clinician will serve as a disincentive to participate in the all-payer option. Additionally, as we noted above, the contract between the plan and the medical group or IPA likely would not speak to the terms of individual clinician compensation. For example, in a staff model group, the risk contract would exist between the group and the health plan; individual employment contracts would exist between the group and the clinicians.

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[13] 82 Fed. Reg. 30,190.
[14] 82 Fed. Reg. 30,201.
[15] 82 Fed. Reg. 30,204.

We question whether the individual approach outlined in the rule would require that group to disclose every employment agreement with its contracted clinicians so that CMS could assess how much risk each individual is bearing. Clearly this creates a substantial burden on physicians and physician organizations.

In addition, this requirement is inconsistent with what CMS has implemented for traditional Medicare, where risk is judged at the group level. Consistent standards should be used across the payer types to harmonize requirements and incentives and reduce complexity for clinicians. We recommend that CMS assess risk threshold requirements at the APM entity level for the all-payer option just as it does for the Medicare option.

c. CMS should eliminate the clinician cap for CPC+.

In prior rulemaking, CMS finalized a different financial risk standard for medical homes. Along with the financial risk standard, CMS finalized a requirement that entities must have fewer than 50 eligible clinicians at the parent entity level to qualify for the advanced APM bonus beginning in 2018. In this proposed rule, CMS says it would exempt Round 1 participants in the comprehensive primary care plus (CPC+) program from the 50 clinician cap. However, participants in round two of CPC+ would be subject to the 50 clinician cap.[16]

We strongly support incentives for patient-centered medical homes and we believe that primary care is a necessary foundation for risk-based coordinated care. Many CAPG members are engaged in medical home initiatives, including CPC+.

We oppose the proposed 50-clinciian cap for medical home models. Given the limited number of available advanced APMs for the first several years, we believe that completely closing off one model to interested organizations is inappropriate. While we understand CMS's policy goal of moving larger organizations into accountable care organizations and other population health models, we do not believe that larger organizations should be precluded from the advanced APM bonus because they have elected one of a small handful of available APM options. In addition, while we support carving out the Round 1 participants, we note that creating these distinctions in eligibility based on participation year will add unnecessary complexity to the Quality Payment Program at a time when the agency seeks to streamline the program. A more favorable approach would be to allow all CPC+ participants, regardless of parent entity size, to receive the advanced APM bonus for their 2018 participation in the model. This policy could be re-evaluated in subsequent years when more advanced APM options come online.

d. CMS should provide clarity on treatment of the MACRA APM bonus in MA benchmarks.

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[16] 82 Fed. Reg. 30,172-30,174.

There remains a lack of clarity as to whether CMS will factor the advanced APM bonus under MACRA into MA benchmark determinations. In earlier rulemakings the agency indicated it would address this issue in the Rate Notice and Call Letter for Medicare Advantage. To date, we have not seen guidance on this point. We call on the agency to provide clarity as to its treatment of these payments for MA benchmarking purposes.

IV. CAPG Comments on MIPS Proposals

a. MIPS Overview

Under the MIPS path, physicians and physician groups are subject to a potential bonus or penalty depending on their performance. MIPS consists of four performance categories (1) quality; (2) cost; (3) advancing care information; and (4) improvement activities. In MIPS, eligible clinicians receive a composite score on a scale of zero to 100. CMS sets a threshold score. If the eligible clinician or group meets or exceeds the threshold, the clinician or group will receive a neutral or positive update. If the clinician or group falls below the threshold, the clinician or group receives a negative adjustment. The amount of the bonus or penalty increases over time and there is the potential for additional bonuses due to a scaling factor and exceptional performer funds.

b. CMS proposes the implementation of virtual groups

In the proposed rule, CMS proposes to define a virtual group as a combination of two or more TINs composed of a solo practitioner or a group of 10 or fewer clinicians under a TIN that elects to form a virtual group with at least one other such solo practitioner or group for a performance year.[17] CMS is not proposing to establish an overall size limit on virtual group participants.[18]

Virtual groups would be required to make an election by December 1 of the year preceding the election year (December 1, 2017 for the 2018 performance year, for example). CMS would also require that TINs comprising a virtual group establish a written formal agreement between each member of the group prior to an election.[19]

CAPG strongly supports the creation of virtual groups with no limit on the overall size of the group. We have seen firsthand how successful and independent practice association model can be. Many of our IPA members have had strong outcomes in terms of improving quality and reducing cost trend in MA, while allowing clinicians to remain in their independent practices. We welcome the opportunity to begin to introduce this model in traditional Medicare and to allow clinicians to come together to take accountability for cost and quality as a group. We

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[17] Proposed Rule, 42 U.S.C. 414.2305.
[18] 82 Fed. Reg. 30,038.
[19] *Id.*

encourage CMS to simplify and streamline contracting and paperwork requirements for virtual groups to encourage their rapid formation.

c. CMS should weight the cost category at 10 percent for 2018.

We agree with CMS that "measuring cost is an integral part of measuring value as part of MIPS."[20] Beginning in calendar year 2015, CMS applies the value modifier to payments for groups of 100 or more eligible professionals (based on a 2013 measurement year). The value modifier included six cost measures. Since that time, large groups have continued to be measured, and rewarded or penalized, based on their performance on quality and cost.[21]

In the 2016 final rule, CMS outlined concerns about the differences between the value modifier program and MIPS when it comes to cost measurement: primarily the attribution methodology and the scoring is different. At the time, CMS indicated that a transition year with cost weighted at zero percent would give clinicians an opportunity to familiarize themselves with these changes.[22] CMS emphasized that it was "not reducing the weight of the cost category due to concerns with attribution, risk adjustment, or the measure specifications."[23] In fact, the agency stated its belief that its methods are sound.[24]

In this year's proposed rule, CMS again proposes a zero percent weighting for the cost component of MIPS. AS CMS notes in the proposed rule, for the next performance/payment year (2019/2021), the cost performance weight is set at 30 percent under the statute.[25]

As we stated above, CAPG is committed to creating a smooth on ramp for clinicians in MIPS and moving into advanced APMs. We are concerned that the jump from the proposed zero percent quality weight to the required 30 percent quality weight will feel more like a cliff than a ramp. We further note that most of the clinicians remaining in MIPS will have experience with cost measurement from the value modifier program. Finally, we think it makes good policy to expose groups to the effects of the cost measure when that category is weighted at 10 percent and there is a relatively low composite performance requirement rather than to implement the cost weight at 30 percent when the composite performance threshold is set at the mean or median.

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[20] 82 Fed. Reg. 30,047.
[21] 2015 Value-Based Payment Modifier Program Experience Report (Jan. 16, 2015), available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-VM-Program-Experience-Rpt.pdf (accessed Aug. 2, 2017).
[22] 82 Fed. Reg. 77,164-66.
[23] 82 Fed. Reg. 77,165.
[24] *Id.*
[25] 82 Fed. Reg. 30,047-48.

d. CAPG supports the use of a 15-point threshold in MIPS for the 2018 payment year.

Under MACRA, the Secretary of Health and Human Services is required to set a performance threshold with respect to which the final scores of MIPS eligible clinicians are compared for purposes of determining MIPS bonuses or penalties. In general, the performance score must be either the mean or median of the final scores for all MIPS eligible clinicians. MACRA sets out a special rule for the first two years of implementation. CMS used this flexibility to set a performance threshold of three points for the first year of MACRA implementation (2017 performance, 2019 payment).[26]

This year, CMS is proposing to use its statutory flexibility to set the performance threshold at 15 points. CMS states its belief that this represents a meaningful increase in performance as compared to 3 points in year one, while encouraging participation in MIPS.[27] CMS outlines a couple of ways that a clinician would hit the threshold: submitting the maximum number of improvement activities; or full participation in the quality category, for example. CMS considers other alternatives, such as setting the performance threshold at six points or at 33 points.

Again, we think a key principle for MACRA implementation is to create on-ramps to pay-for-performance that lead to on-ramps for two-sided risk models. We believe that it is appropriate to adjust the performance threshold upward from 3 points to some greater number that will encourage more robust participation in MIPS and prepare clinicians to advanced APM participation. While we defer to CMS on what the exact threshold number should be to achieve that level of preparation and participation, we think it is important to keep an eye on the forthcoming requirement that the performance threshold be set at the mean or median and to prepare clinicians as to what will be required to avoid a penalty in later years.

e. CAPG supports the creation of a complex patient bonus.

In the proposed rule, CMS acknowledges that social risk factors, such as income, education, race and ethnicity, employment, disability, community resources, and social support (socioeconomic status) play a major role in health.[28] As CMS continues to work with stakeholders to determine how to best account for social risk factors and reducing disparities, CMS is proposing to include a complex patient bonus in MIPS in the 2020 payment year. CMS proposes to calculate an average Hierarchical Condition Category (HCC) risk score using the model adopted for MA risk adjustment purposes and to use the average HCC risk score to apply a complex patient bonus. This bonus would be up to three points.[29]

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[26] 82 Fed. Reg. 30,147.
[27] 82 Fed. Reg. 30,148.
[28] 82 Fed. Reg. 30,134.
[29] 82 Fed. Reg. 30,138.

Our member physician organizations witness firsthand the importance of addressing social determinants in improving overall population health outcomes. We strongly support the creation of a complex patient bonus and we support using HCC risk scores to do so. This will create alignment across MA and traditional Medicare, an important policy goal.

f. CAPG is neutral on the creation of a bonus for small practices.

CMS is proposing to add a small practice bonus of five points to the final MIPS score for those in groups with 15 or fewer eligible clinicians.[30] The bonus is proposed as a short-term strategy to assist small practices in the transition to MIPS. CMS states in the rule that with the five point bonus, a small practice could achieve the 15 point threshold by reporting two quality measures or one quality measure and one improvement activity.[31]

We recognize the challenges facing small practices as they prepare to participate in MIPS. The creation of a small practice bonus may incentivize some practices to submit quality information where they otherwise would not have done so. CAPG is neutral on the small practice bonus.

g. CAPG calls on CMS to continue to evaluate the low volume threshold over time.

In the proposed rule, CMS would increase the low volume threshold to exclude from MIPS clinicians or groups who have Medicare Part B allowed charges less than or equal to $90,000 or provides care for 200 or fewer Part B-enrolled Medicare beneficiaries.[32] We understand that there are many clinicians across the country who are not yet prepared to participate in a pay-for-performance program. Therefore, we understand CMS's desire to increase the low-volume threshold to give clinicians more time to prepare. We support the creation of an option for low-volume clinicians to participate in MIPS if they desire to do so. Broader participation in the QPP is desirable, although we believe it is more important at this time for the agency to focus on getting these clinicians into APMs than getting them into MIPS.

Taken together with other proposals, we think the expansion of the low volume threshold will result in many CAPG members (large physician organizations) being the main MIPS participants. We are seeing that their MIPS status can be a powerful incentive for our members to move into advanced APMs. We believe that this was one of the policy goals of MACRA – to move providers from MIPS into advanced APMs, using MIPS as one tool to encourage this movement. However, for MACRA to be successful in this transformation, there must be available options for physicians and physician groups in the advanced APM track. That is why we are calling on CMS to create an MA APM option for physician groups who seek to leave MIPS but find that the available options in Part B do not meet their needs.

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[30] 82 Fed. Reg. 30,140.
[31] 82 Fed. Reg. 30,139.
[32] Proposed Rule, 42 C.F.R. § 414.1305.

h. CAPG is concerned about the agency's policy clarification that it intends to apply MIPS incentives and penalties to Part B drug spending.

In the proposed rule, CMS clarifies that it intends to apply MIPS adjustments to payments for Part B drugs. This is a departure from prior performance programs where incentives and penalties applied to physician services but not to payments for Part B drugs. We are concerned that this may create unintended consequences for the use of Part B drugs. We encourage CMS to continue to evaluate this policy.

i. Physician compare should be modified to include quality information for physicians in MA.

MACRA requires that certain QPP information be published on Physician Compare. Specifically, MACRA requires that CMS publish the MIPS eligible clinicians final score; performance under each of the four categories; names of clinicians in advanced APMs and the performance of those models; and aggregate information on MIPS.[33]

Physician Compare is intended to provide meaningful, actionable information to consumers over time. By providing information about quality performance in a web format, patients will be able to evaluate their options and select the best provider for their specific care needs.

However, Physician Compare contains no quality information for patients and physicians participating in MA. Today, 30 percent of Medicare seniors are enrolled in MA and that program's enrollment continues to grow. These seniors can access information about the quality of their health plan options on the Plan Finder site, but no quality information for physician groups is available. This approach omits a crucial piece of the picture necessary for consumers to make informed choices.

We ask that CMS add MA quality information to Physician Compare. We encourage CMS to develop a strategy to incorporate an apples-to-apples comparison of quality performance in MA to FFS. Quality information at the physician group level is currently available using the existing MA 5 Star program. While some measures are specific to health plans, many measures are determined by physician performance. The Integrated Healthcare Association (IHA) has developed a quality ranking program at the physician group level. Using existing measures in MA, IHA develops a 5 star rating score for the physician group and publishes the results on its website. We encourage CMS to consider how it could similarly develop and post quality information for MA.

V. Conclusion

MACRA creates an exciting opportunity to transform care delivery in Medicare. The challenges facing the Medicare program are well-documented. As the number of Medicare-eligible seniors

[33] 82 Fed. Reg. 30,164.

grows and cost pressure continues, we know that the delivery system must adapt to meet the challenges of the future. Two-sided risk arrangements have the potential to dramatically improve the quality of care and contain costs in traditional Medicare. CAPG looks forward to working with you to continue to implement the law. If you have questions, please contact Mara McDermott, CAPG's Vice President of Federal Affairs, mmcdermott@capg.org.

Sincerely,

Donald H. Crane
President and CEO
CAPG

APPENDIX A:

Submission Template for Approval of Contract between MA Plan and Physician Organization

Name of submitting physician group or IPA:

Name of Medicare Advantage Alternative Payment Model:

Counties or service areas covered by this arrangement:

Term of the arrangement (start date and end date):

Describe how the physician organization is accountable for quality measures (attach a list of quality measures used by the organization):

Describe the contract's requirement that participating clinicians use certified electronic health records technology:

Describe how the physician organization takes risk under the contract:

Other details about care coordination under the contract that demonstrate qualification as an advanced APM (optional):

Attach a list of clinicians participating in the arrangement. Please include the NPI for each clinician listed.

APPENDIX B

Submission Template for Risk Threshold Determination

MACRA requires that APM entities meet certain risk thresholds to qualify as advanced alternative payment models eligible for the five percent bonus. While CMS has access to the traditional Medicare revenue information, you will need to disclose your Medicare Advantage contracting information.

Physician groups and IPAs will report the total MA revenue paid to the group or IPA. This will be broken down as follows (aggregated across all contracts submitted to CMS and approved as advanced APMs).

Category	Amount
A. Physician organization's total MA revenue	
B. Physician organization revenue paid to physician organization through CMS-approved MA advanced APM contracts	
C. Physician organization's total count of MA beneficiaries	
D. Physician organization's count of MA beneficiaries through CMS-approved advanced MA APM contracts	

APPENDIX C

Template Letter from IPA to Eligible Clinicians

To: Physicians participating in approved MA APM contract model

From: Independent Practice Association

Re: Notice of Ability to Qualify for MACRA Advanced Alternative Payment Model Bonus Payments

Dear Clinician,

We have submitted our Medicare Advantage contracts for consideration as advanced alternative payment models (APMs) under the Medicare Access and CHIP Reauthorization Act (MACRA). As part of this submission, we have listed you as a clinician that participates in this model.

As you may know, MACRA created a new payment system for traditional Medicare. Clinicians may participate in either the merit-based incentive payment system (MIPS) or in an advanced APM. Clinicians in MIPS have an increasing percent of their fee-for-service payments tied to their performance. Clinicians in APMs are eligible for a bonus payment applied to their Part B revenue, provided that they meet certain criteria.

Our IPA has submitted our Medicare Advantage risk contracts to qualify as an advanced APM. If our IPA qualifies, you will be eligible for a bonus payment and will be exempt from MIPS.

If you have questions, please contact [contact person].

Sincerely,

IPA Executive

Appendix D

Acknowledgment from IPA Clinician

[DATE]

[Address to IPA]

Dear IPA Executive,

I, [insert clinician name], hereby acknowledge that I have received information and instruction from [insert IPA name] regarding by participation in the Centers for Medicare and Medicaid Services (CMS) Quality Payment Program.

The information I have received indicates that I will be listed as a participating provider in the IPA's Medicare Advantage Alternative Payment Model contract by virtue of my meaningful participation with the IPA in a Medicare Advantage contract.

By signing below, I am indicating my consent to be included on the IPA's submission. I recognize that this may qualify me to be exempt from the merit-based incentive payment system (MIPS) and may qualify me for a five percent incentive payment in traditional Medicare.

_____ _____

Signature of IPA Clinician Date