The Voice of Accountable Physician Groups

June 27, 2016

Andrew Slavitt
Acting Administrator
Center for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-5517-P Medicare Program: Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule and Criteria for Physician-Focused Payment Models

Dear Acting Administrator Slavitt,

We appreciate the opportunity to comment on the Medicare Access and CHIP Reauthorization Act (MACRA) Proposed Rule. CAPG represents over 250 multi-specialty physician organizations across 40 states, Washington, DC and Puerto Rico. Our members participate in risk-based payment models across Medicare Advantage, traditional Medicare, Medicaid and commercial arrangements.

CAPG members have vast experience in alternative payment models (APMs). From the "on-ramp" (e.g., bundled payments) to the destination (e.g., global capitation), our members have participated in risk-based coordinated care for decades. Our members' preferred model of risk-based coordinated care is prepaid capitation. This model best aligns the incentives for physicians to provide high quality coordinated care. Overall, this model offers a superior quality and care experience for patients.

MACRA sets the country on the right path forward, toward the risk-based coordinated care models that our members have proven can be successful. By putting an end to the relentless cycle caused by the sustainable growth rate formula, consolidating fragmented reporting programs and creating an incentive for risk-based coordinated care, MACRA puts traditional Medicare on a firmer foundation to meet the needs of the aging population in the future.

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Overview: CAPG's Comments on the Proposed Rule

CMS proposes to begin MACRA implementation on January 1, 2017. We strongly support the agency's proposed time frame and encourage the agency to move forward with this proposal on the timeline laid out in the rule.

CAPG members are committed to the bold new vision that MACRA articulates – a strong, nationwide pay-for-performance program and incentives to kick-start two-sided risk arrangements. We have seen firsthand the better care that can result from both a MIPS path and an advanced APM path – many of our members have operated in these types of payment environments for decades.

Our nation's seniors and physicians cannot wait any longer for these reforms to take hold. Healthcare costs continue to rise and the population aging into Medicare is living longer, with more chronic conditions, than ever before. The demands and needs of this new population will strain the system unless there is swift, robust change. Therefore, while we know the road to implementation may have a few bumps along the way, we call on you to stay the course and finalize the time frames as proposed.

Below is an overview of our comments.

<u>Advanced Alternative Payment Models (APMs):</u>

- **CAPG applauds the agency's commitment to two-sided risk models in the definition of advanced APMs**. We have a long-held belief that downside risk is necessary to motivate behavior change. We are encouraged to see that CMS has proposed standards that adhere to this principle in defining the models eligible for advanced APM designation.

- **CMS must provide clarity at the outset of the reporting period as to whether an APM is a MIPS APM or an Advanced APM**. The current timeline for APM participation and threshold determinations is unsatisfactory in that it essentially requires advanced APMs to participate in MIPS or risk penalties. CMS should adjust the time frame to create certainty for advanced APMs.

- **CMS should create equal incentives for participation in risk-bearing relationships in Medicare Advantage**. Medicare Advantage is consistently overlooked in delivery system reform. MACRA presents an opportunity to create equal incentives for the movement to risk in Medicare Advantage. We call on the agency to bring Medicare Advantage into the delivery system reform conversation by providing equal incentives for risk-bearing provider organizations participating in APMs with MA plans.

<u>Merit-Based Incentive Payment System (MIPS):</u>

- **CAPG supports using MIPS APMs to create an "on ramp" to risk**. We are pleased that, consistent with CAPG recommendations, CMS has adopted a favorable scoring methodology for MIPS APMs (those APMs that do not meet the definition of advanced

APMs and therefore remain in MIPS). In the proposed rule, CMS would distinguish between regular fee-for-service participants and alternative payment model participants in MIPS. We believe that this will encourage participation in APMs at the entry level to risk and strongly support the construct.

- **CMS should deploy greater flexibility in the definition of "groups" for purposes of MIPS reporting**. The current definition, which requires that physicians reassign their billing rights to a TIN, does not meet the diverse business needs of our member companies, particularly IPAs.

- **The CAPG Standards of Excellence Survey™ should satisfy the clinical practice improvement category requirements**. CAPG's SOE® currently contains seven out of eight of CMS's high-weighted CPIAs and 32 out of 82 of the medium-weighted activities. Given the substantial overlap between this tool and the proposed CPIA activities, we encourage the agency to deem participation in the CAPG SOE® survey satisfactory for full credit in the CPIA MIPS category.

Physician-Focused Payment Models Technical Advisory Committee (PTAC)

- **We support the criteria outlined in the proposed rule that emphasize physician-focused payment models that will fill gaps in the delivery system reform portfolio**. We look forward to submitting our proposed Third Option model to PTAC.

We thank the agency for the opportunity to submit comments on the proposed rule. We look forward to working with you to successfully implement MACRA. Our more detailed comments on the specific proposals in the rule are provided below.

Detailed Comments

I. Implementing the Alternative Payment Model (APM) Path

MACRA provides a significant opportunity to move the delivery system along the continuum to risk. While there are very few risk-bearing providers in traditional Medicare today, MACRA's five percent bonus opportunity could dramatically change the landscape over the next five years. MACRA provides the incentive to change that behavior going forward – to move traditional Medicare away from its reliance on flawed volume-driven reimbursement models. Consistent with that view, the incentives to move to risk must be clear, strong and certain.

a. CMS should create certainty for organizations that qualify for the advanced APM path

Beginning January 1, 2017, physicians and physician groups will have the option to participate in MIPS or advanced APMs. In MIPS, physicians and groups have a potential base bonus or penalty of four percent. However, the statute affords additional opportunities in the form of a scaling factor (similar to the one used in the value-based payment modifier) and an exceptional

performer bonus. In total, the MIPS bonus potential reaches approximately 22 percent in the 2019 payment year. In the advanced APM path, physicians have the opportunity to achieve a maximum bonus of five percent.

While this imbalance was present in the law, the incentive remained to enter the advanced APM path. While the MIPS bonus could be high, MIPS path-takers would participate in an uncertain, budget-neutral environment. Achieving any bonus at all would depend on the performance of all other participants and the availability of funds to be paid. In contrast, those in the advanced APM path would have the certainty of a five percent bonus applied to 100 percent of their Part B claims. Therefore, participants would choose between the uncertainties of MIPS, albeit with a higher potential bonus on paper, and the certainty of advanced APM incentives. In this context, the advanced APM pathway would likely be more attractive.

However, we are concerned that the agency's proposal for the first year of MACRA implementation virtually eliminates the certainty in the advanced APM path. We strongly suggests instead that advanced APM participants also participate in MIPS.

This is due in large part to the timing of the advanced APM threshold calculation determinations in the proposed rule. In the advanced APM path, MACRA requires that APMs have a certain threshold of their Part B covered professional services furnished through the APM entity. Consistent with the statute, CMS is proposing options for calculating the threshold by revenue or patient count.

In the proposed rule, CMS introduces a new methodology for calculating these thresholds under either the revenue or patient count option. CMS then proposes to notify organizations in mid-2018 whether those thresholds have been achieved. An organization that narrowly misses the thresholds will become a partially qualifying provider and could opt to participate in MIPS. But an organization that misses the thresholds by more than five percent would become a MIPS APM. However, at that point in mid-2018, such an organization would have missed the opportunity to report for MIPS (because the MIPS reporting period is the 2017 calendar year).

This proposal essentially requires organizations to either confidently predict their APM threshold calculations in advance of the performance year or, more likely, to participate in MIPS even if they intend to ultimately become an advanced APM. We believe that this structure is contrary to congressional intent. We offer alternative suggested approaches below.

We encourage the agency to notify APM entities whether they are advanced APMs or not before the MIPS performance period. This way, organizations will know whether they need to report MIPS or not before it is too late.

If that timing is not possible from CMS's perspective, the agency should, at least for the first year, allow these advanced APMs to receive the higher of the two possible bonuses – MIPS or advanced APMs. While it may not be very likely, it is certainly possible that the MIPS bonus would exceed the five percent bonus in the advanced APM path. To the extent that an organization participates in both paths, the organization should also be able to benefit from the more attractive path, even if that is MIPS in the first year. After the first year, presumably

advanced APM entities will at least have some baseline data available as to how CMS calculates the threshold, and will be better able to predict which path they will land in for future years.

Finally, as a related item, we are concerned about the CMS proposal to identify eligible clinicians within the APM entity at a single point in time (December 31 of the performance year). We encourage CMS to take a more flexible approach that reflects the changing nature of participation in unique advanced APM models.

b. Financial Risk for Monetary Losses in Excess of a Nominal Amount

The MACRA statute required that advanced APMs take more than nominal financial risk for monetary losses to qualify for the five percent bonus. In the proposed rule, CMS lays out the definitions of financial risk in excess of a nominal amount.

In the proposed rule, CMS sets out requirements around bearing financial risk for monetary losses. In general, CMS is proposing that an APM must include a provision that if actual expenditures for which the APM entity is responsible under the APM exceed expected expenditures during a specified performance period, CMS can withhold payment for services. CMS can: (1) withhold payment for services to the APM entity and/or its eligible clinicians; (2) reduce payment rates to the APM entity and/or its eligible clinicians; or (3) require the APM entity to owe payments to CMS.[1] In this section, CMS comments that it is not proposing to allow business risk or investment risk to satisfy the requirements for the advanced APM "more than nominal risk" standard.[2]

CMS then proposes that if the APM meets the financial risk standard above, the agency will consider whether the risk amount exceeds a nominal amount. CMS proposes to require that a risk arrangement have: (1) a marginal risk rate of at least 30 percent; and (2) total potential risk of at least four percent of the expected expenditures.[3]

We support the proposed definitional requirements for risk arrangements. Specifically, we support CMS's decision not to include investment or start-up costs in this definition of risk. We believe that the agency has achieved a good middle ground for non-risk bearing APMs in MIPS and believe that strong incentives for downside risk are necessary to move the nation in that direction.

c. Definition of Capitation

We are pleased with and strongly support the agency's proposal to include capitated arrangements in MACRA's financial risk definition. Our members have had robust success with capitated payment arrangements outside of traditional Medicare. Prepaid capitation provides

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[1] Medicare Program: Medicare-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed Rule, 81 Fed. Reg. 28,162, 28,304 (May 9, 2016) ("Proposed Rule").
[2] *Id.*
[3] Proposed Rule, 42 C.F.R. 414.1415(c)(3).

practices with the resources to invest in patient care and to improve care delivery. We strongly encourage the development of these types of payment models in traditional Medicare.

In the proposed rule, CMS defines "full capitation" to mean an arrangement in which a per capita or otherwise predetermined payment is made to an APM entity for all items and services furnished to a population of beneficiaries and no settlement is performed to reconcile or share losses incurred or savings earned by the APM entity. Arrangements between CMS and Medicare Advantage plans are explicitly excluded.[4]

We recommend modifications to this definition. First, we encourage the agency to define what is intended by "full capitation." We believe that professional capitation would be a more accurate descriptor for this purpose than "full." We also encourage clarification that the capitation is for "all agreed upon items and services furnished to a population" to make clear that the scope of the services would be agreed upon with CMS. Finally, we encourage you to delete the language prohibiting settlement to reconcile losses or savings. Many existing, proven capitated models use settlement strategies to achieve desirable financial arrangements. For example, sharing savings on hospital spend is often done through reconciliation. We recommend a modified definition that addresses these concerns.

d. Risk Standards for Medical Homes

CMS proposes a different financial risk standard for medical homes. For a medical home to be an advanced APM it must include provisions that: (1) withhold payment for services to the APM entity and/or its clinicians; (2) reduce payment rates to the APM entity and/or its eligible clinicians; (3) require the APM entity to owe payments to CMS; or (4) lose the right to all or part of an otherwise guaranteed payment if either: (a) actual expenditures for which the APM entity is responsible under the APM exceed expected expenditures during a specified performance period; or (b) APM entity performance on specified performance measures do not meet or exceed expected performance on such measures for a specified performance period. In addition, for a medical home, CMS proposes to impose different financial risk standards and adds a requirement that the entity have fewer than 50 eligible clinicians to qualify for the bonus beginning in 2018.

We strongly support incentives for patient-centered medical homes and we believe that strong primary care is a necessary foundation for risk-based coordinated care. Many CAPG members are engaged in medical home initiatives, including the Comprehensive Primary Care initiative (the predecessor to the Comprehensive Primary Care Plus initiative).

We oppose the proposed 50-clinician 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 at this time. While we understand CMS's policy goal of moving larger organizations into accountable care organizations (ACOs) and other population health models, we do not believe that those models and medical homes are mutually exclusive. Instead, medical homes can serve as a foundation for the development of population

[4] Proposed Rule at 42 C.F.R. 414.1415(c)(6).

health initiatives. Therefore, incentives to participate in such a model, regardless of organization size, are appropriate. We encourage CMS to eliminate the cap.

e. Aligning the Medicare Shared Savings Program to MACRA Implementation

Much of the proposed rule implementing MACRA encourages participation in the Medicare Shared Savings Program. We believe that the MSSP participants in Track One will have advantages in participating as MIPS APMs. MSSP Tracks 2 and 3 will have the opportunity to become advanced APMs in the earliest years of that path's development.

Consistent with the structure, we are encouraging CMS to adopt the following key changes to the program.

- **Permit MSSP track changes within the three-year contract cycle**. As we understand it, MSSPs are only permitted to move to risk tracks at the beginning of a new three-year contract cycle. Given the time-limited nature of the APM incentives, ACOs should be permitted to advance to greater levels of risk within their three-year contract cycle. If the overall goal is to encourage greater participation in risk-bearing arrangements, limiting the flexibility to take on risk as they are ready seems at cross purposes with achieving the objective.
- **Improve beneficiary "stickiness" in ACO program**. In the ACO program, beneficiaries remain free to see any provider of their choosing, whether the provider is in or out of the ACO. This is at odds with MACRA's revenue and patient thresholds that hold the APM entity accountable for the amount of revenue or patients in the APM. CMS must continue to develop tools to allow ACOs to engage beneficiaries in the ACO model. Examples might include the types of beneficiary incentives that are slated to be tested in the Next Generation ACO program.
- **Create different benchmarking options**. In your recent Final Rule regarding MSSP benchmarking, the agency declined to adopt a menu of benchmarking options, electing instead a benchmarking methodology increasingly based on regional factors. Because the agency itself acknowledges that this approach creates winners and losers in MSSP, we urge you to revisit this in the future and to create fair benchmarks that allow organizations to participate equally in advanced APMs.

II. All-Payer APMs and the Importance of Medicare Advantage in Delivery System Reform

Under MACRA, to qualify for the five percent bonus, APMs also must have a certain threshold of their Part B covered by professional services furnished through the APM entity. The threshold increases over time. Beginning in 2021, the statute allows eligible APMs to include "all payer" revenue, including Medicare Advantage, into the risk threshold calculation. **However, the statute requires that 25 percent of an entity's Medicare Part B payments be attributable to an APM, even in the all-payer option.** This means that a physician or physician organization that is capitated in Medicare Advantage cannot qualify for an APM bonus unless they are also

participating in an APM in traditional Medicare. This is true even if nearly all of the physician or physician group's Medicare revenue is in a risk-bearing arrangement in MA.

a. Medicare Advantage APMs Should Count Toward the APM Threshold

Today, Medicare Advantage enrollment makes up nearly a third of overall Medicare enrollment. Some of our members participate in MA only, and not at all in traditional Medicare. The MA program has seen explosive growth, due in large part to the superior value it provides for seniors. All indications are that this program will continue to grow at a rapid clip in the coming years. MA's inclusion in the All-Payer Threshold is an important step but does not go far enough to recognize the value and importance of this program in achieving high quality, risk-based coordinated care. Physician groups should be able to qualify for APM incentives based on their participation in Medicare Advantage APMs for 2019 to 2024.

We encourage three steps to remedy the problem.

First, rather than a Medicare Part B threshold, organizations should be able to qualify based on a Medicare threshold (Medicare Part B and Medicare Advantage). MA contracts that include payment with more than nominal financial risk should count toward achieving the Medicare threshold for 2019 to 2024. APM contracts between MA plans and physician organizations in which the physician group takes more than nominal financial risk, including capitation, should then explicitly count toward achieving this Medicare threshold. We call on CMS to use its available regulatory authority to include Medicare Advantage revenue in the threshold for the 2019 payment year.

Second, the same financial incentives for risk in traditional Medicare should be available for physician groups taking risk in MA. That is to say, for a group that participates in MA, the APM incentive should apply to their MA revenue for physician services, not just their Part B revenue. This incentive should be paid directly to the physician or physician group taking the risk. The structure should be the same as MACRA: once a physician organization exceeds the threshold for risk, bonuses should be paid not just for traditional Medicare but also for Medicare Advantage. The amount of the bonus should be adjusted to account for the financial incentives for health plans (our third recommendation).

Third, financial incentives should be available to health plans that enter into two-sided risk arrangements with physician groups. With increasing frequency CAPG hears from its members, among the most sophisticated risk-bearing physician organizations in the country, that there are health plans unwilling to offer risk-bearing arrangements to capable physician groups. Therefore, we encourage you to consider incentives for plans that enter capitated, delegated arrangements with physician groups. We believe that this type of incentive could be achieved through the Star Ratings program. Specifically, we encourage CMS to adopt a Stars measure or measures that looks at risk-based payment relationships between plans and providers. The measure should be assigned sufficient weight to create an incentive for MA plans parallel to that created in traditional Medicare.

This structure is critical. Research shows that Medicare Advantage, when offered through an integrated, capitated delivery system (which is an advanced APM) offers higher quality for

seniors than traditional Medicare. The quality difference is striking. For example, some CAPG members have readmissions rates as low as six or eight percent, compared to a fee-for-service average readmission rate that hovers around 18 percent. Clearly, Medicare Advantage plays a crucial role in advancing high quality care for seniors.

In addition to being a high-value option for seniors, Medicare Advantage plays a critical role in delivery system reform. While physician relationships with plans are on the same overall trajectory from fee-for-service to alternative payment models, Medicare Advantage has the distinct advantage of having "reached the destination" when it comes to risk-bearing relationships with providers. While not every relationship between a plan and a physician is a risk-bearing arrangement, Medicare Advantage is the one place where two-sided risk-bearing relationships between payers and providers not only exist, but succeed today. Some CAPG members participate in two-sided risk arrangements, including capitation, with health plans in Medicare Advantage. Other CAPG members are actively seeking out these relationships. But there are still large swaths of the United States where these types of risk-bearing relationships between plans and providers do not exist and should be encouraged. While CAPG has tried to gather information about what percentage of MA is tied to risk-bearing or capitated arrangements today, we have not been able to determine the percentage with certainty. We estimate that when examining the contracts between MA plans and physicians or physician groups, less than 20 percent of MA is currently capitated. This represents substantial opportunity to improve care for seniors.

Finally, the Affordable Care Act sought to achieve parity between Medicare Advantage and traditional Medicare, bringing the MA benchmarks, on average, to 100 percent of fee-for-service across the country. We believe that MACRA has inadvertently tipped the balance in favor of traditional Medicare, offering payments substantially above 100 percent of fee-for-service in traditional Medicare but not in Medicare Advantage. All the while, MA offers a glimpse into the most innovative, advanced payment arrangements in Medicare. In the proposed rule, CMS implies that the five percent bonus payments to advanced alternative payment model participants will not factor into the Medicare Advantage benchmark determinations because they are made outside of the claims payment system.[5] The MA plans would see no benefit from the physicians' involvement in risk-based coordinated care. We believe this underscores the need for separate incentives in Medicare Advantage that encourage risk-bearing contracts between physician groups and MA plans.

b. Calculation of the All-Payer, Medicare Payment Threshold

Under current law, MACRA allows physicians, beginning in 2021, to count their all-payer revenue toward the threshold for eligibility for an APM bonus. In the proposed rule, CMS begins to address the submission of information for the Other Payer Advanced APM determination.

CMS proposes that submissions "must include at least sufficient information for CMS to determine whether the payment arrangement meets the Other Payer Advanced APM criteria." CMS proposes that submissions must include specific payment and patient numbers for each

[5] Proposed Rule at 28,335.

payer from whom the eligible clinician has received payments during the performance period. CMS is proposing that the following data must be submitted: payment amounts or patient-furnished service through the other payer APM for each payer; and the sum of the payment and/or number of patients furnished any service from each payer.[6] CMS then proposes that each payer attest to the accuracy of all submitted information including the reported payment and patient data. Contracts may be subject to audit by CMS. If the payer does not attest to the accuracy, the data will not be assessed under the all-payer option. CMS acknowledges in the rule that physicians may not have control over whether or not a payer attests.

CAPG recommends that physicians and physician organizations certify or attest to the nature of their relationships with payers and as to whether the physician or physician group meets the threshold requirements for the all-payer category. We believe that the attestation approach has been used successfully in other contexts and can and should be done here as well. We do not agree that it is necessary to have a health plan attest to the data.

Many CAPG members contract with multiple health plans — in some cases, as many as six or more different plans. The physician group in this instance is clearly in the best position to attest to the portion of its revenue across all of these arrangements that are at risk. While a health plan could attest to the accuracy of one specific arrangement, that piece of information alone would not help CMS accomplish the goal of determining the amount of the physician's or physician group's revenue at risk. Therefore, the added requirement of health plan attestation creates additional burden without achieving the ultimate result.

We agree that verification of the information is important and serves a valuable function. We believe that this can be achieved with auditing, which CMS has also proposed to impose.

III. CAPG Recommendations for Implementing the Merit-Based Incentive Payment System (MIPS)

Background

Under the MIPS path, physicians and physician groups are subject to a potential bonus or penalty depending on their performance. MIPS comprises four performance categories: (1) quality, (2) resource use, (3) electronic health records, and (4) clinical practice improvement activities. In MIPS, the eligible professional will receive a composite score that determines whether there is a penalty or bonus. The amount of the bonus/penalty increases over time, with the potential for additional bonuses due to a scaling factor and exceptional performance.

a. CAPG Applauds the Proposed MIPS APM Structure, Which Encourages Participation in Non-Risk-Bearing APMs

Overall, CAPG applauds CMS for its proposed structure in the rule. The proposed rule would differentiate in MIPS between organizations in regular fee-for-service and those in upside-only alternative payment models in MIPS, and further differentiate those organizations in two-sided

[6] Proposed Rule at 28,335.

risk arrangements (advanced APMs). CAPG is pleased to see that the agency adopted this construction from our comments on last year's request for information. This structure holds true to MACRA's statutory intent and will serve as a strong pathway to get organizations on the ramp to risk regardless of their starting point on that journey.

We support the creation of favorable scoring for MIPS APMs. Specifically, we support the agency's proposal to allow Medicare Shared Savings Program (MSSP) ACOs in Track One to use their MSSP quality performance to satisfy their MIPS quality component; affording zero percent weighting to the resource use category for the first year; and affording partial credit for CPIAs. We believe that this approach will encourage the development and continued participation in Track One and other "on-ramp" APMs. We encourage CMS to continue to evaluate this favorable scoring mechanism and to make changes over time to respond to the needs of the delivery system and Track One ACOs.

a. MIPS reporting

We are pleased that CMS is proposing to allow eligible clinicians to report as groups or individuals for purposes of MIPS. However, CMS is proposing to define a "group" for purposes of MACRA as a single tax identification number (TIN) with two or more MIPS eligible clinicians, as identified by their individual NPI, who have reassigned their Medicare billing rights to the TIN.[7] We have two concerns with this approach.

First, we do not believe that the TIN is the best way to group clinicians for purposes of MIPS reporting. As we stated in our response to the agency's request for information, we encourage CMS to adopt a different MIPS identifier and to deploy a flexible approach for providers to identify clinicians who fall within the MIPS identifier.

CAPG member physician organizations differ in terms of their structure. While some physician groups may have a single TIN, some of our groups and independent practice associations (IPAs) consist of numerous TINs. As an example, one medical group may consist of upwards of 30 unique TINs. For MIPS purposes, the group may want a single score across all 30 of those TINs, or the group may want to aggregate TINs in specific combinations depending on its nature.

Second, we are concerned that the agency's reliance on TIN-level reporting will limit options for IPAs to participate in the new MACRA environment. In many cases, physicians contracting with IPAs do not reassign their billing rights to the IPA's TIN and therefore the IPA would not fit within the proposed definition of a group.

Independent practice associations are a valuable practice option for physicians who want to maintain their independence yet receive infrastructure support and group reporting. We believe that IPAs hold tremendous potential in the new MACRA environment to allow physicians

[7] Proposed Rule at 28,381.

who want to maintain their independence to do so and still successfully participate and report in MIPS or advanced APMs.

To best accommodate the variety of physician groups across the country, we encourage CMS to develop a different approach to group reporting. Specifically, we think the use of provider lists could work in the MIPS context, as it does in the accountable care organization and other APM models.

b. MIPS Quality Performance Activities

One of the four categories for measuring MIPS performance is quality. For purposes of this category, we believe that it is important for CMS to develop the measures set with an eye towards alignment across programs, reducing burdens and creating a single set of measures on which all physician groups can be assessed and compared. We continue to believe that the agency's ultimate goal should be empowering consumers to choose providers across fee-for-service, Medicare Accountable Care Organizations and Medicare Advantage with "apples to apples" quality information to guide their decisions. MACRA represents an important opportunity to create such an alignment and to facilitate true comparisons for patients and their families.

CAPG recommends that the agency take this opportunity to align the MIPS and APM measures in traditional Medicare to the CMS Medicare Advantage (MA) 5-Star Rating Program. We believe that the MA measures applicable to physicians and physician groups are a better indicator of provider performance.

We additionally note that CAPG is engaged in the Core Measures Collaborative, along with a number of other critical stakeholders including the National Quality Forum and CMS. We believe that this Collaborative's work should be considered in future measures development.

c. Participation in the CAPG Standards of Excellence Survey™ Should Satisfy the MIPS CPIA Requirement

One of the four MIPS categories is "clinical practice improvement activities" (CPIAs). CMS proposes over 90 different CPIAs in the proposed rule. CMS proposes that MIPS-eligible clinicians submit a yes/no response for activities that are performed for at least 90 days during the performance period.[8] For scoring of the CPIA category, CMS proposes to award full credit for participation in a patient-centered medical home, half credit for participation in an APM, and the opportunity to achieve points for activities in high-weighted and medium-weighted categories. High-weighted activities receive 20 points, medium-weighted activities receive 10 points. Clinicians with a score of 60 points will receive full credit for the MIPS CPIA category.

[8] Proposed Rule at 28,384.

The CAPG Board of Directors and clinical leaders developed the Standards of Excellence™ (SOE®) Survey as an annual, comprehensive survey of coordinated care infrastructure for accountable physician groups. The survey examines the attributes of a successful, financially and clinically accountable physician organization. Importantly, SOE® contains seven of the eight high-weighted activities and over 30 of the medium-weighted activities. The survey assesses a number of other attributes of risk-bearing physician organizations. Physician organizations that participate in the CAPG survey receive a star score of zero to five stars. Groups that receive five stars are given an "elite" rating. NCQA analyzes, reviews and scores the survey.

Due to the substantial overlap between the proposed CPIAs and the SOE®, we ask that physician organizations that receive an elite SOE® rating also receive full credit for the CPIA category in MIPS. We ask that CMS add the CAPG Standards of Excellence™ survey to the list of CPIA activities.

CAPG would welcome the opportunity to continue to engage with the agency to recommend new CPIAs for the inventory going forward. We have a robust process in place to develop these types of activities for our own survey. We believe that our experience in this area will serve as the primary resource for CMS measures development efforts in the future.

IV. Other proposals

a. Low-Volume Threshold

The MACRA statute requires a MIPS exclusion for eligible clinicians who are below a low-volume threshold set by the Secretary. CMS is proposing to define the low-volume threshold for an individual MIPS eligible clinician or group as having Medicare billing charges of $10,000 or less and providing care for 100 or fewer Part B enrolled Medicare beneficiaries during the performance period.[9]

We agree with the agency's policy goals of driving quality improvement across the broadest range of MIPS eligible clinician types and specialties. Therefore, while we do not have data available to provide comment on the specific thresholds provided, we encourage CMS to maintain appropriately narrow MACRA exclusions. We believe that the success of nationwide delivery system transformation requires participation by the broadest possible population.

b. Physician Compare Should Be Modified to Include Quality Information for Physicians in Medicare Advantage

[9] Proposed Rule at 28,178.

CMS is proposing to add MIPS, APM and other MACRA-related information to Physician Compare, the agency's publicly available website containing information on physician performance.[10]

As we understand it, 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 physician options in their area and select the best provider for their specific healthcare needs.

However, Physician Compare contains no quality information for patients and physicians participating in the Medicare Advantage program. Today, 30 percent of Medicare seniors are enrolled in the Medicare Advantage program and enrollment continues to grow. For these seniors, quality information about health plans is available through the Medicare Stars Rating program; however, no quality information at the physician level is made available by CMS. Omitting this data leaves out a crucial piece of the picture necessary for consumers to make informed choices.

The omission of Medicare Advantage quality information also creates an incomplete picture of physician performance for those physicians that participate in the Part C program. For example, some CAPG physicians have such a small amount of Part B business (less than 10% of the patients treated), their results on Physician Compare will not reflect what might be a large share of Medicare patients treated, because those patients are enrolled in MA.

CAPG requests that CMS add Medicare Advantage quality information to Physician Compare. We encourage CMS to develop a strategy to incorporate an apples-to-apples comparison of quality performance in Medicare Advantage and FFS. We suggest two steps for accomplishing this goal. We believe that quality data at the physician group level is available using the existing Medicare Advantage Stars program measures. While some measures are specific to health plans, many measures are determined by physician performance. For example, the Integrated Healthcare Association (IHA) has developed a quality ranking program at the physician group (rather than health plan) level. Using existing measures in Medicare Advantage quality assessment, IHA creates a 5-star quality score for the physician group and publishes the results on the IHA website. We encourage CMS to consider how it could similarly develop and post quality information for physician groups participating in Medicare Part C on the Physician Compare website.

V. Developing New Physician Group–Focused Payment Models

In addition to continuing to improve the existing programs, we agree with MACRA's authors that more models are necessary and should be tested as soon as possible. The Physician-Focused

[10] Proposed Rule at 28,289.

Payment Models Technical Advisory Committee (PTAC) has the potential to achieve that objective.

a. Proposed Definition of Physician-Focused Payment Model

CMS proposes to define these models as alternative payment models that include physician group practices or individual physicians and target the quality and cost of physician services.[11] CMS proposes specific criteria for physician-focused payment models including that the payment methodology differ from current payment methodologies and why the model cannot be tested under existing methodologies.[12] We strongly support these criteria and believe that the goal of the PTAC should be to fill gaps in the existing delivery system reform portfolio.

One area where we see a gap is for organizations that are more experienced with risk. While the "on-ramp" to risk is now well developed with bundled payment options, upside-only shared savings, and two-sided shared savings and loss arrangements, we see very few options for organizations at the "destination." We would like to see prepaid capitated payment options and arrangements made available through the work of the PTAC.

b. PTAC Time Frame

Given that the advanced APM incentive payments are available for a limited amount of time, we think it is of utmost importance that the PTAC begin the work of reviewing, approving and recommending models as quickly as possible. We request that CMS put in place a process to quickly review and then implement the PTAC-recommended models to ensure that physicians and physician groups are given the opportunity to fully take advantage of MACRA's incentive structure.

Conclusion

MACRA presents a new and exciting opportunity to transform care delivery in Medicare. The challenges facing the Medicare program are well documented. As the number of Medicare-eligible seniors grows and cost pressure continues, we know that fee-for-service is unsustainable for the future. MACRA is intended to take a bold step toward ensuring a sustainable future for Medicare. This requires a massive and swift shift from fee-for-service to advanced alternative payment models. The transformation must be systemic and must completely overhaul the existing fragmented delivery model. Two-sided risk arrangements have the potential to dramatically improve the quality of care and to contain costs in the Medicare program. We appreciate the enormity of the task CMS has in front of it: completely overhauling the physician payment system into one that is geared to offer high quality, efficient, coordinated care. CAPG

[11] Proposed Rule at 28,346.
[12] Proposed Rule at 28,396.

looks forward to working with you throughout the rulemaking process. If you have any questions, please do not hesitate to contact us.

Sincerely,

Donald H. Crane