September 27, 2019

The Honorable Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: CMS-1715-P– Medicare Program; CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations

Dear Administrator Verma:

America's Physician Groups (APG) appreciates the opportunity to provide comments for the CY 2020 Medicare Physician Fee Schedule (PFS) Proposed Rule . We thank you in advance for your consideration.

APG is a national professional association representing over 300 physician groups, the approximately 195,000 physicians, and the nearly 45 million patients they care for. Our tagline, "Taking Responsibility for America's Health," truly represents our members' vision and efforts to move away from the antiquated fee-for-service (FFS) reimbursement system where clinicians are paid "per click" for each service rendered rather than on the quality or outcomes of the care provided. Instead, our members are taking responsibility for improving the health of the patients and communities they serve by holding themselves accountable for the cost and quality of care through alternative payment models (APMs). Our preferred model of capitated, delegated and coordinated care avoids incentives for the high utilization associated with FFS reimbursement. This model aligns incentives for physicians to provide the right care in the right setting, thus improving the health of entire populations, particularly chronically ill and fragile individuals. **We are so pleased to see in the 2020 proposed rule an increased recognition and alignment with the risk-based philosophy for which APG stands**.

Summary of APG's Comments

Medicare Physician Fee Schedule

- **CY 2020 PFS Conversion Factor:** APG supports the increase in the conversion factor from $36.0391 to $36.0896 but requests clarity regarding projected increases after CY 2020.
- **Payment for Evaluation and Management (E/M) Services:** APG supports CMS's decision to revert to five coding levels for established payments and decreasing to four the coding levels for new patients. APG membership appreciates the analysis conducted by CMS and the AMA RUC committee.
- **Physician Supervision Requirements for Physician Assistants (PAs):** APG supports the proposal to modify regulations on physician supervision of physician assistants to give PAs greater flexibility to broaden their practice.
- **Proposal to have Single Advance Beneficiary Consent:** While we are in support of this generally, we have concerns regarding how this will be achieved at the practice level.
- **Review and Verification of Medical Record Documentation:** APG supports the proposal to allow physicians, physician assistants, nurse practitioners, clinical nurse specialists and certified nurse midwives to review and verify (sign and date), rather than re-documenting notes in the medical record by other physicians, residents, nurses, students or other members of the medical team.
- **Care Management Services:** APG supports the rate increase for Transitional Care Services (TCM). We also welcome the additional billing codes for Chronic Care Management (CCM) services and the proposed new codes for Principal Care Management (PCM) services but have some reservations on the use of temporary G codes which can increase administrative burden.
- **Stark Advisory Opinion Process:** APG supports the reduction in response time and simplification of application requirements and we seek clarification on whether risk-based entities such as ACO's can rely on past physician self-referral advisory opinions for substantially similar arrangements.

Quality Payment Program

- **MIPS Value Pathways (MVPs):** APG supports the concept of MVPs to drive development of competencies to be successful in risk-based contracts and reduce provider confusion in the Merit-based Incentive Payment System (MIPS); however, more analysis must be done to explore long-term efficacy.
- **Advanced APMs of Quality Payment Program (QPP):** APG requests that the 5 percent Advanced APM bonus be paid by June 30 in subsequent payment years. APG recommends that CMS allow that if the Medicare Advantage (MA) plan declines to submit prior to the start of the performance year for the "Other Payer," then the clinician has the option to submit in place of the plan prior to the start of the performance year. We recommend launch of additional Total Cost of Care (TCOC) Advanced APMs and options to balance the 5 percent bonus for Advanced APMs as opposed to 5.78 percent estimated for MIPS participants' that score 100 percent. APG supports modifying the definition of full capitation and excluding services such as transplants, hospice, and out of network emergencies.
- **QPP Year 4 Categories and Weights:** APG supports the increase of the threshold to 45 and the bonus adjustment to 80 points. APG agrees with the new attribution definitions of Medicare Spending Per Beneficiary (MSPB) and Total Per Capita Cost (TPCC) and we applaud CMS in continuing to reduce the number of quality measures to have the focus on meaningful

outcomes rather than processes. However, a recognition of the cost of building and then eliminating these measures from providers' electronic health records (EHRs) must be factored into these annual changes by CMS.

Medicare Shared Savings Program (MSSP)

- **Aligning the MSSP Quality Score with the MIPS Quality Performance Score:** APG does not support moving to a single methodology formula or having a single quality score between MIPs and MSSP at this time. APG does not support the elimination of the pay for reporting year for the first year of an Accountable Care Organization (ACO). APG does not support implementing claims-based measures at this time.
- **Global and Population Based Measures:** APG cautions in moving too rapidly in replacing web interface with global administratively claims based measures.
- **2020 MSSP Changes:** APG does not support the addition of the ACO-47 at this time.

Medicare Physician Fee Schedule

I. Proposed Changes to Evaluation and Management Documentation Requirements and Reimbursement in the Physician Fee Schedule

The 2020 proposal would increase the Medicare conversion factor slightly—from $36.04 to $36.09, which is 5 cents more than last year. We understand that this is due to the further rollout of the Medicare Access and CHIP Reauthorization Act (MACRA) legislation that suspends annual fee schedule adjustments until 2026. We seek clarity on CMS plans post 2026 in terms of continued increases in the conversion factor.

The proposed rule also aims to roll back last year's decision to collapse office/outpatient Evaluation and Management (E/M) Levels 2, 3 and 4 codes and instead adopt a proposed new framework recommended by varied groups of provider stakeholders. We commend this year's proposal which will simplify coding and billing for office-based E/M services. Specifically, starting in 2021, the proposal would align E/M coding with changes laid out by the CPT Editorial Panel for office/outpatient E/M visits by:

- retaining five levels of coding for established patients,
- setting only four levels for office and outpatient E/M visits for new patients,
- revising the times and medical decision-making process for all office-based E/M codes and requiring performance of history and exam only as medically appropriate, and
- allowing clinicians to choose the E/M visit level based on either medical decision-making or time.

After many hours of discussion with our members, it is evident that the proposed changes to E/M reimbursement will be financially positive for some of our members and financially negative for others depending on specialty and specific local market conditions. We would like to supply feedback and comments from our members to inform CMS of the impact these changes will have on risk based and integrated care models. It is our hope and intention that these comments will inform the decisions that CMS will make in the final rule.

APG membership is appreciative that CMS is recognizing the value of primary care services and efforts to streamline and reduce documentation burdens in line with the Patients Before

Paperwork initiative by the many positive changes proposed in the 2020 proposed rule.

We support the CMS proposal to adopt the new coding, prefatory language, and interpretive guidance framework issued for E/M visits by the American Medical Association (AMA) CPT Workgroup in place of last year's finalized policies specifically to delete CPT code 99201 (level 1 office/ outpatient visit for new patients) for CY 2021 onward. APG also supports CMS' decision to revert to five coding levels for established payments and decreasing to four the coding levels for new patients. We agree that beginning in CY 2021, level 1 visits would only be used for visits performed by clinical staff for established patients.

We support CMS' proposal to replace the history and physical exam criteria for selecting the appropriate code level for office/outpatient E/M Code levels 2 through 5 with time or medical decision-making criteria. We strongly support all measures to alleviate burdensome medical record keeping requirements. However, we are concerned that if time is used as the criteria, practitioners would have to meet the minimum time thresholds set by the CPT Editorial Panel to qualify for each code level. These changes **could** require more robust medical record entries than under the formerly proposed method.

We support CMS' proposal to eliminate the uniform payment rate it established for levels 2-4 E/M office/outpatient visits established last year. We agree with CMS' proposal to provide different payment rates for each level and establish separate values for new and established patients within each code level.

We welcome the proposal to create a new CPT Code 99XXX to give practitioners credit for prolonged office/outpatient E/M Visits and delete the add-on code proposed last year (GPR01). We are appreciative of the agency's efforts to recognize and reward the work associated with the furnishing of primary care across the continuum, however, we are concerned that CMS is perhaps proposing to only count time spent on the date of service to determine the E/M code level and therefore request further clarity.

II. Review and Verification of Medical Record Documentation

CMS proposes to establish a general principle to allow the physician, the physician assistant (PA), or the advanced practice registered nurse (APRN) who furnishes and bills for their professional services to review and verify, rather than re-document, information included in the medical record by physicians, residents, nurses, students, or other members of the medical team. CMS states that this principle would apply across the spectrum of all Medicare-covered services paid under the PFS.

Our members recognize the value of team-based care and support the CMS proposal to allow the physician, PA, or APRN who furnishes and bills for their professional services to review and verify, rather than redocument, information included in the medical record by physicians, residents, nurses, students or other members of the medical team to be applied across the spectrum of all Medicare-covered services paid under the MPFS. **We further agree with the CMS proposal to amend regulations for teaching physicians, physicians, PAs, and APRNs to add this new flexibility for medical record documentation requirements for professional services furnished by physicians, PAs, and APRNs in all settings.**

III. Care Management Services

CMS proposes changes to increase utilization of care management and care coordination codes pertaining to Transitional Care Management (TCM) services, Chronic Care Management (CCM) services and a new Principle Care Management (PCM) service. In principle, we appreciate the

expansion and revision of codes in this crucial piece of the care continuum.

Transitional Care Management Services: CMS, based on RUC recommendations, proposes increasing Medicare Transitional Care Managements payments to recognize clinicians for time spent managing a patient's care during transition times such as post discharge with a slight increase in work Relative Value Units (RVUs) associated with the TCM codes. **Acknowledging the high resource cost of treating chronic diseases**, **we applaud CMS taking the RUC recommendations and proposing to increase payment for TCM services.**

Chronic Care Management Services: CMS proposes to implement a set of Medicare-developed Healthcare Common Procedure Coding System (HCPCS) G codes for certain CCM services in recognition of the additional time spent on non-complex CCM services. The initial G code would describe the first 20 minutes of clinical staff time and the second G code would describe each additional 20 minute increments thereafter. CMS also proposes changes to complex CCM CPT codes that currently require establishment or substantial revision of the comprehensive care plan which the agency notes may be unnecessary. There is a proposal to add two new temporary G codes that would not include the service component of substantial care plan revision. **We commend CMS recognizing the additional time that providers spend on CCM services, however, we feel that there needs to be more clarity around the use of temporary G codes that can increase administrative burden. We recommend that the agency wait for the revision of CPT codes for CCM. Additionally, we see potential for misuse of these codes by the utilization of vendors to manage CCM by specialists further fragmenting care and driving up costs.**

Principal Care Management Services: Currently, CCM codes require patients to have two or more chronic conditions. CMS is proposing separate coding and payment for PCM services, which describe care management services for one serious chronic condition. **We support CMS proposing to create new coding and reimbursement for PCM services, which would pay clinicians for providing care management for patients with a single serious and high-risk condition** but have concerns that this proposal could result in duplicative care management by focusing on a single disease state rather than the total care management of the patient. We also seek clarification on which specialists could bill under these codes as they care for patients with a single complex chronic condition that requires substantial care management in addition to primary care. We worry that this could lead to fragmented care and a decrease in overall coordination of care and thus increased costs.

Overall, however, we appreciate that CMS has acknowledged, through numerous meetings with stakeholders, that changes are needed in E/M codes to be more reflective of the needs of the growing chronically ill population. The complex documentation needed for E/M codes for patients that experience multiple chronic conditions have resulted in increasing burnout and stress among clinicians. With physician burnout being a recognized national problem, almost any solution that would reduce it would be strongly supported by the industry.

IV. Stark Advisory Opinion Process

CMS proposes modifications to clarify issues that qualify for advisory opinions and the parties that may request them. CMS would specify that a request for an advisory opinion must "relate to" (as opposed to "involve") an existing arrangement or an arrangement that a requester specifically plans to enter into. CMS notes there are other avenues for stakeholders to find answers to questions about the application of the Physician Self-Referral Law, including its Physician Self-Referral Call Center and responses provided in the FAQs.

CMS proposes to enumerate in the regulation another reason for rejecting a request for an advisory opinion: requesters who do not provide a sufficiently detailed description of the arrangement or who fail to timely respond to CMS requests for additional information about the arrangement at issue.

CMS proposes to ease the restriction at §411.370(e)(2) which currently states that the agency will not issue an advisory opinion if it is aware that the same, or substantially the same, course of action is under investigation or is, or has been, the subject of a proceeding involving the Department of Health and Human Services (HHS) or other government entities. CMS proposes to modify the language to indicate that it "may elect not to" accept an opinion request or issue an opinion if, after consulting the Office of the Inspector General (OIG) and Department of Justice (DOJ), it determines the action described in the request is substantially similar to conduct that is under investigation or is the subject of a proceeding involving HHS or other law enforcement agencies, and issuing an advisory opinion could interfere with the investigation or proceeding. We agree that CMS retain its prohibition on advisory opinions when there is an active investigation involving the same subject matter.

The agency notes that a favorable advisory opinion on the Physician Self-Referral Law would not insulate parties from potential liability under the Anti-kickback Statute or other federal laws or regulations.

APG supports the reduction in response time and simplification of application requirements proposed in response to last year's request for information (RFI). **We believe that certain aspects of the physician self-referral law can impede the care coordination needed with value-based risk contracts and request that the law be revised to reduce provider burden and uncertainty around compliance. We strongly support the agency reviewing and revising its policies and regulations to address limitations or restrictions that may unnecessarily impede a more robust opinion process.**

V. Physician Supervision Requirements for Physician Assistants

CMS proposes to revise §410.74(a)(2) to provide that the statutory physician supervision requirement for PA services at section 1861(s)(2)(K)(i) of the Act would be met when a PA furnishes their services in accordance with state law and state scope of practice rules for PAs in the state in which the services are furnished. In the absence of state law governing physician supervision of PA services, the physician supervision required by Medicare for PA services would need to be documented in the medical record indicating the PA's approach to working with physicians in furnishing their services. Documentation would need to be available to CMS, upon request. CMS notes that this has the benefit of substantially aligning its regulation on physician supervision for PA services with its current regulations on physician collaboration for nurse practitioner (NP) and clinical nurse specialist (CNS) services.

We support CMS proposal to modify its regulations on physician supervision of PAs with an aim toward allowing PAs to practice more broadly, in accordance with state scope-of-practice and other laws. This modification regarding PA supervision will further the aims of team-based care that is critical to bringing costs down, increasing patient access and supportive of transitional and chronic care services which are key components to the success of risk-based contracts. We do, however, recommend that documentation requirements and oversight are not diluted in the process.

VI. Proposal to Have Single Advance Beneficiary Consent

CMS seeks comments on whether a single advance beneficiary consent could be obtained for a number of communication technology-based services. The consent process will continue to require that the beneficiary is aware of the cost sharing associated with these services. CMS notes that stakeholders are concerned that requiring advance beneficiary consent for each of these services is burdensome. For the interprofessional consultation services, stakeholders find it difficult for the consulting practitioner to obtain consent from a patient they have never seen. CMS makes separate payment for services

furnished via telecommunications technology: evaluation of recorded video and/or images, virtual check-in, and interprofessional consultation services and requires advance beneficiary consent for each of these services.

We support a single advance beneficiary consent to be obtained for certain communication- based technology services designated in the final 2019 MPFS, including virtual visits, remote evaluation of images and Interprofessional Internet Consultations. We agree that obtaining advance beneficiary consent for each service is overly burdensome and creates a barrier for the use of these services and therefore support the proposed single advanced beneficiary consent. However, we have concerns with potential program integrity issues associated with allowing advance consent and seek information on how to minimize these concerns. We also seek clarity around the appropriate interval of time or number of services for which consent could be obtained, for example, for all services furnished within a 6 month or one-year period, or for a set number of services.

Quality Payment Program

VII. MIPS Value Pathways (MVPs)

CMS is proposing changes to improve the Quality Payment Program (QPP) by streamlining the program's requirements with the goal of reducing clinician burden. The proposal includes a new, simple way for clinicians to participate in MIPS through a new framework called the MIPS Value Pathways (MVPs). This would begin in the 2021 performance period and move MIPS from its current state, which requires clinicians to report on many measures across the multiple performance categories, such as Quality, Cost, Promoting Interoperability and Improvement Activities, to a system in which clinicians will report on fewer measures. Under MVPs, clinicians would report on a smaller set of measures that are specialty-specific, outcome-based, and more closely aligned to APMs - new approaches to paying for care through Medicare that incentivize quality and value. These measures would be layered on top of a base of population health activities. The providers would be assigned to the MVP based upon their specialty and given actionable data from CMS.

APG recognizes the value of this simplified and standardized approach for non-APM providers in the participation of MIPS. However, our concern is that this approach will hinder the movement to higher levels of value-based contracting by encouraging providers to remain at a basic pay for performance world (without taking on financial risk found in the APMs). This will not fundamentally move the industry in reducing total cost of care that is so essential for the solvency of the trust fund. **If CMS decides to move forward on this concept, we would recommend a time limit (similar to the timeline of Pathways to Success) is set for providers to remain in an MVP.**

Additionally, CMS has proposed that the scoring standard for MIPS and ACOs are to be aligned but MVPs would be scored differently which appears inconsistent to the goal of aligning ACOs and MIPS.

APG supports the concept of MVPs to drive development of competencies to be successful in risk-based contracts and reduce provider confusion in MIPS; however, more analysis must be done to explore long-term implications and potential unintended consequences of this change.

VIII. QPP Year 4 Categories and Weights

CMS is proposing to increase the performance threshold to 45 points for the 2020 performance year, up from 30 points in 2019 and the bonus adjustment from 75 to 80. The performance threshold is the minimum number of points needed to avoid a negative payment adjustment. CMS proposes reducing MIPS quality performance category to 40 percent in 2020, 35 percent in 2021 and 30 percent in 2022. This will allow them to reach the statutory requirement of 30 percent/30 percent for both quality and cost by 2022. **APG supports the increase of the threshold to 45 and the bonus adjustment to 80 points.**

For the performance year 2020, CMS proposes to remove 55 measures, citing minimal uptake, duplication and "topped out" status. It further proposes to add seven new specialty sets that address the eligible clinician groups that were added in CY 2019 final rule, change 78 measures and add four new measures addressing functional status, pain management and immunization status. CMS is also proposing to establish a guideline for removing quality measures which do not meet the case minimum and reporting volume required for benchmarking after two consecutive years in the MIPS program.

We applaud CMS for continuing to reduce the number of quality measures to have the focus on meaningful outcomes rather than process; however, a recognition of the cost of building and eliminating these measures from providers EHRs must be factored into these constant yearly changes by CMS. We urge CMS to begin to stabilize the program and minimize the quality measurement changes yearly. We understand the need for flexibility during the first few years of the program but there is a cost to providers with these yearly changes.

In the cost category**,** CMS proposes increasing the weight of MIPS' cost performance category to 20 percent in 2020, 25 percent in 2021 and 30 percent in 2022 per statutory requirement. **We agree with this proposal to increase cost category weight to 20 percent.**

CMS is also proposing to move forward with the inclusion of 10 new episode-based cost measures for implementation in 2020 which brings the total to 18. **APG supports the addition of the 10 new episode MIPS cost measures which will assist specialists in developing competencies to participate in Total Cost Of Care contracts with primary care colleagues**.

CMS is proposing changes to both the MSPB (Medicare Spend Per Beneficiary) measure and the TPCC (Total Per Capita Cost) measure. CMS has proposed a change in the attribution methodology to distinguish between medical episodes and surgical episodes for MSPB. CMS has proposed numerous changes to the TPCC measure, which include a revised primary care attribution methodology, a revised risk adjustment methodology, service and specialty category exclusions for clinicians that perform non-primary care services, and evaluating beneficiary cost every month rather than an annual basis.

APG supports the new attribution definitions of MSPB and TPCC which is more representative of everyday practice. However, each Taxpayer Identification Number (TIN) should receive a report detailing the risk adjustment calculation in both TPCC and MSPB in order to assess co-morbidities of patients attributed to their practice.

IX. Global and Population Based Measures

MACRA allows the Secretary to use global outcome measures and population-based measures for quality performance category. The April 2019 LAN document, *Roadmap for Driving High Performance in Alternative Payment Models*, indicated that a blend of Healthcare Effectiveness Data and Information Set (HEDIS) quality measures with administrative claims-based measures are frequently used in designing APMs. CMS would like to integrate additional global measures to the MIPS program.

Even though the use of global measures would decrease provider burden, it needs to be undertaken in a slow and deliberate manner. Providers typically are hesitant to embrace global measures for a variety of

reasons ranging from a perception of "boiling the ocean" to inability to track progress in real time. It is much easier for a practice or an ACO to be tracking compliance to an HEDIS measure like HBA1c rather than readmission rates of individuals with multiple chronic conditions. APG embraces the concepts of moving to population-based measures but believes that the data systems are unable to track in real time and **thus we caution against inserting additional global measures and reducing provider submitted measures for MIPS until there are further technological advances in the underlying data systems.**

X. Advanced APMs of QPP

Providers that qualify as Qualified Provider (QP), who participate in Advanced APM models, and who reach the required threshold of patient counts or revenue will receive a five percent bonus. Unfortunately, we are now nearing the end of the third quarter of 2019 and it is our understanding that no participants have received the expected bonus to date. In contrast, physicians and other clinicians participating in MIPS began receiving payment adjustments on January 1, 2019 for their 2017 performance. The reason for the holdup is unclear. The delay in payment of the Advanced APM bonus unfairly penalizes those that have diligently prepared for MACRA implementation by making investments with the expectation of a five percent positive adjustment in 2019. If these payments are not made soon, we fear clinicians could be dissuaded from participating in Advanced APMs in the future, or worse, be forced to make difficult budgetary choices in the short-term that could hinder patient care or inhibit their ability to succeed in APMs, such as letting go of additional staff hired to support enhanced care coordination and other essential functions.

We are committed to seeing MACRA's continued progress, recognizing that policies may need to evolve and change over time. **Accordingly, APG urges CMS to expeditiously pay the 2019 Advanced APM bonuses and commit to pay these bonuses no later than June 30th in subsequent years.**

APG is also concerned that in 2020 performance year, MIPS with a perfect score may receive 5.78 percent while Advanced APM participants that assume much greater risk will only receive 5 percent. Additionally, the 5.78 percent will begin January 1 with the first billings and the 5 percent bonus payment is up to discretion of CMS. **We recommend that CMS explore options to develop a more equitable system to deter high performer providers from moving out of Advanced APMs and into MIPs arrangements.**

APG also strongly recommends that The Center for Medicare & Medicaid Innovation (CMMI) quickly launch the new Direct Contracting Models and other Advanced APMs to increase the number of TCOC Advanced APM models that experienced providers can participate in with Medicare FFS. Our members are anxiously waiting for details and the formal application.

In CY 2017, CMS finalized a capitation standard that indicated that a full capitation arrangement met the definition of Advanced APM financial Risk. As CMS gathered more information from providers, they noticed that services such as hospice, organ transplant, and out-of-network emergency services are typically excluded. CMS is proposing in the 2020 rule to allow certain items or services to be excluded and still have the arrangement be counted as Full Capitation (Advanced APM) and they have requested comment from provider experiences.

When health plans contract on a statewide or national basis for high-cost or unusual/infrequent services, they often will use "Centers of Excellence" for transplants since APMs do not have a significant volume to contract for these services on their own. Out-of-Area Emergency Services are usually carved out of capitation as the health plan uses its contracts with Out-of-Area providers which the APM typically dos not have. Hospice is frequently carved out for MA plans as the benefit reverts to Medicare.

APG supports this direction to have transplants, hospice, and out of network emergency services excluded from the full capitation definition within Advanced[i]ed APM models.

CMS established that in payment year 2021, a new track will be available referred to as the "All-Payer Combination" option. This allow providers to become QPs (in order to receive the 5 percent bonus) through participating in Advanced APMs in Medicare, MA, Medicaid, and Commercial arrangements. It does not replace or supersede the initial Medicare FFS threshold hurdle of 25 percent patient counts and 20 percent Medicare FFS revenue.

However, APG believes that with the growth of MA plans, and the research demonstrating the superiority of MA in both cost and quality, that MA arrangements in "All Payer" must be viewed as **equal** to Medicare FFS in terms of the initial threshold 20 percent revenue and 25 percent patient counts.

The Integrated Healthcare Association (IHA) released its California Regional Health Care Cost & Quality Atlas 2.0, which tracks cost and quality measures across the state for over 29 million beneficiaries and compares different levels of integration on a multi-payer platform with commercial insurance, Medicare and Medi-Cal data. Not only did the Atlas 2.0 study find that the average risk-adjusted cost per patient for coordinated products (HMOs) were 10 percent less that uncoordinated (PPO) products, they found that in MA the average risk- adjusted, per-member-per-year cost was 25 percent less than traditional Medicare.[1] MA also vastly outperformed traditional Medicare FFS on hospital utilization, and, most importantly, clinical quality. The data is clear – capitated MA delivers superior value with higher quality performance and overall lower cost. Millions of Americans depend on MA for quality, patient-centered health care and that number is growing fast; over one-third of all Medicare beneficiaries are now enrolled in a MA plan. For the ultimate goal of MACRA to be realized, MA must no longer be excluded from the programs and incentives therein. **Therefore, APG is recommending that MA arrangements should be viewed as identical to Medicare FFS in terms of the initial threshold counts that must be met before counting the "Other Payer" arrangements.**

CMS has established the "Other Payer" process in a way in which the plan submits the required information prior to the performance year, but the providers can only submit the information after the performance year is completed (and only if the plan does not first submit any information). This leads to anxiety by the providers for the entire year regarding whether the arrangements met the criteria to qualify. For example, for MA arrangements, the plans can submit between April 2019 to June 2019 but the clinicians in those arrangements can only submit from September 2020 to November 2020. This means that they are submitting for approval of an arrangement after the performance year is completed.

APG members have commented that their partner MA plans chose not to submit any data for the performance year either due to complexity, the burden of the application, or the fact that they were unaware of the application process at all. Having the clinician-initiated process at the end of the performance year is leading to frustration for the clinicians that are committed to Advanced APMs. **APG recommends that CMS allow a third track if the plan declines to submit prior to the start of the performance year, then the clinician has the option to submit in place of the plan prior to the start of the performance year, not at the end of the performance year.**

---

[1] *Integrated Healthcare Association. (2018). California Regional Health Care Cost & Quality Atlas 2.0. Retrieved from https://costatlas.iha.org/*

Medicare Shared Savings Program

XI. Aligning the MSSP Quality Score and Methodology with the MIPS Quality Performance Score

CMS is soliciting comment on how to potentially align the MSSP quality performance scoring methodology more closely with the MIPS quality performance scoring methodology. CMS believes it is essential for consistency of the MACRA program to align MSSP quality reporting with MIPS in order to conserve resources and eliminate confusion within provider groups. Using a single methodology between MIPS and MSSP quality is believed to ultimately reduce burden by leading to a smaller set of measures under a unified scoring methodology.

Below is a chart that details that differences in the methodologies between MIPS and MSSP quality scoring:

	MSSP	MIPS
First Year Measurement	Pay for Reporting	Pay for Performance
Incomplete Reporting of any 1 CMS Measure	Zero points for all measures and fails the quality standard	Zero point for just that measure that is incomplete
Bonus Points	Can earn up to 4 points in each of the 4 domains	Up to 10 percent of total quality score is allowed
Minimum Attainment	30th percentile (equal to 4th decile of MIPS) of benchmark on at least one measure in each domain to receive shared savings	At least 4th decile across all quality category scores

Using MIPS scoring methodology, several of our members calculated that they would perform better under MIPS scoring methodology due to the additional bonus points; however, even under this scenario, **APG does not support the proposal to this single methodology formula between MIPs and MSSP quality scoring at this time**. APG recognizes the value of aligning MIPS and ACO quality methodologies but this is too recent from the rollout of the Pathways to Success program. In June 2019, CMS launched a departure from the previous MSSP program by beginning an ACO model in which participants move through mandatory risk levels. Due to the recentness of the change, we are recommending that the alignment of the two quality programs be postponed until the Pathways to Success program has matured. Eventually aligning the methodology formula between MIPS and MSSP quality performance scoring would allow a more equitable calculation of the score between the programs.

We recommend that CMS investigate the most optimal method to align the programs quality methodologies rather than simply adopting MIPS methodology for MSSP. Another option would be to form a Technical Expert Panel (TEP) comprised of providers in both programs to advise CMS.

Since providers have been participating in MACRA for several years, **APG does not support the elimination of the pay for reporting year for the first year of an ACO**. We understand the value to the ACOs to have one year to develop infrastructures and competencies to be successful in the quality measurements however careful selection of MIPS quality measures can achieve the same objective.

CMS has also requested comment on a single quality performance score (in addition to aligned methodology) for both programs. This would only pertain in the MSSP tracks that do not meet the definition of an Advanced APM. CMS would convert the MIPS quality performance score to a percentage of points which would be utilized to calculate the shared saving rate. **APG does not support a single quality score between MIPS and ACO**. Providers participating in TCOC risk-based contracts require a different set of quality measures than providers who are predominantly practicing in an FFS environment.

In addition to the above changes, CMS is requesting comment on simplifying MIPS by implementing only claims based measures that are focused around communities or populations. APG supports the concept of moving to claims-based measures rather than web interface in order to reduce provider burden. However, implementing global population measures without additional resources to address social determinants of health (SDOH) variables will lead to provider frustrations. Providers have felt that impacting population-based goals is the ultimate goal but frequently SDOH variables such as food and housing can greatly impact success. Additionally, moving to claims-based measures will not allow providers to monitor their quality score in real time. The current blend of web interface and population based allows a measured approach in addressing this issue. **Thus, APG does not support implementing claims-based measures at this time.**

XII Changes in 2020 MSSP Quality Measures

CMS is proposing to refine the MSSP measure set by removing one measure (ACO-14- Preventive Care and Screening Influenza Immunization) and adding another to the CMS Web Interface (ACO-47- Adult Immunization) to move to a broader preventive health perspective. This would begin in performance year 2020 and would result in 23 quality measures for ACOs (same as previous).

ACO-47 would include not only influenza that was in ACO-14 but has added tetanus, diphtheria, pertussis, zoster, and pneumococcal. It would be pay for reporting until performance year 2022. We understand the value of adding these additional vaccines, but we caution CMS in moving forward with this initiative due to heavy beneficiary financial burden of beneficiaries without Part D plans. Additionally, we believe that due to the different recommended frequencies of these vaccines, it will be burdensome to track and coordinate.

APG does not support the addition of the ACO-47at this time.

Conclusion

APG applauds CMS and the Agency's work to put forth bold proposals aimed at responding to stakeholder requests on burden, red tape, flexibility, and advancing the value movement. We look forward to continuing to work with you to improve our nation's healthcare system. The challenges will only grow. It is essential that CMS continue to advance proposals that measure both the cost and quality of health care services rendered and provide for additional opportunities for participation in APMs that do so. APMs, especially two-sided risk arrangements with delegation and capitation, have the potential to dramatically decrease the fiscal pressure on the Medicare system while simultaneously improving the quality of care patients receive.

We support the proposals which are aimed at reducing burden, recognizing clinicians for the time they spend with patients, removing unnecessary measures and making it easier for them to be on the path towards value-based care. We are aligned with the Administration's efforts to establish a patient-driven healthcare system that focuses on better health outcomes and is projected to save 2.3 million hours per year in burden reduction.

Thank you in advance for your consideration of our comments. Further, we offer ourselves and our members as a resource to you as you continue to work to strengthen and improve the MA program. Please do not hesitate to contact me or my Federal Affairs staff (Valinda Rutledge, VP of Federal Affairs vrutledge@apg.org; Anu Murthy, Director of Federal Affairs amurthy@apg.org) with any questions you may have.

Sincerely,

Donald H. Crane
President & CEO
America's Physician Groups