

December 19, 2016

Andrew M. Slavitt  
Acting Administrator  
Centers 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-FC  
Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Final Rule With Comment Period

Dear Acting Administrator Slavitt:

We urge that several changes be made in the rules issued on November 4 governing implementation of the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) (81 FR 77008-77557). We also urge that these changes be made no later than March 31, 2017.

**1. Allow 8% of an APM Entity's estimated Parts A and B revenue to meet the "more than nominal financial risk" standard in (Advanced) Alternative Payment Models for a period of at least six years (Performance Periods 2017-2022).**

The Medicare Access and CHIP Reauthorization Act (MACRA) requires that in order for a physician to be exempt from MIPS and to qualify for the bonus payments authorized by Congress, the alternative payment entity must bear "financial risk for monetary losses under ... [an] ... alternative payment model that are in excess of a nominal amount." The term "financial risk for monetary losses" in MACRA clearly refers to *losses in the operations of the alternative payment entity*, not to losses or increased spending in the Medicare program.

We commend CMS for recognizing this important distinction and including in the final regulations an option for APM Entities to count 8% of the APM entities' Medicare revenues as "more than nominal risk." However, the regulations only authorize this option for Performance Periods 2017 and 2018, and without a change to the regulations, the requirement for "more than nominal financial risk" will increase to 3% of the Medicare expenditures under the APM for the 2019 and subsequent Performance Periods. Although 3% of Medicare expenditures is lower than what was in the proposed rule, it is still excessive, and it could represent more than 100% of the total revenues for many physician practices.

As a practical matter, limiting the 8% standard to Performance Periods 2017 and 2018 means that this standard of financial risk would only be applicable to newly-created APMs for at most one year (Performance Period 2018). It is unreasonable to ask physicians to develop a new Alternative Payment Model or to agree to participate in one if the risk standards in future years are unknown or likely to change dramatically. The passage of MACRA was intended to eliminate the annual uncertainty about payment amounts under the Physician Fee Schedule that existed under the Sustainable Growth Rate, and CMS should not recreate the same type of uncertainty regarding the risk standards under APMs.

The preamble suggests that CMS would only continue using a standard based on an APM Entity's revenues in future years if it were significantly increased to 15% of revenue. We believe that this would be an excessively high standard that is far beyond the "more than a nominal amount" that Congress required in MACRA. Defining financial risk as 8% of revenue is appropriate and should be made available for a six year period.

**We urge that you delete the phrase "For QP Performance Periods 2017 and 2018" from §414.1415(c)(3)(i)(A).**

## **2. Exclude Part B Drug Revenue from the Practice Revenue**

Consistent with the principle that "financial risk" should be defined in terms of a physician practice or APM entity's revenue rather than total Medicare spending, Part B drug revenues should not be included when calculating the 8% of revenue standard. Medicare payments for drugs under Part B are almost entirely a pass-through from Medicare to a drug wholesaler, not compensation to the physician practice for its services. For some physician practices, such as oncology and rheumatology, the revenues for these drugs are many times higher than the revenues used to pay for the physicians' professional services, and the practice's costs for the drugs are many times higher than the practice's other expenses. This means that placing such a practice at risk for eight percent of its total Part A and B revenues would mean that it could be at risk for losing most or all of the revenues it receives to pay for its professional services to patients, and that could bankrupt the physician practice.

**We urge that you revise §414.1415(c)(3)(i)(A) to read:**

***For ~~QP Performance Periods 2017 and 2018~~, 8 percent of the average total Medicare Parts A and B revenues of participating APM Entities other than revenues received for Part B drugs.***

## **3. Allow APM Entities to include the cost of unpaid services they deliver to patients to be included as financial risk.**

The gains or losses of the Alternative Payment Entity are a function of both the *costs that the APM Entity incurs* to implement the alternative payment model as well as the revenues it receives under the model. One of the important advantages of many alternative payment models is to give physician practices a way of delivering high-value services to patients that Medicare does not currently pay for directly. If a physician practice hires the necessary staff to deliver these non-billable services, it will be incurring costs in excess of its fee-for-service revenues; if it shifts existing resources away from billable services to deliver these otherwise unbillable services, it will decrease its fee-for-service revenues below its costs. Either way, the practice is

placing itself at financial risk if it does not receive adequate payment under the alternative payment model to cover those costs or revenue losses. An appropriate measure of financial risk should consider the costs the practice incurs in delivering these unbillable services.

Although you indicated in the preamble to the final rule that you do not believe you can objectively and accurately assess these costs, you could easily do so when the physician practice in the APM is delivering a service described by a CPT code that is not currently billable under the Physician Fee Schedule. The physician practice in the APM could submit this code on a claim form to indicate that the corresponding service was delivered; CMS would not pay the practice for this service directly, but it would deduct the cost of this service (measured by the product of the relative value assigned to that code and the current RVU conversion factor in the Physician Fee Schedule) from any amount owed to CMS or reduce any payment to be forfeited under the APM by that amount.

We recommend adding the following language to **§414.1415(c)(3)**:

*(ii) In calculating the amount that the APM Entity would owe CMS or forgo under the APM, CMS shall deduct the costs of services that the physicians participating in the APM delivered to patients who are part of the APM if those services are described by a CPT code that is not billable under the Physician Fee Schedule.*

#### **4. Align the financial risk requirements for Medicare and Other Payer APMs**

The final rule establishes a much higher and more complex standard for “more than nominal financial risk” for APMs involving individuals who are covered by Medicaid or who are insured by commercial health plans than the standard set for APMs involving Medicare beneficiaries. This will discourage the development of multi-payer APMs and it will likely discourage physicians from participating in Medicare APMs if they cannot expect to receive credit for participating in a comparable APM for their other patients.

We urge that you revise **§414.1420(d)(3)** to read:

*(3) Other Payer Advanced APM nominal amount standard. Except for risk arrangements described under paragraph (d)(2) of this section, the total amount that an APM Entity potentially owes or forgoes under an Other Payer Advanced APM is at least equal to 8% of the average total revenue the APM Entity receives from that Payer other than revenues paid for drugs administered by physicians participating in the APM.*

#### **5. Define physician-focused payment models as APMs in which Medicaid as well as Medicare is a payer.**

The final rule limits the definition of physician-focused payment models that the Physician-Focused Technical Advisory Committee (PTAC) can review and recommend to APMs “in which Medicare is a payer.” This restriction prevents the PTAC from reviewing and recommending APMs focused on maternity care, pediatric care, and other models with potential to improve the delivery of care for patient populations that are likely to be insured by Medicaid but not Medicare. Maternity care is one of the largest areas of Medicaid spending, for example, but Medicare is unlikely to be a payer. In MACRA, Congress specifically amended the list of payment models in Section 1115A(b)(2) of the Social Security Act to include payment models

“focusing primarily on Title XIX,” so the PTAC should have the ability to review these types of payment models as well as those involving Medicare beneficiaries.

We urge that you revise **§414.1465(a)(1)** to read:  
***(1) In which Medicare or Medicaid is a payer;***

Finally, we urge that all of the above changes be made no later than March 31, 2017. Many physician practices and other organizations are currently actively working to develop Alternative Payment Models, and the Physician-Focused Payment Model Technical Advisory Committee has begun to receive and review proposals for physician-focused APMs. Because of this, it is essential that the problems in the current rule be corrected soon and that clarifications about the financial risk standards for 2019 and beyond be provided as quickly as possible. It would be inappropriate to wait until the Physician Fee Schedule rule for 2018 is issued to resolve these issues.

I would be happy to answer any questions you may have about these recommendations or to provide any additional information or assistance that would be helpful to you in implementing them.

Sincerely,

A handwritten signature in black ink, appearing to read "H. Miller", written in a cursive style.

Harold D. Miller  
President and CEO

cc: Patrick Conway