

August 21, 2017

Seema Verma
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-5522-P: Medicare Program; CY 2018 Updates to the Quality Payment Program

Dear Administrator Verma:

In response to your request for comments, we would like to recommend a number of changes in the modifications that you have proposed to make to the regulations governing the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) authorized by the Medicare Access and CHIP Reauthorization Act (MACRA) (82 FR 30010-30500).

I. Recommendations Related to the Definition of “More Than Nominal Risk” in Alternative Payment Models

The Risk Standard Based on 8% of Revenue Should be Calculated for Each APM Entity, not Averaged Over All APM Entities

Under §414.1415(c)(3) of the current regulations, an APM entity can meet the “generally applicable nominal risk standard” if the total amount the APM entity potentially owes CMS or foregoes under an APM is at least equal to “8 percent of the estimated average total Medicare Parts A and B revenues of participating APM Entities.” We and many others believed that this meant that an individual APM Entity’s losses could be limited to 8% of that *individual* Entity’s average Part A and Part B revenues.

However, in the proposed rule, CMS indicates that it interprets this language to mean that it will calculate the average Medicare revenues of *all* of the APM Entities that are participating in the APM, and the APM will be determined to meet this standard as long as the amount an individual APM Entity potentially owes CMS is less than 8% of this overall average amount. This is problematic for two reasons:

- The risk for a small physician practice to participate in the APM could be much higher than eight percent of its own revenues if there is also participation in the APM by large entities for which the APM represents a smaller portion of revenues. For example, assume that a small,

single-specialty physician practice with \$500,000 in total Medicare revenue participates in an APM that will represent \$300,000 of its revenue and will involve \$2.5 million in total Medicare spending for its APM patients. Assume further that a large multi-specialty practice with \$50,000,000 in total revenue participates in the APM, and the APM represents \$15,000,000 of its revenue and \$130 million in total Medicare spending for its APM patients. If the APM requires repayments to Medicare of up to 3% of Medicare spending, that would only represent an average of 7.9 percent of the revenues of the two entities ($(3\% \times \$132,500,000) / \$50,500,000 = 7.9\%$) but it would represent 15 percent of the small practice's revenues ($(3\% \times \$2,500,000) / \$500,000 = 15\%$).

- It would be impossible for anyone to know whether an APM met the risk standard or what the risk to any individual entity would be until after the end of each year, when all of the participating entities and their revenues were known.

The regulation should be modified to indicate that an APM meets the nominal risk standard if it limits each APM Entity's potential repayments to Medicare to 8% of that *individual* Entity's total revenues.

The Part A and Part B Revenue Used in Calculating the Risk Standard Should Only Be Based on the Providers and Suppliers Who Own or Control the APM Entity or Are Otherwise Responsible for Repayments to CMS

In the proposed rule, CMS states that it intends to clarify that the 8% standard applies to the estimated total Medicare Part A and B revenue of "providers and suppliers at risk for each APM entity." However, the proposed revision to §414.1415(c)(3)(i)(A) reads "8 percent of the average estimated total Medicare Parts A and B revenue of all providers in participating APM Entities," which is much more ambiguous than what the preamble states. For example, we are concerned that this could be interpreted as meaning the revenues of a hospital would be included if the hospital provided services to patients managed by an APM Entity, even though the hospital was not sharing in the risk of the APM.

The language should be revised to read "8 percent of the average estimated total Medicare Parts A and B revenue of all providers ~~in a participating APM Entities~~ that own or control the participating APM Entity or are otherwise responsible for all or part of any repayments the APM Entity must make to CMS."

The Part B Revenue Used in Calculating the Risk Standard Based on 8% of Revenue Should Only Include Part B payments for Professional Services, not Drugs

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 those specializing in oncology and rheumatology, the revenue they receive to cover the costs they incur in purchasing these drugs is many times higher than the revenue they receive for the physicians' professional services, and the practice's spending on the drugs is many times higher than the practice's other expenses. 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. That could bankrupt the physician practice and/or reduce access to care for Medicare beneficiaries.

The Risk Standard Based on 8% of an APM Entity’s Revenue Should be Extended to 2021 and Beyond

CMS has defined three different standards for “more than nominal risk:”

1. 8% of APM Entities’ Part A & B Revenues
2. 3% of expected expenditures for which an APM Entity is responsible under the APM; and
3. 5% of APM Entities’ Part A & B Revenues for Medical Home models operated by APM Entities with 50 or fewer clinicians or by entities participating in the first round of the CPC+ Model

The current regulations provide that the second and third standards will apply to years 2021 and beyond, but the first standard will only apply to 2017 and 2018. The proposed regulations would only extend the first standard to 2019 and 2020. In the proposed rule, CMS states its belief that “8 percent... represents a reasonable standard,” so there is no good reason why the other two standards should apply in 2021 and beyond but the first standard should not. This creates significant and unnecessary uncertainty for both APM Entities and physicians.

Medical Home Models and Medicaid Medical Home Models Should Include Specialty Physician Practices as Well as Primary Care Practices

The provisions in the regulations requiring that both a “Medical Home Model” and a “Medicaid Medical Home Model” use primary care physicians and deliver primary care services are unnecessarily and inappropriately restrictive. A growing number of specialty physician practices are providing services to patients with serious chronic diseases that have four or more of the elements listed in characteristic (3) of the definitions in §414.1305. Contrary to what is stated in the proposed rule, there is no provision in MACRA enabling unique treatment of primary care medical home models that have not been expanded under Section 1115A(c), nor does MACRA indicate that only primary care medical home models expanded under Section 1115A(c) would automatically qualify as an Advanced APM. Moreover, Section 1848(q)(5)(C)(i) of MACRA grants both a physician practice certified as a patient-centered medical home and a “comparable specialty practice” the highest potential score under the Clinical Practice Improvement Component of MIPS.

The proposed rule states that the rationale for treating Medical Home Models differently is that they “tend to be smaller in size and have lower Medicare revenues relative to total Medicare spending than other APM Entities, which affects their ability to bear substantial risk, especially in relation to total cost of care.” However, just like primary care practices, many specialty physician practices primarily deliver E&M services to their patients, and they receive the same payment amounts for those services that primary care practices receive, so the rationale for separate treatment applies equally to these specialty practices.

CMS Should Recognize “Other Payer Medical Home Models,” and They Should Include Specialty Physician Practices as Well as Primary Care Practices

There is no logical reason for CMS to give a practice favorable treatment for delivering care under a Medical Home Model to Medicare and Medicaid beneficiaries but not to other types of patients. In fact, private health plans are supporting Medical Home Models with more physician practices and in more parts of the country than CMS is.

Lower Risk Thresholds for Medical Home Models and Medicaid Medical Home Models Should Not Be Restricted to Organizations With Fewer than 50 Clinicians

The fact that a primary care practice has 50 physicians does not mean that it has the ability to manage four times the financial risk that a practice with 49 physicians does, yet that is what the proposed regulations would require. In 2018, a Medical Home Model operated by an Entity with fewer than 50 clinicians would only need to be at risk for 2% of its total Part A & B Revenues, whereas an Entity with 50 clinicians would have to be at risk for 8% of its total Part A & B revenues. This arbitrary threshold should be eliminated.

Lower Risk Thresholds Should Be Established for Small and Rural Practices in APMs Other Than Medical Home Models

The proposed rule requests comments on whether a different, revenue-based nominal amount standard should be established for small practices and practices in rural areas that are not participating in a Medical Home Model. Any risk standard will be more problematic for very small practices and for practices in rural areas than for larger practices and practices in urban areas simply because, all else being equal, smaller practices and practices in sparsely populated areas will have higher costs per patient, lower margins, and less capacity to take financial risk. Consequently, lower risk standards should be established for practices with small numbers of clinicians and low numbers of patients per clinician. In the proposed rule, CMS expresses concern that a lower standard could reduce “the likelihood that potential Advanced APMs will ultimately result in reductions in the growth of Medicare expenditures.” However, Congress made it clear in MACRA that the goal of APMs is not just to reduce the growth of Medicare expenditures but to improve the quality of care for Medicare beneficiaries, and beneficiaries living in rural areas deserve better care every bit as much as those living in urban areas.

In the proposed rule, CMS states that a lower standard should not apply to small or rural practices in a Medical Home Model because the regulations already establish a lower standard for practices with fewer than 50 clinicians. Yet in the proposed rule CMS also states its belief that the “meaning of the word ‘nominal’ depends on the situation in which it is applied.” Requiring a solo physician practice in a sparsely-populated rural area to repay 5% of its revenue to Medicare will likely be a much bigger deterrent to APM participation for that practice than for a practice with 49 physicians or even a small practice in a densely populated area, so lower risk standards are appropriate for the smallest practices under the Medical Home Model as well.

II. Recommendations Related to Determinations Regarding Other Payer Alternative Payment Models

Other Payer Advanced APM Determinations Should Remain in Effect as Long as the Essential APM Characteristics Have Not Changed

CMS is proposing that its determinations as to whether payment models implemented by other payers meet the requirements for Other Payer Advanced APMs would only be in effect for one year at a time. This creates unnecessary uncertainty for physicians and unnecessary administrative burden on CMS. CMS should automatically renew its determination of an Other Payer Advanced APM as long as either the payer or the physician has submitted an attestation that the key characteristics of the APM that were used to make the initial determination remain in place.

All Payers Should Be Permitted to Request and Receive Other Payer Advanced APM Determinations in 2018

CMS has proposed delaying until 2019 determinations of Other Payer Advanced APMs from payers other than Medicaid, participants in CMS Multi-Payer Models, and Medicare Health Plans. This unfairly penalizes physicians who have many patients insured by other types of payers and who have successfully negotiated APM contracts with those other payers. CMS should be equally able to make a factual determination as to whether an APM meets the requirements for an Advanced APM regardless of the type of payer.

Payers Should Be Given More Than 10 Business Days to Respond to CMS Requests for Additional Information on Advanced APMs

CMS is proposing that if a payer has requested an Other Payer Advanced APM determination and if CMS determines that the payer has submitted incomplete or inadequate information, the payer would have only 10 business days to respond, otherwise no determination would be made on the request. This is an unreasonably and unnecessarily strict requirement, and it could jeopardize the ability of physicians participating in multi-payer APMs to meet the QP thresholds. As long as the payer can respond with the necessary information in sufficient time for CMS to make a determination consistent with other program timeframes, the payer should be given the time it needs to respond.

CMS should also establish a reasonable timeframe for submitting requests for information to payers (e.g., 30 days after receiving a payer's submission) so that delays in sending those requests do not make it impractical for payers to respond.

III. Recommendations Related to the Determination of QP Status

If a Physician Qualifies for QP Status, They Should Be Treated as a QP in the Next Year

The regulations require that QP determinations will be made based on a clinician's participation in APMs two years prior to the payment year. This is an unnecessarily and inappropriately restrictive approach. For example, assume there are no APMs in which a physician can participate in 2018, but new APMs become available during 2019, the physician agrees to participate in one or more of those APMs, and she receives 25% or more of her revenues through an APM in 2019. Under the regulations, the physician would have her Medicare payments in 2020 adjusted by MIPS even though she is participating in an APM at the minimum level MACRA requires for exemption, simply because her QP status in 2020 had been determined based on 2018 instead of 2019.

MACRA states that QP determinations are to be made based on "the most recent period for which data are available." Since CMS is proposing to make QP determinations based on fewer than 12 months of data, it is quite feasible to use data from the immediately prior year and still make a determination on QP status prior to the beginning of the payment year. Consequently, the appropriate approach would be to determine a physician's QP status each year, and decide whether to adjust their payments using MIPS based on the physician's QP status during the immediately previous year, rather than the second-previous year.

Since the QP determination will be made every year, the physician will still have adequate notice of the potential need to report on MIPS measures during the following year. For example, if the physician does not meet the QP threshold in 2018 and is not certain she would meet the threshold in 2019, she could decide to report on the MIPS measures in 2019. However, if she was confident she would meet the QP threshold in 2019, she could decide not to report on MIPS measures in 2019.

QP Status Should Be Determined Under the All-Payer Combination Option Using the Same Procedures as the Medicare Option

CMS has proposed that if a physician's QP status is being determined based on the "Medicare Option," the Threshold Score will be calculated collectively for all of the physicians in the APM Entity, but if QP status is being determined based on the "All-Payer Combination Option," the Threshold Score will only be calculated for each physician individually. The rationale given for this in the proposed rule is a belief that "in many instances ... the eligible clinicians in the APM Entity group ... would likely have little, if any, common group-level participation in Other Payer Advanced APMs."

However, if it makes sense to determine the Threshold Score at the APM Entity level for the Medicare Option then it is problematic not to do so if the APM Entity is participating in Other Payer Advanced APMs. This could force individual physicians to try and selectively see patients of the Other Payers rather than Medicare beneficiaries in order to increase their individual Threshold Score under an APM.

In Example 1 below (based on a modified version of Table 55 from the proposed rule), Clinician A would fail to meet the All-Payer Threshold Score calculated at the individual level, even

though the APM Entity as a whole would meet the 50% threshold. Consequently, as shown in Example 2, Clinician B might decide to shift attention away from Medicare beneficiaries to patients of the Other Payers in order to increase their All-Payer Threshold Score in the APM.

EXAMPLE 1

	Medicare Advanced APM Payments	Medicare Total Payments	Medicare Threshold Score	Other Payer Advanced APM Payments	Other Payer Total Payments	All-Payer Threshold Score
Clinician A	\$90	\$200	45%	\$570	\$1,150	49%
Clinician B	\$200	\$800	25%	\$500	\$500	52%
APM Entity	\$290	\$1,000	29%	\$1,070	\$1,700	50%

EXAMPLE 2

	Medicare Advanced APM Payments	Medicare Total Payments	Medicare Threshold Score	Other Payer Advanced APM Payments	Other Payer Total Payments	All-Payer Threshold Score
Clinician A	\$50	\$200	25%	\$625	\$1,150	50%
Clinician B	\$200	\$800	25%	\$500	\$500	52%
APM Entity	\$250	\$1,000	25%	\$1,125	\$1,700	51%

The most appropriate approach would be to determine whether the same APM Entity and essentially the same physician members are participating in the Other Payer Advanced APM, and then make the Threshold Score calculations accordingly. This is what could be done under §414.1440(b) and §414.1440(d)(3) of the current regulations, and there is no reason to change it.

IV. Recommendation Related to the Definition of Physician-Focused Payment Models

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

The current regulations limit 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 and pediatric care are two of the largest areas of Medicaid spending, for example, but Medicare only pays for a small number of these services. 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 payment models focused on Medicaid participants as well as those involving Medicare beneficiaries. We urge you to **revise §414.1465(a)(1) to read:**

(1) In which Medicare or Medicaid is a payer;

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. D. Miller". The signature is fluid and cursive, with the first letters of the first and last names being capitalized and prominent.

Harold D. Miller
President and CEO