

August 18, 2017

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: File code CMS-5522-P

Dear Ms. Verma:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) **Medicare Program; CY 2018 Updates to the Quality Payment Program proposed rule**. We hope our comments are helpful to staff as they work to implement this complex program.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the sustainable growth rate formula and established a new set of requirements governing fee-for-service (FFS) clinician payment in Medicare. Starting in 2017, clinicians participating in Medicare FFS will generally be in one of two tracks—the path for clinicians who participate in an Advanced Alternative Payment Model (A-APM) at a level sufficient to qualify for an A-APM incentive payment and a path for clinicians who are subject to the Merit-based Incentive Payment System (MIPS).¹ CMS refers to the system in total as the Quality Payment Program (QPP). This proposed rule sets out policies for the second year of the QPP, which will define participation and reporting requirements in 2018 and affect payments in 2020.² CMS's implementation of this rule is bounded by the legislative requirements in MACRA, which are fairly prescriptive.

In the first year of the QPP (2017 reporting for the 2019 payment year), CMS elected to adopt a delayed implementation strategy with respect to MIPS, requiring a minimal participation in MIPS to avoid a negative payment adjustment. CMS also released the list of models that qualify as Advanced Alternative Payment Models for 2017:

- Next Generation Accountable Care Organization (ACO) model
- Comprehensive Primary Care Plus (CPC+)

¹ A third category of clinicians are exempt from MIPS reporting.

² Throughout the comment letter, we generally refer to the reporting year (2018 for this NPRM) and note where we mean the payment year.

- The Medicare Shared Savings Program (MSSP) Tracks 2 and 3
- The ESRD Seamless Care Organization (ESCO), risk-bearing arrangement
- The Oncology Care Model, risk-bearing arrangement
- The Comprehensive Care for Joint Replacement (CCJR) model (Track 2)

CMS has released preliminary estimates stating that it currently projects that all participants in the first five models listed above will qualify as A-APM participants in the 2017 reporting year (CMS did not release an estimate for CCJR). CMS has also stated that two additional models will likely qualify as A-APMs in 2018: the Vermont Medicare ACO and the ACO Track 1+ model.

We would reiterate our comments in the 2016 and 2017 Report to Congress chapters on MACRA implementation and our comment letters for the 2017 MACRA proposed rule, Episode Payment Model, and physician fee schedule rules.³ The comments we make below derive from that work and are classified in the following three topic areas: the Merit-based Incentive Payment System (MIPS), Advanced Alternative Payment Models, and A-APMs and the Medicare Advantage program.

The Merit-based Incentive Payment System (MIPS)

Assessing clinician performance is difficult, and the national Medicare program faces a particular challenge in assessing performance in a way that is comparable and fair across clinicians. There is not unanimity on how clinician performance should be measured, and whether (and how) differences in performance should result in differences in payment. Since 2006, the Medicare program has employed four quality incentive programs for clinicians and three programs designed to promote use of electronic health record technology (Figure 1).

³ Medicare Payment Advisory Commission. 2017. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

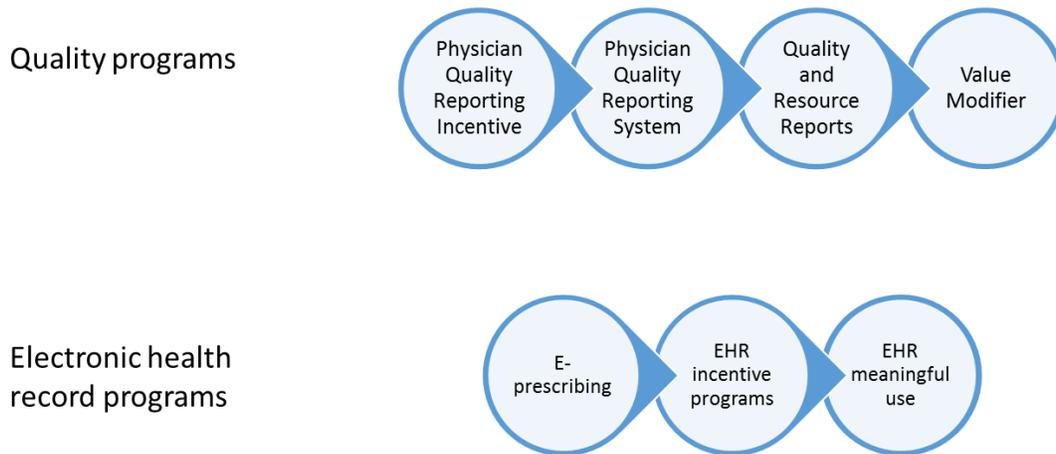
Medicare Payment Advisory Commission. 2016. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2016. MedPAC comment on CMS's proposed rule on episode payment models and the cardiac rehabilitation incentive payment model. September 30.

Medicare Payment Advisory Commission. 2016. MedPAC comment on CMS's proposed rule on the Merit-based Incentive Payment System and alternative payment models. June 15.

Medicare Payment Advisory Commission. 2016. MedPAC comment on CMS's proposed rule on the physician fee schedule and other revisions to Part B for CY 2017. August 26.

Figure 1. Predecessor quality and electronic health record programs in Medicare



Note: EHR (electronic health record)

For many of these programs, issues became immediately evident, CMS had to modify or delay implementation, and Congress had to retool the programs in the next iteration. For example, in the 2018 fee schedule rule, CMS proposes to reduce the maximum penalties under the value modifier and is proposing to delay requirements for clinicians to use updated versions of EHR technology. In addition, CMS has proposed, at various points, to publicly report information on quality and EHR performance on the Physician Compare website, but at this point, only a select amount of information is available for a small subset of clinicians.

Presently, two years after full implementation of the value modifier (and four years after it began), CMS is implementing the Merit-based Incentive Payment System using much the same quality, advancing care information (use of electronic health records), and cost measures that have been used in prior programs.

Like these earlier programs, the Merit-based Incentive Payment System uses clinician-chosen and reported measures to assess clinician performance on quality, claims-based and CMS-calculated measures to assess clinician performance on cost, plus a set of measures for which clinicians attest to activities they undertake in their practices and meaningfully use EHR. Performance on these four MIPS categories (quality, cost, clinical practice improvement activities (CPIA), and advancing care information (ACI)) will be merged into a composite performance score for each clinician (or group of clinicians, depending on whether they report as a group or as an individual). Clinicians select the quality measures on which they will be measured, and they report their own scores to CMS.

We understand the challenges CMS faces in implementing a value-based purchasing program for clinicians, and the statutory constraints under which CMS operates. CMS has made a significant effort to ensure that clinicians have multiple ways to participate in MIPS—multiple reporting

options, phased-in reporting requirements, and extra consideration if they are in certain practice environments (small practices, rural practices, non-patient facing clinicians) or have patients with particularly complex conditions.

However, this has also had the effect of further complicating MIPS, and the resulting system is characterized by exclusions, special scoring, complex reporting, and a scoring process that limits Medicare’s ability to differentiate clinician performance and that could result in broad swings in payment adjustments. And overall, we are concerned that the resulting system is one that will result in arbitrary payment adjustments with little or no relationship to value. We elaborate on these points below.

Many clinicians are excluded from MIPS reporting altogether, or eligible for special scoring

In the NPRM, CMS is proposing to expand the low-volume criteria for 2018 from the 2017 requirements, exempting a higher number of clinicians from reporting MIPS. In 2018, more clinicians will be exempt from MIPS due to the proposed low-volume threshold than are required to participate in MIPS (Table 1). Even among those required to report, a significant number of clinicians will have modified scoring or may be exempted from certain requirements.

Table 1. Estimated number of clinicians in each category

	2017	2018
Exempt (low-volume)	384,000 (Less than \$30,000 in Medicare payments per year or fewer than 100 patients)	586,000 (Less than \$90,000 in Medicare payments per year or fewer than 200 patients)
Exempt (other reasons in statute)	285,000	310,000
Required to participate in MIPS	Between 600,000 and 640,000	572,000
A-APM participants	Between 70,000-120,000	Between 180,000-245,000

Note: By statute, certain Medicare-billing entities are excluded from MIPS: those in the first year of Medicare participation and clinicians in certain specialties.

Source: Centers for Medicare & Medicaid Services. 2017. Medicare Program; CY 2018 Updates to the Quality Payment Program proposed rule, and Medicare Program; CY 2018 Updates to the Quality Payment Program proposed rule.

Complex reporting process

As a result of the requirement for CMS to collect clinician-reported information, CMS currently will need to support several of different paths for clinicians to report information to the Medicare program. For example, clinicians participating in MIPS as individual clinicians may use four paths for reporting quality information to Medicare: reporting quality information on no-pay claims, qualified clinical data registries (QCDR), qualified registries, and electronic health records (EHR). Clinicians reporting as groups may use these four paths (no-pay claims, QCDR, qualified

registries, and EHR), plus they may use a web interface and a CMS-approved survey vendor for the Consumer Assessment of Healthcare Providers and Systems (CAHPS®).

CMS proposals in the 2018 NPRM are motivated by increasing flexibility for clinicians, but the proposals also increase complexity by allowing clinicians to use multiple paths for reporting information in each MIPS area. For example, a clinician could use four different methods to report six quality measures. This complexity further undercuts comparability between clinicians because clinicians are compared only to other clinicians that reported the same quality measure using the same reporting method (resulting in over 600 different measure/reporting combinations for the MIPS measures). For example, a clinician reporting via registry a quality measure that assessed blood sugar control would only be compared to other clinicians that reported the blood sugar quality measure using the registry method. In other words, the actual method of reporting can affect a clinician's score.

Structure of MIPS results in clinicians receiving high scores, limiting CMS' ability to differentiate performance

Under the current MIPS scoring mechanism, clinicians have an incentive to select quality measures for which they believe they can maximize their score (which may not correlate to actual performance improvement or meaningful differences in performance). Although the details of the scoring methodology vary by year, this could be accomplished, for example, by reporting topped-out measures (measures where performance is compressed at the top of the distribution), reporting measures through relatively less-commonly used reporting methods, or reporting measures with no benchmarks.

Of the 686 total MIPS measures/reporting method combinations in 2017, 178 are topped out.⁴ However, CMS is proposing to address the use of only six of these topped-out measures in 2018 (by modifying how these measures are scored). For the rest of the topped-out measures, CMS is proposing a four-year process for removing the measures from the MIPS measure set. This long timeframe is meant to avoid disadvantaging certain clinicians who may report these measures. In the meantime, clinicians can still report these measures and count the maximum points for a measure. In addition to the issue of topped-out measure use, fully 287 of the 686 measure/reporting combinations have no benchmarks at all (and the role of these measures in assessing performance is unclear).

CMS has made explicit decisions elsewhere in the NPRM to help clinicians receive the maximum score. For example:

- For clinicians who report the same quality measure through multiple reporting mechanisms, CMS will select the highest score.
- For clinicians who report more than six quality measures, CMS will count the six highest-scoring measures.

⁴ Centers for Medicare & Medicaid Services. 2017. 2017 quality benchmarks.
https://qpp.cms.gov/docs/OPP_Quality_Benchmarks_Overview.zip

- For clinicians who could qualify for facility-based scoring, CMS will allow clinicians to see their scores first then elect whether to use the facility scoring.
- CMS will select the highest score for participants reporting through two group practices (for example, a clinician billing under two Taxpayer Identification Numbers).
- The MIPS scoring methodology allows points to total over 100 percent in all scored areas in 2018 (due in part to bonus points for improvement, high-priority measures, complex patient adjustments and incentives for small and rural practices).

In sum, most clinicians are likely to receive high performance scores. This calls into question the ability of MIPS to meaningfully detect differences in performance among clinicians, and for the Medicare program to make differential payment adjustments based on any differences in performance.

The MIPS scoring process will result in small payment changes now but could result in large changes in future years

Despite the significant effort involved to report (and the resulting complexity of CMS's calculation of MIPS performance), most clinicians in 2017 and 2018 will receive minimal payment adjustments. This is a result of two factors: 1) CMS's intent to allow clinicians to maximize their performance scores; and 2) CMS's decision to set the MIPS performance threshold at a very low level (well below where most clinicians' scores are expected to be).

In its estimates of the proposed rule impacts, CMS projected that the average clinician will have a MIPS performance score above 80 points (out of 100). Despite this estimate of high scores for most clinicians, CMS has set a very low MIPS performance threshold for 2018—15 points out of 100. That means that everyone scoring above 15 points will receive a positive adjustment. (CMS also set the MIPS exceptional performance threshold—which qualifies clinicians to receive payments from a pool of \$500 million per year—at 70 points out of 100).

CMS estimates that nearly all clinicians will receive a positive payment adjustment in 2018, and the majority will receive an additional payment through the MIPS exceptional performance bonus. Specifically, over 95 percent of clinicians will receive a positive payment adjustment and 77 percent of clinicians will receive the MIPS exceptional performance bonus.

In the near term, CMS's approach will result in most clinicians receiving a very small (positive) payment adjustment—well less than 1 percent in the first year. This is because the bar is set so low that very few clinicians will receive a penalty. Because the basic MIPS adjustments are budget neutral, if there is a small penalty pool that must be spread across a significant number of clinicians who cleared the bar, the overall positive increases will be very small. However, we are concerned that in future years the MIPS scoring method will result in small differences in performance yielding large differences in payments, because of certain MACRA provisions, as we explain below.

MACRA gives CMS the authority to set the MIPS performance threshold in the first two years of the program (2017 and 2018, the year of this NPRM). And CMS has set and is proposing to

continue to set a low threshold in 2017 and 2018 in order to allow clinicians to participate in a minimal way and avoid a payment penalty.

CMS will not have this flexibility to set a low performance threshold next year (the 2019 reporting year). At that point, the MACRA statute requires CMS to set the MIPS performance threshold at the median or mean of MIPS performance scores. When this is the case, there is the potential for small differences in MIPS performance scores to result in very different payment adjustments.

This could occur if the average MIPS performance score is high (for example, 90 points out of 100). Clinicians with a score of 90 points would receive no payment adjustment and clinicians with a score of 100 points would receive the maximum MIPS payment adjustment (in 2019) of 7 percent, plus the maximum MIPS exceptional performance amount. In other words, a clinician with a score just 10 points higher than average performance could receive a payment adjustment well in excess of 10 percent.

Overall, the key point is that the way that MIPS adjustments are to be derived and calculated after 2018, small changes in performance may result in large changes in payment. CMS has stated a concern with ensuring that clinicians are prepared for full implementation of various features of the QPP. Clinicians should also be prepared for significant swings in payment from minimal differences in performance.

Next steps for MIPS

In our June 2017 Report to Congress, we discussed a possible redesign of MIPS that would eliminate individual clinician reporting and offer clinicians the option to be measured at a larger entity- or group-level. Each clinician entity would be assessed based on the same set of population outcome measures. Individual clinician reporting would be eliminated, and CMS would use claims and survey data to calculate clinical outcome, patient experience and resource use measures. Payment adjustments would be made only at the entity (or group) level.

Such an approach avoids some of the pitfalls of individual clinician quality measurement, while eliminating the reporting burden on clinicians and providing for a more comparable set of measures to assess performance and make payments. This approach would not preclude the use of clinician-level or clinician-reported quality measures by intermediate groups (e.g., ACOs or health systems) for other purposes, nor would it preclude the use of clinician-level or clinician-reported measures for public reporting.

Therefore, our suggestion to CMS (within the current statutory limitations of the MIPS program) is to enhance the features of QPP and CMS's plans in the NPRM that could support the quality measurement program of the future: building the infrastructure for virtual groups; adopting facility measurement where possible; establishing meaningful cost measures; and targeting payment incentives to practices that treat a high share of dual-eligible beneficiaries or are in isolated or underserved areas.

Virtual groups: In fact, in the NPRM, CMS proposes to permit creation of virtual groups for clinician reporting. Virtual groups could be constructed from solo practices and group practices with ten or fewer clinicians. Clinicians should, to the extent possible, be able to elect to be measured for quality purposes with other clinicians with whom they may not share a formal contractual relationship. We support this concept, as we suggest above, and would urge CMS to expand the model beyond the current limitation of component groups of 10 clinicians. Since the NPRM would allow virtual groups as small as two clinicians (i.e., a solo clinician paired with another solo clinician), CMS should provide feedback and technical assistance to clinicians considering forming virtual groups to ensure that resulting groups are of sufficient size to pass minimum thresholds of statistical comparability and so achieve meaningful measures.

Facility-based measurement: CMS proposes to allow certain clinicians with a significant amount of their practice in a hospital-based setting to elect to use the hospital value-based purchasing program. Clinicians would not be required to report quality measures, nor attest to CPIA or ACI activities. Instead, they would be assessed based on the measures in use in the hospital value-based purchasing (VBP) program—claims-calculated outcome measures, patient experience, and resource use/cost. CMS’s discussion of the hospital VBP illuminates a number of differences between the programs and aligns well with our current consideration for a redesigned value-based purchasing program based on population-level measurement.

For example, the hospital VBP shows a meaningful distribution of performance scores versus the very high scores projected initially for MIPS. The hospital VBP uses a set of claims- and survey-calculated outcome and cost measures, as well as hospital-reported infection measures. Clinicians do not need to report any measures to CMS—only that they elect to be measured using their hospital’s VBP score. In our June 2017 Report to the Congress, we outlined a similar approach for assessing clinician performance in groups (virtual or otherwise) using a set of claims- and survey-derived measures. In this construct, clinicians would only have to identify the group with which they wish to be measured.

Cost: CMS proposes to give zero weight to the cost category again for the second year of MIPS to allow clinicians additional time to understand cost measures. Further, CMS would use just the Medicare Spending per Beneficiary (MSPB) and total per capita costs measures for the cost category, abandoning the 10 resource use episode measures that had previously been included. In their place, CMS is developing several new episode measures, with additional clinical input, and plans to provide feedback to clinicians on their performance on the new measures in the fall of 2017.

MedPAC has several concerns about these cost proposals. First, given that the cost category will be comprised solely of the MSPB and total per capita costs measures, there is no need to continue to exclude this category from calculation of the MIPS performance score. As recognized by MACRA, cost is an essential component of value. The two cost measures are straightforward, easily understood measures that have been used in clinician performance and feedback programs for years. Second, while we have no issue with retiring the 10 resource use episode measures that were used in the first year of MIPS, we are concerned that CMS’s plans to test several new episode measures in the coming months reveals a measure development process not materially different

from previous processes that resulted in failure. While clinician input on the episode measures is important, it is not the sole key to success, as evidenced by the fact that all previous episode measures were also developed with clinician input.

Among other necessary characteristics, successful resource use episode measures must be constructed upon and consistent with an underlying foundation—a theoretical framework that forms the basis of all episode measures. This is because, unlike quality measures that can assess discrete events or conditions that may be unrelated to patients’ other health services, cost-based episode measures are different. Episode measures are designed to work as part of an episode grouper that combines patients’ health services into distinct treatment episodes and then attributes responsibility for these episodes to appropriate clinicians. Episode groupers tend to include hundreds of potential episodes that have been constructed following the pattern of the underlying foundation. This foundation addresses fundamental questions such as:

- If a patient undergoes a major procedure, are there separate episode types for the procedure and the condition it treats, and how is the episode or episodes attributed to the surgeon who performs the procedure and the clinician or clinicians managing the condition?
- For episodes involving acute conditions (e.g., pneumonia), are there separate episodes for stand-alone presentations of the condition versus those that are exacerbations of chronic conditions, or is a single episode type adjusted in some fashion to account for this difference?
- For long-term chronic conditions that tend to present with comorbidities (e.g., diabetes and chronic kidney disease), are hybrid episode types created or are separate episode types for each of the discrete conditions used, and how do services that treat more than one of the discrete or comorbid conditions get grouped to episodes?

Considering the implications of potential answers to these types of questions, it is clear that proceeding with constructing a handful of episode measures before finalizing the underlying episode grouper foundation, risks yielding more episode measures that will prove to conceptually diverge from the foundation when it is later refined. As a result, these initial episode measures will conflict with future episode measures, as CMS continues to build out the episode measure set. We urge CMS to delay developing new cost-based episode measures, even for clinician feedback, until the underlying organizational foundation for a Medicare episode grouper is thoroughly developed, vetted, and refined. This tested foundation should then inform the development of a full or nearly full set of episode measures, which in turn should be subject to rigorous review, as feedback on the individual episodes may suggest refinements to the foundation and vice versa.

Complex patient adjustment: CMS proposes to make adjustments to the composite MIPS score for providers who see patients with high complexity (based on their composite patient panel hierarchical condition categories (HCCs) score). This approach could result in an additional incentive for clinicians to increase coding intensity without meaningfully changing their care. Another approach that CMS discussed is to use patient dual-eligibility status as an indicator of relatively more complicated patients. We support this latter approach to complexity adjustment, rather than the HCC-related approach. Dual-eligible beneficiaries (and beneficiaries entitled to Medicare on the basis of Disability Insurance status) are less likely to report being able to obtain

care when needed, and thus a payment incentive may be better targeted to clinicians treating large numbers of these patients.

Small and rural practices: In the NPRM, CMS proposes adding 5 points to the final score of any clinician or group based solely on their inclusion in a small practice, defined as 15 or fewer clinicians, as long as the MIPS-eligible clinician or group submits data on at least one performance category in an applicable performance period. CMS also seeks comment on whether the small practice bonus should be extended to all clinicians practicing in rural areas, without regard to practice size. It may be that certain Medicare clinicians and practices could use additional assistance in the MIPS program in its current form. However, we believe that the current proposal is poorly targeted and in fact may shift resources from clinicians more legitimately in need to those who are less in need. Neither the small size nor the rural location of a clinician's practice alone is sufficient grounds for distinguishing these practices from their peers. Any additional points and technical assistance should be focused on practices that are in both rural and underserved areas or practices that serve a disproportionate share of dual-eligible beneficiaries.

Moving forward on A-APMs

Advanced Alternative Payment Models (A-APMs) should be those that further the goal of delivery system reform and promote the coordination of care over time and across settings. We are concerned that CMS, in the MACRA implementation process, has identified many models as A-APMs for 2017 and beyond that could instead promote only silos of care, not the totality and coordination of patient care.

For example, episode payment models (such as bundling models) may include incentives for providers to lower costs within an episode, but there is no incentive for controlling the number of episodes or for coordinating with the usual primary care provider. In addition, episode models could undercut more comprehensive models, such as two-sided ACOs. ACOs have more promise for controlling the number of episodes because ACO entities are responsible for total Medicare Part A and Part B spending.

Managing the overlap of beneficiaries, providers, and savings between episode models and ACOs will be a challenge for CMS and could easily confuse participants in the models or even result in providers deciding not to participate at all. Single-specialty based episode-based payment models coming from the Physician-focused Technical Advisory Committee (PTAC) could add to this complexity.

As we discussed in our previous comment letter on MACRA implementation, the Commission has developed principles for A-APMs. They are:

- Clinicians should receive an incentive payment only if the Advanced APM entity in which they participate is successful in controlling cost, improving quality, or both.
- The Advanced APM entity should be at financial risk for total Part A and Part B spending.
- The Advanced APM entity should be responsible for a beneficiary population sufficiently large to detect changes in spending and quality.

- The Advanced APM entity should have the ability to share savings with beneficiaries.
- CMS should give Advanced APM entities certain regulatory relief.
- Each Advanced APM entity should assume the financial risk and enroll clinicians.

As we discussed, several of the models proposed as A-APMs do not accord with these principles. For example, clinicians in the CPC+ and the Oncology Care Model will receive guaranteed additional payments much larger than the risk they will assume and thus may not have strong enough incentives to coordinate care or control spending; this is not in accord with our first principle. CMS's overall emphasis on increasing the number of clinicians receiving the A-APM incentive payment (for, by example, setting the patient count threshold lower than the statutory revenue threshold) could result in extra spending without commensurate value. CMS has released initial estimates that all clinicians in most of the 2017 A-APMs appear to have met the A-APM incentive payment threshold in the first year.

This approach is also creating more complexity. There are four ways to qualify for the A-APM incentive (permutations of percent of revenue, percent of patients, individual, and group), and there will be eight ways when the Medicare plus All-Payer calculation is available, starting in the 2019 measurement year. The All-Payer rules proposed will create even more complexity for clinicians and plans, requiring them to submit to CMS information on specifically which contracts meet A-APM criteria.

A-APMs and Medicare Advantage

The NPRM requests comments on ways to reward A-APM participation within Medicare Advantage (MA) plans prior to the implementation of the All-Payer Combination Option in 2021. The proposed rule notes that options could involve the use of CMS's waiver and demonstration authorities to give clinicians credit, in years before 2021, for participation in A-APMs in MA. Additionally, there has been public discussion of creating an incentive for A-APM participation in Medicare Advantage that would apply to a clinician's MA revenue (paid either to the plan or the MA clinician directly). Our comments are in response to both the request in the NPRM and that public discussion.

Before embarking on such a policy, we would raise a number of questions about the purpose and effect of such a program, and urge CMS to consider this policy in the context of the overall purpose of the Quality Payment Program and the recognition of A-APMs. With regard to the NPRM request for comments on participation in MA as counting towards QP determinations under the Medicare Option and thereby increasing FFS payments, our concerns relate to:

- *Consideration of whether MA practice patterns will "spill over" into a clinician's FFS practice patterns.* We would question whether it is reasonable to assume that A-APM participation within MA would have an effect on FFS utilization. There is some evidence of a "spillover" effect of MA practice patterns affecting FFS in an area. More work needs to be done to understand the magnitude of this effect, and whether it is dampened in certain situations.

- *What specific clinician contracting arrangements in MA would be counted as A-APMs?* The financial arrangements between an MA plan and its clinicians have traditionally been viewed as private contracting arrangements among private entities, with CMS not involved in determining the nature of those arrangements. Rather than using clinician payment models similar to some A-APM models (such as full-risk capitation), a plan might prefer to emphasize alternative strategies for achieving cost savings. If CMS now intends to delineate specific practices participating in MA plans, this would represent a departure from Medicare's current policy of allowing plans to decide how to compensate their clinicians and to decide what practices the plan will use to improve its efficiency. Such practices may be different from A-APM models that the agency might be seeking to promote in MA.

With regard to the public discussions of creating an incentive for A-APM participation in Medicare Advantage that would apply to a clinician's MA revenue (paid either to the plan or the MA clinician directly), the following issues should be considered:

- *The purpose of making A-APM incentive payments to MA (either the plans or the participants in those plans).* We are not convinced that making A-APM incentive payments to MA plans is consistent with the overall goal of promoting efficiency within MA. A policy of making additional payments to MA plans (or their participants) could undermine one of the objectives of the MA program, which is to secure Medicare program savings. How plans go about achieving the goal of providing services more efficiently—including clinician services—has historically been a matter for plans to decide. In addition to specific financial arrangements (such as capitation) in which clinicians assume risk for total spending and outcomes (which could be A-APMs), plans use strategies such as utilization management, provider credentialing and selection, and may even have cost sharing incentives to encourage beneficiaries to use more efficient providers.
- *Whether the payment would go directly to clinicians for their MA A-APM participation or to the plans.* CMS does not have a direct payment mechanism for clinicians in MA plans. Making payments to the plans would be consistent with the statute that requires Medicare's payments for services for MA enrollees be paid to the MA plans, rather than directly to the clinicians.
- *Using the MA quality bonus program.* If the above issues can be addressed and CMS does wish to promote A-APM activities within MA, a possible approach that would not require waivers or demonstrations is to use the MA quality bonus program (the star rating system). CMS could develop a star rating measure that measures the level of A-APM use within an MA contract. Contracts with higher A-APM use would have higher star ratings; those with lower use would have reduced star ratings. If the intent is to encourage all contracts to have extensive use of A-APMs, the cut-off points for bonus-level stars (at 4 or higher) could be set at a high pre-determined level, rather than being set on a relative basis across contracts. Such an approach could be budget-neutral to current policy.

Conclusion

The Commission appreciates the opportunity to comment on the proposed rule. We also value the ongoing cooperation and collaboration between CMS and Commission staff on technical policy issues. We look forward to continuing this productive relationship.

If you have any questions, or require clarification of these comments, please feel free to contact Mark Miller, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

A handwritten signature in black ink that reads "Francis J. Crosson M.D." in a cursive script.

Francis J. Crosson, M.D.
Chairman