

June 15, 2016

Mr. Andrew Slavitt, Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
200 Independence Avenue, SW  
Room 445-G  
Washington, DC 20201

**RE: File code CMS-5517-P**

Dear Mr. Slavitt:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) **Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, proposed rule**. The proposed rule addresses implementation of provisions in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). In view of their competing demands, we especially appreciate your staff's thoughtful approach to this complex matter.

In this letter we comment on several issues raised in the proposed rule with an emphasis on its proposals for MIPS and APMs. We have assessed these proposals in light of the principles the Commission has developed over the past years on alternative payment models and performance measurement in Medicare. Our goal for alternative payment models is to encourage delivery system reform that results in beneficiaries' access to high quality health care services and a sustainable Medicare program. The Commission's basic principles for APMs, as set out in our June 2016 report to the Congress, 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.<sup>1</sup>
- 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.

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<sup>1</sup> Throughout this comment letter we have adopted the nomenclature used in the proposed rule (such as Advanced APM) even when it differs from that in MACRA, with the intent to make our comments as useful as possible to CMS.

The subsequent principles build from the first principle that incentive payments should be made only if the entity is successful in controlling cost, improving quality, or both. In other words, incentive payments would be available only for clinicians in entities that improved value for beneficiaries. We recognize that this principle departs from the MACRA legislation—incentive payments under MACRA are made to qualifying APM participants regardless of the entity's performance. However, this first principle derives from the Commission's long-held view that Medicare payments should not be dictated by the status of the provider but rather by the value of the service provided to the beneficiary.

In particular, we bring forth this principle here because we are concerned that the 5-percent payment incentive may drive entry into Advanced APMs but bring no real change to the health care delivery system. For example, the 5-percent incentive payment (and eventually higher updates) might outweigh the risk an entity faces even under some two-sided risk models. In that case, clinicians would not face a strong incentive to change their practice patterns. This could result in higher Medicare spending with little benefit to beneficiaries or taxpayers. We think it is important that performance be taken into account from the start; relying on the system to improve without a clear incentive to do so is not prudent. Although it could be argued that investment is needed at the start and then clinicians will change their practices for the better once clinicians are in Advanced APMs, similar strategies often have not worked in the past. Moreover, programs once started in Medicare are difficult to stop or alter even if they do not fulfill their original intended purpose, because they build constituencies that are dependent on them. Thus, our first principle is to only give rewards based on performance rather than mere participation in a particular model.

Our principles are designed to work together. For example, Advanced APM entities should receive regulatory relief from statutory requirements designed to protect against overuse only if they are at risk for total Part A and Part B spending for their attributed beneficiaries. Similarly, having a beneficiary population of sufficient size to detect changes in spending or quality is of particular importance when measuring total spending and the kinds of population-based outcome measures (such as avoidable hospitalizations) of greatest importance to beneficiaries and the program.

We comment on the following issues drawing on the principles we have developed.

- Technical aspects of Advanced APMs
- Inclusion of the Comprehensive Primary Care Plus Model (CPC+) and the Oncology Care Model (OCM) as Advanced APMs
- Appropriately measuring quality, resource use, clinical practice improvement activities, and advancing care information in MIPS while minimizing burden and not rewarding (or penalizing) insignificant differences in performance
- Defining physician-patient relationship categories
- Coordinating the requirements for MIPS and APMs to reduce burden on clinicians and preserve flexibility
- Exempting clinicians in MIPS APMs from certain MIPS requirements
- Criteria for Physician-Focused Payment Models

We hope that our comments will help CMS address these complex topics.

## **Advanced APMs**

MACRA creates incentives for clinicians to participate in Alternative Payment Models (APMs) designed to improve care coordination for Medicare beneficiaries and, thereby, theoretically control cost growth and improve quality. CMS proposes a set of Advanced APMs that meet the criteria enumerated in MACRA for APMs that allow clinicians to qualify for the incentive payment. Clinicians who participate to a significant extent in Advanced APM entities will receive a 5-percent incentive payment (computed based on the clinician's Part B fee schedule FFS revenue) each year they qualify from 2019 to 2024 and a higher update in 2026 and beyond. They also will be exempt from MIPS. CMS states that its goals are, among others, to "expand the opportunities for participation in APMs" and to "maximize participation in current and future Advanced APMs." The models proposed as Advanced APMs are:

- Next Generation ACO Model
- Medicare Shared Savings Program (MSSP) Track 2 and Track 3
- Comprehensive ESRD Care Model (Large Dialysis Organization arrangement)
- Oncology Care Model Two-sided Risk arrangement (available in 2018)
- Comprehensive Primary Care Plus (CPC+)

All but the CPC+ model are two-sided risk models.

One of the criteria for Advanced APMs in MACRA is that the model requires entities to be at "risk above a nominal amount." CMS proposes that "risk above a nominal amount" be defined conceptually as risk that is substantial enough to drive performance. CMS proposes to hold that an entity is at-risk if, when actual expenditures exceed expected expenditures, CMS can withhold payment, reduce payment rates, or require repayment. CMS proposes that to be at "risk above a nominal amount" the total potential risk must be at least 4 percent of expected expenditures.<sup>2</sup> CMS proposes a different definition of nominal risk for small clinician practices participating in certain Medical Home models.

### ***Technical aspects of Advanced APMs***

#### *Comment*

We broadly support the proposed rule's definition of nominal risk. We also support defining the set of Advanced APMs as models with two-sided risk. Many of these models conform to our principles of entities being at risk if actual Part A and Part B spending exceeds expected spending and being large enough to reliably detect changes in cost and quality. In keeping with our principles, we would also suggest that the models give the entity the ability to share savings with beneficiaries, that CMS extend certain regulatory relief, and that each entity assume financial risk and enroll its clinicians (as distinct from the clinicians holding the risk individually). Several of the models include these provisions, (e.g., the Next Generation ACO model has a reward for beneficiaries using in-network providers and extends certain regulatory relief).

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<sup>2</sup> There are also thresholds for marginal risk and minimum loss rate.

CMS sets as its goal maximizing participation in Advanced APMs. In contrast, our principles would lead to a smaller set of Advanced APMs with potentially fewer participants. However, participants in those models would have stronger incentives to change the delivery system. Whether to have a larger group of Advanced APM participants with weaker incentives, versus a smaller group of Advanced APM participants with stronger incentives is a key policy decision.

The Commission has considered this issue in the context of ACOs. Because four of the six initially proposed Advanced APMs are ACOs or similar to ACOs (we raise concerns with the remaining two Advanced APMs below), our logic on ACOs applies in the APM context as well. Our goal is for Medicare to design efficient ACOs that create real value for beneficiaries, the Medicare program and taxpayers—not to simply maximize the number of ACOs or to ensure that every provider can join an ACO.<sup>3</sup> Thus, CMS should not weaken ACO standards, or by extension, Advanced APM standards, just to increase participation. At the same time, the risk and reward should be significant enough to encourage clinicians to form high-performing APMs and take the difficult steps necessary to transform care delivery. Creating those conditions in each program—setting benchmarks, designing incentives, and measuring performance—is difficult and lessons being learned from ACO experience should be applied to Advanced APMs.

A crucial issue under the statute is determining if a clinician has a significant share of his or her revenue coming through an Advanced APM.<sup>4</sup> This share determines if the clinician is a Qualifying APM Professional (QP) which in turn determines if the clinician receives the 5-percent incentive payment and also if the clinician is exempt from MIPS. We support the proposal to use only potentially attributable beneficiaries (and their revenue) when computing the ratio of revenue coming through an Advanced APM entity to total revenue for the clinician.<sup>5</sup> We also support the concept proposed in the rule of evaluating clinicians in an Advanced APM entity as a group for the QP calculation. (Within this concept of evaluating the clinicians in an Advanced APM entity as a group, it may be preferable to only count clinicians who can be used for beneficiary attribution in the model. This could result in a higher ratio of revenue coming through the entity than if all clinicians—including specialists who are not used for attribution—were included.)

However, we do not support the proposal that the QP determination should have a significantly lower threshold when it is assessed by patient count rather than by revenue. In 2021, for example, the rule proposes that the threshold for revenue would be 50 percent and for patient count 35 percent. It would appear that the purpose of this lower threshold is to maximize Advanced APM participation, a goal we do not share given the absence of a strong connection between performance and reward under current law.

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<sup>3</sup> Medicare Payment Advisory Commission. 2015. Comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule entitled "Medicare shared savings program; Accountable care organizations proposed rule." Letter to the Administrator. February 2. <http://medpac.gov/documents/comment-letters/medpac-comment-on-cms-s-medicare-shared-savings-program-accountable-care-organizations-proposed-rule.pdf?sfvrsn=0>.

<sup>4</sup> The statute specifies the threshold for the percentage of a clinician's revenue coming through an Advanced APM to qualify as: 25 percent in 2019 and 2020, 50 percent in 2021 and 2022, and 75 percent in 2023 and thereafter.

<sup>5</sup> We commented on a similar issue in the MSSP benchmarking proposed rule.

### ***Inclusion of CPC+ and the Oncology Care Model (OCM) as Advanced APMs***

The rule includes a list of proposed Advanced APM models for 2019. An important aspect of each model, in our view, is the amount of guaranteed additional revenue that practices receive before they face any financial risk. The relationship between guaranteed additional payment and payment at risk is important because the signal for clinicians to improve their care processes and reduce unnecessary utilization must be strong enough to motivate change. Furthermore, models should not create additional incentives to overprovide services.

Two of the six models listed as Advanced APMs allow practices to receive a significant increase in payment from Medicare even if their performance remains constant. The first is CPC+ and the second is the Oncology Care Model (OCM). We discuss each below.

**CPC+ model.** The law includes as Advanced APMs models with more than nominal risk and medical home models that have been expanded under section 1115A(c)—but the CPC+ demonstration does not meet either of those criteria. However, the notice of proposed rule making (NPRM) proposes an exception for certain small practices participating in Medical home models that defines being at risk as “losing the right to all or part of an otherwise guaranteed payment or payments.” CMS’s justification for this exception is that small practices cannot take on large amounts of risk but still must have “more than nominal risk” to qualify as an Advanced APM. It is this proposed exception that would allow CPC+ to be an Advanced APM.

Under CPC+ (a CMMI demonstration), a limited number of primary care practices in specified geographic areas will receive additional payments from 2017-2021. Most of the new payments for practices is guaranteed, and only a minor share is a performance-based payment subject to adjustments based on cost and quality performance (Table 1). All of these payments are new revenue to the participating practices, and will be in addition to their FFS revenue.

**Table 1. Proposed CPC+ payment adjustments**

<b>Total monthly payment per beneficiary</b>	<b>Track 1</b>	<b>Track 2 (partial capitation)</b>
Average monthly care management fee	\$15.00	\$28.00
Performance-based payment	\$2.50	\$4.00

#### *Comment*

The proposed rule asserts that the amount of payment at risk in the CPC+ model is more than nominal. However, we note that the performance-based payment is the only one at risk, and it represents an additional payment to begin with. Whatever their performance, the CPC+ practices will continue to receive their traditional FFS payments as well as the monthly care management fees. In addition, receiving a 5 percent incentive payment on all fee-schedule revenue in addition to the monthly management fee would make any risk of losing the small performance-based payment less than nominal.<sup>6</sup>

<sup>6</sup> This is not to say that we do not support the aim of the CPC+ model. The Commission strongly supports increasing payments for primary care relative to payments for specialty care, given primary care’s key role in redesigning the

**Oncology Care Model.** OCM makes payments of \$160 per beneficiary per month to participating oncology practices for the six months following the initiation of chemotherapy. In the version of the model that qualifies as an Advanced APM, participating practices also face shared losses.

*Comment*

We reiterate a few concerns regarding the OCM.<sup>7</sup> First, practices will receive a significant increase in payments even if their quality and cost performance remains the same, which blunts the financial incentive to improve their practice patterns and goes against our first principle. Second, because the \$160 per beneficiary per month payment in OCM is large relative to the average per beneficiary oncology practice revenue, there is the potential for practices to increase the number of beneficiaries treated or the number of episodes per beneficiary (to the extent clinically possible). For these reasons, we do not believe that the OCM represents the same level of improvement over current payment methods as the other Advanced APMs.

**The Merit-based Incentive Payment System (MIPS)**

The Merit-based Incentive Payment System (MIPS) will make payment adjustments for clinicians who are not qualifying (or partial qualifying) APM participants.<sup>8</sup> MIPS combines parts of the Physician Quality Reporting System (PQRS), the Value Modifier (VM) Program, and the Medicare EHR Incentive Program into one single program. MIPS-Eligible Clinicians (ECs) will receive positive or negative payment adjustments based on their total MIPS performance. ECs will be measured on:

- Quality
- Resource use
- Clinical practice improvement activities
- Advancing care information

The payment adjustments under MIPS will start in 2019, and CMS proposes a process where clinicians would report relevant quality, clinical practice improvement activities, and advancing care information in 2018, based on the care they provide in 2017. The base MIPS payment adjustments will be budget neutral in 2019 at the national level, and the maximum negative

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delivery system. This includes redesigning primary care payment to include a care management fee, the option for partial capitation, and payment based on performance—all of which are present in CPC+. However, in our view additional revenue for primary care services should be funded from other sources within the fee schedule. The imbalance between payment for procedural services and payment for primary care services is fundamentally a result of mispricing in the fee schedule coupled with the ability of some clinician specialties to more easily increase the volume of the services they provide (and thereby their revenue from Medicare). CPC+ represents all new funding, and so does not address the core fee schedule imbalance.

<sup>7</sup> Medicare Payment Advisory Commission. 2015. Report to the Congress: Medicare and the health care delivery system. Washington, DC: MedPAC.

<sup>8</sup> “Partial-qualifying participant” is a statutory category encompassing participants in A-APMs that are within 5 percentage points of meeting the numerical threshold for the APM incentive payment. Partial-qualifying participants can elect to participate in MIPS if they choose to.

adjustment at the provider level will be -4 percent.<sup>9</sup> An additional \$500 million per year from 2019-2024 is available for high performers.

We discuss each MIPS performance category and also physician-patient-relationship categories in detail below.

### *Quality*

The quality component of MIPS as defined in the NPRM retains many parts of the current PQRS and VM. CMS is proposing that MIPS-ECs self-report six quality measures (versus the nine measures currently required under PQRS). One of the six measures must be an outcome measure and one must be a cross-cutting measure. The final approved measures will be released in November, but the proposed list includes 268 possible measures, about a quarter of which are intermediate outcomes or outcome measures. Clinicians can receive additional credit for submitting outcome and high priority measures, and for reporting quality measures through certified EHRs. The MIPS quality category will also include two or three claims-based population-based measures calculated by CMS (readmissions, avoidable hospitalizations from chronic conditions, and avoidable hospitalizations from acute conditions), depending on group size.

To calculate the total quality performance category score, each of these eight or nine clinician measure results will be scored up to 10 points. To determine the number of points the clinician's measure results should receive, CMS will calculate an array of benchmarks based on performance during the baseline period, dividing baseline period measure performance into deciles. Then, an EC's actual measure rates will be compared to the benchmarks to determine the number of points that should be assigned for the quality component of their MIPS score.

### *Comment*

The Commission supports CMS's continued focus on outcome measures. Therefore, we support the proposal to require clinicians to be scored on at least one outcome measure, and incentives for clinicians to submit additional outcome measures and other high priority measures (patient safety, appropriate use, efficiency, patient experience and care coordination). But clinicians still will have about 200 non-outcomes measures from which to choose for the other quality measures. The proposed rule explains that these measures, even measures that have topped out performance, are needed to accommodate differences in specialty and practices. The Commission maintains that many of these measures weakly correlate with health outcomes, measure basic standards of care, can reinforce the incentive to provide low-value care and reinforce "silos" by specialty.

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<sup>9</sup> The total MIPS adjustments will be scaled to be budget-neutral. Thus, for example, if many fewer clinicians are eligible for the upward adjustment than the downward adjustment, the money available for upward adjustments would be distributed across a smaller pool of clinicians and the adjustment would be greater than 4 percent. The maximum upward adjustments are capped at 3 times the maximum negative adjustment and thus the base adjustment cannot exceed 12 percent in 2019. The additional performance adjustment is capped at an additional 10 percentage points, and so the maximum in 2019 is technically 22 percent.

Within the confines of MACRA, The Commission urges CMS to improve the value of the measure set by removing: topped out measures, duplicative measures (e.g., *controlling high blood pressure* and *hypertension: improvement in blood pressure*), measures of basic standards of care (e.g., *documentation of current medications in the medical record*), and the nine measures for children and adolescents, which are only marginally relevant to the Medicare population (i.e., only about 2,500 Medicare beneficiaries are under the age of 19).

The intent of MIPS is to adjust a percentage of clinician payments based on performance and outcomes. This requires MIPS to distinguish between high- and low-performing clinicians. When payment is tied to self-reported quality measures, clinicians have an incentive to select and report measures on which they perform well, especially when they have a large number of measures from which to choose.

Also, clinicians are not likely to select certain high priority measures because of unfavorable results, such as overuse measures (e.g., imaging for low-back pain), or because of the effort required to collect the measure (e.g., CAHPS). Self-reporting will tend to produce compressed ranges for measures that are scored in MIPS, which means clinicians will receive different incentive payments based on very small gradations in performance. This highlights the limitation of using self-reported measures to distinguish between high- and low-performing clinicians.

An alternative to the proposed design of MIPS would be for CMS to establish a measure set that the agency could calculate on behalf of clinicians using claims, Qualified Clinical Data Registry (QCDR) data, and potentially other clinical data that clinicians report with their claims or through EHRs. These claims-based measures should include some measures that apply to a broad scope of clinicians, and also some overuse measures (e.g., imaging for non-specific low back pain). CMS also could include measures from other settings, such as inpatient hospitals because some clinicians, such as hospitalists, may be best measured through hospital quality measures (e.g., hospital readmissions). As in the current VM program, clinicians would receive reports with their measure results. This approach could reduce clinician reporting effort. CMS also would be able to understand overall (local and national) provider performance on certain measures, because all measures would be calculated for each clinician. CMS also would have more complete information to remove topped-out measures, and to prioritize measures based on performance gaps.

### ***Resource use***

The rule proposes using some existing measures for the resource use performance category of MIPS. Those measures include: total per capita costs, Medicare Spending Per Beneficiary (MSPB)<sup>10</sup>, and some episode-based measures. (The four condition-specific per capita cost measures would not be used.) All measures would be adjusted for geographic payment rate differences and beneficiary risk factors. In addition, the rule proposes to apply a specialty adjustment to the total per capita cost measure, retire the specialty adjustment currently applied to the MSPB measure, and asks for comments on whether to adjust episode-based measures by

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<sup>10</sup> MSPB measures all Medicare Part A and Part B spending for services provided to beneficiaries during episodes spanning three days prior to an inpatient hospital admission through 30 days after discharge.



specialty. To ensure that the individual resource use measures selected are reliable, the rule proposes to use a 0.4 (or moderate) reliability threshold,<sup>11</sup> plus a minimum of 20 cases for all three types of measures.<sup>12</sup>

*Comment*

The Commission has supported the use of both per capita and episode-based measures (appropriately standardized and risk adjusted) for examining physicians' resource use.<sup>13,14</sup> Therefore, we support CMS's proposals to:

- use both the total per capita and MSPB cost measures for MIPS,
- continue adjusting for geographic payment rate differences and beneficiary risk factors, and
- remove specialty adjustment from the MSPB measure.

We do not support applying a specialty adjustment to the per-capita cost measure, and oppose adjusting for specialty for any of the resource use measures. The Commission maintains that data used in resource use measures should be risk adjusted to ensure appropriate comparisons. However, we have noted that "it would be critical that the program not adjust away any spending differences that Medicare should be concerned about, such as spending differences correlated with differences in the supply of specialists."<sup>15</sup> By design, applying specialty adjustment following beneficiary risk adjustment rewards specialties that provide more expensive treatments that are not explained by patient differences and penalizes specialties with more efficient practice patterns.

The Commission has raised concerns about the reliability of measures applied to individual and small group clinicians, but also has a policy principle that resource use measures should ideally be applied to both individual and group practices.<sup>16,17</sup> We support CMS's proposal of a minimum of

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<sup>11</sup> Reliability in research is an assessment of the extent to which a measure produces consistent results; in other words, for MSPB, it quantifies the extent to which variation in the measure result is due to variation in hospital episode spending, rather than random variation in the sample of cases observed. There are multiple tests of reliability (e.g., quintile rank stability); a typical reliability test is based on the amount of within-clinician variability in spending per hospital episode, the across clinician variability in spending per hospital episode, and the number of episodes attributed to each clinician.

<sup>12</sup> The 0.4 reliability threshold standard means that the majority of MIPS-eligible clinicians and groups who meet the case minimum required for scoring under a measure have measure reliability scores that exceed 0.4.

<sup>13</sup> Medicare Payment Advisory Commission. 2013. Comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule entitled "Medicare Program; Revisions to payment policies under the physician fee schedule, clinical laboratory fee schedule, and other revisions to Part B for CY 2014." Letter to the Administrator. August 30. [http://medpac.gov/documents/comment-letters/083013\\_medpac\\_partb\\_comment.pdf?sfvrsn=0](http://medpac.gov/documents/comment-letters/083013_medpac_partb_comment.pdf?sfvrsn=0).

<sup>14</sup> Medicare Payment Advisory Commission. 2009. Report to the Congress: Improving incentives in the Medicare program. Washington, DC: MedPAC.

<sup>15</sup> Medicare Payment Advisory Commission. 2009. Report to the Congress: Improving incentives in the Medicare program. Washington, DC: MedPAC.

<sup>16</sup> Medicare Payment Advisory Commission. 2013. Comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule entitled "Medicare Program; Revisions to payment policies under the physician fee schedule, clinical laboratory fee schedule, and other revisions to Part B for CY 2014." Letter to the Administrator. August 30. [http://medpac.gov/documents/comment-letters/083013\\_medpac\\_partb\\_comment.pdf?sfvrsn=0](http://medpac.gov/documents/comment-letters/083013_medpac_partb_comment.pdf?sfvrsn=0).

<sup>17</sup> Medicare Payment Advisory Commission. 2009. Report to the Congress: Improving incentives in the Medicare program. Washington, DC: MedPAC.

20 cases for each resource use measure along with a moderate reliability threshold for the majority of clinicians who meet the minimum. We encourage CMS—once MIPS is underway—to also assess the stability of clinicians’ scores year-to-year, release detailed measure performance data publicly, and consider modifications to minimum thresholds as appropriate.

The Commission has called for CMS to develop a Medicare-specific episode grouper.<sup>18,19,20</sup> Episode groupers are software packages that use clinical logic to assign claims to clinically distinct episodes of care—a series of clinically related health care services over a defined time period, such as all claims related to a patient’s diabetes condition or knee replacement. Episode-focused comparisons of clinicians to their peers provide more detailed and thus more actionable information than analyses that look at all types of care provided in a clinician’s practice. Because episode groupers create measures of distinct conditions or procedures, packages typically consist of hundreds of episode types to capture the breadth of health care services.

However, we are concerned about the state of readiness of the two episode grouper methods that CMS is proposing (Method A and Method B). More than six years have passed since the agency awarded contracts to assess episode grouper methodologies.<sup>21</sup> To date, only a total of 41 episodes are available for use in the first year of MIPS. Furthermore, these 41 episodes are relatively new and untested; none have been used for adjusting payment, and 20 have never been used for clinician feedback. In addition, the 41 episodes were developed by two contractors using separate, incompatible methodologies. In fact, the two contractors developed competing episodes for three conditions and events—kidney and urinary tract infection, hip replacement or repair, and knee arthroplasty or repair—so there is actually a total of just 38 unique episodes. Of greatest concern is that neither methodology may prove to be an acceptable foundation for building a complete set of episodes going forward. We have concerns about both the Method A and Method B approaches, including that Method B has never been subject to an independent evaluation.

The Commission has described a set of policy principles for clinician resource use measurement that we encourage CMS to adopt in implementing MIPS.<sup>22</sup> The first principle calls for CMS to adopt a measurement methodology that is transparent. Assessing clinicians’ performance using separate, incompatible methodologies, including duplicate episodes for the same procedure or condition, presents an unnecessary obstacle to understanding the episode grouping methodology. We recognize that MACRA imposes a tight timeline for implementing resource use measurement.

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<sup>18</sup> Medicare Payment Advisory Commission. 2005. Report to the Congress: Medicare payment policy. Washington, DC: MedPAC.

<sup>19</sup> Medicare Payment Advisory Commission. 2008. Comment on the Centers for Medicare and Medicaid Services’ (CMS) “Development of a Plan to Transition to a Medicare Value-Based Purchasing Program for Physician and Other Professional Services: Issues Paper.” Letter to Tom Valuck. December 19. <http://medpac.gov/documents/comment-letters/ValuckLetter2.pdf?sfvrsn=0>.

<sup>20</sup> Medicare Payment Advisory Commission. 2009. Report to the Congress: Improving incentives in the Medicare program. Washington, DC: MedPAC.

<sup>21</sup> CMS subsequently awarded a contract for developing a Medicare-specific episode grouper (Method A), and a few years later awarded a second contract (Method B). The same contractor that developed Method B advised CMS on selecting amongst the field of competitors in the original assessment, and performed the evaluation of Method A.

<sup>22</sup> Medicare Payment Advisory Commission. 2009. Report to the Congress: Improving incentives in the Medicare program. Washington, DC: MedPAC.

However, given the discretion the law grants the Secretary on episode-based measures, the status of the current Medicare-specific episode groupers, and concerns about the ability of either Method A or B methodology to serve as a foundation for completing a full set of episodes, we urge the Secretary to delay using episodes in MIPS to allow sufficient time to determine a single, coherent episode-grouping methodology. This Medicare episode-grouper method must support the creation of both procedure episodes and acute and chronic condition episodes and should acknowledge that Medicare beneficiaries often have multiple conditions.<sup>23</sup> The choice of episode grouper methodology should not be restricted to Method A and B alone as neither may be the best option for Medicare. CMS should consider the possibility of tailoring other existing episode groupers to construct the Medicare-specific grouper. Given the inherent complexity of episode grouper methodologies, CMS's method then should be subject to an independent evaluation that includes opportunity for clinical and other stakeholder input.

### ***Clinical practice improvement activities (CPIA)***

MIPS adds a new performance category, clinical practice improvement activities, to clinician payment incentives. A portion of clinicians' MIPS scores will be based on clinicians attesting that they have activities in place that aim to improve care coordination, beneficiary engagement, and patient safety. The current proposal includes 90 activities that clinicians can choose to report. Some activities will be weighted more highly than others, so if clinicians attest to those activities they will receive more points. Clinicians can receive automatic credit for the category if they participate in APMs or Patient-Centered Medical Homes.

### ***Comment***

CMS, as required in MACRA, must score clinicians on their clinical practice improvement activities as a part of MIPS. The Commission questions the value of the clinical practice improvement activities category because evidence on whether these activities lead to improved health outcomes is limited. Also, clinicians will be scored on a set of activities on which they opted to report because they expected to perform well. Therefore, many clinicians will likely receive full credit and there may be little to no distinction between high- and low-performing clinicians in this category.

### ***Advancing care information***

The advancing care information category replaces the Medicare EHR Incentive Program (also known as meaningful use). Under the American Recovery and Reinvestment Act of 2009, eligible professionals and hospitals were able to receive incentive payments for the meaningful use of certified electronic health record technology from 2011 through 2014 through either Medicare or Medicaid. Under the Medicare EHR incentive payment program, up to \$44,000 was available to clinicians who demonstrated meaningful use. Beginning in 2015, eligible professionals who do not successfully demonstrate EHR meaningful use are subject to a payment penalty, starting at 1

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<sup>23</sup> We are concerned that Method B focuses on procedure episodes and, according to the proposed rule, creates "measures [that] examine services independently, regardless of other episodes a patient may be experiencing, and episodes do not interact with each other." This might not support the construction of a comprehensive set of episodes.

percent and increasing each year that an eligible professional does not demonstrate meaningful use, to a maximum of 5 percent.

The advancing care information proposed requirements revise Meaningful Use Stage 3 requirements, which were planned for 2018, to reduce reporting effort, and emphasize interoperability, information exchange, and security measures.

CMS proposes adding to the current meaningful use program (in operation until 2019) and the advancing care information category of MIPS a required attestation that clinicians have cooperated with the surveillance of certified EHR technology under the Office of the National Coordinator for Health Information Technology (ONC) Health Information Technology (HIT) Certification Program. CMS also proposes adding an attestation requirement that an eligible clinician, eligible hospital or critical access hospital has not knowingly and willfully taken action (such as to disable functionality) to limit or restrict the compatibility or interoperability of certified EHR technology.

#### *Comment*

CMS, as required in MACRA, must score in MIPS a clinician's advancing care information activities based on current meaningful use requirements. The Commission is not convinced that these activities benefit the patient and improve health outcomes. We understand that CMS is trying to minimize the burden for clinicians by removing two meaningful use objectives and their measures, *Computerized Physician Order Entry* and *Clinical Decision Supports*—both of which are “topped out.” However, the Commission has long been concerned with the overall approach in meaningful use and advancing care information of paying clinicians to purchase an EHR, and requiring clinicians to report information demonstrating its use. A better approach, in the Commission's view, is to ensure that the payment system itself creates a business case for the use of EHRs and encourages vendors to market products that improve care and interoperability.

The Commission supports CMS's proposal to require clinicians to cooperate with the surveillance of certified EHRs, especially if the surveillance advances the connectivity of electronic health information and interoperability of health information technology. We also support the attestation that providers have not willingly and knowingly limited the interoperability of EHRs. We also encourage the Inspector General to investigate parties (vendor or providers) who knowingly or willingly block HIT compatibility.

#### ***MIPS summary comments***

Both the Congress, in drafting MACRA, and CMS, in its proposed rules implementing it, face a trade-off in assessing individual clinicians' performance. Clinician-reported quality measures, like those used in PQRS (and proposed for use in MIPS) are often process measures, many of which are duplicative, have topped-out performance, or measure clinically insignificant care. In addition, clinicians' ability to choose which measures to report raises equity concerns across clinicians. Population-based outcomes measures, which the Commission finds of higher value, show less reliability at the individual clinician level, and clinicians argue that they did not assume responsibility for the entire continuum of care that determines outcomes.

Resource use is critical. However, of the measures proposed in the rule, only two (total per capita cost and MSPB) are acceptable. The episode measures do not have the level of maturity one would expect for use in adjusting payments and neither of the two methods used may prove to be a viable option for creating a comprehensive set of episodes. The other two categories (clinical practice improvement activities and advancing care information) are new, but as proposed likely will follow a ‘check-the-box’ formula and allow clinicians to achieve very high scores without commensurate improvement in the care they provide.

Thus, the likely overall result of MIPS is that clinicians will be scored on: a set of compressed quality measures on which they opted to report because they expected to perform well, resource use measures that include episodes that do not cover a meaningful amount of clinician’s practice patterns, and two other categories in which many clinicians are likely to have high scores. Therefore, MIPS will likely score clinicians and adjust their payments based on small gradations of performance on measures that are unlikely to capture true value.

An alternative approach, which requires fundamental change, offers more promise. Congress could consider in future legislation to aggregate population-based outcome measures across providers in a local area sharing the same hospitals and clinicians. The Medicare program then could assess performance across all FFS clinicians in the local area, and consider whether modest payment adjustments would be appropriate for those clinicians considered as a group.

Within MACRA, there is a provision which would allow virtual groups for MIPS assessment, and we suggest CMS move quickly to implement that provision. Aggregating into virtual groups results in a larger number of cases for performance measurement and could encourage movement towards more organized systems—both goals the Commission supports.

If individual-level clinician performance measurement is pursued, then CMS should ensure that measures are appropriately applied to this population by setting thresholds for reliability and for a minimum number of cases for solo practitioners. In addition, the Medicare program could move to claims-calculated measures, and focus on clinicians whose performance on population-based outcomes measures and resource use shows them to be significant or persistent outliers compared to their peers.

MACRA policies that encourage quality measurement using EHRs and QCDRs could contribute to evaluation of a population-based measure set at an individual clinician, group, or market area level; for example, clinical data could be extracted from standardized EHRs or added to claims.

### **Physician-patient relationship categories**

Section 1848 of MACRA requires the development of patient relationship categories and codes that define the relationship and responsibility of a clinician to a patient at the time of service. As of January 1, 2018, clinicians must begin including the new patient relationship category codes on claims, as well as the National Provider Identifier (NPI) of the ordering physician or practitioner (if different from the billing physician or practitioner). The Secretary then can use these patient relationship codes to attribute patients to clinicians to compare resource use and, if so, must use

“per patient total allowed charges for all services under Parts A and B” and other measures deemed appropriate.

MACRA describes several types of patient relationship categories, such as a physician or practitioner who:

1. considers him or herself to have the primary responsibility for the general and ongoing care for the patient over extended periods of time;
2. considers him or herself to be the lead physician or practitioner and who furnishes items and services and coordinates care furnished by other physicians or practitioners for the patient during an acute episode;
3. furnishes items and services to the patient on a continuing basis during an acute episode of care, but in a supportive rather than a lead role;
4. furnishes items and services to the patient on an occasional basis, usually at the request of another physician or practitioner; or
5. furnishes items and services only as ordered by another physician or practitioner.

Based on the categories from MACRA, CMS proposed the following patient relationship categories on its website:

1. clinician who is the primary health care provider responsible for providing or coordinating the ongoing care of the patient for chronic and acute care;
2. clinician who provides continuing specialized chronic care to the patient;
3. clinician who takes responsibility for providing or coordinating the overall health care of the patient during an acute episode;
4. clinician who is a consultant during the acute episode; and
5. clinician who furnishes care to the patient only as ordered by another clinician.

*Comment*

We welcome efforts by CMS to use claims to gather more information about clinicians’ relationships to patients. We agree with CMS that differentiating between acute and chronic care could be helpful in constructing these patient relationship codes. However, we are concerned that clinicians are frequently unaware of the extent to which other clinicians are involved in the care for the patients they treat, and thus they will fail to report these new codes or report values that are inaccurate. In addition, some of the proposed categories appear to overlap, which could complicate the reporting process. For example, it is unclear whether a clinician who is caring for a patient during an acute exacerbation of an underlying chronic illness would report his or her relationship with the patient under the first or third proposed category.

Although we recognize that CMS is required by law to develop and collect data on patient relationship codes, we are concerned about the poor quality of data that CMS is likely to receive from these codes. Thus, we suggest that CMS attempt to validate reported relationship codes by comparing these data to existing patient attribution methods and other information included on claims and in administrative data. For example, claims in which clinicians indicate that they provided primary or specialty care through a patient relationship code could be compared to

specialty information on the claim and enrollment information from the Provider Enrollment, Chain, and Ownership System (PECOS). The results of this evaluation could be used to modify the patient relationship codes and conduct outreach to clinicians to help them report accurately.

Further, we encourage CMS to implement the provision in Section 1848 of MACRA that requires the billing practitioner to report the NPI of the ordering practitioner on the claim if the ordering practitioner is different than the billing practitioner. CMS currently requires such reporting on claims for diagnostic tests but not for many other services. For example, a claim from a specialist for an office visit or surgical procedure does not indicate whether another practitioner referred the patient for the visit or procedure. Such reporting could help CMS identify who initiated an episode of care. It also could assist CMS in examining aberrant practice patterns, such as high use of certain surgical procedures.

We also suggest that CMS require practitioners who bill for two types of services to identify those services on claims using a modifier:

- Services that are billed by clinicians who do not personally perform them (“incident to” services).
- Certain services that are ordered and performed by the same provider (self-referred services).

The Office of Inspector General (OIG) has concluded that incident-to services may be vulnerable to overuse and may place beneficiaries at risk of receiving services that do not meet standards of care.<sup>24</sup> Incident-to services are billed by clinicians but performed by others; for example, a physical therapy service that is billed by a physician but performed by a physical therapist. Based on a review published in 2009, OIG found that unqualified non-clinicians performed 21 percent of incident-to services (they lacked the necessary licenses, certifications, credentials, or training). Medicare claims do not identify incident-to services. The OIG recommended that CMS require clinicians to indicate these services on claims to help the agency ensure that they are being performed by non-clinicians with appropriate qualifications. In addition, to further strengthen Medicare’s ability to monitor incident-to services, we encourage CMS to require that claims for these services include the NPI of the person who performed the service if that individual has his or her own NPI.

In three reports, the Government Accountability Office (GAO) found that the financial incentives for self-referring providers were likely a major factor driving the increase in referrals for advanced imaging and anatomic pathology and the use of intensity-modulated radiation therapy for prostate cancer.<sup>25,26,27</sup> In each report, GAO recommended that CMS require providers to indicate on claims

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<sup>24</sup> Office of Inspector General, Department of Health and Human Services. 2009. *Prevalence and qualifications of nonphysicians who performed Medicare physician services*. OEI-09-06-00430. Washington, DC: OIG.

<sup>25</sup> Government Accountability Office. 2013. *Higher use of costly prostate cancer treatment by providers who self-refer warrants scrutiny*. GAO-13-525. Washington, DC: GAO.

<sup>26</sup> Government Accountability Office. 2012. *Higher use of advanced imaging services by providers who self-refer costing Medicare millions*. GAO-12-966. Washington, DC: GAO.

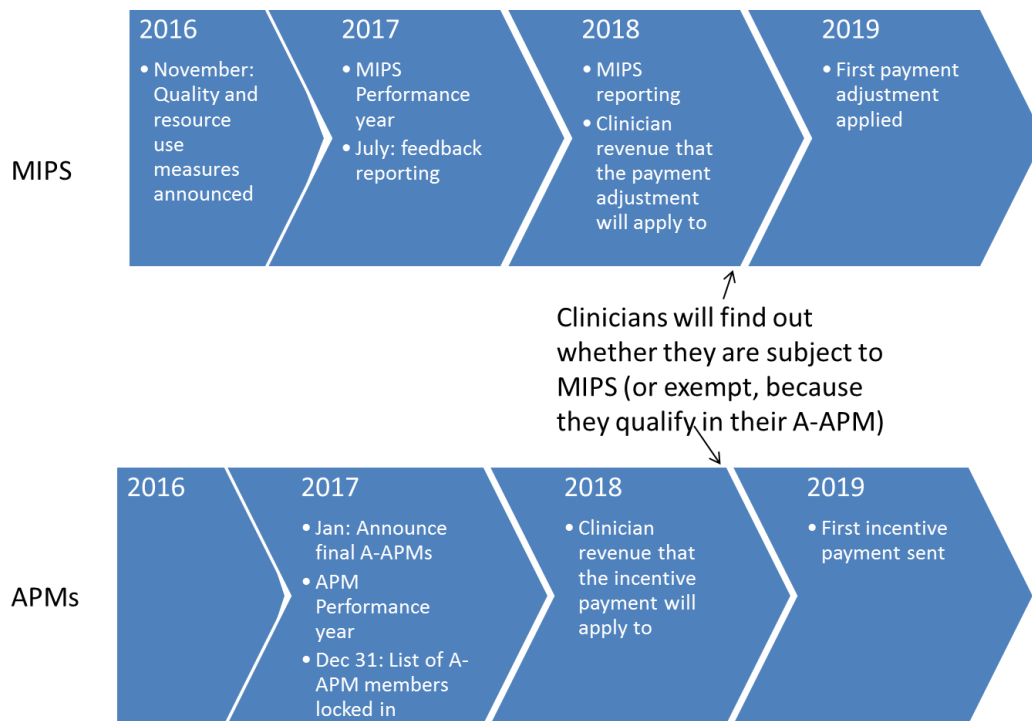
<sup>27</sup> Government Accountability Office. 2013. *Action needed to address higher use of anatomic pathology services by providers who self-refer*. GAO-13-445. Washington, DC: GAO.

whether or not these types of services were self-referred. CMS could use this information to examine the prevalence of self-referral and identify services that may be inappropriate or potentially harmful to beneficiaries. For example, CMS could perform targeted audits of self-referring providers who perform an above-average number of biopsy procedures to ensure they are appropriate.

### Coordinating requirements of MIPS and APMs

The MACRA statute causes a timing issue for clinicians who are in Advanced APMs. CMS proposes to announce the Advanced APMs about one year ahead of the date when the clinician would have to be on the APM participant list to qualify for an incentive payment. However, clinicians will not know if they are subject to MIPS or exempt until after they would have had to report for MIPS purposes. This is because they not only have to know that they are participating in an Advanced APM but also if they are a QP (and hence exempt from MIPS) as discussed on page four of this letter. CMS proposes to use data from 2017 to determine if clinicians are QPs, which means the result will not be known until sometime in 2018 (Figure 1).

**Figure 1. Relevant dates for the first MIPS and APM year, 2016 – 2019**



Note: A-APM: Advanced Alternative Payment Model.



### ***MIPS APMs***

In part to address concerns about MACRA timing issues that could require clinicians in Advanced APMs to have to report twice (once for their specific APM requirements and again for the MIPS requirements), CMS, proposes to create a new category of APMs, called MIPS APMs. This new category would encompass Advanced APMs but would also include others as well (see Appendix A). Including clinicians in APMs other than Advanced APMs (such as those in the Bundled Payment for Care Improvement model) would alleviate concerns about duplicative reporting for these clinicians as well (since they are already reporting quality and being assessed on cost performance). CMS proposes that MIPS APM clinicians would receive a MIPS score based on a subset of MIPS categories (advancing care information and clinical practice improvement activities).

### ***Comment***

We appreciate CMS's effort to address potential overlap and ensure that clinicians know what they need to do to be on the MIPS or APM path. The MIPS APM designation is one way to address the potential duplicate reporting and measurement facing clinicians. But as CMS mentions, because the potential performance score for clinical practice improvement activities and advancing care information is over 100 percent, it may be easier for clinicians to perform well on these categories than in the quality and resource use categories. Therefore, under CMS's proposal, clinicians in MIPS APMs could disproportionately receive MIPS bonuses, simply because they do not have quality or resource use scores.

We support the alternative formulation discussed in the rule that clinicians in MIPS APMs be held harmless for the purposes of MIPS scoring, unless they report all MIPS categories and elect to be measured. This would provide greater equity across all clinicians receiving MIPS adjustments than CMS's proposal.<sup>28</sup>

### **Criteria for Physician-Focused Payment Models**

MACRA establishes another pipeline for the development of potential APMs through the Physician-focused Payment Model Technical Advisory Committee (PTAC). The PTAC was chartered in January 2016, and the Secretary of HHS has a statutory deadline of November 1, 2016 to establish criteria for Physician-Focused Payment Models (PFPMs) that could be used by the PTAC in its review of models. Models reviewed by the PTAC and submitted to the Secretary would then go through the standard CMMI vetting process for models, before they would be considered to be APMs.<sup>29</sup> In this NPRM, HHS sets out the following proposed criteria for PTAC to use in reviewing PFPMs:

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<sup>28</sup> Our suggestion is analogous to the treatment of partial qualifying Advanced APM participants, who are held harmless for MIPS but can elect to be measured on the MIPS categories if they choose.

<sup>29</sup> CMMI released its Model Design Factors (that it uses to assess whether to test a model) in the MACRA Request for Information ([innovation.cms.gov/Files/x/rfi-websitepreamble.pdf](http://innovation.cms.gov/Files/x/rfi-websitepreamble.pdf)).

(1) Incentives: Pay for higher-value care.

- Value over volume: Provide incentives to practitioners to deliver high-quality health care.
- Flexibility: Provide the flexibility needed for practitioners to deliver high-quality health care.
- Quality and Cost: Are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.
- Payment methodology: Pays APM Entities with a payment methodology designed to achieve the goals of the PFPM Criteria. Addresses in detail through this methodology how Medicare, and other payers if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the Physician-Focused Payment Model cannot be tested under current payment methodologies.
- Scope: Aim to either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM entities whose opportunities to participate in APMs have been limited.
- Ability to be evaluated: Have evaluable goals for quality of care, cost, and any other goals of the Physician-focused Payment Model.

(2) Care delivery improvements: Promote better care coordination, protect patient safety, and encourage patient engagement.

- Integration and Care Coordination: Encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the Physician-Focused Payment Model.
- Patient Choice: Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.
- Patient Safety: Aim to maintain or improve standards of patient safety.

(3) Information Enhancements: Improving the availability of information to guide decision-making.

- Health Information Technology: encourage use of health information technology to inform care.

*Comment*

The PTAC can play an important role in developing new APMs by ensuring that clinicians and other stakeholders have an opportunity to suggest models to CMS that could improve care or reduce cost for Medicare beneficiaries. Ideas for innovative models can (and should) come from all quarters.

The Commission supports HHS's proposed criteria for PTAC, and suggests a few additional considerations. First, the model design should strive to not further fragment care delivery (by focusing on specific specialties or sites of care without consideration of the continuum of health care delivery). Second, entities in the models should be large enough to detect changes in spending and outcome measures. Third, models should mitigate the risk of excess spending (perhaps by limiting guaranteed additional payments), or ensuring a balance between guaranteed payment and performance-based payment. And fourth, it may be particularly helpful to ensure that there are sufficient models addressing vulnerable and underserved beneficiary populations.

### **Conclusion**

The Commission appreciates the opportunity to comment on the proposed rule and is encouraged by the direction CMS is taking. 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." The signature is written in a cursive, flowing style.

Francis J. Crosson, M.D.  
Chairman

## Appendix A. MIPS APMs

CMS defines MIPS APMs as those having: a participation agreement with CMS, a participation list with MIPS-eligible clinicians, and where the APM bases payment on performance on quality or cost.

The group of MIPS APMs can be viewed as an intermediate step between all APMs and Advanced APMs. CMS is careful to state in the NPRM that not all Advanced APMs will necessarily be MIPS APMs. However, based on the preliminary list of Advanced APMs for 2019, it appears that MIPS APMs are a subset of all APMs, and that the Advanced APMs are a subset of MIPS APMs.

