June 27, 2016

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

RE: CMS-5517-P, 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

Dear Acting Administrator Slavitt:

The Center for Health Policy at The Brookings Institution, with support from the Schaeffer Initiative for Innovation in Health Policy, a partnership between Brookings and the University of Southern California, welcomes the opportunity to comment on the Centers for Medicare and 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.** We appreciate the opportunity to provide comment on the proposed rule, which addresses the implementation of provisions of MACRA.

We applaud the efforts CMS has taken to solicit and respond to feedback particularly toward the proposed rule. We believe the currently proposed rule moves Medicare physician payment in the right direction, and we offer three suggestions to further improve MACRA implementation by better supporting providers' pipeline to APMs.

MACRA established incentives intended to spur greater provider participation in APMs that meet certain qualifying criteria. As a reward for meeting these conditions, providers will receive an automatic 5% bonus for the first six years of the program and, from 2026 onward, a base rate increase three times as much as providers in MIPS -- .75% versus .25%. Since, unlike MIPS, the Advanced APM track is not budget neutral, it offers the real chance to drive cost savings. However, CMS estimated in the proposed rule that as few as 4% of Medicare physicians may qualify into the Advanced APM track in its first year.

We suggest three ways in which CMS can further achieve its stated goal to "expand the opportunities for participation in APMs" by better supporting providers' transition under MACRA. These suggestions are to: 1) identify ways to increase the number of existing Medicare APMs that qualify as Advanced APMs; 2) establish a multi-year plan for new models that begins with initial minimal risk and grows to require more risk over time; and 3) allow eligible clinicians to qualify either as individuals or as a part of an APM Entity.

1. ***Identify ways to increase the number of existing Medicare APMs that qualify as Advanced APMs.***

MACRA outlines that under qualifying APMs "payments are made under arrangements in which…certified EHR technology is used." As is done for each of the three criteria for Advanced APM qualification, the proposed rule clarifies that this determination is made based upon the model, not

upon the APM entity. In other words, when participating in APMs that do not contractually require CEHRT, the provider's CEHRT usage is immaterial to qualification into the Advanced APM program. Admittedly, this basis of qualification is not only more easily measurable but also provides APM Entities with the certainty that their APM qualifies and is not subject to their more uncertain year-by-year performance. However, this remains a problem particularly for participants in the 15 existing Medicare APMs that fail to meet this criterion.

Among the existing Medicare APMs excluded are the widely implemented Bundled Payments for Care Improvement (BPCI) Initiative models and the Comprehensive Care for Joint Replacement (CJR) model. These exclusions are acutely felt among specialists, for whom bundled payments represent a significant share of their collective APM participation to date.

We suggest that the proposed rule be modified so as to provide provisional approval of the CEHRT criterion to current participants in existing APMs. One option would be to provide provisional approval of the CEHRT for those meeting a newly proposed APM Entity CEHRT usage threshold in Years 1 and 2. This would allow time for the models to be updated so that participation contractually requires CEHRT usage and, thereafter, meets the Advanced APM CEHRT use criteria.

The second option would be to expand the exception given to the Medicare Shared Savings Program, which passes the CEHRT usage requirement because it ties payment to CEHRT use (along with the other 32 quality measures included in the model). Advanced APM qualification could then be earned if CEHRT usage is one of several performance measures tied to payment. This would still require a period of provisional approval for current participants in existing models to qualify as Advanced APMs for Years 1 and 2 while the models are updated, ensuring a smoother transition into the Advanced APM track for participants in existing APMs than if they are excluded in the initial years.

Another criterion that excludes a number of existing Medicare APMS, and thereby their participants, is the criterion that qualifying Advanced APMs must base payment on quality measures similar to those in MIPS. Here again, BPCI and other models are excluded from the Advanced designation because their payments are not expressly tied to quality metrics. Yet, BPCI and other models have been evaluated and monitored with respect to quality metrics, and many participants may perform well enough on these measures if they were required of them.

We suggest that the proposed rule be modified to allow provisional approval of the quality metrics criterion to current participants in existing APMs. Provisional approval of the quality metrics criterion would establish a newly proposed APM Entity quality performance threshold in Years 1 and 2, above which providers could earn Advanced APM program qualification based upon their performance. Those that do not meet the new APM Entity thresholds in Years 1 or 2 would instead be judged under MIPS. This would allow time for the models to be updated so as to contractually tie payment to similar-to-MIPS metrics. After this provisional time period, no Entities participating in APMs that continue to lack ties to quality metrics would qualify.

2. ***Establish a multi-year plan for new models that begins with initial minimal risk and grows to require more risk over time.***

MACRA's third criterion requires that all qualifying APMs require that participants accept "nominal financial risk." The proposed rule requires a strict standard for nominal financial risk, as measured in three ways:

- **Marginal Rate,** or the share of potential losses for which that APM entity would have to pay back, must be at least 30%;
- **Minimum Loss Ratio**, or the threshold as a percent of expected expenditures above which providers would begin sharing in losses, must be no greater than 4%; and
- **Total Risk,** or the maximum total as a percent of total expected expenditures, must be at least 4%.

Many provider organizations have criticized this definition as being too narrow and restrictive for most physicians, as it neglects upfront costs to transforming practices and has high benchmarks. Many providers may need time and will have to invest substantial resources in order to transform their delivery. Conversely, CMS is concerned about paying out benefits without providers' assumption of risk that may generate cost savings.

While this seems to be an either-or determination, two of CMS's proposed Advanced APM qualifying models give insight into how to provide eligible clinicians with a longer on-ramp while assuring Medicare and taxpayers on costs. First, the Comprehensive Primary Care Plus (CPC+) model qualifies as an Advanced APM, having an enhanced FFS payment structure with additional incentive payments that are at risk for pay-backs based on performance. The Next Generation ACO model, which also qualifies as an Advanced APM, incorporates a progression toward more and more provider acceptance of financial risk.

We suggest that CMS establish a multi-year plan for newly qualifying Advanced APMs that begins with initial minimal risk and grows to require more risk over time. CMS should offer the resources and path for providers to transition to an at-risk environment, potentially in the form of a multi-year plan that starts providers out with minimal risk and gradually requires them to take on more risk. We can look to certain existing models for ideas on how to do this. These models can form the foundation for a pipeline of increasing risk for providers in transition. Providers could even be required to pay back Advanced APM payment bonuses if they do not subsequently move to taking greater risk.

By providing a more flexible structure for financial risk through a set of progressive requirements for new APMs, CMS can better support providers' transitions to the Advanced track and encourage more providers to move to take risk.

3. ***Allow eligible clinicians to qualify for Advanced APM incentives either as a part of an APM Entity or as individuals.***

Finally, the proposed rule stipulates that qualification into the Advanced APM track will largely be done at the APM Entity level. (E.g. for Tracks 2 and 3 of MSSP, inclusion in the APM Entity is based on the ACO's official participant list.) As a result, if the APM Entity as a whole meets the minimum revenue or patient thresholds, all official participants in the APM Entity would qualify for the Advanced APM bonus or higher base rate update. The proposed rule makes an exception allowing individual provider qualification for providers participating in multiple APMs.

Basing qualification for the Advanced APM bonuses or higher base rate updates at the APM Entity level creates problems, beyond that of adding a layer of complexity, for specialists and small practices in particular. If CMS proceeds with determining qualification at the entity level, clinicians who provide high

quality care may not receive bonuses they deserve if the APM Entity they are in does not collectively meet the thresholds.

We propose allowing eligible clinicians to qualify for Advanced APM incentives either as a part of an APM Entity or as individuals. CMS should consider expanding Advanced APM incentive qualification to allow individual clinicians to qualify, in addition to qualification at the APM Entity level. We applaud the exception made for eligible clinicians participating in multiple APMs, but we believe the individual assessment should be offered to all providers, including those who are involved with a single APM but who would not qualify because their APM Entity did not collectively meet benchmarks. While CMS indicates in the proposed rule that they estimate the discrepancy of a dilution scenario (i.e. some eligible clinicians not becoming QPs when they might have qualified individually) to be a minor one, we believe it is an unnecessary exclusion of physicians from participation in the Advanced track.

Further, based on industry norms, Participant or Affiliated Practitioners Lists might be more inclusive of some specialties than others. Relaxing regulatory barriers like this one to being a Qualifying Participant would encourage more physicians to more directly participate in APMs and meet thresholds. Supporting robust participation across all specialties may require CMS to consider alternate ways of determining APM participants.

Conclusion

We admire CMS's push towards focusing on quality instead of quantity in physician reimbursement. The proposed rule makes important strides in this direction. However, it is important to note that certain aspects of the implementation, particularly the projected proportion of participation in MIPS vs. Advanced APMs, are not as consistent with Congressional intent as they could be. Participation in Advanced APMs can be increased by 1) pursuing opportunities to increase the number of existing Medicare APMs that qualify as Advanced APMs; 2) offering a multi-year plan for new models with progressively increasing risk requirements; and 3) allowing eligible clinicians to qualify either as individuals or as a part of an APM Entity.

The Center for Health Policy appreciates the opportunity to comment on the proposed rule. We are encouraged by the work that CMS has done thus far and believe that by further bolstering the pipeline for physicians toward Advanced APMs, CMS will appropriately enable greater physician engagement in increasing the value of health care in Medicare.

If you have any questions about these suggestions, please do not hesitate to contact the Center's Associate Director, Loren Adler, at LAdler@brookings.edu.

Sincerely,

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