



August 21, 2017

Ms. Seema Verma  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-5522-P  
P.O. Box 8013  
Baltimore, MD 21244-8013

Re: CMS-5522-P Medicare Program; CY 2018 Updates to the Quality Payment Program

Dear Administrator Verma:

The Physicians Advocacy Institute (PAI) appreciates the opportunity to provide comments on the Medicare Program; CY 2018 Updates to the Quality Payment Program (QPP) proposed rule, published in the Federal Register on June 30, 2017.

PAI is a not-for-profit organization that was established to advance fair and transparent policies in the health care system to sustain the profession of medicine for the benefit of patients. As part of this mission, PAI seeks to better understand the challenges facing physicians and their patients and to educate policymakers about these challenges. PAI also develops tools to help physicians prepare for and respond to policies and marketplace trends that impact their ability to practice medicine. PAI's Board of Directors is comprised of CEOs and former CEOs from nine state medical associations: California Medical Association, Connecticut State Medical Society, Medical Association of Georgia, Nebraska Medical Association, Medical Society of the State of New York, North Carolina Medical Society, South Carolina Medical Association, Tennessee Medical Association, and Texas Medical Association, and a physician member from Kentucky. As a physician-based organization, PAI is equipped to provide comments and insight into many of the challenges facing the medical profession.

PAI is committed to helping physicians adapt to, and succeed under, the QPP rules. To that end, PAI has launched a comprehensive, free educational initiative to guide physicians at every stage of readiness to succeed under the QPP and other value-based payment programs. These resources are available at [www.physiciansadvocacyinstitute.org](http://www.physiciansadvocacyinstitute.org). PAI welcomes the opportunity to partner with the agency and HHS to help educate physicians to succeed under the program.

## Overview

PAI is committed to advancing policies that protect the ability of patients to receive high-quality care, and is supportive of the goals of the QPP of reducing costs and improving outcomes and the quality of care for patients. PAI commends the agency for continuing some transition year policies and easing the burden of participation in the QPP for physicians. We are pleased to see many of the changes proposed provide greater flexibility for physicians, incentivize participation of small practices, and reward quality improvement over time. However, PAI has concerns about several proposals that may unintentionally put some patients, physicians, and practices at a disadvantage and with other proposals that lack clarity and increase the complexity of the program.

PAI would like to stress the importance of and need to rely on empirical data from the program to support significant changes that could have a substantial impact on physicians' reimbursements. Furthermore, there needs to be an assurance that the data supporting any program changes is verified, accurate, and validated. Without transparency and data from the program, it is challenging to affirmatively support changes that could put physicians at risk for greater potential losses.

In this letter, we provide comments in response to several proposals and questions posed in the proposed rule, including the following:

- Merit-based incentive payment system (MIPS) low-volume thresholds
- MIPS submission mechanisms
- MIPS performance category weights and requirements
- MIPS performance scoring
- MIPS audit, targeted review, and appeal processes
- MIPS virtual groups
- MIPS Advanced alternative payment models (APMs)
- Medicare Advanced APMs
- Other-Payer Advanced APMs

Our comments are based upon the advocacy priorities of PAI as they relate to the QPP, which are to simplify the program and reduce physician burden, make the program translatable across specialties and settings, make the program more predictable, make it accessible, as well as make it relevant to positive patient impact and related to everyday practice. PAI is committed to advancing these priorities to ensure physicians are afforded opportunities to successfully participate in the QPP, and to continue providing and being rewarded for their high-quality patient care.

## Merit-based Incentive Payment System (MIPS) Low-Volume Thresholds

In the 2017 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 (MIPS and APM Final Rule), the agency finalized a low-volume threshold

that excluded physicians and other clinicians (individuals and groups) from MIPS participation if they fell below a threshold based on allowed charges or patient panel size. For the 2017 performance period, the low-volume threshold was less than or equal to \$30,000 in Medicare Part B allowed charges or providing care to 100 or fewer Medicare Part B patients. The proposed rule would increase this threshold to less than or equal to \$90,000 in Medicare Part B charges or providing care to 200 or fewer Medicare Part B patients.

PAI supports increasing the threshold as it will specifically help small and rural physicians avoid a negative payment adjustment and not subject them to participate in a program too burdensome for their practice size. Because of this, PAI encourages the agency to retroactively apply the higher low-volume threshold for the 2017 MIPS performance period if technically feasible, but only for those individual eligible clinicians (ECs) and groups who may be required to participate under the current 2017 threshold and who actively elect to be exempt. This could be accomplished by including a new feature to the current look-up tool available on the QPP website that notifies ECs and groups that fall above the current 2017 performance threshold, and below the new, proposed low-volume threshold, that they have the option to be exempt from 2017 MIPS participation.

Additionally, PAI recommends that the agency offer physicians and other ECs who fall below the new, proposed low-volume threshold in 2018 the option to opt-into the program, as well as be eligible for payment adjustments, regardless of whether they exceed even one of the low-volume threshold components. Some physicians and practices who were subject to MIPS in 2017, but would be excluded under the higher thresholds in 2018, may have already invested resources to prepare for participating in 2018. Some physicians and practices who would fall below the proposed threshold also may be high-quality performers and would now unfairly and unexpectedly be excluded from the opportunity to earn a positive payment adjustment.

PAI would like to emphasize that the 2017 retroactivity opt-out and 2018 opt-in should both be optional and provide ECs and groups with further flexibility for participating in MIPS, and that neither of these options should be forced upon an EC in one year based on their participation decision in another year. For example, we can envision a situation in which a physician is exempt under the proposed 2018 low-volume threshold, but was subject to MIPS participation in 2017. It is possible that this physician received a positive payment adjustment and an exceptional performance bonus in 2017. That physician's positive adjustment and bonus should not be automatically taken away (or recouped) because that physician is now exempt under the proposed 2018 proposed low-volume threshold. Additionally, that physician should not be forced to participate in 2018 just because they did well in 2017. Because that physician now falls below the proposed 2018 low-volume threshold, the physician should be exempt from 2018 performance but have the option to opt-in to participate in MIPS in 2018. We believe that ECs and groups should have the ability to tailor their participation in MIPS based on what is most advantageous to them/their practice in any given year.

## MIPS Submission Mechanisms

For the 2017 MIPS performance year, ECs and groups were limited to using one submission mechanism per performance category to report the applicable data. Beginning with the 2018 performance period, the agency is proposing to permit ECs and groups to use multiple submission mechanisms to report data for a MIPS category.

PAI is supportive of this proposal but requests that CMS clarify that the use of multiple submission mechanisms is optional and not mandatory. While PAI believes that permitting the use of multiple submission mechanisms would allow greater flexibility and make it easier for some practices to meet reporting requirements, it should not be required. Our specific concern would be a requirement that an EC use multiple mechanisms if it is unable to meet the minimum measures requirement using just one submission mechanism. This could impose additional reporting costs for EC's. For example, an EC could elect to report the quality performance category measures using the claims submission mechanism, but may only be able to report four applicable measures. The EC, then, should not be required to also contract with a vendor and incur additional costs and fees to report two additional measures to meet the six measures minimum for the quality performance category. The use of multiple submission mechanisms should offer ECs greater flexibility and options for participation, not be burdensome to them.

## MIPS Performance Categories

### MIPS Performance Period and Category Weights

As part of the 2017 MIPS and APM Final Rule, the agency finalized several "transition year" policies to help physicians and other ECs transition and become more familiar with MIPS. These policies included a 90-day performance period for the improvement activities and advancing care information (ACI) categories; not scoring the cost performance category for the 2017 performance year (and 2019 payment adjustment year); and weighing the quality performance category at 60%, the ACI performance category at 25%, and the improvement activities performance category at 15% of the 2017 MIPS final score.

The agency is proposing to continue these transition year policies for the 2018 performance period (and 2020 payment adjustment year). PAI is supportive of maintaining a 90-day performance period for the ACI and improvement activities performance categories.

PAI also supports maintaining the cost category at 0% of the 2018 MIPS final score. However, PAI believes that ECs should be allowed to "opt-in" and have the cost category weighted based on their performance in the Medicare Spending per Beneficiary and total per capita cost measures. An opt-in for the cost category would allow those practices that feel they are prepared to have their performance evaluated based on these two cost category measures and be able to earn an appropriately greater payment adjustment for the 2020 payment adjustment year. PAI recommends the following category weights for those who opt in for having the cost category weighted for 2018 MIPS performance: quality at 50%, ACI at 25%, improvement activities at 15%, and cost at 10%. PAI recognizes that there would be several issues involved in implementing this approach, but also

recognizes (as noted in the proposed rule) the MACRA statute requires that the cost category weight be increased to 30% by the third MIPS performance period. Based on what we have heard from physicians in the field, we believe that providing this optional implementation will facilitate achieving the statutorily required 30% weighing.

PAI also encourages the agency to continue the 2017 “pick your pace” options for the 2018 performance period. The “pick your pace” approach allows ECs three participation options (not including non-participation): a test option where ECs can report a minimum amount of data to avoid a negative penalty; a partial year participation option where ECs can report data for a minimum of 90 consecutive days; and a full-year participation option where physicians can submit data for the entire calendar year.

We believe it is important to continue the “pick your pace” policy for 2018 as many ECs are still trying to understand the MIPS requirements and how their participation in the program will affect their practices. Alternatively, if the “pick your pace” options are not continued for the 2018 performance period, at a minimum, PAI recommends that the agency also offer a 90-day reporting period for the quality category, similar to the ACI and improvement activities categories. This would result in consistency across the performance categories instead of adding another level of complexity to the program, and requiring ECs to keep track of which performance period applies to which category. Based on feedback we have received from our members, we believe that if this complexity is increased, there could be additional reporting errors due to the confusion.

### MIPS Quality Category

The proposed rule contains several proposals related to the quality performance category measures and scoring, including maintaining that a minimum of six measures be reported. PAI supports maintaining the six measures requirement. In addition, PAI supports maintaining current policy that ECs and groups are only required to report “applicable measures” (which could be fewer than six). PAI also seeks further guidance and clarification on the standard used for applicable measures, especially in the context of multispecialty practices.

Additionally, the agency is proposing to maintain the data completeness criteria for quality category measures at 50% for the 2018 MIPS performance period, and increasing it to 60% for the 2019 MIPS performance period. The agency proposes that measures that do not meet the data completeness criteria will be assigned one point, a reduction from the current three points assigned for the 2017 MIPS performance period, but three points would continue to be assigned to measures reported by small practices. PAI agrees with the agency’s approach of maintaining the 50% completeness criteria for the 2018 performance period, and eventually increasing the threshold over time. However, PAI believes that the data completeness criteria should not be increased, and the three-point minimum should not be decreased, until the agency publishes participation reports and other data that demonstrates that physicians and other ECs are successfully meeting the current 50% threshold and should be held to a higher standard. Further, it is important that CMS share information with

physicians on a timely basis. PAI also supports the agency's proposal to continue to assign three points to measures that are submitted but do not have a benchmark or meet the case minimum.

### MIPS Advancing Care Information (ACI) Performance Category Hardship Exceptions

The ACI performance category requires the use of certified electronic health record technology (CEHRT) for participation to receive a score for the category. However, some ECs and groups may qualify for a reweighting of the ACI performance category to 0% of their final MIPS score if they qualify for automatic reweighting by CMS or if they meet one of three hardship exceptions related to the availability of CEHRT. The agency is proposing to include a new category for automatically reweighting the category for ambulatory surgical center-based physicians, and to add the following two new hardship exceptions: 1) ECs in small practices; and 2) ECs using decertified CEHRT. The proposed rule also contains a proposal that would allow ECs to continue to use 2014 edition CEHRT for the 2018 MIPS performance period.

PAI is supportive of all these proposals. Many physicians in small practices may not have the resources (*e.g.*, funds to purchase a CEHRT) or the ability to submit the information required for the ACI category. Furthermore, PAI believes that the new hardship exception for decertified CEHRT and allowing ECs to use current CEHRT editions for another performance period is a step in the right direction and away from penalizing physicians for actions that are the responsibility of their vendors. Physicians are often unjustly penalized for reliance on vendors and trusting that their vendors will become certified, maintain their certification, and appropriately submit their data to CMS on their behalf. Many vendors have delayed their updates and continue charging practices exorbitant fees for these updates, even when they are delayed or not completed.

Even with this new hardship exemption, the agency must still hold vendors accountable for updating to 2015 edition CEHRT to allow for ample testing time and predictability in the program. Additionally, PAI urges the agency to continue to hold vendors accountable for compliance with program requirements and encourages the agency to consider developing a "Vendor Compare" that would publicly report vendor data and error rates, just as physicians and other ECs participating in the program are held accountable for their performance on Physician Compare. Furthermore, PAI recommends that the agency create a new "hold harmless" policy or hardship exemption if any MIPS-related vendor commits data collection and/or data submission errors that result in poor performance scores or failed reporting for ECs or groups. We believe that this is a high priority, especially when the issue is out of a physician's or other EC's control.

### MIPS Cost Category

In the 2017 MIPS and APM Final Rule, 10 episode-based measures were finalized for the cost performance category that would be scored beginning with the 2018 performance period. The agency is proposing to replace the previous episode-based cost measures that were finalized as part of the 2017 MIPS and APM Final Rule. PAI supports this proposal as there are currently attribution and risk-adjustment issues that need to be resolved with the cost category overall. We believe that this would be an opportunity for all stakeholders to further engage in and work closely on the

development of cost category measures that more accurately assess the utilization of health care services and appropriately attribute costs.

### MIPS Improvement Activities Category

The agency also proposes inclusion of accredited continuing medical education (CME) as an improvement activity beginning with the 2018 MIPS performance period. In the proposed rule, the agency describes the following criteria for completion of an accredited performance improvement CME program that addresses performance or quality improvement:

- The activity must address a quality or safety gap that is supported by a needs assessment or problem analysis, or must support the completion of such a needs assessment as part of the activity;
- The activity must have specific, measurable aim(s) for improvement;
- The activity must include interventions intended to result in improvement;
- The activity must include data collection and analysis of performance data to assess the impact of the interventions; and
- The accredited program must define meaningful clinician participation in their activity, describe the mechanism for identifying clinicians who meet the requirements, and provide participant completion information.

PAI is supportive of the inclusion of this as an improvement activity, and stresses the requirement that the CME must be accredited, but also not overly burdensome for physicians to obtain the accreditation. We encourage the agency to develop several accredited performance improvement CME activities that are available to physicians at no or low-cost.

## MIPS Performance Scoring

### MIPS Performance Threshold

The MIPS final score and related payment adjustment for ECs and groups is determined based on their performance compared to a MIPS performance threshold. Currently, for the 2017 MIPS performance period, the threshold is set at three points. The agency is considering increasing the threshold to 15 points. PAI does not support this proposal and believes that an increase from three points to 15 points is too steep at this juncture in program implementation. Instead, PAI recommends a more gradual increase over time, and is supportive of maintaining three points for the 2018 performance period, or, alternatively, increasing the threshold to six points for the 2018 MIPS performance period.

### Small Practice Bonus

Beginning with the 2018 MIPS performance period, the agency is proposing to provide a bonus to ECs or groups in a small practice, defined as fifteen or fewer clinicians. Five bonus points would be added to their final score if the EC or group submits data on at least one performance category for the 2018 performance period. PAI is supportive of this proposal to provide small practices with a bonus that will help “level the playing field” and allow them to earn a positive payment adjustment.

## Improvement Scoring

Currently, there is no explicit mechanism in place for tracking, encouraging, or rewarding ECs or groups that improve their MIPS score over time. CMS is proposing to adopt two different methodologies for taking into account improvements in scoring from year to year for the quality and cost performance categories. For the quality performance category, the agency is proposing that improvement scoring be assessed at the category level because ECs can elect different reporting mechanisms and measures that are most meaningful to their practice and these can vary each year. For the cost performance category, the agency proposes that improvement scoring will be assessed at the measure level because ECs do not have a choice and are instead assessed on all measures based on the availability and applicability of the measure to their practice, based on information derived from administrative claims data.

PAI believes that improvement scoring is important to the overall goals of MIPS and the QPP. PAI strongly advocates that the methodology and calculations used for improvement scoring be transparent and can be easily understood by physicians and practices. It also recommends that the maximum points achievable for improvement scoring for each category be increased so that ECs and groups that are making significant strides in improving outcomes are rewarded for quality improvement activities and providing cost-effective care.

## Complex Patient Bonus

To protect access and the quality of care for complex patients and to avoid placing MIPS ECs at a potential disadvantage for caring for complex patients, the agency is proposing to add a complex patient bonus, but only for the 2018 MIPS performance period. Complex patients are defined as those with high medical risk; the agency is proposing that the complex patient bonus score would be calculated based on the average Hierarchical Condition Category (HCC) risk score across all patients seen by the EC or group. Alternatively, the agency initially also identified, and is seeking comments on also incorporating, a complex patient bonus based on social risk as measured through the proportion of patients with dual eligible status. The proposal also includes capping the maximum bonus at three points that can be added to the MIPS final score.

PAI is supportive of a complex patient bonus, but does not believe that only one approach should be used to determine this bonus, nor that this bonus should be limited to the 2018 MIPS performance period. As discussed by the agency, HCC scores are diagnosis-based indicators and are a poor proxy for social economic conditions, while dual eligible status is indicative of other social economic conditions and factors that could contribute to the health status of patients. Each approach captures a different “complex patient” population, so it is important to provide guidance on what the agency means by “high medical risk” and what population specifically the agency intended to capture in this complex patient score. Furthermore, it is possible that in some regions, a practice could have a patient population that has low HCC scores, but a high number of dual eligibles, and vice versa.

Therefore, PAI believes that the agency should use a similar methodology to what it has proposed for the All-Payer Qualifying APM Participant (QP) determinations, and conduct two complex bonus calculations, one using the average HCC risk scores and another using the ratio of dual eligibles, and apply the bonus amount that is the most advantageous to the EC or group. We believe that this approach would help better capture the appropriate population for a specific practice. Furthermore, we encourage the agency to continue to explore if there are additional appropriate methods for capturing complex patients, and ensuring that access and quality of care for these patients continues to be protected, recognizing that both the HCC and dual eligible status approaches have their shortcomings and may not be fully indicative of a patient's complexity.

### Facility-Based Measures

For the quality category, the agency is proposing to implement facility-based measures beginning with the 2018 performance period. Facility-based measures would apply to those ECs whose primary professional responsibilities are in a health care facility (e.g., in a hospital). Performance in the cost and quality categories would be assessed based on the performance of the facility in another value-based purchasing program if ECs select this option. PAI is supportive of this optional assessment based on the facility an EC may be affiliated with. PAI recommends that implementation and requirements of this option be applied consistently across facilities and practices.

### MIPS Audit, Targeted Review, and Appeal Processes

PAI has several concerns with the MIPS data validation, targeted review, and appeal processes. While PAI is actively monitoring the QPP, including the CMS QPP website, and is aware that the agency has published some materials on the data validation criteria for different performance categories, there remains much uncertainty as to what is required to meet the data validation requirements. Specifically, it remains unclear exactly what documentation is required in order to support an audit; this remains vague in the current materials available on the QPP website. Additionally, ECs who receive a request of an audit currently only have 10 days to respond.

PAI insists that the agency establish a fair and transparent auditing process, specifying the documentation necessary for audit purposes so there is no misinterpretation by the EC or group, and the agency should ensure that the data validation criteria be posted prior to the beginning of the performance period so ECs and groups have adequate notice of what is expected and required of them. Furthermore, ECs or groups should be granted additional time to respond to an audit request if it is for a valid reason (e.g., patient care, no time/resources, email/letter overlooked, vacation, etc.).

In regard to the targeted review process for appealing a MIPS payment adjustment determination, this is currently a one level, asymmetrical review process. ECs and groups must currently submit an online application and provide a summary of their position and reason for appealing the payment adjustment determination, to which CMS responds with a final determination via email, and the process is complete. PAI believes it is necessary to expand this process and transform it into a true appeal process. As part of its initial determination and in response to any appeal application, the agency should provide detailed information that clearly explains its rationale for the payment

adjustment determination and/or appeal response. This would allow ECs to better understand why they received a certain payment adjustment, and determine whether they can or should appeal the initial determination. Additionally, ECs and groups should have the opportunity to further discuss the appeal after the agency's email response to allow them to correct any misunderstanding or gain additional information that could help their performance in the subsequent performance period.

Lastly, PAI would likely to emphasize the importance of sharing feedback reports on a timely and continuous basis so that practices have adequate time to not only make improvements for the remainder of a current performance period, but also for the subsequent performance period to improve their overall MIPS performance scores.

## MIPS Virtual Groups

The 2018 MIPS performance period is the first period that ECs and groups will be able to participate in MIPS using the virtual groups option. The virtual groups option allows ECs and groups to form a virtual group for collectively reporting and meeting the MIPS performance category criteria. In the proposed rule, the agency has proposed criteria for virtual groups composition, scoring and payment adjustment, election process, and agreements. Because these are extensive proposals, PAI has specific comments on some proposals and more general comments on the virtual groups option, rather than detailed comments on each policy and criteria.

### General Comments on Virtual Groups

Overall, PAI recommends as much flexibility for virtual groups as possible. We believe that the same options for individual ECs and groups be extended to virtual groups, including the flexibility to report on different or same measures through the same or multiple reporting mechanisms, and the scores should be based on the top six measures with the highest score regardless of which practice within the virtual group reported the specific measures.

PAI requests further clarification and guidance about participation in virtual groups. While the proposed rule aims to provide details about some aspects of virtual groups, there are still many aspects that are unclear and could potentially hinder the formation of virtual groups. Specifically, PAI asks the agency to consider the following issues and provide guidance in response:

- Are ECs and groups permitted to be parties to multiple virtual group applications, but ultimately only permitted to being part of one virtual group? We foresee a situation where, if an EC is limited to only one virtual group application, that EC may be left with no options if that application to form a virtual group is denied. This EC would then be required to participate in MIPS on their own, which would likely be difficult for that EC given that they committed to and applied to be part of a virtual group in the first place. Thus, ECs and groups should have the flexibility to be part of more than one virtual group application and ultimately decide which approved group they would like to align with.

- While the proposed rule lays out the criteria that must be submitted as part of a virtual group application, there is a lack of detail on what grounds a virtual group application would be accepted or rejected. PAI requests the agency issue further guidance on this topic.
- PAI also believes that it is important to extend the application of the Federal Trade Commission (FTC) and Department of Justice (DOJ) Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations (ACOs) Participating in the Medicare Shared Savings Program (MSSP) to virtual groups. This policy statement provides clarity on antitrust issues and guidance on forming procompetitive ACOs. The policy statement applies a rule of reason analysis to determine if an ACO is likely to have anticompetitive effects, and if so, whether its efficiencies are likely to outweigh those effects. PAI believes that virtual groups will likely incur and have to address similar antitrust issues, and it is important that these be resolved at the beginning rather than mid-year, and create an obstacle to participation in virtual groups and MIPS.
- The agency should also be mindful of other laws and regulations that could be impediments or obstacles for the formation of virtual groups, and that appropriate exemptions should be extended and applied to virtual groups, for example, Stark Law exemptions that are similar to those for group practices.
- There is also a lack of clarity about which platform, if any, virtual groups are expected to use to submit their MIPS data - whether the expectation is that all participants in the virtual group use the same or different submission mechanism. Questions include: Is one party required to submit the data on behalf of all participants in the virtual group, or can each participant submit their own data? How are resource and investment costs expected to be shared among virtual group participants? How will the agency be able to accurately and correctly collect and evaluate the data submitted by the virtual group?
- Feedback reports for the overall virtual group and each individual practice are also critical, as well as further specifications surrounding how appeals and audits would be handled for virtual groups and their individual participants.

### Exclusion of Low-Volume Threshold ECs and Groups

PAI would like to reiterate our comments above regarding the opt-in provision for ECs and groups who fall below the new, proposed low-volume threshold. We believe that those ECs and groups should be allowed to come together and form a virtual group for MIPS participation. Excluding those who fall below the low-volume threshold from having the option to form a virtual group may undermine the intent of this participation option. It is our understanding that this option is to allow ECs and small groups to collaborate and share the responsibility and burden of participation, but still be eligible to have a “stake in the game” and earn a positive payment adjustment, collectively. As such, we appreciate and support the agency’s decision to not support any restrictions on the composition of virtual groups, nor is there any upper limit (“cap”) on the number of National Provider Identification numbers (NPIs) or tax identification numbers (TINs) that can collectively form a virtual group, and we believe the flexibility should also be extended to those who fall below the low-volume threshold.

## Role of Third Parties and Independent Physician Associations (IPAs)

The proposed rule outlines the elements and criteria for virtual group agreements and who can be a party to those agreements. One such proposal states that IPAs cannot participate in the virtual group agreement. PAI understands that an IPA cannot participate in the virtual group itself as a MIPS participant, but seeks further clarification from the agency about whether IPAs and other third parties can help facilitate and support the formation of virtual groups. Since no restrictions are being proposed that participants in virtual groups must be in the same geographic area of the same specialty, an outside party could help bring the appropriate ECs and groups together and assist them in ensuring that they have met all requirements necessary to form virtual groups and that the virtual group participants have the required infrastructure and processes in place to support their participation in MIPS. PAI encourages the agency to not restrict or limit the valuable role and service that could be provided by IPAs and other third parties.

## MIPS APMs

MIPS APMs are an alternative participation option to “strict” MIPS participation and “strict” Advanced APM participation. There are two ways ECs and groups can participate in a MIPS APM: 1) if they are part of an APM Entity that is participating in an Advanced APM but do not achieve a QP determination exempting them from MIPS performance; and 2) if they are part of an APM Entity that is participating in an APM that may not be considered an Advanced APM, for example, MSSP Track 1 ACOs. These ECs and groups have a special scoring standard applied to them based on their participation in the APM. For the 2017 performance period, the agency assigned different category weights depending on the type of MIPS APM an EC or group is participating in. However, the agency is proposing the same category weights for all MIPS APMs: quality at 50%, improvement activities at 20%, and ACI at 30%. PAI supports aligning the category weights for the MIPS APM scoring standard across all MIPS APMs. We believe this reduces the complexity of the program.

For Other MIPS APMs (non-Medicare MIPS APMs) there may be instances in which there are no measures available to score for the quality category. In these cases, the agency is proposing to reweight the categories as such: improvement activities at 25% and ACI at 75%. There may also be Other MIPS APMs in which the APM Entity qualifies for 0% weighting of the ACI category, in which case the agency is proposing to reweight the categories as such: quality at 80% and improvement activities at 20%. PAI is supportive of this reweighting proposal as no APM or practice is one-size-fits-all, and this would allow for tailoring the category weights by practice depending on the Other MIPS APM they have elected to participate in. PAI also supports the agency’s proposal to add a fourth snapshot date—December 31—for determining participation in full TIN MIPS APMs (Medicare and Other) only.

## Medicare Advanced APMs

CMS is seeking comments on whether to have a lower revenue-based nominal amount standard for small practices and those in rural areas for the 2019 and 2020 performance periods, and whether that should apply to only small and rural practices that are participants in the Medicare Advanced APM or those practices that join larger APM Entities to participate in Medicare Advanced APMs. PAI

is supportive of having a lower revenue-based nominal amount standard for small practices and those in rural areas, and it should apply to both practices that are participants in the Medicare Advanced APM as well as those that join larger APM Entities to participate in the Medicare Advanced APM. The current nominal risk standard is too high for small group practices and ECs and often deters them from participating in an APM. To entice small groups, PAI recommends starting with fairly low nominal amount standards and gradually increasing them as small groups get comfortable taking on more risk.

### Medicare Advantage

While full capitation models like Medicare Advantage would count as Other Payer Advanced APMs, these Medicare Advantage models do not qualify automatically as Medicare Advanced APMs, nor do the payments or patients served count towards the Medicare Advanced APM QP/PQ determinations. However, the agency is seeking comments on additional pilots or demonstrations that could qualify Medicare Advantage arrangements differently.

PAI urges the agency to allow physician contracts with MA plans that meet the risk, quality and certified electronic health information technology requirements to be counted as Medicare Advanced APMs. PAI believes that Medicare Advantage payments and patients should also count towards the Medicare Advanced APM QP/PQ determinations, as these are models based within Medicare that include a significant share of Medicare beneficiaries.

### Other Payer Advanced APMs

Beginning with the 2019 performance period, ECs and groups will have the opportunity to have their participation in non-Medicare, Other Payer Advanced APMs count towards their QPP participation for the QP/Partial QP (PQ) determinations. Other Payer Advanced APMs would include: Medicaid APMs and Medicaid Medical Home Models; CMS multi-payer models; Medicare health plans (including Medicare Advantage, Medicare-Medicaid Plans, 1876 and 1833 Cost Plans, and PACE); and commercial and other private payers. The proposed rule included proposals specifying the requirements for the All-Payer QP/PQ Combination Option, focusing on general criteria that would qualify payment arrangements as Other Payer Advanced APMs. One proposal the agency is seeking feedback on is whether an EC should submit Other Payer Advanced APM payment/patient data to CMS for CMS to make the QP determination.

PAI supports expanding Advanced APM options for ECs and groups to receive QPP credit for participation in non-Medicare APMs, and defining and offering broader options for physicians. Under the Other Payer Advanced APM option, physicians and other ECs would receive credit for participation in APMs with other, non-Medicare payers that also contribute to increasing the quality and value of care provided to patients. However, PAI has concerns about the proposal that would require an EC to submit their own payment or patient data for the All Payer Combination option. As CMS notes, ECs would be required to first acquire this data from their payers and then share it with CMS. This would be quite burdensome, time consuming, and difficult for an EC. Thus, PAI supports the agency's alternative proposal that would require APM Entities to submit the information on the

EC's behalf. We encourage the agency to have a strong mechanism in place to begin negotiations with APM Entities well in advance of this expected exchange of information. This would ensure that there are appropriate safeguards in place that would protect physicians and other ECs from issues that may arise from data exchange and communications between the APM Entities and CMS, that could prevent them from receiving credit for participating in Other Payer Advanced APMs.

### All-Payer QP Determinations

In the proposed rule, the agency provided guidance on the proposed process it will utilize to make QP/PQ determinations under the All-Payer option, which would utilize both Medicare and Other Payer Advanced APM patient/payment data. The agency is proposing that under the All-Payer option, determinations would only be made at the EC level, not the APM Entity level like they are under the Medicare QP/PQ determination process. To reconcile the two different approaches, the agency's proposed process and steps for making the determination at the EC level under the All-Payer option are as follows:

- CMS will look at the APM Entity for the Medicare Option and determine if the QP threshold is met.
- If QP threshold is not met, then CMS will go through the All-Payer option using the individual EC payment and patient data for QP determinations
- For step one of the All-Payer calculation, CMS will calculate the EC's Medicare threshold scores both individually and using a weighted methodology (reflecting the EC's individual Medicare volume as part of the APM Entity). CMS will then use most advantageous calculation when making the QP determination under the All-Payer option.

PAI is supportive of this process that provides some flexibility in how the determinations are made, and because the most advantageous calculation will be used to support the QP/PQ determinations. We are hopeful that this will result in more physicians and other ECs receiving QP/PQ credit for their participation in both Medicare and Other Payer Advanced APMs.

### All-Payer Performance Period

The agency is proposing a separate All-Payer QP Performance Period for the All-Payer QP/PQ determinations that is different than the Medicare QP performance period. The proposed All-Payer QP Performance Period would last from January 1 – June 30, and determinations would be made based on 2 snapshot periods:

- January 1 – March 31
- January 1 – June 30

This is different than the Medicare QP Performance Period which CMS is proposing to maintain at January 1 – August 31. PAI is supportive of the All-Payer QP Performance Period proposals, but believes that, for ease of participation, the All-Payer QP Performance Period should align with the Medicare QP Performance Period. We believe this would make it easier for APM Entities to predict

whether they satisfy QP requirements under the Medicare option or the All-Payer option using claims from the same period.

## Conclusion

Overall, PAI supports CMS's efforts to streamline and reduce unnecessary burdens placed on physician practices and continuing transition year policies for the second MIPS performance period. PAI and the medical associations represented on the PAI Board of Directors welcome the opportunity to work with the agency to further implement and advance the QPP in a meaningful and impactful way. If you have any questions, please contact me at [rseligson@ncmedsoc.org](mailto:rseligson@ncmedsoc.org), or Kelly C. Kenney, PAI's Executive Vice President and CEO, at [k2strategiesllc@gmail.com](mailto:k2strategiesllc@gmail.com).

Sincerely,



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