

## HAP Comments—Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models

In April of 2015, H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015 became law. This act, known as MACRA, permanently repealed the sustainable growth rate (SGR) formula and made reforms to Medicare physician payments intended to encourage quality and value.

This legislation called for a new Quality Payment Program (QPP), which is intended to transition providers from Medicare payments based on volume to payments based on value.

The QPP is comprised of two paths:

- MIPS—requires performance measures, data submission mechanisms, reporting timeframes, scoring methodology, and various administrative processes. It also would replace electronic health record meaningful use requirements for physicians with a more flexible set of “advancing care information” measures.
- APMs—requires that an entity participating in an eligible APM bear financial risk for any excess Medicare spending over projected expenditures, or be a specified medical home. For 2019 APM incentive payments, eligible models based on financial risk would be Tracks 2 and 3 of the Medicare Shared Savings Program, the Next Generation ACO model, the Comprehensive End-stage Renal Disease Care model, and the two-sided risk model in the Oncology Care program. The newly-announced Comprehensive Primary Care Plus initiative would qualify as a medical home.

Payment under these models does not begin until 2019, though measurement for the MIPS programs begins in 2017.

### The Merit-Based Incentive Payment System

MIPS essentially consolidates three existing physician payment programs: the Physician Quality Reporting System (PQRS), the Physicians Value-based Payment Modifier (VM), and the Medicare Electronic Health Record (EHR) Incentive Program. Under the new program, there are four performance categories:

Performance Category	CY 2019	CY 2020	CY 2021+
Quality	50%	45%	30%
Resource Use	10%	15%	30%
Clinical Practice Improvement Activities (CPIA)	15%	15%	15%
Advancing Care Information (ACI)	25%	25%	25%

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### *Impact of Budget Neutrality—MIPS Model*

On page 676 of the 962-page proposed rule, CMS estimates that during 2019, for the first payment year of the program:

- 87 percent of eligible solo practitioners will be subject to a negative payment adjustment
- 70 percent of practices with two to nine physicians are estimated to have negative payment adjustments
- 59 percent of practices with 10 to 24 clinicians are estimated to have negative payment adjustments

**While CMS appears to recognize the challenges of small practices and has outlined specific “flexibilities and supports” for small practices in a fact sheet, HAP urges CMS to continue to review and refine its approach to ensure that small practices, such as those associated with rural or critical access hospitals, are not unfairly penalized under the new QPP.**

### *MIPS Performance Categories*

- *Quality*

The quality performance category of the MIPS program as proposed is a combination of existing programs: the Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (VM), and the EHR Incentive Program.

Providers in Pennsylvania currently are experiencing a proliferation of quality metrics across various payer programs. Commercial payers already have begun introducing programs and initiatives to move hospitals and health systems along the continuum of volume to value and each payer includes a unique set of quality metrics.

In addition to federal and commercial initiatives, in October, the Pennsylvania Department of Human Services (DHS) issued a Request for Proposal (RFP) to re-procure its physical health managed care program. The RFP includes a number of program changes including setting targets for value-based payments as a percentage of total contract value, which would begin in 2017, with a target of 7.5 percent increasing over the term of the contract to 30 percent by 2019. “Value-based” payments would be defined in the contract, and could include financial incentives around accountable care organization (ACO) models, gainsharing, episodes of care, primary medical homes, and bundled payments, among others. These changes could potentially create additional sets of varying quality metrics for providers to manage.

**HAP urges CMS to streamline the quality metrics associated with all of its initiatives to focus on a core, manageable set of measures that are nationally endorsed and not resource intensive and overly burdensome to administer. This recommendation includes aligning hospital and physician measures and focusing on high-priority measures with the greatest opportunity to promote successful outcomes.**

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The proposed rule requires providers to choose to report six measures rather than nine measures in the current PQRS program. One of these measures must be an outcome measure or a high-quality measure, and one must be a crosscutting measure. Clinicians also can choose to report a specialty measure set.

Large multi-specialty practices will likely be challenged in defining what measures the practice should focus on overall.

**HAP supports CMS' initiative to simplify quality measurement by reducing the overall number of quality measures. HAP urges CMS to continue to simplify the program as it remains too complex, especially in the early years of transitioning providers from volume to value.**

**HAP also encourages CMS to better align the measurement period with the payment year. Current programs are structured with a gap of two years between measurement and payment, which hinders physicians' ability to benefit from their quality improvement efforts.**

**HAP believes risk adjustments, including consideration for socioeconomic/ demographic factors in setting targets for quality metrics in the MIPS program, is essential to ensure providers are not unfairly penalized for patients negatively affected by social determinants of health.**

- *Resource Use*

Performance in the resource use category is based on the average score of over 40 resource use measures including total cost per capita, Medicare spending per beneficiary (MSPB), and clinical condition and treatment episode measures. The measures are all calculated utilizing claims. Providers must have at least 20 cases to be scored for performance on a measure.

While the total cost per capita and the MSPB measures are adjusted using a process known as "payment standardization," which removes the effects of geographic variations in payment and add-on payments and includes a clinical risk adjustment, they do not include socioeconomic adjustments. **HAP urges CMS to analyze the impact of socioeconomic factors and incorporate adjustments as needed.**

The clinical condition and treatment episode measures (approximately 40 condition-specific episodes of care) have not been utilized in performance scoring in previous CMS payment programs such as the VM program. **HAP encourages CMS to delay implementation of the clinical condition and treatment episode measures until they have been fully vetted, including providing assurance that an appropriate ICD-10 crosswalk has been completed.**

- *Clinical Practice Improvement Areas (CPIA)*

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The CPIAs performance category is a new category in the MIPS program. This category will measure activities related to improving clinical practice or care delivery in ways that are likely to improve outcomes. CPIAs include activities such as expanded practice access, population management, care coordination, beneficiary engagement, patient safety and practice assessment, and participation in an APM. Activities are designated as high or medium weights and are worth different amounts of points, 20 and 10 respectively. Participation in a certified patient-centered medical home provides for full credit in this category, however, participation in an APM provides for only partial credit.

**HAP urges CMS to simplify the measure by removing the high and medium distinction and to lower the year one maximum points from 60 to 30.**

- *Advancing Care Information (ACI)*

ACI, formerly known as meaningful use, measures providers who possess a certified EHR, use the functionality of a certified EHR, and report on objectives and measures specified for the ACI performance category over a specified performance period.

The provider community is committed to furthering care improvement, care coordination, and new care models by utilizing certified EHR technology.

**HAP appreciates the proposed flexibility within the ACI performance category. However, HAP remains concerned that it still contains a high degree of complexity and providers will not have sufficient time to report on a full year beginning January 1, 2017. HAP recommends that CMS offer a reporting period of 90 days for calendar year 2017.**

**HAP also recommends that CMS accelerate efforts to align the provider and hospital communities on the use of EHRs and the exchange of health information under the Medicare and Medicaid EHR Incentive Program.**

#### *Hospital-based physician participation*

MACRA allows for CMS to develop a hospital-based physician MIPS participation option using the physician's hospital's CMS quality and resource use measures.

**HAP supports immediate efforts to develop programs for hospital-based physicians to further align hospitals and physicians in meeting the goals of the triple aim. HAP recommends that CMS require all physicians and groups to self-designate whether they qualify as hospital-based as this option may not be appropriate for all hospitals and all hospital-based providers in the MIPS. HAP also urges CMS to investigate all measures from CMS' hospital quality reporting and pay-for-performance programs for use in hospital-based physician reporting options to ensure that a wide variety of specialties would have the ability to use the option.**

#### **Alternative Payment Models**

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The proposed rule stipulates that payment models must meet three criteria to qualify as an advanced payment model.

1. Base payment on quality measures comparable to those in MIPS
2. Require use of certified EHR technology
3. Either (1) bear more than nominal financial risk for monetary losses or (2) be a medical home model expanded under CMMI authority

**HAP supports the effort to align quality measures across the MIPS and APMs. However, HAP urges CMS to broaden the definition of nominal risk to account for the significant up-front investments that providers must make to participate and be successful in the APMs. This investment exists even in upside-only models.**

#### *Qualifying Advanced APM models*

MACRA promotes and provides incentives for providers participating in *advanced* APMs beginning in 2019. The proposed rule includes a list of models that qualify as advanced APMs for the first performance year. They include:

- Comprehensive end-stage renal disease care model
- Comprehensive primary care plus
- Medicare shared savings program (MSSP)—tracks two and three
- Next generation ACO model
- Oncology care model two-sided risk arrangement

CMS notes that this list will be updated annually to add new payment models as they continue to develop.

It is estimated that approximately 30,000 to 90,000 providers will qualify to participate in the APM track in year one.

CMS has clearly stated that one goal of MACRA is to shift providers to APM-like models. The current proposal severely limits the number of qualifying providers. Recent models that were introduced by CMS, such as the Medicare Shared Savings Programs (MSSP) track one required a minimum commitment of three years. Early adopters of these programs are not permitted to change tracks due to the three-year commitment. **HAP urges CMS to consider the broadening of the year one definition to include CMS-designed programs such as the Bundled Payments for Care Improvement (BPCI) initiative, Medicare Shared Savings Programs (MSSP) track one, and the recently implemented Comprehensive Care for Joint Replacement (CJR) model.**

While CMS attempted to provide a glide path for providers participating in APMs that do not qualify as advanced APMs, providers will still be required to split their efforts between the MIPS program and obtaining success in APMs.

**HAP urges CMS to reconsider the benefits offered to providers that will be participating in both programs and safeguard that those benefits reduce administrative burden and ensure alignment so provider efforts can be focused rather than divided.**

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### *Qualifying Volume to Participate in Advanced APMs*

In order to qualify for incentive payments under APMs, a significant portion of their business must be through the Advanced APM. Providers have two options to qualify, including the percentage of payment through an Advanced APM and the percentage of patients through an APM.

CMS also proposes to allow providers to be assessed individually or as part of a group.

**HAP commends CMS for considering both the percentage of payments from an APM as well as patient counts from an APM and using the measurement that is most favorable to allow the provider to qualify for participation. Using both methods will alleviate unintended consequences such as the impact of successful APMs lowering costs/payments over time, which may decrease the amount of Medicare payments for those patients attributed to the APM. This also would help if there are significant changes in the attributed population over the measurement year. HAP also supports the flexibility to be assessed as part of a group to meet the requirements of APM participation.**

### **Implementation Timeline**

This proposed rule will have a significant impact on professional payments beginning in 2019 based on performance measurement beginning January 1, 2017. The final rule will not be issued likely until November 2016. This provides for limited time to make significant changes to operations, data reporting and analysis, IT systems, etc. **HAP urges CMS to consider the significant “lift” this rule requires for providers, monitor the readiness of the field to implement MACRA, and be willing to provide appropriate flexibility in the timeline to allow for a successful implementation.**

### **Legal Impediments**

New payment models introduced by CMS require extensive collaboration across the health care continuum. As these models hasten the shift from volume to value, antiquated rules and regulations, once necessary in the fee-for-service world, have become barriers to providers' ability to succeed in these models.

**HAP urges CMS to work in collaboration with other agencies and Congress to identify and remove legal and regulatory barriers to clinical integration. These barriers include the Stark Law, the anti-kickback statute, and the applicable civil monetary penalties. HAP also encourages CMS to continuously evaluate policies for their impact on providers' ability to work together to better the health of the population for which they serve.**

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