California Medical Association
Physicians dedicated to the health of Californians

June 27, 2016

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

Re: 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 (CMS-5517-P)

Dear Acting Administrator Slavitt:

On behalf of the more than 40,000 physician members and medical students of the California Medical Association (CMA), we want to thank you for the opportunity to provide comments on the Notice of Proposed Rulemaking (NPRM) regarding the implementation of the Merit-Based Incentive Payment System (MIPS) and the Alternative Payment Model (APM) program under the Medicare Access and CHIP Reauthorization Act (MACRA). The CMA actively participated on the American Medical Association's (AMA) MACRA Task Force and we fully support the comments submitted by the AMA. We are deferring detailed comments on the quality and clinical measures to the rigorous review appropriately being conducted by the national specialty societies. In addition, the CMA created a MACRA Technical Advisory Committee (TAC) comprised of physicians from across the state in both small and large group practices from a wide range of specialties. **The CMA is submitting additional California-specific comments based on the recommendations of the TAC. Our recommendations represent the MACRA priorities of California physicians based on our practice environment and our historical experience with the private payers in implementing a value modifier, financial risk arrangements, and innovative payment models.**

We want to thank you and your staff for the ambitious outreach to the physician community during the comment period, including the listening sessions, webinars and meetings with CMA leaders. We also appreciate CMS' statements about trying to reduce the barriers to participation in the Medicare program by simplifying the reporting burdens of MIPS, and promoting true innovation through the APMs and Physician-Focused Payment Models.

The CMA believes that the MACRA law is an improvement over the previous SGR-based payment system. The MACRA law directed CMS to consolidate, simplify, and reduce the burdens of the Medicare reporting programs - Cost (value modifier), Quality (PQRS) and EHR (Meaningful Use). It also reduced the 13% Medicare penalties physicians were facing this year and reinstated substantial bonus payments. All of the bonus opportunities under current law

had expired. The new MACRA law also established a track for physicians to develop alternative payment models that were required to be led by physicians. We believed that the APM track held great promise and opportunity for physicians. The MACRA law allowed physicians to define quality and clinical improvement, and design the APMs. Both the MACRA Fee-for-Service (FFS) MIPS program and the APM program were intended to promote improvements in the delivery of care for Medicare patients.

CMA recognizes the improvements CMS made in the proposed rule to reduce the program burdens. CMS took many of CMA's and organized medicine's comments into account when developing the proposed rule. We appreciate that the pass/fail system has largely been eliminated and physicians can obtain proportional credit for the quality and EHR measures that are met. CMS significantly reduced the number of quality measures and eliminated the redundant EHR measures. The rule also provides a great deal of flexibility for physicians to report measures through claims, EHRs, registries, web interfaces, and as individuals or groups. The option to report through virtual groups after Year 1 is extremely important for small practices. And there are more options to choose from when reporting on quality and clinical improvement. Finally, we appreciate the flexibility provided to the APMs in meeting quality, EHR and patient threshold standards.

However, CMA is extremely concerned that the proposed rule does not go nearly far enough to fix the outlandish administrative burdens in the Medicare program as required by MACRA. In several instances, the MACRA MIPS rule is more complex than the existing programs. And the promising Alternative Payment Model track has been all but amputated.

Our most serious concerns with the proposed rule are summarized below followed by CMA's specific and constructive recommendations for improvement. The more detailed CMA comments on the proposed rule are attached.

Summary of CMA's Priority Concerns

1. **The accomodations for solo, small and rural practices are inadequate.**

2. **The MIPS reporting programs continue to be unnecessarily burdensome and complex, particularly the EHR Advancing Care Information category.**

3. **There is no accountability for EHR vendor compliance and interoperability.**

4. **The MIPS Resource Use category will continue to discourage physicians from treating high-risk, vulnerable patients.**

5. **The Advanced Alternative Payment Models are limited and the financial risk requirements severely inhibit the expansion of innovative APMs.**

6. **The performance reporting period starts too soon - January 1, 2017.**

Summary of CMA's Recommendations for Improvement

1. The accomodations for solo, small and rural practices are inadequate.

CMA Recommended Improvements:

A. **Significantly expand the permanent MIPS low-volume exemption** for small practice physicians and physicians located in Health Professional Shortage Areas (HPSAs). It should be voluntary for physicians.

B. **Create an additional phase-in pathway for small and rural practices to transition to MIPS.** It would exempt the 40th percentile of all small and rural practices in each specialty in Year 1; the 30th percentile of all small and rural practices in each specialty in Year 2; the 20th percentile of all small and rural practices in each specialty in Year 3; and the 10th percentile of all small and rural practices in each specialty in Year 4. This phase-in is voluntary and would provide more time for resource-limited small practices to prepare, finance new systems and upgrades, change workflow, and transition to MIPS.

C. **Exclude the Dual Eligible Medicare-Medicaid beneficiaries** from all MIPS measure calculations for at least Years 1-4. California physicians have a substantial dual-eligible patient caseload that will hinder their ability to be successful under MIPS. In 2/3 of California's counties, more than 20% of Medicare beneficiaries are dual eligible. In fifteen of the largest California counties, more than 30% of the Medicare population is dual eligible. This exclusion would help small practices avoid penalties for treating high-risk, low-income patients and will ultimately protect access to care for these vulnerable patients.

D. **Immediately Allow virtual groups** to report on behalf of small and HPSA practices starting in Year 1. Virtual groups could provide the infrastructure to help small practices successfully report and meet the MIPS standards.

E. Exempt small practices from MIPS penalties until CMS authorizes virtual groups.

2. **<u>The four MIPS reporting programs (Quality, EHR-Advancing Care Information (ACI), Resource Use, and the Clinical Improvement Activities (CIA)) continue to be unnecessarily burdensome and complex.</u>**

<u>CMA Recommended Improvements:</u>

A. **Reduce the scoring complexity.** The four reporting programs need to be more unified with similar scoring methods to reduce the complexity of the composite score calculation so physicians can understand it and plan for the future.

B. **Allow physician groups to use the group's sub-tax identification numbers** based on the Medicare physician fee schedule area or the hospital payment area in which they provide care.

C. **Telehealth services should be treated the same** as all other in-person services for purposes of calculating MIPS program requirements.

D. **For the Quality Category:**

- **Further reduce the number of required quality measures.**
- **Maintain the existing requirement to only report on 50% of a physician's patients vs. the proposed 80-90% of patients.**
- **Eliminate the manual chart audits for the quality measures.**
- **Ensure quality measure uniformity between the Medicare MIPS program and the Medicare Advantage program.**

E. **For the EHR-Advancing Care Information Category (ACI):**

- **Physicians should be given partial credit for the Base Score** which should automatically advance physicians to the Performance Score component.
- **Reinstate the 90 day performance reporting period** instead of the proposed 365 day period for at least Years 1 and 2.
- **Maintain all existing Meaningful Use Program exclusions and hardship exemptions** and provide additional exemptions for physicians close to retirement, subject to cyber attack or experiencing vendor problems.
- **Eliminate the irrelevant Meaningful Use Stage 3 measures** related to "coordination of care through patient engagement" and "health information exchange."
- **Reduce the number of required Clinical Improvement Activities and provide more credit for the key patient quality activities.**

3. **<u>There is no accountability for EHR vendor compliance and interoperability.</u>**

<u>CMA Recommended Improvements:</u>

A. Vendors must be held accountable for compliance and interoperability with stronger enforcement penalties.

B. **Certify only those EHRs with the ability to satisfy all MIPS measures requirements** in its basic package, including the ability to securely interface with health information exchanges, registries and hospitals.

C. All software vendors should have a standardized implementation timeline for interoperability that is clearly outlined in a vendor's contract with physicians.

D. Interoperability should be a software vendor's basic responsibility and there should be no additional cost to physicians for interoperability to either State or Regional Health Information Organizations (RHIOs).

E. Remove the proposed Advancing Care Information (ACI) mandate for physicians to attest on data blocking. This is a vendor responsibility. Instead, CMS should institute a mandatory revocation of vendor certification for systems that are not interoperable.

F. Physicians contracting with vendors that lose their certification should be made whole by those vendors and granted an automatic hardship exemption by CMS if the system is not updated to compliance within 90 days.

G. Clarify that physicians do not need to develop EHR communication interfaces with patient electronic health monitoring devices, such as FitBit.

4. <u>The MIPS Resource Use category will continue to discourage physicians from treating high-risk, vulnerable patients.</u>

<u>CMA Recommended Improvements:</u>

A. A specific adjustment should be made for the number of Dual Eligible Medicare-Medicaid beneficiaries in a physician's practice to protect physicians from penalties for treating these complex patients and to protect access to care for those most in need.

B. **Bonus points should be awarded to physicians treating a certain threshold of Medicare-Medicaid dual-eligible patients** to ensure that physicians are not discouraged from treating fragile, costly, high-risk patients and to protect access to care. In 2/3 of California's counties, more than 20% of Medicare beneficiaries are dual eligible.

C. **Eliminate the Medicare deductible for Medicare-Medicaid Dual Eligible beneficiaries** who are not enrolled in health plans so physicians are not disincented from caring for these patients.

D. Vast methodology improvements should be made to the Resource Use category including better adjustment for 1) subspecialty physician expenditure comparisons; 2) geographic cost adjustment factors, and 3) socioeconomic status of the patient (race, ethnicity, income, previous insurance coverage).

E. The total per capita cost and the Medicare spending per beneficiary (MSPB) measures for individual physicians should be removed until better measures are developed. The proposed episode groupers should be thoroughly pilot tested before being implemented.

F. Physicians within 1-2 standard deviations of the national average should be rewarded and the all-or-nothing component removed.

5. The Alternative Payment Models are limited and the financial risk requirements severely inhibit the expansion of innovative APMs.

CMA Recommended Improvements:

A. Multiple APM pathways should be provided so that more physician organizations can participate. Track 1 Shared-Savings ACOs should be included.

B. Physician APMs should only be at-risk for costs they can control.

C. Varying levels of financial risk should be established for different types of APMs:

- Path 1: 1% total financial risk for a Part A and Part B expenditure benchmark.
- Path 2: 2.5% total financial risk for a Part B expenditure benchmark.
- Path 3: Upside only Shared-Savings organizations. Shared-Savings risk includes start-up and administrative costs, and the 18 month waiting period for potential shared savings.

D. **Alternatively, financial risk could be set at 2.5% of an APM's Medicare Part B revenue vs. the proposed 4% of an APM's total Medicare expenditures.** The percent can be increased for integrated physician-hospital APMs.

E. Medical Homes:

- **No additional downside financial risk should be imposed on Medical Homes** beyond the initial standard due to their rigorous regulatory requirements, high start-up costs, and the need to promote access to primary care.
- **Eligibility should be expanded to specialty medical homes.**
- **The 50 clinician cap should be eliminated.**

F. A Division of Financial Responsibility (DOFR) should be created for APMs modeled after the California health plan-medical group risk arrangements that exclude from the expenditure benchmark calculation the following services: out-of-area emergency services, out-of-area urgent care services, pre-existing cancer conditions, cancer care, mental and behavioral health care services, burn cases, transplants, cases costing over $100,000 annually, and Medicare Part B and Part D prescription drug costs.

G. The APM Minimum Loss Ratio should be increased from 4% to 10% of the APM's benchmark. A reasonable MLR will help small APMs manage the substantial start-up and administrative costs that consume a large percentage of their budgets.

H. <u>Most important for California</u>, the APM expenditure benchmarks must be set at the national mean of Medicare expenditures per beneficiary so that efficient physicians are not penalized and discouraged from participating. Otherwise, physician groups who have consistently provided high value care (high quality/ low spending), such as California's medical groups, will not be able to participate in the APM track.

The APM expenditure benchmark must include any current year inflation-related Medicare Physician Fee Schedule payment increases, such as the conversion factor, the geographic practice cost index (GPCI), and the CBSA hospital wage index updates.

I. The Advanced APM Comprehensive Primary Care Plus Initiative application deadlines need to be extended to allow California primary care physicians time to collaborate with the private payers to develop robust, multi-payer medical homes.

J. Multiple Physician-Focused Payment Models should be approved and expedited by the Technical Advisory Committee and CMS.

6. <u>The performance reporting period starts too soon - January 1, 2017</u>

<u>CMA Recommended Improvements</u>

A. The performance reporting period should start on January 1, 2018 instead of January 1, 2017 to give all physicians, vendors and registries time to prepare and update their systems since the final program requirements will not be published until October or November 2016.

Conclusion

The detailed CMA comments and background information are attached. CMA is committed to working constructively with CMS to ensure the successful implementation of MACRA for both physicians and their patients. If you need additional information, the CMA contact is Elizabeth McNeil, Vice President, Federal Government Relations, emcneil@cmanet.org; 415 310 2877.

Thank you again for the open dialogue and the opportunity to work together.

Sincerely,

Steven E. Larson, MD, MPH
President

Cc: California Congressional Delegation
Ashby Wolfe, MD, Medical Director, CMS Region IX

DETAILED CMA COMMENTS ON THE MACRA PROPOSED RULE

MERIT BASED INCENTIVE PAYMENT SYSTEM
ALTERNATIVE PAYMENT MODELS
PHYSICIAN-FOCUSED PAYMENT MODELS

1. Inadequate Accomodations for Small Practices and Physicians Practicing in HPSAs

The MACRA law was clear that there be accommodations and assistance for small practice physicians and physicians practicing in health care professional shortage areas (HPSAs). Yet the regulation provides little recognition of the challenges facing small practices with limited resources. CMS proposed a "low-volume threshold" exemption which excludes physicians with 100 Medicare patients and $10,000 in Medicare allowed charges billed. This proposal only exempts 10% of small practices.

According to a 2016 *Health Affairs* study, "US Physician Practices Spend $15.4 Billion annually to Report Quality Measures," a physician and their staff spend an average 15 hours per week dealing with external quality measure reporting issues at an average cost of $40,000 annually ($50,000 for primary care). This does not include implementation costs, EHR vendors fees that range between $10,000- $25,000 (according to a recent CMA survey), staff training or downtime. Moreover, small practices do not enjoy the economies of scale afforded larger organizations. CMS estimates that physicians will expend an additional $128 million to comply with the MIPS rule. Because the cost of reporting is so high for small practices and the real threat of penalties or inadequate bonus payments that do not cover the costs to report, few small practices can participate. The proposed low-volume threshold is not a meaningful exemption for small and rural practices that cannot afford the upfront investments.

More important, there is no phase-in period to help small practices transition and no immediate opportunity for virtual groups that could provide the infrastructure to assist small practices. In fact, all practices must be ready to report on January 1, 2017 - a mere two months after the publication of the final rule.

Furthermore, the rule dramatically increases the quality reporting burden by increasing the reporting threshold from 50% of patients to 80/90% of patients and the impossible EHR Meaningful Use (MU) Stage 3 standards remain. The majority of small practices are not successfully meeting the PQRS and MU Stage 2 measures now. If practices can't meet the lesser requirements now, how will they ever transition and meet these more stringent requirements (i.e., MU Stage 3) under the proposed rule? The intent of MACRA was to significantly decrease the reporting burdens yet the proposed rule has actually increased some of the barriers.

California has 5.6 million Medicare beneficiaries – more than any other state. Small practices are the backbone of the Medicare program serving these patients. Solo and small practice physicians must be given a legitimate opportunity for positive incentive payments. If we don't protect small practices, these physicians will be forced to leave the Medicare program or retire early. Many of them are within 5 to 10 years of retirement. If we lose these physicians, access to care for Medicare patients will become an even bigger challenge, particularly for the most fragile patients.

CMA recommends that the permanent low-volume exemption be significantly expanded. Many small California practices, particularly physicians close to retirement, made the decision to accept the Medicare penalties because the cost of investing in systems was too prohibitive. Psychiatry is an example of a specialty that is predominantly solo and small practice. They have few quality measures and have not broadly adopted expensive EHRs. Moreover, an individual psychiatrist may practice in multiple settings which further complicates the reporting process. Psychiatry is a specialty in high demand with significant shortages. Primary care and addiction medicine are other specialties that are predominantly small practice, in short supply, and unable to afford the infrastructure investments. Practices such as these must be maintained to protect access to care.

Other small practice physicians made the investments but experienced difficulty successfully reporting and received penalties. These penalties make it even more difficult for physicians to afford the shift to MACRA. Whether physicians participated in the previous reporting programs or not, all practices will now need to make extensive changes and upgrades to their systems to comply with the new MACRA requirements.

Because the final regulations will not be published until October-November of 2016, only two months before the initial reporting period, **CMA requests that CMS consider a phase-in period for small practices in addition to the permanent exemption.** These practices need time to prepare, finance new systems, and transition. We believe this is entirely consistent with the statute. Moreover, the CMA MACRA TAC could not agree on a dollar/patient threshold exemption because it is so variable depending on a physician's specialty, practice size, patient mix and location. Therefore, we are recommending a phase-in for small practices that would encompass at least the 40th percentile of physicians within each specialty in Year 1 based on their billings. The phase-in detail is listed below. All of the exemptions listed below should be voluntary because some small practice physicians may wish to participate.

CMA is also recommending that CMS exclude the Medicare-Medicaid Dual Eligible patients from all MIPS calculations for at least Years 1-4 to help small practices successfully meet the MIPS requirements. This is a significant issue in California where a substantial portion of our Medicare patients are low-income, and medically and socially complex dual eligible patients. These dual eligible patients make up 20% of the Medicare population in 2/3 of California's Counties. In fifteen large urban and rural counties, at least 30% of the Medicare beneficiaries are dual eligibles. The vast majority of dual-eligible patients in the Medicare FFS system are treated by physicians in small practices. If Medicare does not appropriately adjust for this growing population of high-need patients, physicians will be heavily penalized for accepting

them. Small practices will be disproportionately impacted. Unfortunately, this could lead to access problems for dual eligible seniors. Therefore, CMA is recommending that dual eligible patients be excluded from the MIPS calculations at least until small practices are successfully participating in MIPS. See the discussion under the Resource Use category.

CMA was extremely involved in crafting the MACRA legislation and we strongly advocated for MACRA to allow virtual groups to report on behalf of solo and small practice physicians. Virtual groups could provide the infrastructure and support to help small practice physicians successfully report. Such groups would also ensure that the data is aggregated and there are statistically valid numbers of patients on which to report. It gives small practices equal standing with larger groups and may be one of the only plausible ways for solo and small group physicians to compete for bonus payments under MIPS. With the budget neutral bonus/penalty payment structure in MACRA, CMA insisted that virtual group reporting be part of MIPS. Virtual groups also provide a transition pathway for small physicians to gain expertise to become medical homes or participate in other alternative payment models. The proposed rule does not allow virtual groups in Year 1. CMA is advocating for CMS to authorize virtual groups to begin immediately in 2017. If CMS is not ready to establish virtual groups, then CMA is supporting a plan proposed by the American Association of Family Physicians (AAFP) that requires small practice physicians (defined as practices with 5 or few physicians) to report and participate in MIPS but it exempts them from penalties until CMS promulgates regulations to establish virtual groups.

CMA Recommendations for Improvement:

A. **Significantly expand the permanent MIPS exemption** for small practice physicians and physicians located in Health Professional Shortage Areas (HPSAs). This exemption would be voluntary for the physician.

B. **Create an additional phase-in pathway for small and rural practices to transition to MIPS.** It would exempt the 40th percentile of all small and rural practices in each specialty in Year 1; the 30th percentile of all small and rural practices in each specialty in Year 2; the 20th percentile of all small and rural practices in each specialty in Year 3; and the 10th percentile of all small and rural practices in each specialty in Year 4. This phase-in is voluntary and would provide more time for resource-limited small practices to prepare, finance new systems and upgrades, change workflow, and transition to MIPS.

C. **Exclude the Dual Eligible Medicare-Medicaid beneficiaries** from all MIPS measure calculations for at least Years 1-4. California physicians have a substantial dual-eligible patient caseload that will hinder their ability to be successful under MIPS. In 2/3 of California's counties, more than 20% of Medicare beneficiaries are dual eligible. In fifteen of the largest California counties, more than 30% of the Medicare population is dual eligible. This exclusion would help small practices avoid penalties for treating high-risk, low-income patients and will ultimately protect access to care for these vulnerable patients.

D. **Allow virtual groups** to report on behalf of small and HPSA practices starting in Year 1 to provide the infrastructure to help small practices successfully report and meet the MIPS standards.

E. **Exempt small practices from MIPS penalties until CMS authorizes virtual groups.**

F. **See Recommendations #2, 3, 4, and 6 below** which will also assist small practices.

2. MIPS Reporting Programs Continue to be Unnecessarily Burdensome and Complex

CMS' failure to truly consolidate the four programs, has created an unnecessarily complex scoring system that few physicians can understand and make plans for the future. There are different scoring mechanisms for each category that do not add up. They are combined into a composite score with a different formula and then weighted. It's overly complex and unnecessary. We urge CMS staff working in different departments to work together to streamline and simplify the four reporting programs and develop a uniform scoring methodology.

Furthermore, the proposed rule does not substantially reduce the burdens of the quality and EHR reporting programs as required by MACRA. There are still significant barriers to participation and many measures continue to be irrelevant to quality patient care or the functionality of a truly interoperable EHR system. CMA urges CMS to improve the chance of success by providing partial credit for all MIPS categories, and further reducing the number of required measures.

Quality Category: As mentioned above, inconsistent with the intent of MACRA, CMS dramatically increased the patient threshold for reporting quality measures from 50% of patients to 80-90% of patients. Mandating an 80-90% patient threshold creates an environment with little room for error or vendor problems. CMA urges CMS to reinstate the 50% threshold. We also urge CMS to reduce the number of quality measures, by eliminating the outcome and cross-cutting measures. CMS should select a few measures that have a high impact on patient care rather than focusing on compliance-related measures that are irrelevant. Another way to reduce burdens on physicians would be to eliminate the manual chart audits, for services such as mammograms, which are often difficult, time-consuming, and completely unnecessary.

Advancing Care Information Category: Of all the MIPS programs, CMA physicians continue to be most concerned with CMS' lack of responsiveness to the legitimate issues that physicians have raised with the Meaningful Use and now Advancing Care Information program. The ACI category continues to be burdensome and irrelevant to patient care. The pass/fail requirement remains in the base score which could actually prevent a physician from gaining points under the ACI performance score category. Physicians should receive partial credit for activities in the base score. The Meaningful Use Stage 3 measures related to "coordination of care through patient engagement" and "health information exchange" should be eliminated for now.

Physicians need basic functionality before they can move forward with these measures. As mentioned earlier, the vast majority of physicians have failed to meet the Meaningful Use Stage 2 measures. Imposing more difficult Stage 3 measures that are compliance driven rather than patient centric is not realistic and irrelevant to the purpose of an EHR.

Under the Clinical Improvement category, the population health measures were developed for use at the hospital level and are not statistically reliable at the individual physician level. Those measures should be removed. Moreover, some of the more important patient activities should count as high-weight clinical improvement activities.

Finally, CMS currently allows physicians to report individually or as a group through one TIN. However, many California medical groups are large and provide care across several Medicare geographic payment regions with substantially different payment rates. **These medical groups have requested the option to report to CMS through their sub-tax ID numbers** based on the Medicare physician fee schedule area or the hospital payment area in which they provide services. This would be an issue for virtual groups as well.

CMA Recommendations for Improvement:

A. Reduce the scoring complexity. The four reporting programs need to be more unified with similar scoring methods to reduce the complexity of the composite score calculation so physicians can understand it and plan for the future.

B. **Allow physician groups to use the group's sub-tax identification numbers** based on the Medicare physician fee schedule area or the hospital payment area in which they provide care.

C. **Telehealth services should be treated the same** as all other in-person services for purposes of calculating MIPS program requirements.

D. **For the Quality Category:**
- **Further reduce the number of required quality measures.**
- **Maintain the existing requirement to only report on 50% of a physician's patients vs. the proposed 80-90% of patients.**
- **Eliminate the manual chart audits for the quality measures.**
- **Ensure quality measure uniformity between the Medicare MIPS program and the Medicare Advantage program.**

E. For the EHR-Advancing Care Information Category (ACI):
- **Physicians should be given partial credit for the Base Score** which should automatically advance physicians to the Performance Score component.
- **Reinstate the 90 day performance reporting period** instead of the proposed 365 day period for at least Years 1 and 2.

- **Maintain all existing Meaningful Use Program exclusions and hardship exemptions** and provide additional exemptions for physicians subject to cyber attack, experiencing vendor problems, or close to retirement.
- **Eliminate the impossible, irrelevant Meaningful Use Stage 3 measures** related to "coordination of care through patient engagement" and "health information exchange."
- **Reduce the number of required Clinical Improvement Activities and provide more credit for the key patient quality activities.**

3. No Accountability for Vendor Noncompliance or Interoperability

The CMA MACRA TAC ranked this problem as one of the top priorities for reform. California physicians continue to be frustrated that they are held accountable for vendor-caused problems beyond their control which have multiple negative consequences for physician and their patients. The proposed rule lacks adequate accountability and penalties for problems caused by the quality/EHR vendors. Moreover, the add-on fees imposed by the vendors have become unnecessary and prohibitive. Ironically, the proposed rule holds physicians accountable for vendor interoperability which is unreasonable. Vendor systems that are not interoperable should be decertified by CMS and ONC. And physicians who cannot comply with MIPS because of vendor decertification should be granted a safe harbor or a hardship exemption from the MIPS penalties. Moreover, these physicians should be made whole by their vendors because they were kept from collecting potential bonus payments. This is a significant issue that creates barriers to the appropriate exchange of information necessary to improve care. The interoperable exchange of information is the entire basis for an electronic health record.

The lack of vendor accountability in digital health technologies is a major barrier to physicians meeting the Advancing Care Information program measures. While CMA applauds CMS' general goal to promote interoperability in its Office of National Coordinator for Health IT *2016 Interoperability Standards*, requiring eligible physicians to attest that "he or she has not knowingly and willfully taken action to limit or restrict the compatibility or interoperability of a certified EHR technology" is misguided. Data blocking has largely been a vendor issue and the implication that eligible physicians are responsible is inaccurate. Until CMS implements enforcement measures that have penalties against vendors who participate in data blocking or promote systems that are not interoperable, the physician attestation requirement on data blocking should be removed. CMA views the lack of interoperability not only as a barrier to physicians meeting the Advancing Care Information measures, but as a general hindrance to the advancement of digital health.

The CMA also objects to vendors that charge additional fees far above the initial implementation costs for necessary upgrades and interfaces to achieve Meaningful Use and now Advancing Care Information. In a recent survey of CMA members, some physicians reported paying $10,000-$25,000 in additional interface costs to connect their

EHRs to a health information exchange. Therefore, CMA recommends the following reforms in the strongest of terms.

CMA Recommendations for Improvement:

A. Vendors must be held accountable for compliance and interoperability with stronger enforcement penalties.

B. **Certify only those EHRs with the ability to satisfy all MIPS measures requirements** in its basic package, including the ability to securely interface with health information exchanges, registries and hospitals.

C. All software vendors should have a standardized implementation timeline for interoperability that is clearly outlined in a vendor's contract with physicians.

D. Interoperability should be a software vendor's basic responsibility and there should be no cost to physicians for interoperability to either State or Regional Health Information Organizations (RHIOs).

E. Remove the proposed Advancing Care Information mandate for physicians to attest on data blocking. This is a vendor responsibility. Instead, CMS should institute a mandatory revocation of vendor certification for systems that are not interoperable.

F. Physicians contracting with vendors that lose their certification should be made whole by those vendors and granted an automatic hardship exemption by CMS if the system is not updated to compliance within 90 days.

G. Clarify that physicians do not need to develop EHR communication interfaces with patient electronic health monitoring devices, such as FitBit.

4. <u>The MIPS Resource Use category will continue to discourage physicians from treating high-risk, vulnerable patients.</u>

While CMS has made some improvements to the Resource Use category (formerly the Value Modifier), substantial work needs to be done to ensure there is proper risk adjustment for severity of illness and for the socioeconomic status of the patients, as well as the appropriate expenditure attribution at the individual physician level. If the CMS methods are not vastly improved, it will have serious consequences for patients with additional medical and social complexities that accompany low-income status. This is a significant issue in California because our diverse, low-income, high-risk population.

CMA is concerned that despite the CMA-authored requirements in the Affordable Care Act to adjust for geographic cost differences and the socioeconomic status of patients, CMS is not making appropriate adjustments. Without proper adjustment, physicians will be penalized for treating high-risk, fragile patients. Patients with a lifetime history of poverty and poor access to medical care become eligible for Medicare with pent-up demand that results in high costs and difficult outcomes. The 2013 Congressionally-mandated Institute of Medicine report titled, "Variation in Health Care Spending" criticized the Dartmouth Atlas studies, and strongly recommended to CMS that geographic cost inputs and socioeconomic factors be incorporated into the Medicare physician expenditure comparisons under the Value Modifier, now the Resource Use category.

Since the 2013 IOM report, there has been widespread recognition that Medicare spending measures are penalizing both physicians and hospitals that care for lower income and more challenged patients. CMS acknowledges in the preamble to the proposed rule that physicians treating the largest shares of Medicare's sickest patients are most likely to be penalized under the current value modifier program. There is a serious risk that continuing to penalize physicians using the problematic value modifier measures under the MIPS program could force them to avoid caring for patients who have the greatest needs. In the preamble, CMS also acknowledges the extensive comments it has received describing the many problems with the existing value modifier measures, but CMS then proposes to continue using them.

CMA believes that it is inappropriate to use broad measures such as total per capita costs and Medicare Spending Per Beneficiary (MSPB) to evaluate the resource use of individual physicians. Many Medicare beneficiaries have multiple health problems, and in most cases, those different health problems are treated by multiple physicians and other providers. The CMS reports consistently show that the services delivered by an individual physician represent a tiny fraction of the total cost of care for their patients. Moreover, under Medicare rules, beneficiaries have the freedom to see any physicians they wish to obtain treatment for their health problems. Even if each of the individual physicians whom a patient sees is "efficient" in the services they deliver and order, the overall spending on the patient's care may be higher than for other patients because of the number and types of physicians and other providers the patient chooses to use. While CMS' attribution methodology has substantially improved, this remains a problem. Both the total cost of care and the MSPB measures should be removed for individual physicians and replaced with better measures as they become available. The episode groupers should be thoroughly pilot tested before implementation as well.

One way to improve the accuracy of the socioeconomic and health risk-adjustment methodology would be to make a specific adjustment for the number of Medicare-Medicaid dual eligible patients in a physician's practice and if the number of those patients reaches a certain threshold then the physician should be awarded bonus points. Such an adjustment would help to capture a more accurate reflection of the physician's most challenging patients and protect access to care for those patients. **This is a significant issue in California because of the growing numbers of diverse, low-income, medically-challenged patients.** In two-thirds of the counties in California, over 20% of the Medicare beneficiaries are dual Medicare-Medicaid eligible beneficiaries. Dual patients comprise over 30% of the Medicare population in fifteen

California counties. These fifteen California counties include large urban centers, such as Los Angeles and San Francisco, as well as small rural areas, such as Bakersfield and Tulare. If Medicare does not appropriately adjust for this growing population of high-need patients, physicians will continue to be heavily penalized for accepting them and access to care will become more challenging for these vulnerable seniors.

CMA also recommends that patients who are eligible for Medicare because of ESRD be excluded as well. Nephrology services are extremely costly and the current risk adjustment methodologies do not fully account for these patients.

In addition, California medical groups report to CMA that under the Medicare Group Practice Reporting Option, many high quality, efficient medical groups that are within 1 standard deviation from the national mean are not being rewarded properly for such high-value care. CMS has set the bonus threshold at more than one standard deviation from the national mean of Medicare beneficiary expenditures so that only a handful of groups across the entire nation are rewarded. Moreover, this program continues to be a pass/fail program. Physician groups should receive partial credit for the measures that are met. Physician groups providing such value-driven services should be recognized and rewarded by CMS pursuant to the law. California groups are expending significant resources to reach such standards and the intent of the law was for them to be appropriately reimbursed for their high quality and low spending – spending that is well below the national average. Please see the attached graph that illustrates the national group practice performance.

In California, through the Integrated Healthcare Association (IHA) – a regional healthcare improvement collaborative - the private health plans are implementing a value modifier with California's hospitals and large medical groups. However, there are significant differences between the IHA modifier and the CMS value modifier/resource use program. CMA recommends that CMS review the IHA program at www.iha.org. The IHA program is upside only and does not impose penalties on physicians; the incentives are linear rather than the CMS bonus threshold which is set at more than one standard deviation from the national mean; bonuses are provided for minimum performance rather than the CMS pass/fail system; patient satisfaction scores are not included; and the total cost of care is a gateway to additional resources with "resource use" being one metric vs. the complex total per capita cost formula established by CMS.

CMA Recommendations for Improvement:

A. **A specific adjustment should be made for the number of Dual Eligible Medicare-Medicaid beneficiaries in a physician's practice to protect physicians from penalties for treating these complex, low-income patients and to protect access to care for those most in need.**

B. **Bonus points should be awarded to physicians treating a certain threshold of dual-eligible patients** to ensure that physicians are not discouraged from treating fragile, costly, high-risk patients to protect access to care. In 2/3 of California's counties, more than 20% of Medicare beneficiaries are dual eligible.

C. **Eliminate the Medicare deductible for Medicare-Medicaid Dual Eligible beneficiaries** who are not enrolled in health plans so physicians are not disincented from caring for these patients.

D. Vast methodology improvements should be made to the Resource Use category including better adjustment for 1) subspecialty physician expenditure comparisons; 2) geographic cost adjustment factors, and 3) socioeconomic status of the patient (race, ethnicity, income, previous insurance coverage).

E. The total per capita cost and the Medicare spending per beneficiary (MSPB) measures for individual physicians should be removed until better measures are developed. The proposed episode groupers should be thoroughly pilot tested before being implemented.

F. Physicians within 1-2 standard deviations of the national average should be rewarded and the all-or-nothing component removed.

5. The APM Models are Limited and the Financial Risk Requirements Severely Inhibit the Expansion of Innovative APMs.

CMA is extremely disappointed that the Alternative Payment Model (APM) track is limited to those few existing innovation center projects. We have several excellent Track 1 ACOs in California that are helping small practices transition to value-based care systems and we believe they should be provided an opportunity to become APMs. There should also be better pathways for Patient Centered Medical Homes to qualify – whether they are primary care or specialty care. Moreover, many national specialty societies have been working diligently to develop creative APMs and they have been blocked from participation. Of course, these entities can pursue the Physician-Focused Payment Model track but there are no guarantees they will be approved and they will not be eligible for the automatic 5% bonus payments afforded under MACRA. Moreover, CMS has indicated that these models could be subject to a long review process.

CMA worked closely with Congress to develop the MACRA legislation and we never contemplated that the APM track would be so limited or so difficult to participate. The APM concept was to promote improvements in the delivery of care, innovation, integration and coordinated care. CMA urges CMS to provide multiple pathways for physician-led organizations

to become APMs with different levels of financial risk based on the type of organization. Track 1 ACOs should be included and responsible for both Part A and Part B shared savings.

The financial risk requirements in the proposed rule are not realistic for most physician organizations. The risk standards pose enormous barriers to participation. We would argue that the risk standards are well beyond the Congressional intent of "more than nominal financial risk." In fact, in California, an organization would require an insurance license to accept such substantial risk for both physician and hospital services. The California Knox-Keene Act sets strict financial standards (tangible net equity and massive reserves) for organizations accepting financial risk for physician and hospital services, as well as prescription drugs. We agree with the extensive AMA analysis that "more than nominal" is less than the Secretary's definition of significant which is 3% and that since Congress heavily incented the APM track, they certainly would not have imposed greater financial risk on APMs than the 4% penalty under the MIPS program. Therefore, it is reasonable to argue that financial risk should be set at less than 3%. **We would propose that it be set at 2.5% consistent with CMS' medical home financial risk standard.**

Based on the broad medical group financial risk experience of the CMA physicians on the CMA MACRA TAC, we are recommending different levels of total financial risk depending on the services at-risk. 1% total financial risk for Part A and B expenditures; 2.5% total financial risk for Part B expenditures only; and upside shared savings models that are at-risk for two years before they receive any potential shared savings payments. These recommendations are listed below.

Alternatively, CMS might consider basing the financial risk requirements on the APM's Medicare revenues instead of its Medicare expenditures. Again, this is consistent with CMS' 2.5% financial risk standard for medical home revenues. It could be a more appropriate standard that APMs could depend on. And the MACRA law certainly did not require risk to be defined solely in terms of CMS losses. For many physicians in APMs, being at risk for 4% of Medicare spending could wipe-out the physician's overall revenue. For APMs composed of medical practices that only receive revenues for Part B professional services, total risk would be a percentage of their professional services revenues. For APMs involving more integrated physician-hospital organizations, the organization's total risk would be a percentage of both Part A and Part B revenues.

Just as important, CMA urges CMS to promote medical homes, particularly to increase access to primary care physicians. Based on the existing CMS financial requirements for medical homes and the rigorous regulatory requirements, we do not believe that medical homes should be burdened with additional financial risk. The medical home track should be open to both primary care and specialty medical homes and the 50 clinician/provider limit should be eliminated.

Another concept that is important to protecting the financial solvency of risk-bearing APMs, is the California "Division of Financial Responsibility" (DOFR) agreement that is commonly part of contracts between California health plans and contracting medical groups to delineate

financial responsibility for services between the two organizations. Based on this model, we have outlined below the services that should be the Medicare program's financial responsibility and not part of an APM's expenditure benchmark calculation. While we understand that CMS has set limits on the marginal and total financial risk, we believe that the costs in the DOFR model outlined below should not be borne by APMs. For instance, it is not appropriate for physicians to be at-risk for Part B and Part D prescription drugs costs that are determined by the pharmaceutical manufacturers and are beyond a physician's control. There are new treatments for rheumatological (Humira) conditions and various Hepatitis C treatments that are extremely expensive. CMS should take financial responsibility for these therapies and not create incentives for physicians to withhold new, effective, and costly, yet innovative medications.

In addition, we reviewed the budgets of a new ACO and another start-up organization and determined that the **4% Minimum Loss Ratio established by CMS is inadequate**. We fully appreciate CMS' recognition of the substantial start-up costs and on-going administrative costs of operating an APM and that those costs should not be part of the APM's expenditure calculation. However, only exempting 4% of the total benchmark spending for administrative costs is too low. Both California state law and federal law establish an 85% Medical Loss Ratios for public and private health plans to ensure that no more than 15% of the plan's revenue is spent on profit and overhead. While the medical loss ratio is different from the minimum loss ratio proposed by CMS, we believe it is a widely accepted indicator of the administrative costs incurred in the delivery of health care.

For most APMs, administrative costs will consume a substantial portion of the APM's expenditures. The costs of redesigning care delivery to improve outcomes can be significant. Physicians choosing to participate in an APM often need to hire care coordinators and patient and family educators whose services cannot be billed under the Medicare Fee Schedule. Existing staff need to be trained in the new way of delivering care. It is expensive to conduct ongoing data analysis to determine which patients need to be proactively scheduled for a visit or test, to communicate with patients by phone about self-management to control their symptoms or properly take medications, and to reengineer scheduling systems, hire extra staff, and leave appointment slots open to provide rapid access for high risk patients, as well as after-hours access. Care redesign can also require practices to provide additional clinical services to reduce the likelihood of complications that could lead to emergency visits. In addition, physicians in an APM frequently engage in the development of treatment plans, organize multidisciplinary teams to improve care coordination and quality, supervise care managers, communicate frequently by phone and other technology which cannot be billed under the Fee Schedule. A new survey by the National Association of Accountable Care Organizations (NAACOs) found that these and similar operating costs average $1.6 million annually. Therefore, we recommend that the MLR be increased to 10% of the benchmark.

One of the most important issues for California physicians to form and successfully operate APMs, is the financial risk expenditure benchmark calculation. California is one of the most costly states for physicians to operate a medical practice. We have nine of the most expensive Medicare geographic payment regions in the country. Therefore, the expenditure benchmarks

must take into account the APM's geographic practice costs and the socioeconomic status of its patients – just as Medicare adjusts the value modifier (now Resource Use category). California has a high percentage of low-income, high-risk patients in need of extensive medical care.

Moreover, California physicians have operated in a highly regulated managed care environment for decades and thus, our expenditures compared to the national average are relatively low, particularly if the spending is adjusted for geographic cost inputs and the socioeconomic status of the patients. Congress appropriately set the value modifier (now the Resource Use Category) expenditure benchmark at the national average. However, CMS originally set the spending benchmarks for the ACOs at their historical spending levels. And now CMS has set the APM benchmark at the APM's historical spending levels. Such a benchmark discriminates against efficient physician organizations that have already employed innovations and reduced spending. There is little room to further reduce spending and therefore, the margins are too tight to attract California groups to participate in either the ACO program or the MACRA APM program. We realize that CMS recently changed the ACO benchmark to expenditures within the county in which the ACO operates, but many of California's large medical groups cover an entire county and therefore, they are still being compared to themselves. **We strongly urge CMS to set the APM financial risk expenditure benchmark at the national average of Medicare expenditures so that efficient physicians are not penalized and discouraged from participating in APMs. Efficient physicians have been the innovators and can continue to lead change if allowed to operate in a reasonable environment.**

CMA also requests that current year Medicare Physician Fee Schedule payment adjustments, such as the conversion factor, Geographic Practice Cost Index (GPCI), and CBSA hospital wage-index adjustments should be factored into an APM's expenditure benchmark targets which are based on prior year expenditures. This adjustment would ensure that APMs are not penalized for higher costs associated with Medicare Physician Fee Schedule increases.

Finally, the Comprehensive Primary Care Plus timelines prevent Californians from participating. The Comprehensive Primary Care Plus Program is an attractive care delivery model for California primary care physicians. However, CMS published the CPC Plus rule in April and the MACRA APM CPC Plus rule in May. The MACRA rule requires applications from interested physicians and two private payers to be submitted by July 1, 2016. California physicians need more time to collaborate with the private payers to develop robust, multi-payer medical homes. Despite the level of interest and the attractive markets for CMMI PCP models, there aren't any operating in California. We respectfully request that CMS extend the deadlines for new physicians and payers in different geographic regions to participate.

CMA Recommendations for Improvement:

A. **Multiple APM pathways should be provided** so that more physician organizations can participate. Track 1 Shared-Savings ACOs should be included.

B. **Physician APMs should only be at-risk for costs they can control.**

C. Varying levels of financial risk should be established for different types of APMs:

- Path 1: 1% total financial risk for a Part A and Part B expenditure benchmark.
- Path 2: 2.5% total financial risk for a Part B expenditure benchmark.
- Path 3: Upside only Shared-Savings organizations. Shared-Savings risk includes start-up and administrative costs, and the 18 month waiting period for potential shared savings.

D. **Alternatively, financial risk could be set at 2.5% of an APM's Medicare physician revenue vs. the proposed 4% of an APM's total Medicare expenditures.** The percent can be increased for integrated physician-hospital APMs.

E. Medical Homes:

- **No additional downside financial risk should be imposed on Medical Homes** due to their rigorous regulatory requirements and the need to promote access to primary care.
- **Eligibility should be expanded to specialty medical homes.**
- **The 50 clinician cap should be eliminated.**

F. A Division of Financial Responsibility (DOFR) should be created for APMs modeled after the California health plan-medical group risk arrangements that exclude from the expenditure benchmark calculation the following services: out-of-area emergency services, out-of-area urgent care services, pre-existing cancer conditions, cancer care, mental and behavioral health care services, burn cases, transplants, cases costing over $100,000 annually, and Medicare Part B and Part D prescription drug costs.

G. The APM Minimum Loss Ratio should be increased from 4% to 10% of the APM's benchmark. A reasonable MLR will help APMs manage the substantial start-up and administrative costs.

H. Most important for California, the APM expenditure benchmarks must be set at the national mean of Medicare expenditures per beneficiary so that efficient physicians are not penalized and discouraged from participating. Otherwise, physician groups who have consistently provided high value care (high quality/low spending), such as California's medical groups, will not be able to participate in the APM track.

The APM expenditure benchmark must include any current year inflation-related Medicare Physician Fee Schedule payment increases, such as the conversion factor, the geographic practice cost index (GPCI), and the CBSA hospital wage index updates.

It should also be inclusive of other cost inputs that may affect local total cost of care adjustments, such as the hospital rural wage index floor, frontier state payments and the work GPCI floor adjustment.

I. **The Advanced APM Comprehensive Primary Care Plus Initiative application deadlines need to be extended to allow California primary care physicians time to collaborate with the private payers to develop robust, multi-payer medical homes.**

J. **Multiple Physician-Focused Payment Models should be approved and expedited by the Technical Advisory Committee and CMS.**

6. Performance and Reporting Periods

The proposed rule requires that MIPS and APM participation be measured starting January 1, 2017 with the first MIPS payment adjustments being made in January 2019, and the first incentive payments to Advanced APMs being made in mid-2019.

CMA believes that the proposed start date for the performance reporting periods is too early and will create significant problems for the launch and the success of the MACRA programs. MACRA will require some fundamental changes to physicians' reporting systems and therefore, we urge CMS to treat the first year as a transitional period that allows physicians to move away from the existing Medicare reporting requirements, learn about MIPS and APMs, and implement workflow and system changes to become successful MACRA participants. We therefore believe that CMS should not begin the first MACRA performance period until January 1, 2018.

CMA Recommendations for Improvement:

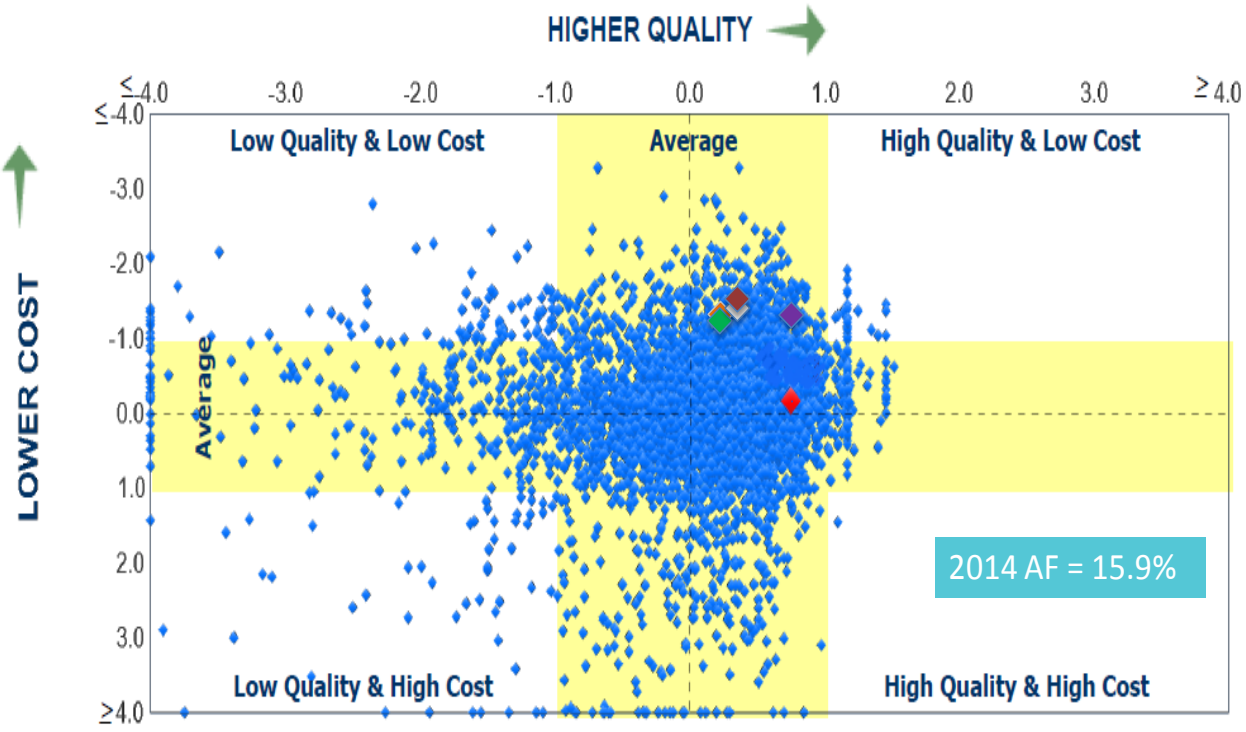
A. **The performance reporting period should start on January 1, 2018 instead of January 1, 2017 to give all physicians, vendors and registries time to prepare and update their systems since the final program requirements will not be published until October or November 2016.**

MEDICARE GROUP PRACTICE REPORTING OPTION PERFORMANCE

Analysis Based on 2014 QRUR reports

Your 2014 score ( ) affects your Medicare Reimbursements for 2016*

The scatter plot below displays your group's quality and cost performance relative to that of your peers.



* The reward size will vary each year, based on an adjustment factor (AF) derived from CMS actuarial estimates.