MGMA comment: MGMA supports a separate, lower risk standard for Other Payer MHMs for the same reasons expressed by CMS, namely that these types of models often have less exposure to risk and would accordingly be less inclined to participate in Advanced APMs if subject to the standard Other Payer risk standards. This standard should mirror that for Medicare and Medicaid MHMs given there is no reason Other Payer MHMs should be disadvantaged in any way, particularly as they are more widespread and developed than government models at this point. Furthermore, CPC+ is a multipayer model, so establishing a consistent standard would further support the growth and development of CPC+ and reduce overall complexity in the QPP. Based on MGMA's consistent principle of not arbitrarily restricting participation in Advanced APMs, we do not support the 50-clinician cap nor imposing any specialty restrictions for Other Payer MHMs. We reiterate our earlier points that MACRA does not restrict specialty models from qualifying as MHMs and many specialty models fulfill the vast majority of characteristics of a MHM outlined in §414.1305. It is inconsistent to recognize these models as MHMs in MIPS, but not APMs.

Other Payer Advanced APM nominal amount standard

CMS proposal (82 Fed. Reg. 30181): The nominal amount standard for Other Payer Advanced APMs would entail three separate measures of risk (marginal risk, minimum loss rate, and total risk), whereas Advanced APMs are only evaluated on total risk. A second Other Payer Advanced APM nominal amount standard based on revenue would be added in addition to one based on expected expenditures, i.e., the benchmark. This would match the revenue-based nominal amount standard for Advanced APMs at 8% of revenues for the 2019 and 2020 performance periods. CMS solicits comments on whether this standard is appropriate and whether it should establish a separate, potentially lower standard specifically for small and rural practices.

MGMA comment: If an Other Payer Advanced APM Entity is willing to accept substantive levels of total risk, this should be considered a sufficient minimum standard for bearing nominal risk, as is the case for Advanced APMs. Adding additional, unnecessary stipulations to becoming an Advanced APM would only discourage development of and participation in new Other Payer APMs, particularly at the outset. As CMS points out elsewhere in the proposed rule, this standard is only a minimum. Individual models could always require higher levels of risk and this level could be theoretically increased over time as practices gain more experience with Other Payer APMs. In the interim, the baseline should be kept as minimally burdensome as possible to achieve the joint industry and CMS goal of widespread participation in Advanced APMs.

As noted in our comments pertaining to the nominal amount standard, we feel that 8% constitutes levels of risk substantially beyond "nominal." Accordingly, we implore CMS not to increase this standard beyond this level for this reason and to ensure stability and predictability for ECs. The revenue-based standard should also be kept open-ended to align with both other nominal financial risk standards. MGMA supports CMS' logic behind implementing a more gradual increase in the MHM risk standard and encourage the agency to apply this same logic to the general nominal amount standard, as doing so would provide a much more effective onramp to widespread Advanced APM participation, particularly in these first critical years. Specifically, we recommend CMS set the nominal amount standard at 4% in 2018, 6% in 2019-2020 and 8% and 2021 and beyond. We remind CMS that Advanced APM Entities will already be facing increasing risk levels due to the statutory Advanced APM participation threshold increases that are up to triple current levels over the course of just a few years. This already represents a substantial increase in risk levels and increasing the nominal amount standard at the same time would likely become too high a barrier for many Advanced APM Entities to overcome and could lead to drastic cuts in participation in value-based payment models.

We agree with the agency that smaller and rural practices have less resources and struggle to meet the same risk standards of larger practices and support a more appropriate, lower risk standard specifically for small and rural practices. We believe it would encourage and enable more of these practices to successfully participate in risk-bearing models. Establishing a separate, lower standard for these types of practices would also give CMS the opportunity to engage an new practices that would not otherwise participate in higher risk models, or those that tried the existing higher risk models, found the risk levels unworkable and would no longer participate anyway. Considering these types of practices often serve some of the most vulnerable patient populations and have less sophisticated infrastructures, they stand to see even higher returns in terms of reduced expenditures by implementing simple value-based strategies such as enhanced care coordination efforts. CMS should seek every opportunity to tap into this market that has the potential to yield substantial reductions in healthcare spending, including establishing more appropriate risk expectations.

MGMA urges CMS not to impose unnecessary restrictions on this standard, as doing so would only handicap its purported goal of encouraging Advanced APM participation by these types of practices. In the interest of consistency, we also implore CMS to apply the same definition of a rural and practice used for MIPS scoring to evaluate whether a practice would qualify as rural for purposes of the revenue-based nominal amount standard for both Advanced APMs and Other Payer Advanced APMs. For the sake of reducing further complexity in the QPP, we suggest the agency use the same definitions for small and rural practices currently used for MIPS scoring and align this standard for small and rural practices with the proposed MHM nominal amount standard.

Other Payer Advanced APM determination process

CMS proposal (82 Fed. Reg. 30183): Payers, states and territories (in the case of Medicaid models) would be able to request determinations prior to each performance year, starting with the 2019 performance year for certain payment arrangements including Medicare Health Plans, CMS Multi-Payer Models and those authorized under Title XIX, and in the 2020 performance year for others. The submission period would occur in the year prior to the relevant performance year, though the exact timeframe would vary by payer to align with existing CMS processes and other relevant deadlines to the extent possible. Following the payer-initiated demonstration process, APM Entities and ECs would have their own opportunity to submit payment arrangements not already nominated.

MGMA comment: MGMA has substantial concerns about the complexity of the proposed Other Payer Advanced APM determination process, including the feasibility of an annual application process. While we understand CMS' intent to maintain up-to-date information given potential changes from year to year, CMS could still maintain accurate records while greatly minimizing burden on all parties involved, including their own staff, by not requiring applications be resubmitted each year when there are no changes. We urge CMS to leave determinations open ended and allow payers, APM Entities and ECs to make any changes as necessary during an annual open application period. If CMS does set expiration dates for Other Payer Advanced APM determinations, determinations should be valid for a minimum of five years to minimize the administrative burden and provide certainty to physician group practices devoting significant resources to success in Advanced APMs.

In many ways, the private payer market is outpacing public payers when it comes to the development and sophistication of APMs, and many MGMA member practices are already engaging in innovative payment models with commercial payers. We see no reason why CMS should delay recognizing these physician group practices who have supported and invested in CMS' vision by partaking in innovative care models. By proposing to allow determinations for Medicaid, CMS multi-payer models and Medicare Advantage (MA) plans to begin in 2019, CMS demonstrates that it has the capability to begin

evaluating Other Payer determinations in 2019, so we see no reason why CMS would arbitrarily delay those determinations if private payers are willing and able to supply the necessary data. Accordingly, we urge CMS to begin all Other Payer determinations in 2019.

Guidance and submission form

CMS proposal (82 Fed. Reg. 30183): CMS intends to release additional information regarding the process and forms for the Other Payer determination process at a future date prior to the first submission period.

MGMA comment: MGMA would like to emphasize the importance of making vital details about the forms and submission process as soon as possible. The QPP has been hindered by the absence of vital information regarding participation eligibility in MIPS and APMs up to halfway through the performance year. This hinders practices' ability to succeed in MIPS by cutting short their window to plan and prepare. A similar rollout could be equally as damaging to the success of Other Payer Advanced APMs. We appreciate the Administration's expressed interest in stakeholder feedback and will intend to submit more precise comments regarding the Other Payer Advanced APM determination process as more information is made available and look forward to working with the Administration to ensure a smooth rollout.

Incomplete information

CMS proposal (82 Fed. Reg. 30184): Should the information submitted be inadequate or incomplete, CMS would notify the submitter and allow 10 business days to submit the required information.

MGMA comment: We appreciate CMS's recognition that there will likely be a learning curve in the first few years of this voluntary Advanced APM determination request process by providing a second opportunity for submitters to provide missing documentation. However, given the complexity of requirements and magnitude of supporting documentation, MGMA believes 10 business days is an insufficient timeframe for a submitter to internally communicate with the appropriate parties, resolve any issues and collect and resubmit the appropriate information to CMS. While we understand the importance of keeping the determination process on track, we believe extending the resubmission window will have exponential returns in terms of APM Entities' ability to comply with documentation requirements and will therefore lead to increased participation in Advanced APMs. CMS should avoid restricting the pathway to Advanced APM participation due simply to an arbitrarily short turn-around for paperwork that would potentially force applicants to wait an entire additional calendar year to resubmit, particularly given the limited timeframe to earn the 5% bonus.

Final determinations

CMS proposal (82 Fed. Reg. 30184): All Other Payer Advanced APM determinations would be considered final and not subject to reconsideration.

MGMA comment: MGMA takes issue with the fact that there would be no opportunity to appeal a determination. Payers, clinicians and APM Entities would have invested a significant amount of time, energy and resources to build an APM from the ground up, supporting the Administration in its drive to value-based reimbursement. It would be short-sighted and counter to the agency's goals to reject qualifying entities with no recourse, potentially for a trivial reason, and not allow them another opportunity to resubmit for an entire year. These first few years are particularly critical, given the inevitable learning curve and limited window to earn the 5% lump sum incentive payments. By

instituting a sink-or-swim approach, the agency could impede its goal of moving the healthcare industry toward value-based reimbursement. Not only would rejected APMs reevaluate continuing to invest extensive resources participating in an APM, a wave of rejections would likely dissuade the future development of new APMs. Therefore, we urge CMS to work with Other Payer Advanced APM applicants and provide feedback explaining why an initial determination application was not approved and to allow submitters at least one additional opportunity to appeal a rejected determination, address any areas of concern and resubmit for consideration. In the interest of lending legitimacy to the process, we recommend this second determination be administered by a separate department within the agency. We urge the agency to install a formal appeals and secondary determination process, as it would have very little to no downside cost for the agency but would yield exponential returns in terms of private sector support of APMs.

CMS notification and posting of Other Payer Advanced APMs

CMS proposal (82 Fed. Reg. 30184): For both the payer-initiated and clinician-initiated processes, CMS would notify submitters of determinations "as soon as practicable" and post a list of approved Other Payer Advanced APMs prior to the start of the relevant performance period.

MGMA comment: MGMA urges the agency to formalize a mandatory turnaround for Other Payer Advanced APM determination requests. A transparent and predictable process for approval as an Advanced APM is vital to ensuring continued private sector development of APMs. CMS noted in the QPP Year 1 final rule that applications submitted by Sept. 1 would receive a determination prior to Dec. 1, so it appears a 60-day turnaround is considered reasonable by the agency. We ask CMS to formalize through rulemaking this timeline for returning final determination requests so that private sector APM developers and participants can appropriately plan.

Medicare Advantage (MA) Advanced APMs

CMS proposal (82 Fed. Reg. 30190): CMS seeks comment on ways to award credit toward the Medicare Option for participating in MA Advanced APMs.

MGMA comment*:* MGMA supports counting MA plans toward the Medicare QP threshold. According to a June 2017 brief by The Henry J. Kaiser Family Foundation, one out of every three Medicare beneficiaries is now enrolled in a MA plan. As MGMA and other stakeholders have expressed in past comment letters, MA plans can and should be counted toward the Medicare QP threshold under the beneficiary count alternative. MACRA does not limit the beneficiary count standard to Medicare fee for service (FFS) patients. CMS can and should include MA enrollees in the patient count methodology beginning with the 2019 performance period. To avert unintended consequences of diluting the denominator for existing Medicare QP calculations, we recommend CMS build on its current multi-step approach in which traditional Medicare FFS payment and patient thresholds would be calculated first, after which Advanced APM Entities that do not meet either threshold would have a second Medicare patient count threshold calculated using combined Medicare FFS and MA patients. If an Advanced APM Entity is not captured in either of these steps under the Medicare threshold, it would then proceed to the All-Payer QP threshold calculations.

Use of CEHRT

CMS proposal (82 Fed. Reg. 30194): For the payer-initiated process, CMS would a payer provide evidence that the CEHRT criterion is satisfied. For the EC-initiated process, CMS would presume an

Other Payer Advanced APM satisfies the 50% CEHRT use criterion given the agency receives documentation demonstrating that the APM requires ECs to use CEHRT.

MGMA comment: MGMA generally supports this proposal, given that it appropriately recognizes use of CEHRT while minimizing burdensome documentation or attestation requirements, particularly at the individual clinician level. However, because contracts between payers and APMs may not use precise language identifying the use of CEHRT and clinicians have little control over the exact language used in these contracts, we urge CMS to give deference to common synonyms, such as EHR and EMR.

Calculation of threshold scores and QP determinations under the All-Payer Combination Option

CMS proposal (82 Fed. Reg. 30198): CMS would make two separate All-Payer QP determinations during the performance period: one based on data from Jan. 1 through March 31 and another overlapping determination based on data from Jan. 1 through June 30. Alternatively, CMS would use only the first period. The same time periods would be used for Medicare data and that of other payers. The agency proposes this shortened timeline in the interest of providing ECs with sufficient time to make their own decision regarding MIPS participation and possibly submit required information by the deadline. CMS would allow the same 90-day claims run out period for other payers as it would for MA APMs but solicits comments on whether a shorter timeframe would be more appropriate.

MGMA comment: MGMA is disappointed the agency would further silo the QPP by proposing a separate All-Payer Combination Option QP determination timeline that differs in both length and format from the Medicare Option, rather than taking this opportunity to reduce complexity in the program by syncing the All-Payer Combination Option determination timeline with the existing Medicare Option timeline. In addition, APMs hoping to qualify under the All-Payer Combination Option would be significantly handicapped by this proposed timeline. APMs qualifying under the Medicare Option are provided with three sequential timeframes in which to meet patient or payment thresholds. However, those hoping to qualify under the All-Payer Combination Option would be tied to their data from January through March, regardless of whether their data from April through June ended up being counted or not–a major disadvantage compared to their counterparts evaluated under the Medicare Option who have three distinct opportunities to qualify.

In proposing a different timeframe to make All-Payer Combination Option QP determinations, the agency violates its own principle expressly stated in this proposed rule that "QP determinations should be based on an eligible clinician's performance over a single period of time" and "lack of alignment compiling participation information from multiple time periods for the purposes of making QP determinations would not appropriately reflect the structure of QP assessment..." (82 Fed. Reg. 30200) To maintain consistency to ensure QP determinations are both accurate and statistically comparable, the agency should use the same timeframe standards to calculate QP determinations for both the All-Payer Option and Medicare Options. Otherwise, the Medicare component under the All-Payer Option would be completely different than under the Medicare Option because they are based on two different windows of time, despite being based the same exact performance data. This could result in some APMs achieving QP status as Advanced APMs and others falling short based on the Medicare component, all due to mathematical manipulations of the same data because one was calculated under the Medicare Option and another was calculated under the All-Payer Option.

Furthermore, the primary justification CMS gives for expediting the timeline for All-Payer Combination Option QP determinations is that it would provide clinicians with advance notice to make appropriate MIPS participation decisions for the given performance period. This logic is flawed on two

levels. First, if the timeline for All-Payer QP determinations was in fact aligned with the current Medicare QP timeline, practices and clinicians qualifying in either of the first two periods (January-March and April-June) would receive QP determinations at the same time as compared to the proposed policy, so they would not be benefitted by this proposed policy. In fact, this proposed policy would make them worse off by preventing clinicians who would have otherwise qualified in the third window (July-August) from qualifying.

Second, MGMA is concerned the agency is perpetuating the same misguided notion of the previous Administration that participating in MIPS is something that can occur at the end of the participation year with the flip of a switch. On the contrary, before a practice or clinician can capture any MIPS data, a number of important logistical decisions need to be made and processes put in place. Clinicians and groups must determine, for instance, which clinicians are eligible to participate, then based on that information evaluate which reporting mechanism or mechanisms would be most appropriate for their needs, select appropriate measures and activities to focus on and capture data for, train staff on reporting protocols, and so on. The vast majority of these reporting mechanisms are not free, and most do not come cheap. Participating in even one Advanced APM is already a major effort and expense of finite practice resources, particularly for small and rural practices. To expect practices to purchase a qualified registry or other reporting mechanism and spend all that time training staff and collecting that data on top of this purely as a backup is unrealistic and financially infeasible for many practices. This is precisely the reason MACRA exempted practices participating in Advanced APMs from MIPS in the first place. While we couldn't agree more with the agency on the importance of providing practices and clinicians "sufficient notice" of their QP determinations so that they can participate and report for MIPS in the same performance year, to be truly "sufficient" this notice would have to occur prior to the performance year, particularly if CMS moves forward with requiring full-year reporting of quality data.

MGMA has repeatedly emphasized the numerous advantages to reducing the performance period for MIPS in previous comment letters and in this letter, including the notable advantage that reducing the performance period for MIPS would allow CMS to move the performance period closer to the actual payment year. This would in turn allow CMS to make Advanced APM QP determinations that are both closer to the payment year, and well in advance of the corresponding MIPS performance period. MGMA appreciates this would require a larger overhaul of the current QPP timeline, and we would like to again express our desire to work with the Administration toward this in the future, but for the more immediate purpose of commenting on the timeline for All-Payer QP determinations proposed in this rule, we would like to emphasize that receiving a QP determination in September or October verses December of the performance period makes little difference to a clinician or practice's ability to successfully participate in MIPS. It could, however, do a great deal of damage in terms of clinicians' ability to qualify as QPs under the All-Payer Option. Therefore, we urge the agency not to finalize this policy as proposed, and to instead finalize an All-Payer QP determination timeline that mirrors the existing timeline for the Medicare Option.

In the interest of keeping the timeline for QP determinations as consistent as possible and given the afore-mentioned points that moving up the timing for QP determinations by a matter of months would yield little benefit in terms of MIPS participation, MGMA urges CMS to retain the same 90-day claims run out window for QP determinations made under the All-Payer Option as is currently used under the Medicare Option.

QP determinations at the EC level

CMS proposal (82 Fed. Reg. 30200): All-Payer QP determinations would be made at the individual EC level only. CMS cites significant logistical challenges with collecting enough other payer data to effectively make QP determinations at the APM Entity group level.

MGMA comment: MGMA has a number of concerns with CMS' proposal to make QP determinations under the All-Payer Combination Option solely at the individual EC level. This proposed approach runs counter to CMS' own philosophy of holding APM Entities collectively accountable for performance and risk. CMS itself states that "it is generally preferable to make QP determinations at the APM Entity level" for this reason and only recommends making these determinations at the clinician level due to anticipated logistical challenges in obtaining the necessary information, including participation lists and payment and patient data (82 Fed. Reg. 30200). MGMA disagrees with this reasoning. In many cases, private payer APMs collect very sophisticated data that in many ways mirror and in some cases even exceed the sophistication of data CMS collects for its own models. CMS provides insufficient rationale for its assumption that private payer models could not supply the same information Medicare models are required to provide, especially if these standards are expressly laid out in advance. CMS could institute formatting requirements that would ensure consistency of private payer data and make it easier to analyze and compare. Alternatively, CMS could have the payers themselves make the necessary numerator and denominator calculations and send only this data to CMS but reserve the right to audit payers for patient and payment records and methodologies. This would drastically reduce the work on CMS' end, streamline data into a more consistent format and provide the agency with all of the necessary data to make All-Payer QP determinations.

One of the biggest advantages to the APM structure is that it allows for more flexibility and variation in design so that a wider range of practice types can succeed in value-based reimbursement models. It is problematic for CMS to undercut this very principle when it comes to making its own QP determinations. CMS should not seek to inhibit itself with unnecessary restrictions. Rather, it should give itself as much discretion as possible so that it can consider the unique design elements of each model to make QP determinations at the most appropriate level. Certainly, there will be some cases like the one CMS describes in the proposed rule in which it makes the most sense to make QP determinations at an individual clinician level. However, there will be just as many, if not more scenarios where participation decisions are required at the TIN-level, just as CMS requires participation at the TIN-level for certain Medicare APMs. To arbitrarily require QP determinations for these types of models be meticulously calculated for every individual clinician would be nonsensical and waste CMS' time and money. CMS has already set a precedent in valuing flexibility by conducting MIPS scoring at varying levels, at the individual clinician, TIN or APM Entity levels. MGMA urges the agency to mirror this existing policy and have APM Entities or participants elect to be evaluated at the clinician, practice or APM Entity level and have this determination status applied to all participating clinicians. Doing so would still allow CMS to make calculations at the clinician level if that is what is most appropriate, but would not force the agency to do so in every case when it would make no logical sense. Particularly with the initial rounds of All-Payer QP determinations, it is important CMS start with a more flexible approach and learn through experience which changes or additional restrictions may prove effective and address this as necessary through future rulemaking.

Physician-Focused Payment Models (PFPMs)

CMS proposal (82 Fed. Reg. 30207): Under previously finalized rules, PFPMs must include Medicare as a payer. CMS seeks comment in this proposed rule on whether to broaden this definition to include

payment arrangements with Medicaid or the Children's Health Insurance Program (CHIP). MA plans would still not qualify.

MGMA comment: MGMA strongly supports expanding the definition of a PFPM to include models with these payers, as it would allow greater opportunities for practices to participate in Advanced APMs and become QPs, particularly for clinicians and practices in certain specialties that treat patients outside of the traditional Medicare population. We urge the agency to expand this definition further to include MA plans. MA plans are becoming increasingly popular among Medicare beneficiaries. CMS has acknowledged this growth by seeking comment about including MA patients and payments in the Medicare Option QP threshold. It would be consistent to also include MA plan models as PFPMs.

PFPM Technical Advisory Committee (PTAC) Review Process of PFPM Proposals

CMS proposal (82 Fed. Reg. 30209): CMS reiterates it would give serious consideration to PFPM recommendations from PTAC, though it is not required to test these proposals.

MGMA comment: While MGMA appreciates the agency's support in this process, we urge CMS to formalize through rulemaking a process and timeline for responding to PTAC recommendations. The PFPM process is a promising way to achieve the Administration's goal of approving more physician-led and developed Advanced APMs and widening the pathway to participation in Advanced APMs. However, without a codified process that ensures these recommendations will ever be acted on by HHS, the PTAC process has little credibility. Doing the background research to design a new model from the ground up that can withstand the scrutiny of both PTAC and CMS requires a significant investment in time and resources and after a certain point of inaction on these recommendations, physician groups will grow weary and have little incentive to put the work into developing new models. Eventually, PTAC and the PFPM development process would cease to serve any practical purpose. To date, two of three proposals were recommended to the Secretary for limited-scale testing and we have yet to see a response from HHS more than 60 days later. To ensure the future viability of this promising APM pipeline, we urge the agency to formalize a process and timeline by which CMS or the Secretary will respond to PTAC recommendations. Specifically, MGMA believes 60 or 90 days would be an appropriate timeframe.

MGMA also urges CMS to work with PTAC and PFPM developers to provide them with any necessary data and technical assistance they need to be successful to the fullest extent possible. These developers are investing countless hours and resources into building these models all to support CMS' goal of developing new innovative payment models that could serve as future Advanced APMs. CMS in many cases retains the unique ability to collect clinical and payment data across payers and should be doing everything it can to support these developers with the logistical support and data they need to be successful. A little bit of effort in this regard can go a long way towards helping these models being successfully tested and implemented, which would advance CMS' goal to widen the pathway to participation in Advanced APMs.

Conclusion

We appreciate the opportunity to share our comments regarding the framework for MIPS and APMs and to offer our recommendations to improve and simplify these programs to support groups practices as they transform their organizations. Should you have any questions, please contact me at agilberg@mgma.org or 202-293-3450.

Sincerely,

/s/

Anders Gilberg, MGA
Senior Vice President, Government Affairs