December 19, 2016

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5517-FC
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Comments on Final Rule CMS–5517–FC: Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule

Dear Acting Administrator Slavitt:

The Healthcare Quality Coalition (HQC) welcomes the opportunity to offer comments on the implementation of the Medicare Quality Payment Program. The CY 2017 final rule provides improvements from the proposed rule, and we are pleased to provide feedback on areas where CMS continues to request input for upcoming rulemaking.

The HQC is comprised of hospitals, physicians, health systems and associations committed to value-based healthcare. Our provider systems, groups and organizations have more than 19,000 licensed hospital beds, more than 21,000 physicians, and 225,000 employees across the country. Organized in 2009, the HQC supports efforts to create a sustainable Medicare system through incentivizing high-value care. We believe value-based payment policies can drive better quality, lower cost of care, and reduce overall costs for the Medicare program. The HQC strongly supports continued implementation of payment systems that reward value over volume, and we are pleased to provide comments on CMS' 2017 final rule for implementing MACRA as part of developing additional policy in 2017.

Merit-based Incentive Payment System (MIPS)

The final rule seeks targeted input on the implementation of the Merit-based Incentive Payment System (MIPS), as authorized in MACRA through the Quality Payment Program. Set to begin in CY 2019, the MIPS is comprised of four categories of measures: Quality, Cost, Advancing Care Information, and Improvement Activities. Each category includes a set of performance measures generated from their respective individual programs and initiatives. In the first year of MIPS, eligible clinicians will be subject to downward, neutral, or modest upward payment adjustment depending on participation on the options of "pick your pace."

To assess performance in the MIPS, categories were established in the MACRA with assigned weights. Once implemented, the MIPS will be comprised of four domains of measures: Quality, Efficiency/Resource Use, Advancing Care Information, and Clinical Practice Improvement activities. To derive a performance score, weights were assigned to each performance category. As finalized for CY 2019, the following weights will be assigned to each category: Advancing Care Information (25%); Quality (60%); Resource Use (0%), and Clinical Practice Improvement (15%). From 2019 through 2020, CMS will have the authority to adjust the domain weights. In 2021 onward, the assigned weights are Quality (30%), Resource Use (30%), Advancing Care Information (25%) and Clinical Practice Improvement (15%).

On behalf of the HQC, we are pleased to provide responses to a number of policy areas in the MIPS asked as part of the final rule with comment.

Provider Identifiers, Groups [81 FR 77055], and Virtual Groups [81 FR 77074-81 FR 77076]: The HQC supports the creation of an optional MIPS identifier and virtual groups for CY 2018 performance year. Creation of a MIPS identifier would accomplish two objectives: 1) allow the option for multiple TINs within the same organization, affiliation, or group practice to report performance together; and 2) allow individuals (NPI) or small groups (TIN) to form virtual groups through a single identifier.

In continuing with the Physician Value-based Payment Modifier and PQRS methodology, we believe it is best to utilize the current National Provider Identifier (NPI) and Tax Identification Number (TIN) to define professionals and groups. We support this provision as finalized, but offer additional options for improvement.

To provide a pathway for streamlined reporting and creating of virtual groups, we support the optional creation of MIPS identifiers. The current PQRS and physician value modifier policies recognize large and small groups only by TIN. While TIN is a reasonable option to use, the HQC suggests CMS to make available an option for multiple practices and virtual groups to report together through a MIPS Identifier in CY 2018. As organizations collaborate and affiliate, an often problem occurring is differing levels of quality reporting and health IT between the individual TINs. To establish an optional pathway for streamlined reporting, allowing multiple TINs within the same organization to optionally join together under a single MIPS identifier would be an improved option. This would allow related TINs to report as a single entity or allow a subset of physicians within a large TIN to form their own group for reporting. In addition, a MIPS identifier would facilitate the easier creation of virtual groups.

MIPS Scoring and Quality Performance [81 FR 77288, 81 FR 77284, 81 FR 77286, 81 FR 77282]: HQC supports the emphasis on "high priority" outcome measures. We believe CMS should continue to score outcome measures higher and place a high priority on outcome measure development through the annual MIPS Measure Development Plan.

CMS requests comment on the final rule provision regarding quality measures. As finalized, MIPS eligible clinicians and groups would need to report on a single measure or improvement activity to satisfy the payment adjustment parameters of MIPS. For full participation, groups and individuals would report on six measures for 90+ days.

Overall, the HQC supports CMS' continued focus on outcome measures. Outcomes provide more meaning and value for Medicare beneficiaries, and are critical for delivering high quality care. CMS should continue to incorporate and incentivize reporting on measures that strongly correlate with better outcomes. The underlying goal should be to transition away from process-based measures, unless outcome measures are not available. We support greater incorporation of outcome measures in future program years.

MIPS Cost performance category. The HQC was surprised by the final rule of not including any cost measures in the 2017 performance year. We continue to support expanding the resource use performance category to include more measures at specific condition and episode levels. In addition, we believe attribution methodology should be considered to reward clinicians who keep patients healthy. We believe it is critical new measures of efficiency/resource use have a quality counter-balancing measure.

The HQC has long advocated for the inclusion of robust measures of cost, efficiency, and resource use in value-based programs. We continue to advocate for value-based care as a reflection of cost and quality, equally weighted. We understand the statutory limitations on the weighting of the resource use category in the first two years of MIPS, but encourage CMS to thereafter ensure that cost is weighted at least equally with quality for all clinicians subject to the MIPS.

We believe the continued use of cost and efficiency measures in the Physician VM as an initial platform for the MIPS resource use category. The strength of resource use measures lies in a set of cost measures that carry a counter balance with measures of quality and we ask this principle be used moving forward.

MIPS Advancing Care Information performance category [81 FR 77209, 81 FR 77216, 81 FR 77226, 81 FR 77275. The HQC agrees with the general direction of the ACI category in relation to current Electronic Health Record (EHR) Meaningful Use (MU) Stage 3 requirements. We generally support the finalized step-based approach to meeting Advancing Care Information performance scoring standards, but continue to be concerned the base score portion of the category in the final rule maintains an "all or nothing" standard. This is inconsistent with messaging and communication.

The newly re-named Advancing Care Information (ACI) category of MIPS includes measures from the previous Electronic Health Record Meaningful Use program. The ACI category includes a base score, performance score and bonus points. The new ACI applies to all clinicians, unlike previous Medicare

EP Meaningful Use requirements (which applied only to Medicare physicians) and provides the opportunity to report as a group or an individual clinician. This category is weighted at 25% of the MIPS score.

The HQC is pleased to see that CMS finalized to mostly move away from the "all or nothing" approach that has resulted in unwarranted penalties under the current EHR incentive program. As indicated in our response to CMS' Request for Information (RFI) on MIPS, when measuring EHR use CMS should award full credit to high performers, but allow other providers meeting minimum requirements to be awarded some points. That noted, the HQC is concerned the finalized base scoring element of ACI maintains an "all or nothing" approach as finalized. Despite strong educational messaging from CMS that ACI is now based on scoring points rather than full achievement, the base score includes measures that must be 100% compliant for any score. This does not align with the goals of moving Meaningful Use from an entirely "all or nothing" to a performance scoring approach. We support removal of the base score portion and move to only a performance standard.

MIPS APMs. The HQC supports CMS' proposals to reduce the reporting burden for entities that participate in APMs but remain subject to MIPS. CMS should create a smooth, effective pathway to APMs and qualifying participation, and recognize efforts to move away from fee-for-service with higher scoring options. It is critical to minimize barriers for transitioning to APMs. As part of educational outreach, we ask CMS to be very clear regarding the options for providers, groups, and organizations to enroll into MIPS APMs. In practice, we have found there is confusion amongst the terminology and urge the importance of distinguishing clearly what is a MIPS APM and what is an Advanced APM.

Because not every APM will be considered an Advanced APM, and because even some Advanced APM entities might not meet participation thresholds, we appreciate CMS' efforts to avoid creating duplicative and burdensome requirements for APM participants that are subject to MIPS. We agree that APM participants should not have to submit data separately for MIPS and for the APM program they participate in.

As part of the transition from MIPS to advanced APM participation, many providers may find themselves enrolling into a MIPS APM. CMS should make MIPS APMs a separate component on the QPP website, and offer options for enrolling into MIPS APMs as a means of transitioning into advanced APMs. Many providers may not be prepared to make the immediate transition from MIPS to an advanced APM.

MIPS composite score and payment adjustment. HQC believes that the scoring methodology should reward those individuals and groups providing high-value care, instead of rewarding only outliers. We understand the first year serves as a transition year, but urge CMS to continue implementation as finalized for 2018 and beyond.

Early experience with the physician value-based payment modifier has highlighted the challenges with identifying meaningful variations in performance among most clinicians, as the vast majority of physicians subject to the value modifier in 2016 were scored as "average" and therefore received no payment adjustment. Many of these "average" groups invested substantial amounts of resources in reporting and transforming their practices to achieve better quality, lower cost care, and saw no reward for their efforts.

We clearly understand 2017 as a transition "pick your pace" options for participation in the QPP and we generally support this approach. But what this policy decision impacted was the ability for high performers to benefit from years of preparation and investment into quality reporting with high upward payment adjustments. Although we recognize 2017 as a year of getting providers onboard, we also believe it is critical for providers and groups that perform well, and invested, to be recognized with a payment reward.

Advanced Alternative Payment Models

In addition to implementation of the MIPS, the MACRA also provided incentives for providers to develop and implement eligible Advanced Alternative Payment Models (APMs). Professionals who meet the criteria for this track will be excluded from the MIPS and will receive a 5% bonus on their Part B revenue from 2019 through 2024. The APMs must require meaningful use of EHRs, be paid based on quality, and--unless the model is a medical home—bear greater than nominal financial risk. To be considered a participant in an eligible APM, a professional must show that a minimum percentage of payments (or counts of patients) are attributable to Medicare Part B services furnished through the eligible alternative payment entity or a combination of all-payer and Part B revenue.

Qualifying APM Participants - Participation thresholds and available models. We remain concerned that the payment thresholds, particularly in later years, are too high for most clinicians given current attribution models and trends, and that a group's payment track will be unpredictable from year to year. Although we are disappointed the final rule offers a very limited set of APMs that will be eligible for qualifying as an advanced APM, we are very encouraged with the direction CMS is taking regarding new advanced APMs and modifying existing models that were not qualified into advanced status.

MACRA prescribes minimum participation thresholds that clinicians in certain Advanced APMs must meet in order to qualify for the 5% bonus payment in 2019-2024 and be exempt from MIPS. The Part B payment thresholds start at 25% in 2019, but increases to 50% in 2021 and 2022, and 75% in 2023 and 2024 and beyond. This means that the question of whether or not an Advanced APM entity qualifies for the 5% bonus will depend a great deal on when and where their attributed beneficiaries receive care.

Under current APMs, beneficiaries are free to seek care from any provider, and APM entities have no tools to control this and therefore have limited control over their population of attributed beneficiaries.

CMS acknowledges that while it expects many Advanced APMs to be able to meet the participation thresholds in early years, it believes that many Advanced APM entities will miss APM thresholds set for later years. This prediction is troubling and negates the incentive MACRA created to encourage organizations to volunteer for innovative, risk-bearing models. To mitigate the unpredictability for Advanced APM participants, CMS should build into the various APMs tools that entities can use to better identify and engage with attributed beneficiaries.

Quality Measures for APMs. The underlying goal is to provide incentives for clinicians to participate in advanced APMs, and reducing the reporting burden is a positive step. We also ask CMS to be open to new outcome measures proposed by healthcare delivery organizations at the health system and community level as quality and cost measure options for future eligible APMs.

To create a smoother path for providers to move into APMs from MIPS, the HQC commented on the need for comparability of quality measures and reporting. If there are applicable measures available in PQRS related to the APM, the organization should consider whether or not to use those measures. We believe it is important that quality measure reporting for an APM be no more burdensome than under MIPS and it appears the final considers this approach. Furthermore, it is also important to focus on harmonizing measures so that there are not different ways of measuring the same clinical outcome that must be used for MIPS vs. APMs, and Medicare vs. other payers.

Other Payer Advanced APMs [APM, 81 FR 77426] and All-Payer Combination Advanced APMs [APM 81 FR 77463]: Overall, we believe the modifications to "nominal risk" are simpler than as in the proposed rule. To help facilitate the transition to advanced APMs, we urge tools and resources be made available on the QPP website to allow providers and groups to calculate risk and advanced APM thresholds. The HQC urges CMS to make the all-payer combination advanced APM attestation in a user-friendly format, and allow for submission of non-Medicare Part B APM information year-round.

CMS seeks comment on the overall design of Other Payer Advanced APMs by non-Medicare payers, in establishing the nominal amount standard for the QP Performance Period in 2019 and later. CMS seeks comment on potential creation of a separate pathway to determine whether Medicaid APMs are Other Payer Advanced APMs prior to a QP Performance Period for the All-Payer Combination Option.

The overall enrollment into advanced APMs can be expected to expand once other payer revenue can be counted toward eligibility. In the final rule, CMS outlines the specific criteria for advanced APMs per statute, and also requires detailed information from non-Medicare payers to attest to the eligibility criteria. There are a number of provisions seeking to minimize or lower the administrative and resource burden to reaching advanced APM status and we appreciate the steps taken in the final rule. However, a number of barriers remain. One such barrier is the definition and level set for nominal risk in advanced APMs. We are concerned that many current advanced APMs will not be able to qualify for

advanced status as a qualifying participant under the finalized parameters. We continue to ask that attestation for the investment of resources and finances used to develop and implement an APM should be considered as a component of nominal risk.

To facilitate the attestation of all-payer combination toward advanced APM status, we ask CMS develop a user-friendly web portal to satisfactorily meet the requirements of attestation. We understand the balance between accuracy and integrity, but providing a seamless program to attest for other payer revenue or patient counts would be a good policy step.

Conclusion

On behalf of the HQC, we appreciate the opportunity to provide comments on the implementation of MACRA. We urge CMS to work together with hospitals and physician groups to ensure value-based payment programs are working in tandem to achieve the goals of better quality and lower cost. Thus far, we have been very pleased with the outreach and engagement from CMS officials and we hope this can continue. We look forward to continuing to provide feedback on the implementation of the new payment programs in the MACRA.

If you have any questions or need clarification, please feel free to contact us.

Sincerely,

The Healthcare Quality Coalition