June 27, 2016

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

Re: Comments on Proposed Rule CMS–5517–P: Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models

Dear Acting Administrator Slavitt:

The Healthcare Quality Coalition (HQC) welcomes the opportunity to offer comments on the implementation of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.

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' proposals for implementing MACRA.

Merit-based Incentive Payment System (MIPS)

The proposed rule seeks input on the implementation of the Merit-based Incentive Payment System (MIPS) as authorized in MACRA. Set to begin in CY 2019, the MIPS is comprised of four categories of measures: Quality, Efficiency, Advancing Care Information, and Clinical Practice Improvement Activities. Each category includes a set of performance measures generated from their respective individual programs and initiatives. The MIPS measures clinicians across four weighted performance categories: Quality, Efficiency/Resource Use, Advancing Care Information, and Clinical Practice Improvement Activities. CMS is proposing the following weighs for 2019: Advancing Care Information (25%); Quality (50%); Resource Use (10%), 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%). In the first year of MIPS, eligible professionals will be subject to an adjustment of up to +/- 4% to their Medicare Part B payments. The applicable percentage gradually increases to 9% in 2022 and beyond.

Below are our comments on specific MIPS proposals:

Provider Identifiers. We support the proposed rule on using the National Provider Identifiers (NPIs) and Taxpayer Identification Numbers (TINs) for identifying individuals and groups. We also support the creation of an optional MIPS identifier, which would allow multiple TINs within the same organization, affiliation, or group practice to report performance together.

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 in the proposed rule.

To provide a potential pathway for streamlined reporting and creating of virtual groups, we support giving clinicians the option to be identified under a single MIPS identifier. The current PQRS and physician value modifier policies recognize large and small groups only by TIN. While TIN is a reasonable option to use, a MIPS identifier would enable organizations with multiple practices and virtual groups to report together and have their performance assessed as a group. This would also allow related TINs to report as a single group or allow a subset of physicians within a large TIN to form their own group for reporting.

Rural and Health Professional Shortage Areas. The HQC supports the funding made available by MACRA to assist small, rural practices to help succeed in MIPS and develop APMs. To move value-based care forward, we believe CMS should recognize the unique challenges faced by rural providers and shortage areas, such as flexible reporting options and volume thresholds. In addition, we strongly support the concept of virtual groups, and urge CMS to make this option available to rural and shortage area providers as soon as possible.

Representing a wide range of providers and practices, including rural areas, we are sensitive to the unique challenges that small, rural, HPSAs, and similarly situated physician practices face in providing care. MACRA does offer flexibility to build a program structure that ensures the viability of these practices in the future. One concept we would like to see CMS further develop is virtual groups. We suggest CMS provide flexibility for virtual groups to form, report, and achieve compliance with the MIPS or in the development of rural-specific APMs.

MIPS Quality performance category. HQC supports the proposed emphasis on "high priority" outcome measures and recommends that CMS incorporate socioeconomic adjustments into

quality performance scores. We believe CMS should place a high priority on outcome measure development through the annual MIPS Measure Development Plan.

Overall, the HQC supports utilizing the existing PQRS infrastructure as the foundation MIPS, and supports CMS' continued focus on outcome measures. Specifically, we support the proposal to require clinicians to report on at least one outcome measure, and to allow clinicians to earn two additional points for each additional outcome measure reported, up to a certain limit. Outcomes provide more meaning and value for Medicare beneficiaries, and are critical for distinguishing between high-value and low-value care. Still, out of the proposed list of 268 possible quality measures clinicians may choose from to meet reporting obligations, only about a quarter are outcome measures. CMS should continue to incorporate and incentivize reporting on measures that strongly correlate with better outcomes.

MIPS Resource use performance category. HQC generally supports the expansion of the resource use performance category to better capture costs for care episodes. However, we encourage CMS to delay the use of the proposed episode measures in the payment adjustment calculation until they can be field tested, with clinical and stakeholder input. During this period, we would strongly encourage CMS to provide reports and feedback on expected performance, drawing from prior year data. In addition, we believe improvements to attribution should be considered to better reward clinicians who keep patients healthy. Finally, it is important that new measures of efficiency/resource use have a counter-balancing quality 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.

In implementing the resource use domain of MIPS, CMS continues to use the Physician Value-Based Payment Modifier (VM) cost measures (Medicare spending per beneficiary and total per capita cost), which links Medicare Parts A and B. We appreciate 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.

Improvements to Resource Use Attribution

In the proposed rule, CMS largely delays for one year any changes to attribution methodologies. The HQC encourages CMS to continue to explore alternative risk-adjusted methodologies.

We believe CMS's attribution methodology must take into consideration when a clinician first begins to care for a patient and reward physicians for keeping patients healthy. Clinicians and group practices should not be penalized for seeing patients with high risk scores or for keeping patients out of the hospital. Under current CMS models, the primary care physician could be attributed the prior costs associated with that patient's care even though at the time they were not involved with the patient's care. Clinicians will continue to be scored at a lower level than they actually are on the average cost per patient unless CMS corrects this attribution methodology. In addition, if a provider has a record or patients declare that a provider is their primary care physician, Medicare should extract that data and count it in the physician's score even if a beneficiary doesn't use services for a given time period. As efforts to move toward population health management continue, CMS must recognize these efforts with keeping patients healthy—a win-win outcome for providers, payers, and our communities.

Improvement in attribution will help the balance with patients that are very healthy with those that need more coordinated care. If attribution is not done correctly, physicians will be dis-incentivized from coordinating care. Spending from other physicians and the associated costs could be attributed to their own cost score if they became involved to a level where they would meet the current CMS threshold for attribution to that patient. In addition, healthy patients who need limited or no services during a performance period also should be attributed to physicians. Physicians who keep their patients well should be rewarded for that care, otherwise only the sickest and highest cost patients will be attributed to the physician.

MIPS Advancing Care Information performance category. HQC agrees with the general direction of the ACI category in relation to current Electronic Health Record (EHR) Meaningful Use (MU) requirements. We support the proposed step-based approach to meeting Advancing Care Information performance standards, but are concerned the base score portion of the category maintains an "all or nothing" standard.

The 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 and a performance score, and allows for bonus points for registry reporting. 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 appreciates CMS's efforts to 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. While CMS's proposal to allow clinicians to earn partial credit (a base score) is a step in the right direction, the HQC is concerned the proposed base scoring element of ACI maintains an "all or nothing" approach. Despite strong messaging from CMS that ACI is now based on scoring points

rather than full achievement, the base score includes measures that must be reported with 100% compliance. This does not align with the goals of moving Meaningful Use from an entirely "all or nothing" to a performance scoring approach.

MIPS Clinical Practice Improvement Activities (CPIA) performance category. HQC supports the proposal to allow clinicians to select from a wide range of activities, and we encourage CMS to expand/amend the list to include participation in regional health improvement collaboratives (RHICs). We also urge CMS to score Maintenance of Certification Part IV for improving professional practice to be scored at the highest category (20 points), and recognize continuing medical education activities.

Under the provisions of MACRA, 15% of the MIPS payment adjustment will include successful completion of Clinical Practice Improvement Activities (CPIAs). Over 90 activities are defined in the proposed rule, assigned as high (20 points) or medium (10 points). Clinicians must participate for at least 90 days during a performance period for points to be awarded. CPIAs are categorized into sub-groups:

- Expanded practice access
- Population management
- Care coordination
- Beneficiary engagement
- Patient safety and practice assessment
- Participation in an alternative payment model

In our comments submitted in the RFI process, we asked CMS to provide a clear list of eligible CPIAs . The HQC applauds CMS for proposing a clear list of activities and several current quality improvement programs in the inventory of CPIAs.

The HQC also advocated for including certain activities sponsored by regional health improvement collaboratives (RHICs) as CPIA, given that several RHICs are already providing resources and quality improvement activities in several of our members' regions. For instance, the CPIA inventory should include activities such as: successful completion of a formal quality improvement initiative sponsored by a RHIC; attendance at one or more collaborative learning events sponsored by a RHIC; and engagement with a RHIC to assess practice patterns such as resource use.

In addition, we ask CMS to recognize the following CPIA on page 28581 at 20 points: "Participation in MOC Part IV for improving professional practice including participation in a local, regional or national outcomes registry or quality assessment program. Performance of activities across practice to regularly assess performance in practice, by reviewing outcomes of addressing identified areas for improvement and evaluating results." CMS should also recognize participating in continuing medical education as a CPIA.

MIPS APMs. 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 recognize efforts to move away from fee-for-service with higher scoring options. It is critical to minimize barriers for transitioning to APMs. We suggest changes to the resource use scoring category that reward points for strong performance while balancing the structural differences in resource use metrics.

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, and we support CMS' proposal in this regard. We also support CMS' proposal to score performance at the level of the APM entity.

We are concerned, however, about CMS' proposal to weight the resource use performance category at zero for 2019 for Shared Savings and Next Generation ACOs, and to weigh both the quality and resource use performance categories at zero for other APMs in MIPS in 2019. But we also recognize there may be different measures and structural incentives in MIPS APMs that do not fully align with MIPS domains and measures.

We would propose that MIPS APMs scoring well in resource use measures be rewarded for doing so. By scoring entities that perform at or above the average, highly efficient APMs may be rewarded as top performers through the MIPS performance adjustment. Meanwhile, MIPS APMs scoring below average could be held harmless in the resource use category.

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 oppose using the Physician Value-based payment Modifier "quality tiering" methodology as the scoring method for MIPS.

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 are encouraged to see that CMS expects most clinicians to receive *some* upward or downward payment adjustment under the MIPS by virtue of the linear sliding scale on which performance is plotted.

Advanced Alternative Payment Models

In addition to implementation of the MIPS, the MACRA also provided incentives for providers to develop and implement eligible Advanced 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. An eligible Advanced APM is defined to include Medicare Shared Savings Program (MSSP) Accountable Care Organizations, certain Center for Medicare and Medicaid Innovation (CMMI) models, or models tested under other demonstration authorities. The APMs must also 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 proposed 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. We are also disappointed the proposed rule offers a very limited set of APMs that will be eligible for qualifying as an advanced APM.

As such, we are concerned that the high bar to entry could thwart MACRA's objective to move more clinicians into Eligible APMs. We ask CMS to recognize this and be willing to work with clinicians and Congress to seek any necessary statutory changes. We urge CMS to take this position into consideration to the extent possible in developing rules, and explore ways to be more flexible in granting Qualifying APM Participant 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. The payment thresholds are linked to the number of attributed beneficiaries furnished services, and the volume of those services, through the year as compared to services furnished to "attribution-eligible beneficiaries." 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.

First-year Medicare enrolled clinician exclusion. We support the first year-Medicare enrolled eligible clinician exclusion for MIPS under § 414.1305, and ask that the same treatment be applied for new Medicare eligible physicians and other eligible clinicians that bill under a TIN that are affiliated with an APM entity.

In the proposed rule, CMS excludes first year Medicare enrolled clinicians from participation in the MIPS. Historical data (i.e. performance period) would not be available to derive a performance score for a newly enrolled Medicare clinician. We would like this same exclusion under the proposed rule for MIPS to be applied to new providers who join an advanced APM entity.

Application of MIPS to Advanced APM Entities that move in and out of QP status. Based on experience from HQC members, we are concerned about the application of MIPS to those clinicians that move in and out of qualifying professional status. We ask CMS to clearly outline how the regulations are intended to apply to professionals that are in an advanced APM, but fall short of qualifying or partial-qualifying thresholds without being penalized by MIPS. We are concerned that in these situations, providers will need to maintain and manage both MIPS and advanced APM measures and reporting. This may be problematic and we ask CMS to identify ways to address these situations.

Patient care volumes and revenues for any healthcare organization fluctuate each day, month, and year. Predictive analytics can help determine some level of understanding about how an APM or advanced APM will fare under the new law and whether or not thresholds will be met. However, changes in patient volumes and revenues can impact participation threshold calculations, such that even an APM entity that is strongly invested in succeeding in an advanced APM could fall short, and be subject to MIPS. This will require organizations to manage two separate payment tracks. We ask CMS to clearly present a plan that recognizes this situation to ensure efforts are recognized and not penalized.

Quality Measures for APMs. The HQC supports the proposed rule that sets no minimum quality measures, with the exception of reporting on at least one available MIPS outcome measure. As noted, the 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, we 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 proposed rule 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.

Defining "nominal" financial risk

Comment: The HQC is concerned the established parameters for defining nominal risk are complex and a barrier to facilitating advanced APM participation. CMS should provide a simpler definition to help expand the models eligible for advanced APM status.

In addition to meeting established revenue or patient approach thresholds, to be an eligible APM, providers must bear an excess of a "nominal" financial risk or be a medical home. For purposes of an entity becoming an eligible APM, by statute entities must assume more than a "nominal amount" of risk for monetary losses (withhold, reduce or clawback payments), which include the following:

- Total Risk (maximum exposure) must be at least 4% of APM spending target
- Marginal Risk (percent of spending above APM benchmark or target price for which Advanced APM Entity is responsible – aka "sharing rate") must be at least 30%
- Minimum Loss Rate (the amount spending can exceed APM benchmark or target price before Advanced APM entity bears loss) must be no more than 4%

The HQC expects initial Advanced APM participation to be low, which is disappointing given the potential for rapid expansion of non-fee-for-service models. We are concerned that many current APMs will not be considered Advanced APMs, even though they have invested resources in infrastructure and care coordination. Further, physicians not currently in Advanced APMs could be dissuaded from future participation to the extent that the models require them to take on risk for total Medicare expenditures, as opposed to just physician revenue. Investment of resources and finances used to develop and implement an APM should be considered as a component of nominal risk, and practices should have more options to participate in Advanced APMs that put physicians at risk for Part B expenditures only.

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. We look forward to continuing to provide feedback on the implementation of the new payment programs in MACRA.

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

Sincerely,
The Healthcare Quality Coalition