November 17, 2015

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–3321– NC
Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

Re: Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models

Dear Acting Administrator Slavitt:

On behalf of the Healthcare Quality Coalition (HQC), we write to provide comments on the Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models. Overall, the HQC strongly supports the development of robust value-based payment initiatives. Our members believe properly structured incentives to provide high value care (i.e., high quality, low cost care) will result in better care for patients at a lower cost for payers.

The HQC is comprised of hospitals, physicians, health systems, and associations committed to value-based healthcare. Combined, our hospitals, health systems, and provider groups have more than 19,000 licensed hospital beds, employ more than 21,000 physicians, and have more than 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 and are pleased to provide comments on the Request for Information (RFI) on implementation of the Medicare Access and CHIP Reauthorization Act regarding the Merit-based Incentive Payment System and Alternative Payment Models.

Request for Input on the Provisions Included in the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015

A. Merit-based Incentive Payment System (MIPS)

In the RFI, CMS seeks input on the implementation of the Merit-based Incentive Payment System (MIPS) as authorized in the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. Set to begin in CY 2019, the MIPS is comprised of four categories of performance measures: Quality, Resource Use/Efficiency, Electronic Health Record Meaningful Use, and Clinical Practice 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 professionals will be subject to an adjustment of up to +/- 4% to their Part B payments. The applicable percentage gradually increases to 9% in 2022 and beyond. Based on the series of questions seeking input, we are pleased to provide responses to a number of policy areas in the MIPS.

Overall MIPS Infrastructure Design and Performance Reporting

Comment: Currently, the MIPS infrastructure is a combination of existing separate programs. Integrating the separate programs into MIPS should be an opportunity to assess, revise, align, and improve the reporting programs. We ask CMS take this opportunity to consult with organizations, health systems, and associations that represent eligible professionals (EP's) and implement changes that will enhance the practicality and utility of all three programs.

The MIPS combines existing, separate quality reporting, value-based payment modifier, and electronic health records programs. The HQC shares the goals of the law in driving a robust value-based payment system. In transitioning from the current reporting and value-based payment programs, we urge CMS to carefully assess the integration of existing programs. It is imperative that a seamless, coherent transition occurs into the MIPS. As such, we ask CMS to integrate the programs through improvement that will eliminate obstacles, streamline reporting, enable interoperability and minimize administrative burden to providers.

Provider Identifiers, Patient Attribution Methodology, and Virtual Groups

Comment: We believe CMS should continue using the combination of National Provider Identifier (NPI) and Taxpayer Identification Number (TIN) for identifying individuals and groups. Also, we ask CMS to consider improving risk-adjusted patient attribution methodologies that recognize providers that work with patients to keep them healthy. Finally, we support options for developing "virtual groups" as an opportunity for providers to improve coordinated care.

Under the MIPS, CMS will need to select and operationalize a specific identifier to associate with an individual MIPS Eligible Professional or a group practice. Under both MU and PQRS, a combination of NPI and TIN are used to assess eligibility and participation where each unique combination is treated as a distinct separately assessed EP In continuing with the Physician Value

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. For example, a provider with three different TINs would receive three different rates. Using a TIN/NPI combination would also enable CMS to calculate performance for MIPS EPs that practice under multiple TINs. Finally, we are encouraged by consideration to allow providers to form "virtual groups." Virtual grouping should not only be for quality reporting purposes only, but for improved coordination of patient care.

There is an opportunity to improve patient attribution to providers. In transitioning to a new value-based payment system, the HQC also believes providers should be recognized for keeping patients healthy and out of the hospital, while also not being dis-incentivized from caring for patients with multiple chronic conditions. Improved patient attribution with robust risk adjustment methodology better reflects value-based care and population health. This would provide an important balance between caring and managing high-risk patients, while continuing to be recognized for maintaining and improving quality outcomes.

Risk-adjustment is a critical part of any quality and pay-for-performance program. Providers should be assessed based on their performance, and their grades should not be influenced by the types of patients they treat. Risk-adjustment helps ensure accurate and fair comparison of patient case mix, taking into consideration severity of illness. In 2006, the National Quality Forum (NQF) established a policy against using sociodemographic factors in risk adjustment methodology for measuring quality of care, including race, ethnicity, and native language. However, the NQF policy has been recently revised in 2014 to reflect changing trends in medical care, and is moving through a trial period where sociodemographic adjustment will be applied to measures, subject to review and endorsement.

Given the many input elements to consider in sociodemographics, we believe CMS should consider steps to stratify and incorporate sociodemographic factors in risk adjustment methodology. This process needs to be through provider input and consensus on how to define, collect, and report these factors and ensure sufficient population size within the measure.

Quality and Resource Use Feedback Reports

Comment: Quality and Resource Use Feedback Reports are very helpful in gauging clinical practice measures. Receiving reports more often, such as quarterly, would enhance quality improvement efforts. The information in the Feedback Reports should be presented to align with the MIPS program structure, including clinical practice improvement activities and meaningful use of certified EHR.

Beginning July 1, 2017, CMS is to provide confidential feedback on performance to MIPS EPs. Specifically, CMS is required to make available timely confidential feedback to MIPS EPs on their performance in the quality and resource use performance categories. CMS requests feedback on making available confidential feedback to MIPS EPs on their performance in the clinical practice

improvement activities and meaningful use of certified EHR technology performance categories. This feedback can be provided through various mechanisms, including the use of a web-based portal or other mechanisms determined appropriate by the Secretary. The HQC believes providing reports more often than annually, such as quarterly, will be more helpful in determining performance benchmarks in MIPS, and also for guidance on whether to pursue APMs. In addition, the HQC suggests aligning the information in the Quality and Resource Use Reports with the performance categories and metrics in the MIPS.

MIPS Performance Categories

To assess performance in the MIPS, categories were established in the MACRA with assigned weights. Once implemented, the MIPS is comprised of four domains of measures: Quality, Efficiency/Resource Use, Electronic Health Record Meaningful Use, and Clinical Practice Improvement activities. To derive a performance score, weights are assigned to each performance category. In 2021 and beyond, the following weights will be assigned to each category: EHR Meaningful use (25%); Quality (30%); Resource Use (30%), and Clinical Practice Improvement (15%). From 2019 through 2020, CMS has the authority to adjust the domain weights.

Quality Measures

Comment: We suggest CMS allow flexibility in selecting measures and reporting options for the quality performance category. In addition, to drive value-based care, we recommend quality measures be appropriately risk-adjusted, relevant to providers, and focused on patient outcomes.

Overall, the HQC supports utilizing the existing PQRS infrastructure as the foundation for drawing quality measures in the MIPS. We also support the overall goals of the National Quality Strategy and CMS in transitioning towards emphasizing outcome-based measures. Outcomes provide more meaning and value for Medicare beneficiaries, and are critical for delivering high quality care. In recognizing the development of relevant quality measures, specialty societies, and associations have been diligently developing quality measures that are applicable to their practice. Providers and health systems should have options available, such as those through Qualified Clinical Data Registries and Regional Health Improvement Cooperatives.

Resource Use/Efficiency

Comment: 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 ask that CMS improve the availability of Medicare prices to providers and continue exploring and proposing measures of cost/resource use that align with quality measures as a better representation of value-based care for MIPS. Also, we remain concerned regarding the use of current proxy input measures in the price standardization methodology for the cost measures in the value modifier.

We appreciate the continued use of cost and efficiency measures in the physician value modifier as a platform for the MIPS resource use category. The strength lies in a set of cost measures that carry a counter balance with measures of quality. Unfortunately, at this point there are not many options available to increase cost measures, which is disappointing. Currently, in the Measures Under Consideration (MUC) for CMS programs, that was released in December 2014, many of the episode of care payment measures were not considered because they do not have a quality measure component. We ask CMS to continue exploring measures of cost/resource use that align with quality measures as a better representation of value-based care.

We would also like to comment regarding the publication and availability of Medicare pricing to providers and price standardization methodology in value-based payment. Currently, although limited pricing is available to providers to make informed, cost-conscious decisions, pricing is not fully available for all facilities and settings of care. We suggest CMS take steps to improve the availability of pricing information for providers to better inform their patients of services available, quality, and cost. Price standardization methodology is for resource use measures that are designed to remove the effect of geographic adjustment factors. For example, the Geographic Practice Cost Index (GPCI) work adjustment was developed to create a mechanism that compensates physicians at the same "real" rate across the country. This is intended to incorporate geographic disparities in costs such as physician earnings, amenities (e.g., access to colleagues; sharing of on-call obligations; available technologies), and other economic factors causing differences across geographic areas, and to adjust payments accordingly. Better data exists for measuring the real rate of physician work, such as recruitment, compensation surveys, and physicians employed at federally qualified health centers.

As we have commented in prior rulemaking, we are concerned about the inaccuracy of the GPCI proxy inputs that result in downward payment adjustments to many HQC members unreflective of the actual cost of physician practices. MedPAC has affirmed issues with inaccuracy in the use of selected proxies for cost adjustment[1], which currently extracts compensation data of other professionals, such as architects. The price standardization methodology utilized in the cost measures for the physician value modifier is designed to reverse the impact of the GPCIs, but it does not cure the inaccuracies of the front-end inputs to the GPCI that continue to push payments to many HQC members downward. Until CMS takes action on correcting issues identified by MedPAC with the use of geographic adjustment, price standardization methodology used in the value based payment modifier for resource use measures will be directly impacted, and we are concerned the standardization methodology will be carried over in the efficiency/resource measures in the forthcoming MIPS program.

Electronic Health Record Meaningful Use Measures

Comment: The HQC suggests CMS consider developing a step-based approach to meeting meaningful use standards. This approach would recognize high performers with top scoring

[1]Transcript, October 4-5 MedPAC Meeting (2012) available at http://www.medpac.gov/transcripts/Oct12Transcript.pdf.

in the EHR category for meeting the highest meaningful use standard, but also balance investments and efforts by awarding meaningful use credit to providers that fall short of the highest meaningful use standard.

MACRA sunsets the existing Electronic Health Record Meaningful Use program at the end of 2018. Under the MIPS, measures from the current program will be wrapped into the meaningful use of certified EHR technology performance category. The EHR category will be assigned a 25 percent weighting of the composite performance score. CMS seeks comments on how to structure the meaningful use performance category. The HQC suggests CMS develop a scoring methodology that is not "all or nothing" in the current regulatory framework. Full credit should be awarded to high performers, but lower performing providers and systems achieving stages and benchmarks should also be awarded some points.

Clinical Practice Improvement Activities

Comment: The HQC offers suggestions on meeting the requirements for clinical practice improvement activities, such as membership in regional health improvement collaborative CMS Partnership for Patients Hospital Engagement Network. Overall, we recommend flexibility in meeting clinical practice improvement activities and urge inclusion of existing programs as part of the MIPS domain. In addition, we ask CMS to clearly articulate in the proposed rule what activities will be available for providers to satisfactorily meet the MIPS category and produce a plan for measuring clinical practice improvement.

Under the provisions of MACRA, 15% of the MIPS payment adjustment will include Clinical Practice Improvement activities. Although specifically undefined, activities will be classified into sub-groups, including:

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

In the forthcoming proposed rule for next year, we ask CMS to clearly articulate what clinical practice improvement activities will be made available, and how providers and groups are to satisfactorily meet the parameters of the domain. As a general matter, we recommend the identified activities be attainable, but also that they require sufficient engagement and effort to ensure that providers are being rewarded for their effort toward improving clinical practice. In addition, we request CMS to recognize current quality improvement programs and opportunities as the foundation for meeting the parameters of Clinical Practice Improvement Activities domain in the MIPS.

As such, we ask CMS to consider the following programs for inclusion as options for providers and health systems as part of the Clinical Practice Improvement criteria:

- Membership in a regional health improvement collaborative (RHIC).
- Successful completion of a formal quality improvement initiative sponsored by a RHIC.
- Attendance at one or more "learning events" sponsored by a RHIC.
- Membership and participation in a CMS Partnership for Patients Hospital Engagement Network

Many state and regional-based collaboratives were created as a means of convening and facilitating quality improvement initiatives with multi-stakeholders. Organizations and groups such as RHIC's and several others exist to facilitate new models and quality improvement initiatives. Included in MACRA is funding for technical assistance for RHIC's for providers in rural and medically underserved areas. Allowing for RHIC involvement in clinical practice improvement activities and other initiatives will provide an important link between funding and goals of MACRA and the new payment system (MIPS).

MIPS Composite Performance Score Methodology

Comment: The HQC is concerned the current Physician Value Modifier program scoring methodology creates performance categories (tiers) rather than attributing an adjustment to actual performance. In the first few years of the Value Modifier we have been disappointed to see the quality tiering methodology has had little or no impact on the overwhelming majority of providers.

We are concerned about a methodology that yields similar results in the MIPS. In the development of the MIPS program, we strongly encourage CMS to propose a performance methodology that resembles composite scoring and linear distribution, such as the method used in the Hospital Value-Based Purchasing (VBP) Program. The Hospital VBP program assigns an actual payment adjustment based on a hospital's individual performance rather than categorically grouping. Based on experience in the physician value modifier to date, over 75% of providers are considered "average"[2] despite acknowledged variation in performance.

In contrast to the hospital VBP program that calculates performance scores and distributes incentives and penalties based on actual net performance and individualized variable rates, the physician value modifier program uses categories of performance. Despite numerous studies indicating significant variation in Medicare spending and quality across the country, in 2015 the value modifier program had over 75% of providers considered "average" and only 13% of providers

[2] Department of Health and Human Services. Centers for Medicare and Medicaid Services. 2015 Value-Based Payment Modifier Program Experience Report. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-VM-Program-Experience-Rpt.pdf

electing quality-tiering gained bonuses. CMS has also stated in the CY 2015 proposed rule that in 2017, only 6% of providers are expected to earn upward adjustments, 11% will receive downward adjustments, and the remaining 83% will not see any payment impact.

We understand the need for CMS to reward only meaningful performance variation, and we are not advocating that CMS force variation among providers where not warranted. However, based on our review of the 2012 Quality Resource Use Reports, there appears to be a $5,000 to nearly $10,000 difference within the range of the *spending per beneficiary* standard deviation denoted as "average" spending. Therefore, a physician group could have a spending measure of $21,500 per beneficiary for heart failure, while another group could have $30,500 per beneficiary spending, and both groups would be placed in the same cost tier. This represents approximately 30% variation within the same quality tier.

The HQC questions the extent to which this is an appropriate application of the physician value modifier and we oppose this scoring methodology for the MIPS. As CMS provides further rulemaking on MACRA and implements MIPS set to begin in 2019, we strongly encourage CMS explore additional ways to recognize differences in performance in a more meaningful way than the physician value modifier that appropriately recognizes actual performance. Providers who are investing in value-based reforms to their practices should be rewarded, and the reward should be something more than the avoidance of a penalty. Rather, it should be a positive and meaningful financial reward.

B. Alternative Payment Models

In addition to implementation of the MIPS, the MACRA also provided incentives for providers to develop and implement Alternative Payment Models (APMs). MACRA creates a separate payment track for professionals participating in "eligible alternative payment models." 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 APM is defined to include Medicare Shared Savings Program (MSSP) Accountable Care Organizations, certain Centers for Medicare and Medicaid Innovation (CMMI) models, or models tested under other demonstration authorities. The APMs must also require meaningful use of electronic health records (EHR); pay based on quality and bear greater than nominal financial risk, unless the model is a medical home expanded under CMMI. To be considered a participant in an eligible APM, a professional must demonstrate 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.

Eligible APM Revenue Thresholds

Comment: Overall, although the HQC understands the established APM revenue thresholds are statutorily-bounded, we are concerned the thresholds are too high for most providers and systems to develop and implement sustainable APMs. We ask CMS to take this position

into consideration to the extent possible in developing rules, and explore ways to be more flexible in meeting the requirements to participate as an APM.

To be an eligible APM, entities must meet statutory thresholds. The primary thresholds are established as minimums where attributed APM revenue is generated to be an eligible APM while secondary thresholds are provided for entities to be a partial-qualifying APM. There are two ways to meet the revenue thresholds: 1) Medicare Part B revenue; or 2) All-payer revenue, which must also include Medicare Part B. From 2019 through 2020, 25% of Medicare Part B payments will need to be an APM to qualify, rising to 50% in 2021 through 2022. In 2023 and beyond, 75% of Medicare Part B will need to be an APM to meet the participating thresholds. To qualify under the All-payer option, in 2021 providers will need to also meet 50% of revenue in an APM, but only 25% must come from Medicare Part B. In 2023, this level rises to 75% all-payer, and 25% must be Medicare Part B revenue.

If a provider or entity does not meet qualifying thresholds, partial-qualifying parameters are established to maintain APM eligibility. However, partial-qualifying APMs are not eligible for the 5-year, 5% incentive payment. In 2019-2020, the Medicare Part B partial qualifying threshold is set to be 20%, rising to 40% in 2021-2022, and 50% starting in 2023 and beyond. For the All-payer option, in 2021 through 2022, the threshold will be 40%, rising to 50% in 2023 and beyond.

Overall, the HQC remains concerned the qualifying thresholds are very high for providers and entities to develop and sustain APMs. Although we understand the statutory limitations, we encourage CMS to utilize tools necessary and allow for flexibility to the extent possible for providers in meeting the established thresholds.

APM Patient Approach Thresholds

Comment: The HQC appreciates that CMS is exploring options to allow for patient numbers in lieu of revenue-only to meet the established APM thresholds. We support this as an option and believe flexibility should be allotted for entities to meet the aggressive thresholds via patient numbers data.

In lieu of meeting the established thresholds via specified Medicare Part B and/or all-payer service revenue, the law grants CMS the authority to use a "patient approach." The patient approach is an alternative method to be an eligible APM, and CMS is requesting comments on using patient numbers and how this should be defined. Overall, we ask for flexibility in attributing patients for purposes of counting towards patient thresholds, but suggest one such optional way to determine eligible services and participation in an APM be based on the percentage of the eligible provider's patients attributed to APM arrangement. This approach would be consistent with the Medicare Shared Savings Program, whereby CMS has a policy goal of achieving 50% of patients covered value based payment under ACO by the third year of the agreement.

The HQC appreciates that CMS is offering a patient approach as an option for meeting the aggressive revenue thresholds. Several HQC members are reimbursed amongst the lowest in the nation per beneficiary in Medicare, so although Medicare patients may represent significant levels of patient visits, the revenue may be very small. As such we believe CMS should be flexible in allowing for various forms of patient number data to be used for purposes of qualifying as an APM.

Defining eligible APM revenue and attributable patients

Comment: We suggest CMS allow flexibility for APMs to define their attributed APM revenue and patient population. This may come in the form of risk-based private pay value-based models, managed care contracts, and state-based Medicaid Patient-Centered Medical Home Models.

The RFI requests input on how to define eligible APM revenue. This is a critical policy decision given the high level thresholds included in the statute. We continue our previous section comment by asking that CMS provide discretion to providers in defining eligible APM revenue and patient counts. Models may come in several different forms where reimbursement is impacted by quality and/or utilization performance which should be considered compliant for purposes of APM revenue/patient population. With an APM target population, eligible APM revenue should recognize the vast diversity in (non) fee-for-service payment arrangements with public and private payers. Managed care contracts and other value-based payment arrangements in the private sector should be applicable for APMs. As Medicare Advantage continues to be a formidable option for Medicare beneficiaries, we strongly recommend APMs include Medicare Advantage revenue towards meeting the APM thresholds.

In the RFI, CMS asks for input on criteria and determination of state Medicaid medical home models to medical home models expanded by CMS. Nationwide, states have implemented various forms of Patient-Centered Medical Homes (PCMH) and "Health Homes" as a means to reduce cost and improve quality for Medicaid enrollees. Despite increased trends in developing medical homes, standards used for designing, implementing, and certifying medical homes take many forms. Some PCMHs, ACO's and health homes have targeted populations (behavioral health) while others develop their own certification standards and quality measures. Thus, we recommend CMS allow for the varying designs of medical and health homes which all have similar policy and clinical goals, to qualify as APM revenue.

Defining "nominal" financial risk

Comment: The HQC recommends that CMS establish flexibility in determining "nominal risk," relative to the model or arrangement that the APM is in.

Under statute, 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. CMS seeks input on defining nominal financial risk to participate as an eligible APM. We would recommend CMS establish flexibility in determining "nominal risk," relative to the model or

arrangement that the APM is in. For example, CMS should take into account costs and resources associated with designing and implementing the APM, and fee-for-service revenue forgone from moving into an APM. We strongly agree with the underlying goal of APMs to reduce costs and improve quality by reducing hospital admissions and expensive tests and procedures but express caution in rigid interpretations of nominal financial risk.

When determining an appropriate level of financial risk, we again reinforce the importance of appropriate risk adjustment and taking into account the baseline population of the APM in determining the intensity of risk. An APM focusing on the sickest patients in poverty-stricken localities will likely have a higher intensity of risk than a healthy population. For example, an APM with an established 10% risk within a population with low health disparities may have a lower intensity of risk compared to a 5% risk for a population with complex conditions and disparate socioeconomic barriers.

Information for Physician-Focused APMs and the Physician Payment Technical Advisory Committee (TAC)

Comment: We ask CMS to establish a clear path and efficient process for becoming an APM. Next, new payment models should encourage forms of capitated payment arrangements, incent an organizational structure that focuses on care coordination, and allow for tools for providers to control over when, where and how the beneficiaries they are aligned with health care services. Finally, coordination across federal agencies will be critical to effectively implementing new payment models.

The HQC believes physician-focused APM's will be instrumental in driving delivery system reform, coupled with a new robust value-based fee-for-service payment system (MIPS). The RFI requests stakeholders to provide input on information and criteria required for physician-focused APMs. In doing so, we ask CMS to establish a clear path and efficient process for becoming an APM. At this point, it remains a bit unclear as to the process for an organization to become an APM other than meeting specified criteria. We ask CMS to clearly articulate in the forthcoming proposed rule the options available for entities and the process of obtaining CMS approval.

In addition, it should be encouraged that existing infrastructure be utilized to the extent feasible. To minimize administrative burden, quality reporting, for example, should build on existing initiatives and reporting infrastructure. Also, Physician-focused APMs should incent an organizational structure that encourages care coordination. Patients will be better served with a team of providers collaborating on their care, as opposed to individual providers operating in silos with limited or no connections to other providers caring for those patients. Integration among providers is a key element to cost and quality improvement.

In delivering coordinated care, new APMs should be encouraged to implement a form of capitated payment structure. By receiving payment up front, through per-beneficiary, per-month payments, providers would have the flexibility and resources necessary to invest in care management and

processes to reduce overutilization, without having to be concerned about how a particular service is reimbursed under Medicare. Providers would also know upfront their patient population and could engage with them to influence how they receive care, and such, need proper tools to improve quality and reduce cost. Providers will be willing to take on more payment risk if they are given more control over when, where, and how the beneficiaries they are aligned with seek health care services.

The HQC appreciates the law's inclusion of technical assistance to small, rural practices and those serving shortage areas. Resources available for rural providers in underserved areas also ensure tools are in place to ensure continuity for vulnerable populations. We believe it is also important for CMS and other regulatory agencies to recognize that different tools maybe necessary to generate provider alignment. Providers should have tools in APMs to help facilitate provider networks, obtain prior authorization, and tiered cost-sharing to allow providers to encourage their patients to seek out high-value care at the right time from the right provider. In addition, formation of clinically integrated physician networks is critical for Physician-focused APM success. CMS and the Physician Payment TAC should consider tools available to allow independent groups to share risk and facilitate care management, and what organizational and operational criteria could physician-focused ACOs meet to obtain tax exempt status.

Conclusion

With the opportunity to transform the healthcare system towards value-based care, the HQC appreciates the opportunity to comment on this important RFI. Representing hospitals, providers and associations, including integrated healthcare systems, 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.

Sincerely,

The Healthcare Quality Coalition

The Healthcare Quality Coalition represents healthcare providers throughout the nation dedicated to the concept of value-based care. In short, we believe healthcare entities should be held accountable for the quality and value provided to the patients and communities we serve. The HQC is committed to developing value-based payment initiatives in a way that encourages fair payment to providers delivering high value care to the patients they serve. www.qualitycoalition.net