THE HEALTHCARE QUALITY COALITION

November 20, 2017

Centers for Medicare & Medicaid Services
Innovation Center
Department of Health and Human Services
Baltimore, MD 21244

Re: Centers for Medicare & Medicaid Services: Innovation Center New Direction

Dear Administrator Seema Verma:

The Healthcare Quality Coalition (HQC) welcomes the opportunity to offer comments on a new direction for the Centers for Medicare and Medicaid Services Innovation Center (CMMI).

The HQC is comprised of hospitals, physicians, health systems and associations committed to value-based healthcare. 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 broad themes to improve the CMMI for existing program models and to facilitate increased participation in alternative payment arrangements.

The coalition includes members that are in agreements with CMMI and non-CMMI alternative payment models (APMs) and others that have explored available programs but have not participated. Nonetheless, members have identified a number of strategic areas and themes that CMMI should take into consideration for soliciting, developing and approving new payment models.

As a key strategy, CMMI should solicit and approve new qualified advanced APMs and Merit-based Incentive Payment System (MIPS) APMs. The enactment of the Medicare Access and CHIP Reauthorization Act (MACRA) consolidated existing legacy programs and set a new direction in physician/professional services reimbursement. For the Quality Payment Program (QPP) to succeed, the role of CMMI should be to focus on models that provide a transition from the MIPS in the direction of advanced APMs.

For example, the implementation of the MIPS allows for preferred scoring for those models approved as "MIPS APMs", such as Accountable Care Organization (ACO) Track 1 models (no downside risk). CMMI

should work in tandem with those managing the QPP to ensure applicable professional service-driven models that are not qualified as advanced APMs be approved and subjected to MIPS APM scoring standards. This will ensure new approved and available models make a meaningful step toward advanced APM status, and are worthwhile for clinicians and organizations to participate.

In addition to Medicare Part B models, CMMI should develop and expand voluntary hospital Alternative Payment Models. There are currently an array of programs and initiatives aimed at reducing cost and improving quality. Since 2015, the HQC has advocated for the focus on hospital-focused APM options. Although the Medicare ACO program has demonstrated mixed results, experience from providers and hospitals participating as an ACO and other innovative models are integral for developing improved payment policy. In addition, the enactment of MACRA was a milestone in Medicare physician payment policy. Improved hospital payment policy should provide the opportunity for encouraging and incentivizing hospitals to undertake new models of care with opportunities for improved integration with clinical services.

In providing opportunities for future hospital and integrated health system APMs to flourish, we ask lawmakers to follow these guiding principles:

- Hospitals should have the opportunity to take on risk—rewarding quality and efficiency.
- Incentivize coordinated care and build on existing initiatives and infrastructure.
- Capitated-based payment should be encouraged.
- Flexibility and proper tools are essential to improve quality and reduce cost, including established provider and hospital networks.
- Beneficiaries should be engaged in delivery system reform, such as patient involvement and understanding their stake in value-based outcomes.

Greater coordination between the Physician-focused Technical Advisory Committee (PTAC) and CMMI is needed. As evidenced by the recent House of Representatives Energy and Commerce Subcommittee on Health Hearing on Alternative Payment Models, the PTAC was created in the MACRA to provide direction and technical assistance for approving new physician APMs. The PTAC is comprised of physicians, healthcare policy and payment methodology experts aimed at approving new models of care delivery and payment.

However, models reviewed and approved by PTAC do not need to be made available by CMMI to public participation. We believe CMMI needs to work closely with PTAC to ensure there is a consistent and clear pathway to approving models for the Quality Payment Program MIPS APM or advanced APM status. This ensures models submitted to the PTAC are meaningful in existing value-based programs.

Models need to be properly structured to manage patient care within a defined network. Models where physicians and providers are unable to coordinate patient care to ensure high quality treatment create significant challenges and force entities to take on risk that is outside of their control or influence. Success

occurs when systems directly manage the care of their patients and can proactively work to improve outcomes for their populations. This ensures accurate patient attribution and management of care.

Lack of actionable and timely data. Improvement cannot occur if models do not have access to current information about quality and costs. Existing data provided to models is often over a year old and fails to capture what change is occurring and areas where there are opportunities for growth. We support efforts to provide data on an ongoing basis. CMMI should also look to help facilitate reports on the data so that APMs can more easily help identify opportunities for improvement and cost savings. For example, reports could include key utilization metrics, such as readmission rates or performance on key quality metrics.

Continue to offer exclusively voluntary models. CMMI models should be voluntary, as it requires significant dedication and resources from participants to make the necessary changes to transform care. Choice also ensures that entities can select which models best fit their patient populations and those ongoing efforts are not disrupted by new mandatory requirement

Multi-payer models. A multi-payer approach would also help to address provider burden and the lack of alignment in reporting requirements. Medicaid programs should also be taken into consideration in multi-payer models to facilitate further alignment. Establishing uniformity in measure reporting across payers would allow the health care delivery system to reduce these burdens and more clearly focus on improving quality. This strategy would also align with the CMS' new meaningful measurement framework that is seeking to make reporting requirements more streamlined. As medical service reimbursement is focused on value over volume—measurement of quality should also focus less on volume of reporting and emphasize measures that are meaningful and outcome-driven.

Conclusion

On behalf of the HQC, we appreciate the opportunity to provide comments on the new direction of the CMMI. We urge CMS to work together with physicians, groups, hospitals, associations, and coalitions 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 new payment and care delivery models offered by CMMI.

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

Sincerely,

The Healthcare Quality Coalition