THE HEALTHCARE QUALITY COALITION

September 10, 2018

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: Administrator Seema Verma
CMS–1693–P
P.O. Box 8013
Baltimore, MD 21244–8013

Re: CMS-1693-P; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019

Dear Administrator Verma:

The Healthcare Quality Coalition (HQC) welcomes the opportunity to offer comments on the implementation of the Medicare Quality Payment Program (QPP). The CY 2019 proposed rule provides updates for program year 3, and we are pleased to provide feedback on areas where CMS requests input.

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 CMS' 2019 proposed rule on the Merit-based Incentive Payment System and Alternative Payment Models.

Quality Payment Program (QPP)

Merit-based Incentive Payment System (MIPS) Structure and Participation

The proposed rule seeks input on the continued implementation of the Merit-based Incentive Payment System (MIPS) as authorized in the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. The QPP commenced in CY 2017 impacting CY 2019 payment adjustments, and MIPS is comprised of four performance categories: Quality, Cost, Promoting Interoperability, and Improvement Activities. Each category includes a set of performance measures generated from their respective individual programs and initiatives.

Comments:

- **We support the proposed expansion of eligible clinicians (ECs) in the quality payment program for CY 2019. In addition, we ask that providers be allowed additional opportunities to list EC's throughout the calendar year.**
- **The HQC has concerns regarding the current low-volume thresholds (MIPS determination policy). We share the concerns raised by members of the Congressional Doctor's Caucus on policies that exclude so many clinicians. Instead, we would support lowering the low-volume thresholds coupled with special scoring considerations for individual and small groups. It is important the MIPS program progress forward to value-based care and include as many clinicians as possible and practical while ensuring fairness.**
- **We support the proposed MIPS opt-in policy starting in 2019. According to the proposed rule, this would increase participation in the program.**
- **The HQC appreciates the continued policies on virtual groups and urge their continuation in the program as a means of fostering collaboration.**

Low Volume Threshold (MIPS Determination Period)

The Low Volume Threshold (LVT) was established to exclude certain clinicians and very small groups from participating in MIPS. In the CY 2019 CMS has proposed adding a third criterion to the low volume exclusion test that would be based on the number of covered professional services provided. The proposed 2019 LVT policy is as follows: Clinicians or groups would need to meet one of the following three criteria: have ≤ $90,000 in Part B allowed charges, OR provide care to ≤ 200 beneficiaries, OR provide ≤ 200 covered professional services under the PFS. CMS estimates that this proposed policy would exclude an additional 1,173 MIPS eligible clinicians in comparison to the 2018 LVT policy.

The HQC continues to have concerns regarding the proposed LVT policies. On July 3rd, members of the House of Representatives Doctor's Caucus delivered a letter to CMS illustrating their concerns regarding exclusionary policies. In their letter, the authors wrote "we are concerned that the low volume thresholds are too high and effectively preclude providers from earning more than a nominal payment adjustment."[1]In the spirit of the law, we agree greater participation is critical to drive meaningful reforms. While we agree with the third criteria including professional services as part of the MIPS determination policy, we believe the thresholds are too high. **We ask CMS to revise the current thresholds to usher greater participation, with consideration for those clinicians participating as individuals and very small groups.**

Optional Participation Policy

[1] David P. Roe, et al. (July 3, 2018). Letter to Administrator Seema Verma on the Medicare Access and CHIP Reauthorization Act. Retrieved from: http://www.amga.org/wcm/Advocacy/Issues/MACRA/20180703.pdf

CMS also proposes a MIPS opt-in policy. Starting in 2019, clinicians or groups would be able to opt in to MIPS if they meet or exceed one or two of the LVT criteria. CMS estimated an additional 42,025 MIPS clinicians are eligible as a result of this policy for the 2021 payment year. Eligible clinicians would be individuals and groups that meet one or two of the exclusion criteria. **The HQC supports the proposed opt-in policy.**

Expanding the Pool of MIPS Eligible Clinicians

CMS has proposed expanding the eligibility to participate in MIPS under their statutory authority to other clinicians in CY 2019. As a result, the pool will be expanded to an estimated 18,303 additional clinicians. The expansion would add Physical Therapists (PT), Occupational Therapists (OT), Clinical Social Workers, and Clinical Psychologists as eligible for the MIPS. **The HQC supports the proposed expansion.**

Virtual Groups

The proposed rule slightly modifies policies for virtual groups. Overall, the HQC appreciates the implementation of virtual groups. We had supported regulations to facilitate the formation of virtual group in past notice and comment cycles and are pleased that CMS proposes to implement continued policies for virtual groups.

MIPS Scoring Methodology, Performance Thresholds and Category Weights

To assess performance in the MIPS, categories were established in the QPP with assigned weights. Once fully implemented, the MIPS will be comprised of four domains of measures: Quality, Cost, Advancing Care Information, and Improvement activities. To derive a performance score, weights were assigned to each performance category. CMS proposes to increase the weight of the Cost Performance Category for the final MIPS score from 10 percent (2018) to 15 percent (2019) and Quality from 50% to 45%. This proposed change would result in the following proposed allocation of the four performance categories for the 2019 Payment Year: be assigned to each category: Quality (45%), Promoting Interoperability (25%), Improvement Activities (15%), and Cost at (15%).

Comments:

- **The HQC supports multiple submission mechanisms for performance categories, so long as they don't create more administrative complexity for eligible clinicians, and the submission mechanisms are fully functional before being implemented. However, we urge less reliance on claims-based quality measures to the extent possible. Other methods have better, more accurate data.**
- **We support the increase in the performance threshold from 15 to 30 points, and high performer threshold increase to 80 points.**
- **Overall, the HQC supports the proposed MIPS category weights for Year 3 (CY 2019).**

Payment Scoring and Performance Thresholds

For the CY 2019 program year, CMS proposes to increase the threshold score in MIPS from 15 points to 30 points out of 100. The threshold score is the minimum points needed to avoid any downward payment adjustment in Medicare Part B for the 2020 payment year. The exceptional performer threshold score will be increased from 70 to 80 points to be eligible for the $500 million bonus funds distribution.

In the past, the HQC expressed general support for transition, but conveyed the importance of moving forward. We are supportive of the proposed policies to increase the performance and high performer thresholds.

MIPS Category Weights

Finalized in prior rulemaking, for the MIPS Year 2, the weighting of the categories were as follows: Quality (50%), Cost (10%), Advancing Care Information (25%), and Improvement Activities (15%). For Year 3 (CY 2019 performance year), CMS proposes to establish the following: Quality (45%), Promoting Interoperability (25%), Improvement Activities (15%), and Cost at (15%).

The HQC expressed concern in prior year rulemaking that setting the weight of cost at 0% was a step back—the Physician Value Modifier included cost measures prior to the enactment of the Medicare Access and CHIP Reauthorization Act (MACRA). We suggested CMS consider weighing the cost performance category at 10% for performance year 2018 as an incremental step toward the required 30% in 2019. With changes to law, CMS now has additional time to bring the cost category up to 30% of weigh. As such, the CY 2019 program sets the cost category at 15% of the total performance score weight. **Given the eventual transition to 30% for the cost category, the HQC supports the proposed MIPS domain weights.**

MIPS Performance Category Measures

For Year 3 of the MIPS, the proposed rule makes modifications to all the categories. The most notable changes come from measures in the cost and promoting interoperability domains.

Comments:

- **The HQC continues to urge CMS to focus on quality measure development, endorsement, and implementation of those measuring patient outcomes. We are pleased with the support on this strategy in the "Measures that Matter" initiative and the proposed (gold, silver, bronze) categorization of quality measures. The list of available measures should achieve a balance between flexibility and meaningfulness.**
- **We are concerned regarding a 3-year removal period for topped out quality measures and suggest CMS consider 2 years for removal so long as relevant outcome measures are included.**
- **While we appreciate the proposed rule including additional measures of cost, we would support an improved strategy on measuring cost. Measures need to be actionable and meaningful. While we had, and continue to support, including cost as**

a category and the measures from the prior Physician Value Modifier, the proposed episodes need further vetting. We recommend a strategy that either: a) includes comparative episode data within existing global-based quality measures to support service-line action; or b) additional vetted and endorsed episode or service-line measures with a counter quality outcome measure.

- **The HQC supports the proposed use of 2015 version of CEHRT for CY 2019 but allow for a reasonable transition for those that have not yet adopted the 2015 version. In addition, we support the proposed promoting interoperability category measures and criteria.**

Quality Measures

We recommend CMS continue prioritize outcome measures that are both narrowly-focused and broad-based to incorporate the quality of medical care practice and to incent keeping patients healthy. We are overall supportive of the "Meaningful Measures" strategy which promotes "Patients over Paperwork." Quality measurement is considered assumed by patients, and it is important it moves forward to meaningful outcomes. In prior rulemaking, we expressed concern regarding the over reliance on process measures, and with more than 60% made available were statistically topped out. Overall, we are supportive of the proposed modifications to the quality measures.

Cost Measures

Currently the Cost Performance Category is based on two measures: Total Per Capita Cost and Medicare Spending Per Beneficiary. CMS proposes the addition of eight recently developed episode-based and inpatient-oriented cost measures: Elective Outpatient Percutaneous Coronary Intervention (PCI), Knee Arthroplasty, Revascularization for Lower Extremity Chronic Critical Limb Ischemia, Routine Cataract Removal with Intraocular Lens (IOL) Implantation, Screening/Surveillance Colonoscopy, Intracranial Hemorrhage or Cerebral Infarction, Simple Pneumonia with Hospitalization, and ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI).

The HQC believes cost is an important component to measurement in the MIPS program. Since MIPS is still driven by predominantly fee-for-service claims, cost should be included toward the transition to alternative payment models, including those with some form of per enrollee capitation. However, proposed cost measures should be vetted, endorsed by the National Quality Forum (NQF), and be provided a one year "dry run" before incorporating into the performance of a clinician(s) subject to payment adjustment. In addition, cost measures should be balanced with a quality outcome measure, and we ask CMS to make this a primary strategy moving forward. We ask CMS to consider a one-year delay before fully implementing in the MIPS program.

Promoting Interoperability

CMS is stipulating that clinicians must use a 2015 Certified Electronic Health Record Technology (CEHRT) for CY 2019. This category is modified in scoring methodology, removing the "base," "performance," and "bonus" scoring components. In its' place, performance will be assessed with e-

Prescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Exchange. The promoting interoperability category effectively goes from six measures that need to be reported on to four, scored at the individual measure level. Old exclusion policies still apply, in which case PI weight will be reallocated to the Quality category. Additional measures are proposed, aimed at the national strategy on opioids. Overall we support the new PI measures, but again request CMS allow a transition period for all providers to update their systems and processes.

Prescription and Opioid Reduction Measures

Proposed E-Prescribing Objective and Measure for 2019 and 2020. In the CMS proposal, E-Prescribing is worth 10 points in 2019 and 5 points in 2020. The HQC would support maintaining 10 points for 2020.

Proposed Measure: Query of Prescription Monitoring Program. The proposed rule adds Query of Prescription Drug Monitoring Program (PDMP) as a new objective measure that is optional in 2019 and mandatory in 2020. We ask that in cases where state-level PDMPs are not capable of directly integrated to electronic medical record, that CMS provide flexibility for providers that require multiple queries across states.

Proposed Measure: Verify Opioid Treatment Agreement. Verification of Opioid Treatment Agreement is a new proposed objective measure that is optional in 2019 and mandatory in 2020. In current language, patients count in the denominator if the current duration of the patient's Schedule II opioid prescription is at least 30 cumulative days within a 6-month look back period. We ask CMS to provide guidance and clarify what is specifically being measured within the opioid treatment agreement as this is unclear in the proposed regulation.

Electronic Health Information

Proposed Measure: Support Electronic Referral Loops by Receiving and Incorporating Health Information. This measure will combine the current clinic PI objectives Incorporate Summaries of Care and Clinical Information Reconciliation to produce this new objective named Support Electronic Referral Loops by Receiving and Incorporating Health Information. While we appreciate the efforts by CMS to reduce administrative burden, we have concerns about the proposed combination and creation of a new objective**.** Combining the two measures would require additional resources for rework and process education to comply with the new objective. Better policy would be for maintaining the two measures than creating new processes to meet the objectives. In this case, the two separate measures are more efficient for reporting and beneficial to patient care because it is easier to specifically target improvement. Keeping the current measure specifications while simply renaming the current measures could accomplish the PI program goals.

Proposed Future Measure: Health Information Exchange across the Care Continuum. There are two new measure options proposed under the Health Information Exchange (HIE) Option. The measures include "Support Electronic Referral Loops by Sending Health Information across the Care Continuum", and "Support Electronic Referral Loops by Receiving and Incorporating Health Information." The focus of these two new measures is to promote and measure HIE exchange with long-term care, post-acute care settings, skilled nursing facilities, and behavioral health settings. This activity is partially measured using the current PI Health Information Exchange measures. We are

concerned creating these new measures may redundant and create additional burden for the hospital PI program.

Improvement Activities

For the 2019 program year, there is proposed to be few changes to the activities needed to achieve full credit for the category. Improvement activities are scored as either "high" or "low." For Year 3, CMS proposes to add 6 new improvement activities, modify 5 and remove 1 (Promoting interoperability Overall, the HQC supports the proposed additional improvement activities in the category. It is important to align, to the extent practical and possible, measures and activities across all the domains of the MIPS program. As in past years, clinicians and groups need to attest to doing the improvement activity for a minimum of 90 days.

Quality Payment Program Alternative Payment Models

Advanced Alternative Payment Models

Comments:

- **The HQC supports extending the 8% revenue-based risk standard through 2024.**
- **We also support the proposed QP determinations made at the individual or Taxpayer Identification level. We requested this flexibility in last year's rulemaking cycle and appreciate its inclusion for CY 2019.**
- **The HQC supports flexibility in meeting the revenue thresholds or patient count methodologies by payer sources. This will help improve pathways to becoming a qualifying professional in the APM pathway.**
- **We urge CMS to create improved pathways to approved Medicare Part B Advanced APMs with better coordination with Physician-Focused Technical Advisory Committee (PTAC). At this point, none of the models vetted by the PTAC have become available for providers through the innovation center.**

Alternative Payment Models (APMs) are approaches to paying for health care that incentivize quality and value. As defined by MACRA, APMs include CMS Innovation Center models (under section 1115A, other than a Health Care Innovation Award), MSSP (Medicare Shared Savings Program), demonstrations under the Health Care Quality Demonstration Program, and demonstrations required by federal law. To be an Advanced APM, a model must meet the following three requirements:

1. Requires participants to use certified EHR technology;
2. Provides payment for covered professional services based on quality measures comparable to those used in the MIPS quality performance category; and
3. Either: (1) is a Medical Home Model expanded under CMS Innovation Center authority OR (2) requires participants to bear a more than nominal amount of financial risk.

CMS proposes to add a third option to assess whether physicians have met the All-Payer threshold. Establish policies to attribute measures at the practice level (Taxpayer ID Number), in addition to the individual level and the APM Entity level. Also, the proposed rule clarifies that APM participants can meet Medicare and Other Payer participation thresholds using patient counts for one threshold and payment counts the other threshold, whatever is most advantageous.

One of the primary modifications to current policy, CMS proposes to increase the requirement relating to use of certified electronic health records technology (CEHRT) from 50 percent of eligible clinicians in each APM entity in 2018 to 75 percent of eligible clinicians in each APM entity in 2019. In the proposed rule, CMS states its belief that this change is consistent with what many Advanced APMs already require of their clinicians. The HQC is concerned with how CMS will verify this requirement and asks CMS to provide examples of how this would be achieved in the final rule.

Previously CMS finalized the financial risk standard as met if the terms of the APM require that an APM entity potentially owes or forgoes the following amount:

- 3 percent of the expected expenditures for which an APM entity is responsible under the APM, such as through a benchmark or target price (the "benchmark standard"), or
- 8 percent of the average estimated total Medicare Parts A and B revenues of participating APM entities (the "revenue-based standard").

CMS previously finalized the revenue-based standard only for the CY 2017 through CY 2020 performance periods, stating that it intended to increase the standard in subsequent years. However, CMS proposes to extend the 8-percent revenue-based standard through CY 2024.

Physician-Focused Technical Advisory Committee (PTAC)

The PTAC was established under the MACRA to provide a process for stakeholders to analyze and develop new APMs for the QPP. The committee has solicited and proposed new models to HHS, but has none have been accepted and made available for an optional APM. While we appreciate additional options being made available under the Bundled Payments and Accountable Care Organization programs, **we ask HHS, and specifically the Centers for Medicare and Medicaid Innovation (CMMI) to work closely with the PTAC to widen the available advanced APMs for providers to become qualifying professionals under the program.**

Conclusion

On behalf of the HQC, we appreciate the opportunity to provide comments on the implementation of the QPP. 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 the implementation of the new payment programs in the QPP.

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

Sincerely,

The Healthcare Quality Coalition