August 21, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

Re: CMS-5522-P – Medicare Program; CY 2018 Updates to the Quality Payment Program; Proposed Rule
Submitted electronically to https://www.regulations.gov

Dear Administrator Verma:

I write to share the comments of the National Coalition on Health Care (NCHC) on CMS-5522-P Medicare Program: CY 2018 Updates to the Quality Payment Program (QPP), established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

NCHC is a nonpartisan, nonprofit organization representing more than 80 participating organizations, including medical societies, businesses, unions, health care providers, faith-based associations, pension and health funds, insurers, and groups representing consumers, patients, women, minorities, and persons with disabilities. The Coalition is committed to advancing—through research and analysis, education, outreach, and informed advocacy—an affordable, high-value health care system for patients and consumers, payers, employers, and taxpayers.

The fee-for-service (FFS) payment model promotes volume and complexity in health care services and drives up costs across the United States. At the same time, it provides little incentive for the robust care coordination and quality that patients—especially the chronically ill and the most vulnerable—require.
Under MACRA, advanced alternative payment models (AAPMs) offer an essential alternative to fee-for-service. Physicians and clinicians have the opportunity to choose models that support the patient-centered care they want to deliver. Patients who receive their care through these models can rest assured that their care is driven by their needs and preferences, not fee-for-service's billing incentives. We commend CMS' leadership in continuing to press forward with the QPP's transition towards alternative payment models (APMs) that reward high-value care and support care delivery innovations.

However, we believe CMS must do more. We urge you to ensure that the Final Rule better support those clinicians who have decided the AAPM track is best for their patients and better assists MIPS practices to progress toward value-based care. Our detailed comments below focus on this pair of objectives.

**Advanced Alternative Payment Models**

**Establish a pathway to recognize Medicare Advantage (MA) Advanced APM arrangements for purposes of the Medicare-only thresholds:**
MACRA affords a five percent bonus to those physicians and other health professionals that take risk in Advanced Alternative Payment Models in Original Medicare (including Innovation Center demonstrations and Medicare Shared Savings Program ACOs). Entities must meet certain risk thresholds to qualify for bonuses. Currently, no MA arrangements count toward MACRA’s Medicare-only risk thresholds, even if physicians are taking substantially more risk from the Medicare Advantage plan than any Original Medicare models currently offer.

NCHC is encouraged that the notice of proposed rulemaking (NPRM) sought comment on this issue. We strongly urge CMS to count MA risk contracts between plans and physicians toward MACRA’s Medicare-only thresholds— as soon as practicable. This could be accomplished either by counting clinician participation in an MA APM towards the patient threshold for Medicare APMs prior to 2021 or use of CMS’ waiver and/or demonstration authority to create an MA Advanced APM.

**Extend the Advanced APM revenue-based nominal amount standard:**
CMS has proposed extending the revenue-based nominal amount standard, which was previously finalized through performance year 2018 for two additional years (through performance year 2020). This standard allows an APM to meet the financial risk criterion to qualify as an Advanced APM if participants are required to bear total risk of at least eight percent of their Medicare Parts A and B revenue.

NCHC supports extending a revenue-based standard to meet the nominal risk requirement. We believe this policy will permit more practices to embrace the movement toward value-based care and pursue advanced APM status—particularly in the first few years of the Quality Payment Program. That said, we do not support the application of a revenue-based standard to a large
entity in lieu of the specific sub-entity for which the standard would have implications. Within and across large organizations, entities can vary drastically in terms of value-based transformation readiness. Success in an APM depends on adapting care to the specific context (i.e., market, population) in which an APM Entity operates and accepting risk for that particular patient population in that specific locale. We believe that locally-based care should not be evaluated on a broad—and, in many instances, national—level.

Additionally, before extending the revenue-based nominal amount standard beyond 2020, we encourage CMS to seek comment on and consider more extensively the implications for the overall Medicare program and its interest in value-based purchasing generally. Other commenters have suggested that the current nominal standard may discourage AAPM Entities from including entities with substantial Part A and B revenue (including hospitals) in their provider list. As it considers the longer-term future of QPP, CMS should consider how to encourage participation of both smaller entities and larger integrated systems in AAPMs while ensuring incentives are optimally aligned toward value across Medicare provider types.

**Broaden Advanced Alternative Payment Model availability:**
The number and diversity of Advanced APMs continues to be much smaller than necessary to support clinicians in the transformation of their diverse practices. A medical home model has yet to be expanded as envisioned under MACRA. And outside of orthopedics, cardiology, oncology, and nephrology, specialty-focused models are not broadly available. We also note that CMS has yet to finalize its planned follow-on voluntary bundled payment model (known as Bundled Payment for Care Improvement 2.0 or BPCI 2.0).

**NCHC urges CMS to:**
- Promptly finalize Advanced APM models now in development including BPCI 2.0.
- Monitor the progress of CPC+ and other advanced primary care models, and proceed as rapidly as possible with the process of certifying and expanding them nationally—once proven successful.
- Prioritize the aggressive development and testing of additional specialty-focused models—provided they meet the same rigorous Advanced APM criteria as other models.

**Align risk requirements for Medicare AAPMs and Other Payer APMs:**
The Medicare Advanced APM risk standard has been established by CMS to be either:

- 8% of average estimated Parts A and B revenues (revenue-based)
- 3% of expected expenditures for which the APM Entity is responsible (benchmark-based)

For Other Payer APMs, CMS would require a more complex benchmark-based standard along three dimensions of risk:

- Total potential risk rate of at least 3% of the expected expenditures for which the APM entity is responsible;
- Marginal risk rate of at least 30%; and
Minimum loss rate of no more than 4%. CMS is not making changes to the tripartite Other Payer standard, but seeks comment on this or other proposed approaches.

CMS’s current proposal—a complex, tripartite nominal risk standard for Other Payer Advanced APMs and a simpler standard for Medicare Advanced APMs—dis-incentivizes physician participation in Other Payer APMs unless clinicians can receive credit for their participation in these models under MACRA. We recommend that CMS either maintain the same nominal amount of risk standard for Other Payer APMs as for Medicare Advanced APMs or ensure flexibility is built into the process to account for nuances in risk arrangements.

Provide for multi-stakeholder input in Advanced APM development and implementation: CMS should ensure consumers and patients are involved in the development of the underlying models categorized as Advanced APMs. We continue to urge CMS to consider how to increase transparency and public input in the development of Alternative Payment Models. Consumers and patients must be co-creators in our health care system and integral partners in developing all new models of care and payment. We believe it is critically important that all stakeholders have the opportunity to weigh in during development and implementation of new payment models. For example, CMS could appoint an advisory committee or Technical Expert Panel (TEPs) consisting of patient and consumer advocates, as well as other stakeholders, when developing new payment models. This is critical to ensuring that Advanced APMs are meeting the needs and priorities of all stakeholders, especially patients and their families.

Merit-Based Payment System

Option to participate in MIPS if excluded due to Low-Volume Threshold: For the 2019 performance period (2021 MIPS payment year), CMS proposes to provide clinicians the ability to opt-in to MIPS if they meet or exceed one, but not all, of the low-volume threshold determinations, including as defined by the dollar amount, beneficiary count, or if it is established, items and services. For CY 2018, CMS proposes to allow groups to voluntarily report, but they would not be subject to the MIPS payment adjustment.

With the implementation of virtual groups, practices with low-volume will be able to aggregate to reach stable measurement levels. Thus, CMS should allow all practices with low-volumes to opt-in to MIPS and receive payment adjustments as soon as possible.

Increase MIPS Performance Thresholds over time: CMS is proposing a performance threshold at a level 15 for the coming year, which it anticipates will be achievable by most physicians. However, we are concerned that extending such a low threshold over time could reduce the number of clinicians who pursue Alternative Payment Model participation in Medicare. They would thereby not be eligible for the five percent bonus and
exemption from MIPS and be ill-prepared for the broader adoption of alternative payment models across other payers.

To help strike a better balance, for CY 2018, we recommend requiring that eligible clinicians participate in at least two performance categories, including the quality performance category, to avoid a negative payment adjustment.

If the proposal to establish a 15-point threshold for avoiding performance penalties for CY 2018 is finalized, NCHC would urge that the threshold be increased in future years to ensure there are appropriate incentives for clinicians to improve performance on MIPS measures.

**Stand up Virtual Groups:** Virtual Groups represent a vital on-ramp option for small and rural practices who wish to begin the transition to value based care. Without this option, these groups would lack the number of patients required for valid measurement or the resources and infrastructure required for practice transformation. NCHC applauds CMS’ proposal to provide a virtual group option to MIPS eligible clinicians, as clearly mandated in the statute.

We recognize that CMS faces challenges in establishing a robust virtual group program by early next year. This only underlines the importance of pursuing a variety of avenues to promote participation. As a first step, we recommend that CMS offer bonus points to incentivize clinicians in small and rural practices to join a Virtual Group and begin moving toward joint accountability for performance.

Additionally, CMS should also explore ways to allow third-party entities to organize small practices and report on behalf of the virtual group for MIPS. Independent Practice Associations (IPAs) have potential to support clinicians in moving toward shared accountability by leveraging existing organized administrative systems to improve a virtual group’s efficiency and accuracy in performance reporting. For example, an IPA could act as a virtual group convener to arrange clinicians into reporting groups by specialty. This would ensure that clinicians are reporting measures that are directly relevant to their practice and that each clinician’s performance has a meaningful contribution to the final quality score.

**Weight cost performance appropriately:** Congress passed MACRA to effect a transition to value-based payments that holds physicians and other health professionals accountable for patient experience, quality of care, and total cost. Toward that end, in the QPP’s third performance year, statute dictates that the cost performance category must be weighted at 30 percent and the MIPS performance benchmark must be set at either the mean or the median score of all MIPS participants.

CMS has proposed reweighting the cost performance category to 0 percent of the final score for CY 2018. We appreciate CMS’ desire to reduce burdens on clinicians, but are alarmed by the potential for unintended consequences ensuing from this proposal. We are particularly concerned that this
proposal would create a payment cliff for clinicians—whereby clinicians would find 30% of their performance score based on measures which were not weighted at all the previous year. Such an outcome would be unmanageable for practices. To ensure the workable implementation of the statute, the Coalition believes cost performance should be integrated incrementally into the MIPS score. NCHC recommends the cost performance category be weighted to at least 10 percent of the final score for CY 2018.

Zero-weighting cost performance actually could reduce the payment options available to MIPS clinicians in the future because it fails to prepare them for the far more robust accountability for cost associated with alternative payment models.

Support clinicians with high-need patient populations through risk adjustment and bonus points: Clinicians who serve the most vulnerable and underserved populations often have few discretionary resources, limited infrastructure, and significant time pressure. Among the stakeholders comprising NCHC’s membership, a diversity of views exists with respect to the wisdom of risk adjusting measures for social and economic factors. But there is broad agreement that payment systems must support, rather than penalize, those clinicians who treat more challenging patient populations.

To that end, NCHC supports the proposal to establish a complex patient bonus in MIPS in the 2020 payment year. CMS proposes to calculate an average Hierarchical Condition Category (HCC) risk score using the model adopted for MA risk adjustment purposes and to use the average HCC risk score to apply a complex patient bonus. This bonus would be up to three points.

As another initial step, we support offering up to three bonus points using clinicians’ mean HCC risk score as well as providing bonus points based on the percentage of a clinician’s caseload of patients who are dually eligible for Medicare and Medicaid. However, we are concerned that dual-eligible status may severely underestimate the number of truly complex patients. There are currently 8.3 million beneficiaries considered dually eligible. However, the total Medicare beneficiary pool is 55.5 million. Additionally, while CMS determines the financial ceiling for eligibility, states have the ability to impose a lower income threshold, which can vary among states. Particularly in states that have not expanded Medicaid, dual status would fail to properly reflect the actual number of complex patients.

CMS should continue to build on and refine these approaches in future years. Another approach worthy of consideration would be to stratify certain measure results to identify and highlight disparities. Such an approach may allow CMS to address those disparities by further adjusting payment or offering bonus points to clinicians who see patients with a disproportionately high rate of disparities in care.

Move to Higher Value MIPS Quality Measures: Clinicians, payers, and consumers alike are overwhelmed by the growing number of quality measures, including many of little value. Over
time, we encourage CMS to reduce the total number of quality measures in MIPS by removing low-value measures and retaining high-value measures of clinical and patient-reported outcomes, patient experience, care coordination, patient safety, and other priority issues. By narrowing the MIPS measures to include only high-value measures, CMS can maintain a low reporting burden for clinicians while prioritizing the most important areas of measurement that both enhance quality improvement and give consumers the necessary information to choose among clinicians for elective procedures. CMS should continue to add high-value measures to the program as they become available.

**Broaden Use of Core Measure Sets:** NCHC supports the move toward core measure sets across payers, as exemplified by the work of the Core Quality Measures Collaborative (CQMC). Broader use of core measure sets can support comparability across clinicians, ultimately making the reported measures more useful for consumers, providers and plans. We applaud CMS’ continued commitment to incorporating these sets as an option into the QPP quality component.

Medicare can and must do more to align its approach with other payers’ increasing reliance on the CQMC measure sets. We recommend that CMS establish a new opportunity to earn bonus points for those MIPS-eligible clinicians who select complete CQMC measure sets as their reported measures under MIPS. This bonus would encourage adoption of core measure sets while maintaining clinicians’ freedom to choose other measures.

**Promote Key Clinical Practice Improvement Activities:**
We support the expanded inventory of activities, particularly the following new activities:

- Provide Clinical-Community Linkages
- Primary Care Physician and Behavioral Health Bilateral Electronic Exchange of Information for Shared Patients
- Advance Care Planning
- CDC Training on CDC’s Guideline for Prescribing Opioids for Chronic Pain
- Consulting AUC Using Clinical Decision Support when Ordering Advanced Diagnostic Imaging

We encourage CMS to further specify the activities which would qualify a practice for the Provide Clinical-Community Linkages and Advance Care Planning activities.

NCHC appreciates this opportunity to provide comment on the proposed rule and the enormous effort which CMS has devoted to making the Quality Payment Program work. If you have any questions about this letter or other issues, please contact me at 202-638-7151 or jrother@nchc.org or NCHC’s Policy Director Larry McNeely at lmcnely@nchc.org.
Yours truly,

[Signature]

John Rother
President and CEO