August 16, 2017

VIA ELECTRONIC MAIL

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Re: CMS–5522–P: Medicare Program; CY 2018 Updates to the Quality Payment Program

Dear Administrator Verma:

The Health Care Transformation Task Force ("HCTTF" or "Task Force")[1] appreciates the opportunity to provide input to the Centers for Medicare & Medicaid Services ("CMS") on the provisions open for comment in CMS-5522-P Medicare Program: CY 2018 Updates to the Quality Payment Program ("Rule"), which implements the second and future years of the Quality Payment Program ("QPP") as authorized by the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA").

The HCTTF supports the policies of MACRA and moving Medicare payment for physician services to a value-based formula that focuses on quality, resource use, clinical practice improvement, and meaningful use of certified EHR technology under the Medicare Incentive Payment System ("MIPS"). As a major proponent of value-based care furnished through alternate payment models ("APMs"), the HCTTF also supports the opportunity for qualifying physicians to benefit from participating in "Advanced APMs" with both Medicare and other payers. The Task Force believes these are important steps toward the desirable future state of two-sided risk models that further reduce cost and improve quality and efficiency. However,

[1] The Task Force is a group of 43 private sector stakeholders that wish to accelerate the pace of delivery system transformation. Representing a diverse set of organizations from various segments of the industry – including providers, health plans, employers, and consumers – we share a common commitment to transform our respective businesses and clinical models to deliver the triple aim of better health, better care, and reduced costs. Our member organizations aspire to put 75 percent of their business into triple aim focused, value-based arrangements by 2020. We strive to provide a critical mass of policy, operational, and technical support from the private sector that, when combined with the work being done by CMS and other public and private stakeholders, can increase the momentum of delivery system transformation.

we are concerned that some of the modifications proposed in this Rule could limit potential advancement towards a value-driven, patient-centered health care system.

The Task Force also anticipated that CMS would implement a new voluntary bundled payment model for CY 2018 and beyond, where the model would be designed to meet the criteria to be an Advanced APM under the Quality Payment Program. We urge CMS to finalize this model and to provide additional opportunities for willing APM entities to adopt payment reforms that promote a competitive marketplace for value-based health care and allow health care organizations to move health care payment from a system that rewards volume of services to one that rewards value of care.

I. MIPS Policy

We strongly encourage CMS to consider the experience gained by clinicians from the first program year and further strengthen the transitional policies to support the future success of clinicians in the Quality Payment Program. We are concerned that the proposed design of the second performance year will not adequately prepare clinicians for the requirements in subsequent years. However, we do support the provisions that present additional flexibilities for eligible clinicians – especially small practices – to successfully participate in the MIPS program.

A. Virtual Groups participation option

CMS has proposed to allow MIPS participation by "Virtual Groups" composed of solo practitioners and groups of 10 or fewer eligible clinicians. The Task Force is supportive of providing a virtual group option, but we believe there are benefits to making this option available to entities which are comprised of more than 10 clinicians. An expanded virtual group policy could enable clinically relevant physician groupings and the grouping of those clinicians who are further along in transformations and/or more prepared for the MIPS reporting requirements to help bring along other clinicians. Alternately, CMS should consider allowing for third-party entities to organize and report for MIPS on behalf of groups of smaller practices. It may not be feasible for solo practitioners or small groups to manage this process internally, and eligible clinicians should be given the option to outsource this service as needed to make participation more viable.

B. Raising the low-volume threshold

CMS has proposed to raise the low-volume threshold to exclude individual MIPS eligible clinicians or groups who bill less than $90,000 Part B billing OR provide care for less than 200 Part B enrolled beneficiaries. **The Task Force does not support raising the low-volume threshold, and recommends maintaining the current policy of excluding clinicians or groups who bill less than $30,000 to Part B or care for less than 100 Part B enrolled beneficiaries.**

In the transition year final rule, CMS estimated that about 32.5% of providers would be exempt from MIPS because they do not meet the low-volume threshold, but the number of providers actually exempted for 2017 was higher than anticipated. The increased low-volume threshold creates an arbitrary cut-off for performance in the MIPS program without first

assessing the effect of the current low-volume threshold on Part B providers, which could be impacted by more volatile scoring if the pool becomes too small. CMS should continue to transition a greater percentage of total Medicare spend away from fee-for-service to payment arrangements that account for quality, cost, and patient outcomes, rather than further reducing the number of providers eligible to participate.

Further, the modified threshold would mean that some clinicians who were eligible to participate in 2017 will be excluded from MIPS in 2018. We recommend that CMS extend the option for clinicians to voluntarily participate in MIPS reporting in 2018 for a performance score and performance-based payment adjustment. Clinicians who made investments and preparations to participate in MIPS during the transition year should not lose out on the opportunity to earn a positive payment adjustment in 2018.

C. Performance threshold

The proposal to set the performance threshold at 15 points to guarantee a neutral or positive payment adjustment places undue burden on providers that have utilized the transition year to prepare for MIPS. We are concerned that setting such a low performance threshold – in combination with the expanded exclusions and new opportunities to earn "bonus" points toward the final composite score – will limit the opportunity for eligible clinicians performing above average to earn up to a +5 percent payment adjustment. Further, we have concerns that clinicians are facing a cliff for the 3rd program year, and having to focus on reporting requirements, managing resource use, and overall performance as measured against peers may have negative consequences for both patients and clinicians.

We recommend CMS require that eligible clinicians participate in at least two performance categories, including the quality performance category, to avoid a negative payment adjustment. We further recommend that the point threshold be set closer to the cumulative number of points a clinician would earn for minimum participation (*i.e.*, reporting) across all MIPS performance categories. A performance threshold set closer to this level[2] would incentivize clinicians who are almost ready for full participation to make the necessary practice changes/investments and recognizes those clinicians who have already done so. Additionally, by requiring clinicians to submit some quality measures that meet the necessary data completeness requirement, clinicians are strongly encouraged to prepare for accountability for quality of care delivered and to become familiar with reporting quality measures and using quality data to support practice improvement. Given the complexity of the program, our recommendations will provide a strong incentive for clinicians to familiarize themselves with all the reporting requirements in the program, particularly the quality performance category, so that they can focus on performance improvement in future program years.

[2] As currently proposed, clinicians that submit all required quality measures with the necessary data completeness (18 points), successfully submit the Advancing Care Information base scores measure (12.5 points), and fully participate in the Clinical Practice Improvement Activities category (15 points) can earn a composite score of 42.5 points.

D. Cost performance category weight and measures

The Task Force supports a transition to value-based payments that hold providers accountable for patient experience, quality of care, and total cost. By statute, in the QPP's third performance year, 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. Introducing cost performance into the MIPS score should be done incrementally, rather than creating a steep cliff from 0 percent weight in PY2 to 30 percent in PY3. **Therefore, the Task Force does not support reweighting the cost performance category to 0 percent of the final score, and recommends this category be weighted to at least 10 percent of the final score**.

Measuring cost is an integral part of measuring value because clinicians play an important role in managing care so as to avoid unnecessary services. We understand that CMS intends to introduce new episode-based measures for the cost performance category in future performance years, and for that reason is not planning to continue to provide MIPS-eligible clinicians with information about their performance based on the transition year episode-based measures in 2018. This presents a missed opportunity for clinicians to understand and learn from their own performance year over year.

Additionally, we believe that the per capita costs for all attributed beneficiaries and the Medicare Spending per Beneficiary (MSPB) measures are necessary but not sufficient to encourage better management of costs at the individual patient and clinician level. The per capita cost and MSPB measures are calculated at the TIN level, and do not incorporate patient relationship categories nor codes into the attribution methodology, resulting in a lack of clarity about the relationship between the clinician and the patient when it comes to reviewing cost performance. The current attribution methodology could also shift accountability away from specialists. We urge CMS to continue to use the transition year episode-based measures for an additional year to provide valuable data to clinicians for the purposes of tracking improvement, and to fully engage the industry in the episode-based measure refinements through technical expert panels as well as additional public comment opportunities.

E. Improvement activities performance category

We support the expanded inventory of Improvement Activities, as well as the new activities eligible for ACI bonus points, and appreciate that CMS intends to continue incentivizing the use of health IT and telehealth to connect patients with the care and community-based services they need. We also support the proposed addition of improvement scoring for the quality and cost performance categories. CMS should also move toward scoring the improvement activities performance category based on performance and improvement, rather than simple attestation, which we believe will help ensure Improvement Activities are indeed helping to improve care. CMS should consider how to utilize patient-reported outcomes measures to track performance improvement.

F. Topped out quality measures

Under the quality performance category, CMS proposes to retire topped out measures due to high performance and low variation, or a change in the evidence supporting the measure. Topped out measures would be identified on an annual basis, and removed from the measure set after three consecutive years of being identified as topped (impacting the 4th performance year). While we support the regular review of quality measures for continued validity, we do not support the proposed approach to remove measure benchmarks identified as topped out from the MIPS quality measure list. **We have significant concerns about the validity of virtually any methodology used to identify topped out measures in a program that uses the menu approach for quality measurement.** When clinicians can choose to report a small handful of measures from a large menu, it becomes impossible to know if a measure is truly topped out – that is, if clinicians are uniformly performing well on the measure, even among those not reporting the measure – or if a measure only appears topped out because it is reported by clinicians who will score well on the measure. To address this issue, we recommend that CMS consider alternative approaches to identifying and scoring topped out measures.

G. Sub-group level reporting

CMS is soliciting feedback on sub-group related policies that would permit participation in MIPS at the subgroup level and create such functionality through a new identifier. Creating sub-groups would allow practices to define their own reporting groups – specifically for multi-specialty practices – which would alleviate many of the challenging dynamics and burden encountered when reporting under MIPS. In addition, the sub-groups allow clinician communities (primary care and specialists) to be grouped in a manner that is consistent with their actual referral patterns and care integration practices. We support this option and believe that CMS should adequately test this type of grouping option during the second performance year to identify any impediments before executing across the program.

H. Complex patient bonus

We support CMS' proposal to include bonus points for providers who serve complex patients. Payment policies should endeavor to offer providers and practices adequate resources to provide high-quality care for their patient population. We appreciate the approach to defining patient complexity to take into account a multitude of factors that have an impact on patient health outcomes including the health status and medical conditions of patients, as well as social risk factors. As CMS' states, we believe this proposal will help address discrepancies in the resources needed to treat high-need patients, without masking provider performance.

II. Advanced APM Policy

As mentioned above, the Task Force posits that the proposed rule goes too far in protecting minimal performers and excluding providers from participation in the Quality Payment Program. Instead, CMS should focus its policy priorities on rewarding high performers, and ensuring that participation in the Advanced APM track is more desirable for eligible clinicians in order to drive greater adoption of APMs.

A. 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 8 percent of their Medicare Parts A and B revenue. **In assessing nominal risk, the Task Force supports adding a revenue-based standard to meet the nominal risk requirement as a flexible alternative to the current three percent total cost of care standard.** Having flexibility to meet the nominal risk standard through an "either/or" test is desirable due to different provider situations.

However, the HCTTF does 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 catering 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 broader, in many instances national, level.

B. Medical Home Model financial risk standard

As communicated in our response to the 2017 final rule, the Task Force supports separate, more flexible, nominal amount and financial risk standards for Medical Home Models. **The Task Force believes that organizations enrolled in the CPC+ program should not be limited in their ability to qualify as Advanced APMs based on a size threshold**. Given that the 50 eligible clinician threshold is meant to serve as a proxy for small, CPC-like practices, the Task Force supports the assessment of all CPC+ organizations using the Medical Home Model Financial Risk Criteria, regardless of size. For example, a CPC+ organization with 60 eligible clinicians should not be assessed using the same financial risk criteria as an ACO with hundreds of clinicians, as these organizations do not have the same risk-bearing capacity.

C. Qualifying APM Participation (QP) performance period

We appreciate that CMS has proposed to modify the performance period for Advanced APMs that start or end during the QP performance period to calculate Threshold Scores using only the dates that APM Entities were able to participate in the Advanced APM. As previously communicated, the Task Force supports the movement away from a "single point-in-time" QP determination option to recognize participation in new Advanced APMs that are introduced midway through the performance year.

D. Qualifying APM participant determination: Medicare option

In the 2017 QPP final rule, CMS declined to incorporate recommended changes to the denominator definition for the payment-based calculation for determining qualified Advanced

APM status that would have created better comparability across the numerator and denominator for episodic programs. The Task Force urges CMS to reconsider this denominator definition for the 2018 performance year. Under current policy, while only the episode payments are contributing to the numerator, the denominator is diluted across all Part B services, which minimizes the benefit of the episodic revenue.

Additionally, CMS should count Medicare Advantage risk contracts between health plans and physicians toward MACRA's threshold requirements for Advanced APMs. We call on CMS to use its regulatory authority to include these arrangements beginning in MACRA's current performance year. This change would allow physicians to qualify as an Advanced APM if they take sufficient levels of risk in MA or traditional Medicare.

E. Calculating and disbursing the 5 percent Advanced APM Part B incentive payment

While recognizing that CMS has limited ability to act on this statutory policy, we raise a concern with the discrepancy in how the 5 percent incentive payment is calculated for QPs compared to the upside/downside payment adjustment calculation for MIPS participants. Under current policy, the MIPS payment adjustment is based on covered professional services and items, while the Advanced APM incentive payment is calculated on covered professional services only. There should be greater parity between the tracks in this regard, and at the very least, the incentive should be greater for the eligible clinicians that are moving into the Advanced APM track.

The misalignment between the determination period and when clinicians receive the incentive payment also limits the attractiveness of the Advanced APM track. QPs that participate in Advanced APMs in 2018 may be required to pay CMS for shared losses in 2019, but will not receive the incentive payment until 2020. This places constraints on the ability for APM Entities to shield risk from their networks. The Task Force sees no strong rationale for calculating the Advanced APM incentive payment based on claims subsequent to the QP determination year, and believes that the calculation should be based on performance year claims and paid out the following the calendar year to maximize APM participation and success.

F. Need for multi-stakeholder input into determining qualification for Advanced APM designation

CMS should ensure consumers, patients, and caregivers are involved in the development of the underlying models that are categorized as Advanced APMs. We continue to urge CMS to consider how to increase transparency and public input into 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, which would serve to balance the input received from industry via the Physician-Focused Payment Model

Technical Advisory Committee (PTAC). This is critical to ensuring that Advanced APMs are meeting the needs and priorities of all stakeholders, especially patients and their families.

III. All-Payer Combination Option/Other Payer Advanced APM Policy

Broad-scale adoption of value-based models among providers is critical to support the transition away from fee-for-service to achieve a truly person-centered system of care. To achieve this objective, alignment among public and private payers is critical. The All-Payer Combination Option for the 2019 QPP performance year presents a positive step in the path to transformation and an opportunity for greater provider adoption of value-based payment.

A. Generally applicable nominal amount standard

In addition to the benchmark-based nominal amount standard finalized for Other Payer Advanced APMs in the 2017 final rule, CMS is proposing to add an 8 percent revenue-based nominal amount standard for models in which risk for APM Entities is expressly defined in terms of revenue. The Task Force is supportive of adding the nominal amount standard as an option for some organizations. In line with our recommendations regarding the Medicare Advanced APM nominal amount standard, above, the HCTTF does 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.

In the anticipated sub-regulatory guidance, CMS should provide additional clarity about what payments can count towards the numerator. It remains unclear what types of payments are considered revenue for purposes of the revenue-based standard, and whether quality incentive payments and per member per month payments for investing in infrastructure and/or processes that lead to better care would be calculated as revenue. We recommend that CMS ensure that the definition of revenue aligns with the current medical loss ratio rules as industry has invested significant resources in designing compliance programs around those requirements.

B. All-Payer QP Performance Period & determinations

To create distinction from the Medicare QP determination process, CMS has proposed to create a separate All-Payer QP Determination Period (January 1 – June 30), and to calculate determination at the individual clinician level only. Under the All-Payer Option, CMS is seeking comment on possible exceptions to making the determination at the eligible clinician level.

The Task Force believes CMS should seek to align the Medicare and All-Payer QPM determination processes as much as possible, including the determination period timing, to reduce burden on clinicians. For many clinicians participating in Medicare APMs, making the All-Payer determination at the individual eligible clinician level presents an unnecessary burden. Where the Other Payer Advanced APM nominal amount standard could be calculated for the same group of clinicians as included in the defined APM entity for Medicare QP determination, CMS should allow for determination at the group level. For many commercial payer arrangements, it is not feasible for providers to determine the denominator for the nominal amount standard calculation at the individual clinician level.

C. Payer-initiated determination of Other Payer Advanced APMs

Starting in 2019, CMS proposes to allow payers to submit payment arrangements authorized under Title XIX, Medicare Health Plan payment arrangements, and payment arrangements in CMS Multi-Payer Models for Other Payer Advanced APM determination, and to open this option to other payer types in future years. There is no particularly strong rationale for limiting the payer-initiated determination option to these payer arrangements**. The Task Force believes that this unnecessarily constrains other payers from submitting data for determination, and recommends expanding this option to any willing payer and including commercial plans.**

With regards to Title XIX authorized payment arrangements, CMS proposes that states will work with and collect data from Medicaid managed care plans to request determination of those arrangements as Other Payer Advanced APMs. **The Task Force recommends extending the option for Medicaid managed care plans to submit information for determination directly to CMS, rather than relying on the state as an intermediary.** The policy as proposed would place an undue burden on states to operationalize this data collection, and in many instances the states may not even have access to the pertinent information.

Payers are in the best position to calculate the nominal amount standard, and expanding the payer-initiated option will thereby reduce the burden on eligible clinicians to do so. For those payers that are participating in CMS Multi-Payer Models (e.g., CPC+) where CMS has already certified certain payment arrangement information, CMS should offer a streamlined process whereby payers only need to submit information to meet the full Other Payer Advanced APM criteria in combination with the previously certified information.

Once a payer's arrangement is certified as an Other Payer Advanced APM, it is unnecessary for the payer to submit a large amount of information and documentation annually unless the payer has made major changes. We therefore recommend a multi-year certification of at least 3 years (consistent with a common term for commercial payer contracts), where the payer could also attest annually that it has made no or only minor changes to the model during the term of a specific contract. If CMS finalizes this proposal, we also seek clarification about what information submitted would be subject to disclosure in response to a FOIA request.

D. Eligible Clinician initiated submission of information and data for assessing Other Payer Advanced APMs and making All-Payer Combination Option QP determinations

When the determination has not already been made through the Payer-Initiated process, APM Entities or eligible clinicians would need to provide CMS information needed to assess the Other Payer Advanced APM criteria for each arrangement. As noted above, expanding the payer-determination option will reduce burden on providers. In line with our comments regarding the payer-initiated process, we urge CMS to streamline the annual process and enact multi-year certification of Other Payer Advanced APMs, as many payment arrangements are multi-year contracts. CMS should consider implementing a process for

eligible clinicians to self-attest (and to submit to an audit) that previously qualified payment arrangements continue to comply with the Other Payer APM requirements.

The HCTTF urges CMS to engage with stakeholders before issuing future sub-regulatory guidance, particularly as it relates to the requirements for the All-Payer Combination Option and Other Payer APM policies. Please contact HCTTF Executive Director, Jeff Micklos, at jeff.micklos@leavittpartners.com or (202) 774-1415 with any questions about this communication.

Sincerely,

Francis Soistman
Executive Vice President and President of Government Services
Aetna

Stuart Levine
Chief Medical and Innovation Officer
agilon health

Farzad Mostashari
Founder & CEO
Aledade, Inc.

Shawn Martin
Senior Vice President, Advocacy, Practice Advancement and Policy
American Academy of Family Physicians

Peter Leibold
Chief Advocacy Officer
Ascension

Warren Hosseinion, MD
Chief Executive Officer
ApolloMed

David Terry
Founder & CEO
Archway Health

Marci Sindell
Chief Strategy Officer and Senior Vice President of External Affairs
Atrius Health

Dana Gelb Safran, Sc.D.
Chief Performance Measurement & Improvement Officer and
Senior Vice President, Enterprise Analytics
Performance Measurement & Improvement
Blue Cross Blue Shield of Massachusetts

Kevin Klobucar
Executive Vice President, Health Care Value
Blue Cross Blue Shield of Michigan

Gary Jacobs
Vice President, Strategic Partnerships
CareCentrix

Kevin Lofton
Chief Executive Officer
Catholic Health Initiatives

Carlton Purvis
Director, Care Transformation
Centra Health

Gaurov Dayal, M.D.
Executive Vice President, Chief of Strategy & Growth
ChenMed

Susan Sherry
Deputy Director
Community Catalyst

Colin LeClair
Chief Development Officer
ConcertoHealth

Kevin Sears
Executive Director, Market & Network Services
Cleveland Clinic

Sowmya Viswanathan
Chief Physician Executive Officer
Dartmouth - Hitchcock

Elliot Fisher
Director for Health Policy & Clinical Practice
Dartmouth Institute for Health Policy and Clinical Practice

Shelly Schlenker
Vice President, Public Policy, Advocacy & Government Affairs
Dignity Health

Mark McClellan
Director
Duke Margolis Center for Health Policy

Chris Dawe
Vice President
Evolent Health

Frank Maddux
Executive Vice President for Clinical & Scientific Affairs: Chief Medical Officer
Fresenius Medical Care North America

Angelo Sinopoli, MD
Vice President, Clinical Integration & Chief Medical Officer
Greenville Health System

H. Scott Sarran, MD, MM
Chief Medical Officer, Government Programs
Health Care Service Corporation

David Klementz
Chief Strategy and Development Officer
HealthSouth Corporation

Richard Merkin, MD
President and Chief Executive Officer
Heritage Development Organization

Anne Nolon
President and Chief Executive Officer
HRH Care Community Health

Leonardo Cuello
Director
National Health Law Program

Debra Ness
President
National Partnership for Women & Families

Martin Hickey, MD
Chief Executive Officer
New Mexico Health Connections

Kevin Schoeplein
President and Chief Executive Officer
OSF HealthCare System

David Lansky
President and Chief Executive Officer
Pacific Business Group on Health

Timothy Ferris
Senior Vice President, Population Health Management
Partners HealthCare

Jay Desai
Founder and CEO
PatientPing

Danielle Lloyd
Vice President, Policy & Advocacy
Premier

Joel Gilbertson
Senior Vice President
Providence St. Joseph

Christopher Garcia
Chief Executive Officer
Remedy Partners

Kerry Kohnen
Senior Vice President, Population Health & Payer Contracting
SCL Health

Richard J. Gilfillan, MD
Chief Executive Officer
Trinity Health

Judy Rich
President and Chief Executive Officer
Tucson Medical Center Healthcare

Mary Beth Kuderik
Chief Strategy & Financial Officer
UAW Retiree Medical Benefits Trust

J.D Fischer
Program Specialist
Washington State Heath Care Authority