



September 6, 2016

VIA ELECTRONIC MAIL

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Re: CMS-1654-P: Revisions to Payment Policies under the Physician Fee Schedule
and Other Revisions to Part B for CY 2017

Dear Acting Administrator Slavitt:

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 CMS-1654-P Medicare Program: Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017 Proposed Rulemaking (“Proposed Rule”), specifically regarding the proposed changes to the Medicare Shared Savings Program (MSSP).

The HCTTF supports moving Medicare payment for physician services to a value-based formula that is person-centered and rewards for Triple Aim outcomes of better care, lower cost, and better health. We believe that the Medicare Shared Savings Program plays a significant role in supporting these goals. Many of our members were early participants in the MSSP and other Medicare Accountable Care Organization (ACOs) programs, and therefore provide a unique perspective founded in on-the-ground experience with the implementation of the programs’ provisions.

¹ The Task Force is a group of 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.

Generally, our members' experience with the MSSP has shown that it is possible, but not easy to improve quality outcomes, and that it is challenging to decrease cost trends against current benchmark approaches. We believe it is critical for the sustainability of Medicare ACO programs to minimize the costs of participating in the program and increase the financial incentives based on quality and cost performance.

The Task Force offers both general comments as well as specific comments addressing particular sections of the proposed Physician Fee Schedule.

I. Improving Payment for Primary Care

High-value primary care is linked with enhanced access to health care services, better health outcomes, lower rates of hospitalization, decreased use of emergency department visits, and improved health equity. The Task Force commends CMS for its ongoing efforts to appropriately reimburse primary care, cognitive services and behavioral health services. We are pleased to see that CMS is expanding beyond traditional primary care and coordination and taking into consideration the needs of the Medicare population that are higher risk and have specialized needs, such as those beneficiaries with cognitive impairments or mobility-related impairments.

We believe these efforts will garner significant positive outcomes and benefit the Medicare program overall. Improving access to these services by establishing reimbursement pathways aligns well with the goals of the Triple Aim. Broadly speaking, CMS' proposed reimbursement changes integrate well with and support the goals of other critical Medicare health system reform efforts, such as ACOs, bundled payment, and medical home models.

II. Quality Measurement

Performance measurement is integral to improving care delivery, protecting beneficiaries, and evaluating success. High-impact quality measures will help drive care transformation and are meaningful to consumers and purchasers. As we continue the transition to value-based care in the American health care system, we must ensure that both quality improvement and costs reductions are critical elements. The Health Care Transformation Task Force supports the following quality principles:

- Quality measurement should focus on outcomes and patient experience;
- Quality measurement should be consensus-based;
- Quality measurement should allow for the rapid accommodation of changes in evidence-based medicine;
- Quality measurement should cross over different payers and programs and every program should prioritize alignment with other programs; and
- Quality measurement should materially impact the financial performance of value driven health care models.

The MSSP generally follows these principles. As the most widely adopted ACO program, the MSSP is uniquely positioned to lead quality measurement refinement across payers. We encourage CMS to continue their efforts in multi-sector alignment and the Agency's movement toward outcome measures.

Regarding the quality measure set, we continue to have concerns over the significant use of process measures which may represent only a small contribution to a patient's outcomes and overall health. More importantly, such process measures may not influence patient outcomes at all, requiring providers to focus on unsuccessful methods. We strongly believe the measure set should focus on outcome measures, both clinical, functional, and patient-reported, **and we urge CMS to accelerate its efforts to replace process with outcomes measures for the MSSP program.** Future sets of measures should also adopt a continually greater focus on measures of patient experience, care coordination and Patient-Reported Outcome Measures (PROMs).

A. CMS Proposed Measure Changes

The Task Force appreciates the efforts of CMS to continually refine the quality measure set by eliminating measures that are either "topped out" or no longer considered to be clinical best practices. With regards to the measures, we support:

- The change to ACO-12 (NQF #0097) for medication reconciliation. This measure emphasizes a robust medication reconciliation at the time it is needed most – care coordination with post-acute care providers – and aligns with Core Measures Collaborative recommendation.
- The elimination of ACO-9 and ACO-10, which both measure condition-specific admissions, and replacement with ACO-37 and ACO-38, two outcome measures that report on inpatient hospital admissions of patient with clinical conditions that could potentially be prevented with high-quality outpatient care. These will be easier for ACOs to track and trend internally for performance improvement purposes.

We support the proposed retirement and/or replacement of the four CMS web interface measures:

- ACO-39 Documentation of Current Medications in the Medical Record – Replaced by ACO-12 (NQF #0097)
- ACO-21 Preventive Care and Screening: Screening for High Blood Pressure and Follow-up Documented
- ACO-31 Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- ACO-33 Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy—for patients with CAD and Diabetes or Left Ventricular Systolic Dysfunction (LVEF <40%)

As noted above, we support replacing ACO-39 with *Medication Reconciliation Post-Discharge* and ask that CMS work closely with the measure developer to ensure the GPRO web interface specifications and guidance are accurate and align with the endorsed measure. When the measure was previously included in the measure set, implementation was challenging with multiple changes to the measure specification during the performance period. **We ask that CMS release preliminary specifications and measure guidance as soon as possible so that ACOs can review and provide questions and feedback to CMS prior to final release of measure guidance.** The *Medication Reconciliation* measure has specifications for clinician-level reporting and health plan or system reporting. **We ask that CMS use the health plan/system version that is specified using a medical record review approach.** While the clinician version is currently included in the PQRS measure set, it is a claims-only measure that relies on CPT-II codes; adapting this version will recreate the prior implementation challenges. The health plan/system version still achieves alignment with PQRS while ensuring the measure can be implemented using the GPRO web interface reporting mechanism.

B. Performance Reporting for Eligible Professionals

Current MSSP regulations do not allow eligible professionals (EPs) billing through the Taxpayer Identification Number (TIN) of an ACO to independently report performance data outside of their ACO. Under the current rule, individual clinicians and group practices are subject to financial penalties if the ACO they participate in fails to satisfy the PQRS reporting requirements. We support the proposed change to allow EPs that bill under the TIN of an ACO to report separately for the PQRS payment adjustment if the ACO fails to report on behalf of its EPs, as this allows physicians more control over their performance in the MSSP. EPs should be given the opportunity to avoid financial penalties by individually submitting quality data.

C. Validating ACO Performance Reporting

Under the current processes, 30 records per audited measure are randomly selected for review, and ACOs will fail the audit if the medical records and reported data have a match rate below 90 percent. We support the proposed modification to the audit process, that the number of records audited will be calculated by the number of records required to achieve a confidence interval of 5 percentage points. This is a more equitable approach to the audit process and will be a significant program improvement when finalized.

We also recommend that CMS allow ACOs to revise submissions to correct for technical submission issues which can arise given the high level and intensity of manual process involved. The GPRO system as currently implemented is resource intensive and can at times be misleading in how status reports and feedback is provided to MSSP participants on data submissions.

D. Alignment of Reporting Requirements

CMS proposes that going forward, ACOs will be required to report all MSSP quality measures through the CMS Web Interface to satisfy reporting requirements for the quality performance category under the Merit-Based Incentive Payment System (MIPS), and any changes made to the CMS Web Interface measure set will be made through Quality Payment Program rulemaking.

We support requiring ACOs to report quality measures as a mechanism for aligning the MSSP reporting requirements with that of MIPS, as not all ACOs will qualify as Advanced APMs. We also support the proposed changes to ACO-11, which aligns the measure with the QPP proposals. Aligning measures should lessen the confusion for providers and enables patients and consumers to compare the quality of care across providers. We appreciate CMS' attention to the reporting burden of multiple measures, and agree it is important to ensure minimal administrative hurdles so that more provider time and resources may be dedicated to patient care and engaging in quality improvement activities.

III. Beneficiary Alignment

We support the proposed voluntary beneficiary attestation process for alignment in MSSP and applaud CMS for implementing this new provision for all three tracks of MSSP. **We strongly support allowing beneficiaries to actively choose assignment and remain attributed despite billing patterns.** However, before beneficiaries can be expected to elect into their chosen primary care provider's ACO, they must have access to materials that help them understand what the ACO model is, how the model of payment and care functions, what attestation means to them, and their rights with respect to accessing care from other providers. Such an outreach and education effort will require CMS, the ACO entity, and participating providers to take a more rigorous, thoughtful, and targeted approach to educating beneficiaries in ways they understand and that allow meaningful communication.

We urge CMS to ensure that a streamlined, automated process is in place and available for all three tracks of the MSSP such that beneficiaries can designate their main doctor directly to CMS (e.g., via www.MyMedicare.gov or 1-800-Medicare). The manual process developed as a test within the Pioneer model was a significant administrative burden for ACOs, and the language provided by CMS for the outreach letter was highly confusing and often at odds with how beneficiaries think about their medical providers. The combination of these barriers resulted in low participation by ACOs. Further, we believe that differences in how the beneficiary attestation is handled for the three tracks will cause unnecessary confusion for beneficiaries.

IV. SNF 3-Day Rule Waiver Beneficiary Protections

The Task Force recognizes that the Skilled Nursing Facility (SNF) 3-day rule waiver can improve quality of care as the patient will be able to leave the hospital earlier or completely

avoid hospitalization thus reducing risk of hospital acquired infections or other complications. Patients directly admitted to a SNF are more mobile from admission and more likely to receive timely rehabilitation therapies. Additionally, direct SNF admit programs reduce total medical expense while improving outcomes.

We appreciate CMS' continued attention to beneficiary protections when the SNF 3-day rule is waived. We support the proposed protections to ensure that beneficiaries are not charged for a SNF stay if the ACO or SNF uses the waiver inappropriately. We believe strongly that beneficiaries should be held blameless as CMS, ACOs, and SNFs are responsible for the utilization of the waiver.

We strongly support CMS' proposal to allow for a reasonable amount of time for ACOs to incorporate beneficiary exclusions into their process. A 90-day grace period from the date that CMS delivers the quarterly beneficiary exclusion file is a reasonable period. The grace period should not be less than 90 days because of the time it takes to process ACO exclusion files. However, we strongly believe that the first grace period needs to be extended to September to accommodate the very large exclusion file that comes in July. It is not uncommon for there to be a change in file format, application of eligibility criteria or the like that takes testing and processing time before the ACO can incorporate that first, large exclusion file.

V. Expansion of the Diabetes Prevention Program (DPP) Model

The Task Force endorses CMS' proposal to expand the DPP. Focusing efforts on preventing chronic conditions that affect a broad range of Medicare beneficiaries is wise policy, and prioritizing resources and selecting a program that has a proven track record in the Medicare population is a reasonable approach to addressing this high priority area for Medicare. We believe this proposal will have a positive impact on the overall Medicare program and the health of its beneficiaries.

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