December 19, 2016

VIA ELECTRONIC MAIL

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

Re: CMS-5517-FC: Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models (81 *Fed.Reg.* 77008 (Nov. 4, 2016))

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 the provisions open for comment in CMS-5517-FC Medicare Program: Merit-Based Incentive Payment System and Alternate Payment Model Incentive under the Medicare Physician Fee Schedule Final Rule with Comment Period ("Rule"), which implements 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

[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.

physicians to benefit from participating in "Advanced APMs" or "MIPS APMs." 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.

Our comments primarily focus on the remaining provisions open for comment addressing advanced APMs and MIPS APMs. We urge CMS to interpret "Advanced APMs" and "MIPS APMs" in ways that support the maturation of ongoing value-based payment models occurring in existing APMs. **We also urge CMS to seek public comment on any provisions of the final rule that are to be finalized, in more detail, in future years.**

I. Advanced APM Revenue-Based Nominal Amount Standard

In assessing nominal risk, the Task Force supports the adoption of a revenue-based standard as an alternative to the total cost of care standard. Having flexibility to meet the nominal risk standard through an "either/or" test based on either the total cost of care or revenue is desirable due to different provider situations.

CMS seeks comment for future consideration on the amount and structure of the revenue-based nominal amount standard for QP Performance Periods in 2019 and later. This includes: (1) setting the revenue-based standard for 2019 and later at up to 15 percent of revenue; or (2) setting the revenue-based standard at 10 percent so long as risk is at least equal to 1.5 percent of expected expenditures for which an APM Entity is responsible under an APM.

The Task Force questions whether the current revenue-based standard needs to be increased up to 15 percent in future years, especially given the significant financial impact on large providers when both Medicare Parts A and B are taken into account. With regard to CMS's two proposed revenue-based standards, **the Task Force only supports a straightforward revenue standard** such as option one above**.** This option is a clearer and simpler standard that can be applied more easily and consistently in the marketplace than a combination of total cost and revenue.

Option two above imposes unnecessary complexity to the standard, and would make long-term financial planning more difficult for organizations. Further, this more complex standard could lead to dysfunctional market dynamics that drive individuals to models that meet the standard rather than utilizing the standard to evaluate any model that an individual clinician may be participating in. A direct percent standard would help organizations with financial assessment, and encourage transformation toward a pre-determined, consistent goal.

Additionally, CMS is considering, in cases where the APM Entity is one component of a larger health care provider organization, using the larger organization as the basis for a revenue-based nominal amount standard. **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. Further, 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.

As noted above, the Task Force urges CMS to seek public comment before finalizing a revenue-based nominal amount standard.

II. Other Payer Advanced APM Financial Risk Criteria

In the final rule, CMS finalized separate and additional risk criteria for other payers that does not align with the risk requirements for Medicare APMs. **The Task Force does not support exceedingly stringent risk criteria for other payers**. The finalization of standard risk requirements for all other payer APMs limits these models before the marketplace dynamics are entirely clear. The Task Force supports flexibility in the Other Payer APM Financial Risk Standard and a reassessment of the Nominal Amount Standard for other payers prior to the 2019 performance year. In addition, the Task Force believes that given the increased market complexities associated with other payers, it may be necessary to provide separate nominal risk standards for certain payers as these models progress. We again encourage CMS to seek additional public comment prior to finalizing these provisions.

III. Medical Home Model Financial Risk Criteria

The Task Force supports separate, more flexible, nominal amount and financial risk standards for Medical Home Models. In the final rule, CMS finalized a size threshold, to become effective in the second performance year (2018), which would limit the Medical Home Model Financial Risk Criteria to medical homes with fewer than 50 eligible clinicians. **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**. 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.

In arriving at the 50 eligible clinician threshold, CMS compared the size of ACOs under the Shared Savings Program with the organizational sizes of CPC practices. This assessment led CMS to conclude that an eligible clinician count is a useful proxy for risk-bearing capacity, and that the 50 eligible clinician cutoff effectively distinguishes between Medical Home Models and those entities capable of meeting the generally applicable financial risk criteria. 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.**

Additionally, we support the assessment of Medical Home Models at the entity level, rather than at the level of the parent organization. As noted above, entities can vary within large organizations. As care is provided locally, and influenced by local factors (*i.e.,* geography,

patient mix, resources), we believe that the financial assessment of models should also take into account the local context.

IV. ACO Track 1 + Model

As discussed in the Task Force's comments on the proposed rule, **we support the creation of a new two-sided risk model that would provide an intermediate step along the continuum to fully mature two-sided risk models for both hospital and physician-led ACOs**. We believe the new model introduced in the final rule, ACO Track 1+, if structured appropriately, will effectively assist MSSP Track 1 ACOs in the transition to MSSP Tracks 2 and 3, or the Next Generation ACO model.

The Task Force suggests the following two options as potential structures and components of an ACO Track 1+ model that would facilitate increased participation in two-sided risk models, increased retention rate of ACOs, and improvements in nationwide cost and quality performance.

Option 1: Nominal Risk plus Prospective Performance Incentive Payments. The Task Force supports the use of a more flexible definition of "more than nominal risk," building on the foundation of the existing MSSP Track 2 model. Our recommendation is that the nominal risk/shared loss rate should be set at 30% for this model. We also recommend that CMS provide upfront capital to providers in the form of "performance incentive payments" at a certain percentage of risk based on the ACO meeting financial and quality performance (similar to the CPC+ and AIM ACO models) to help expedite system improvements; these payments should be excluded from benchmark calculations. Finally, we believe that this model should provide for additional incentive payments/reduced risk for small/rural providers.

Option 2: Care Management Fees at Risk. The HCTTF believes that a payment arrangement that causes an APM entity to lose the right to all or part of an otherwise guaranteed payment should be available as a qualifying financial risk standard for all types of APM entities. We therefore suggest that the current gain sharing arrangement in Track 1 be modified to provide for downside risk at a set percentage based on the ACO meeting financial and quality performance thresholds. We again suggest that CMS provide prospective, performance-based payments, excluded from benchmark calculations, which would help to expedite system improvements, and that additional incentive payments/reduced risk should be available for small/rural providers.

V. QP Determination

As discussed in the HCTTF's comments on the proposed rule, the Task Force supports the movement away from a "single point-in-time" QP determination option. We believe that

the "three snapshot" option will provide sufficient flexibility to capture those clinicians that are participating in Advanced APMs throughout the year.

For clinicians who are participating in models that qualify as MIPS APMs, but will not meet the Advanced APM threshold criteria, the Task Force supports the addition of a fourth "snapshot" on December 31 of the performance year. Currently, clinicians moved into a TIN after August 31 must be evaluated individually. We believe this provides an unnecessary burden to clinicians in MIPS APMs. A December 31 snapshot will allow MIPS APMs to continue group reporting through the end of the performance year, and to use claims data from the entire year. In this situation, the 3 months claims run out from the end of the QP Determination date would not be necessary, and would therefore not impede on the timeline for reporting under MIPS.

VI. Notification of QP Determination

The Task force supports the use of preliminary data to notify APM Entities about their likelihood of meeting the Advanced APM threshold. We believe that the preliminary information provided should include a list of NPIs and data around whether individual clinicians are expected to meet the QP threshold. This would enable corrections to the NPI list prior to the final QP Determination date.

The HCTTF urges CMS to engage with stakeholders in industry before issuing sub-regulatory guidance regarding the notification of QP determinations.

VII. MIPS APMs

In the final rule, CMS again indicated that the APM scoring standard would not apply to MIPS eligible clinicians involved in APMs that include only facilities as participants (such as the CJR bundled payment model). We do not support this approach. Existing hospital-led APMs have shown promise and success to date; that should be recognized. Moreover, facility-led APMs have facilitated clinicians transitioning to APMs by providing additional resources to clinicians, such as care managers and EHR technology.

Disallowing facility-led APMs from qualifying as MIPS APMs will prevent clinicians employed by hospitals from utilizing the APM scoring standard and deter clinicians from participating in facility-led APM models. This would threaten the viability of facility-led APMs in mandatory models as clinicians would be reluctant to engage in contracts based on the APMs quality and cost goals. **We urge CMS to allow facility-led APM entities to qualify as APMs, and to revise the requirement so that the APM entity includes one or more MIPS eligible clinicians on either a Participation List or an Affiliated Providers List. The first criterion could be revised to read as "participates in an APM sponsored by CMS."**

VIII. Virtual Entity Reporting Under MIPS

In the final rule, CMS indicates a desire for stakeholder engagement around the structure and implementation of "virtual groups" in CY 2018 and beyond (CMS is not implementing virtual groups in the CY 2017 transition year). **The Task Force asks that CMS allow the flexibility for organizations to define their own TINs for group reporting.** This flexibility would 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. We ask that CMS apply a similar methodology to virtual groups as is applied to the CPC and Pioneer ACO organizations, which are able to split TINs.

Further, we believe that using CY 2018 as a transition year for virtual groups, and enabling a pilot of organization-defined groups for MIPS reporting purposes, would allow for adequate testing of this process. We believe that a phased-in, pilot approach would ensure that virtual groupings do not overwhelm the current technical infrastructure.

Please contact HCTTF Executive Director, Jeff Micklos, at jeff.micklos@leavittpartners.com or (202) 774-1415 with any questions about this communication.

Sincerely,

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