



November 17, 2015

**VIA ELECTRONIC MAIL**

Andrew M. Slavitt  
Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
7500 Security Blvd  
Baltimore, MD 21244

Re: CMS-3321-NC: MACRA Request for Information

Dear Acting Administrator Slavitt:

The Health Care Transformation Task Force (Task Force) is pleased to provide input to the Centers for Medicare & Medicaid Services (CMS) in response to the October 1, 2015 Request for Information regarding the implementation of the payment models under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ("RFI").

The Health Care Transformation Task Force is an emerging group of private sector stakeholders who are committed to accelerating the pace of delivery system transformation. Representing a diverse set of organizations from various segments of the industry—including patients/consumers, purchasers/employers, providers, and payers—we share a common commitment to transform our respective business and clinical models to deliver the triple aim of better health, better care, and reduced costs.

Our organizations aspire to put 75 percent of their business arrangements into value-based payment models, focusing on the Triple Aim goals, by 2020. We strive to provide private sector leadership through policy, operational, and technical support, and expertise that, when combined with the work being done by CMS and other public and private stakeholders, will increase the momentum of delivery system transformation.

The Task Force supports policies that promote value-based care and applauds the efforts of CMS to enhance these endeavors. The MACRA provisions increase a provider's ability to provide quality care and improve patient outcomes, as well as achieve cost efficiencies. However, care must be taken to define these models in a way that promotes (not hinders) achievement of the desired results.

We strongly support the inclusion of Alternative Payment Models (APMs) in MACRA, and see the Merit-Based Incentive Payment System (MIPS) as a pathway toward APMs. As such, it is important that CMS propose regulations that create allowances and incentives for providers that desire to transition to an APM. Our comments build off this foundation and respond

directly to the following RFI sections under the APM portion of the RFI (unless otherwise specified): (1) EP Identifier (MIPS), (2) Virtual Groups (MIPS), (3) patient approach, (4) nominal financial risk, (5) Medicaid medical home models, (6) eligible APM (“EAPM”) entity requirements, and (7) quality measures.

### ***EP Identifier***

We support the creation and use of a MIPS identifier and the autonomy of providers to determine group accountability under MIPS. CMS should support a principle of self-determination and encourage EPs to create groups that are effective and in-line with their strategic plans. CMS should define a default MIPS unit of measurement and establish a system (*e.g.*, through PECOS) allowing EPs to create a unit group in advance of the measurement period. However, with the creation of unit groups, an identifier that uses a combination of current unit identifiers (*e.g.*, National Provider Identifiers (NPI) and Taxpayer Identification Numbers (TIN)) may be needed.

In the determination of group identifiers, CMS should consider the fact that many physicians practice in multiple groups or across state lines, and that this practice is important for patient access. In addition, there may be instances in which EPs wish to self-organize their TIN into smaller groupings based on geography or specialty, or a large health system desires to unify multiple TINs into a single unit of accountability under MIPS. For multi-specialty practices involved in bundled payment programs, unique group identifiers may allow more effective organization and participation, as not all EPs are necessarily involved in the bundled payments.

- **Providers should be given the discretion to create groupings that are natural for their organization or that help prepare them for future APM participation.** These groups should be consistent across all categories of MIPS, including meaningful use and practice improvement activities.
- **There will be a natural time lag between the measurement period, performance analysis, and payment adjustment.** Because the composition of a group may change within that lag period, CMS is encouraged to adopt a policy that adjusts payments for each NPI within a group, and allow for the adjustment to follow the NPI from its previous group to a new group, if applicable.
- **We support identifiers that allow for the most granular level of quality measurement (*i.e.*, individual provider level).** In order to allow for physician-level measurement with an identifier that could be consistent across payers, we favor using the NPI. MACRA provides the opportunity to strengthen NPI as an individual provider level identifier, rather than creating a new identifier that might not carry over to private payers. We also support using other identifiers, like TINs, in combination with NPIs, to create logical units of how providers are organized and working together.

### ***Virtual Groups***

Under MACRA, an individual MIPS EP, or group practice of no more than 10 MIPS EPs, may elect to be a virtual group with other such EPs or group practices to be assessed on performance. We support the creation of these virtual groups, and generally support robust, yet simple, guidelines regarding their development.

- **If Medicare applies size requirements to virtual groups, the minimum size should be statistically significant** in light of an “acceptable” range for the MIPS quality and resource use metrics applicable to that group’s specialty. This recommended approach may be improved by varying the minimum number of practitioners in a virtual group based on the PECOS-reported specialty or cluster of specialties.
- **CMS should avoid geographic limitations that are potentially inconsistent with the organization of medical care.** State borders, CBSA boundaries, and other geographic lines may separate practices that naturally practice together (*e.g.*, in "Tri-State" regions). Instead, CMS should encourage groups to collaborate across geographic borders in ways that reduce variation and promote consistent, high-quality care. One possibility is to set geographic borders by population density or other similar measures, as regions of the country vary in patient spread.
- **Virtual groups should be assessed no differently than any other MIPS groups on eligibility, participation, and performance.** They should be given a unique identifier and be allowed to collaborate as any other non-virtual group.
- **The number of virtual groups should not be limited in the first year.** Such virtual group programs have previously been implemented and have demonstrated a high level of quality and cost performance. Limiting the number of groups would disadvantage small and independent practices, creating some barriers to success.
- **CMS should allow virtual groups the flexibility to demonstrate an effective method of establishing patient attribution through an application process.** This would allow the group to gauge attribution and performance in real time.

### ***Patient Approach***

In lieu of using payment to determine if an EP is a partial qualifying practitioner or not, patient count could be used, similar to the ACO attribution model that requires EAPMs to submit a list of participating eligible providers. The numerator may be the number of patients in a value-based payment arrangement, and the denominator, total patient attribution.

### ***Nominal Financial Risk***

**We support tracking risk at the EAPM entity level, rather than the individual professional level.** When establishing criteria for level of risk, there are challenges associated with tracking

at the eligible professional level (not to mention the reliability of EP level data when there is a statistically insufficient sample size). For instance, performance—and risk—is often determined at the system level, rather than an individual level. At the very least, CMS should allow for qualifying programs to track risk on either basis, and should only allow use of individual EP level data when there is an adequate sample size (as determined through acceptable statistical sampling methods).

We also believe it is important that when considering the definition of nominal risk, other factors are taken into account. Nominal risk is about encouraging reduced spending and better quality, with more flexibility to innovate to meet these goals. Given that, it is important to consider the results being achieved in addition to the level of risk.

Regarding the appropriate level of nominal financial risk, we urge CMS to consider a progressive standard that encourages participants along the continuum to two-sided risk. We support an ultimate goal of two-sided risk and the move toward value-based payment. We encourage CMS to chart a course with appropriate incentives that entices all types of participants—regardless of their current capacity—to move in this direction.

### ***Patient-Centered Medical Home Models***

Under MACRA, there are significant financial incentives for participation in a patient-centered medical home (PCMH) in both the MIPS and APM reimbursement models. For example, under the statute, patient-centered medical homes established under 1115A(c) of the Social Security Act are exempt from bearing financial risk, but could still qualify as eligible APMs (although in our view PCMHs are really more of a delivery model than a payment model).

To ensure that PCMH's in both the MIPS and APM reimbursement programs provide patient-centered care, we recommend that CMS set forth comprehensive guidelines for PCMHs for purposes of MACRA certification, and for the process by which CMS will determine whether providers have met PCMH certification requirements. We note that these guidelines should also apply to PCMHs reimbursed under MIPS because any eligible professional in a practice certified as a PCMH will receive the highest potential score for the category of clinical practice improvement activities under MIPS. To the extent possible, we urge CMS to use existing certification processes already in place.

- **The guidelines should ensure that a PCMH home understands its patients and provides care that is “whole person” oriented and consistent with patients’ unique needs and preferences.** Patient-centered medical homes are founded in comprehensive and well-coordinated primary care. The practice has a responsibility for coordinating its patients’ health care across care settings and services over time and allowing patients and caregivers the opportunity to contribute information and collaborate on the care received. Interdisciplinary care teams should be established to guide care in a continuous, accessible, comprehensive and coordinated manner.

- **PCMHs should robustly utilize health information technology (HIT) and health information exchange infrastructure.** HIT is a foundational element of improving a practice's ability to share information and communicate. All care providers should have ready access to the patient's complete medical history. HIT and interoperability play critical roles in achieving successful, patient-centered APMs through deployment of beneficial logistics, eliminating barriers to data sharing, and helping achieving effective attribution.
- **The PCMH should demonstrate commitment to high-quality care and continued improvement to ensure that care that is safe, timely, effective, equitable, and patient- and family-centered.** There should be around-the-clock provider availability, with accommodations for patients with limited physical mobility. Regular evaluations and quality performance reports should be carried out and made available to patients and providers.
- MACRA permits CMS to alleviate Medicaid PCMHs from certain EAPM requirements. **The Task Force urges CMS to implement the law with flexibility for Medicaid EAPMs so to help foster movement toward the care delivery model for that patient population.**

### ***EAPM Entity Requirements***

The statutory definition of an EAPM entity includes some challenging requirements. (For example, there are alternate payment models in use today, including the Medicare Shared Savings Program (MSSP) and the Bundled Payments for Care Improvements (BPCI) that do not meet all of the current requirements of an eligible APM, as defined in statute.) While supportive of the statutory standards, we urge CMS to chart a course for how providers can meet the statutory standards as they seek to transition from participation in MIPS into participation in an EAPM. The public policy goal should be to encourage participation in alternate payment models, and CMS's implementing regulations should appropriately balance competing interests to further that goal.

- **CMS should articulate how it will help entities that are in a position to make the transition become EAPMs.** Entities that desire to operate in EAPMs should be given the opportunity to do so, provided financial incentives are appropriately aligned and they commit to meeting the statutory obligations as quickly as possible, subject to a date certain set by CMS. (Entities failing to meet all statutory obligations by the date certain set by CMS could be subject to losing their recognized EAPM status.) MACRA clearly contemplates EAPMs as a particular type of alternate payment model, and physicians and their groups operating in existing APMs should have the opportunity to continue to receive recognition and those benefits as their APMs transition to the new model contemplated by the law.

## **Quality Measures**

A quality component is essential to becoming an EAPM. Understanding how new payment and delivery models in APMs impact quality is essential to a system striving for higher quality, person-centered care. Because many EAPM entities will transition from MIPS, it is also important that the measures used in MIPS are those that are most meaningful.

However, the measurement approach currently used in other programs presents challenges. The slow testing cycle and endorsement process, as well as competing priorities, have resulted in a gap in some measurement categories and over-measurement of others. The development of performance measures is a rigorous process, but a balance must be met among filling measure gaps, investing in infrastructure for future measurement, and ensuring that measures evolve appropriately to support new APMs.

- **Clinical quality improvement activities should be used as a vehicle to implement use of better measures by clinicians.** A reporting subcategory should be added to support continuous quality improvement within a practice through the use of patient-reported outcome tools and corresponding collection of PRO data. Such data collection could improve the use of PROs in clinical practice and future development of PROMs, which is frequently hindered by too few providers using a given PRO tool or by barriers to data access. CMS should provide guidance on acceptable PROs and require data reporting back to CMS that supports measure development efforts.
- Additional payments should be given for using more advanced performance measures that capture important outcomes and patient experience.
- As the implementation of APMs grows, there is an increasing need for measures that indicate quality improvement of both the EAPM entity as well as the individual physician. While some indicators are outside of a physician's control, others are influenced by the decisions of individual providers, which can determine the cost savings and quality outcomes apparent at the entity level. As a result, a **single set of reporting measurements should be developed that have the ability to assess quality at both the entity and provider levels.**
- **A quality program for APMs that is consistent with MIPS is most desirable.** Such comparability will put the programs on equal footing and allow for easier comparison across programs. However, quality and risk requirements should also be consistent across EAPMs. Without consistency, many challenges become apparent, such as the inability to determine program effect or compare providers.

We believe in four main principles that should guide quality measurement development. **These principles should be used as a baseline for all measures incorporated into the MIPS and APM programs.** They should also be incorporated into the funding used to fill measurement gaps and produce more feasible data collection methods. There is still much work to be done to create a

seamless method of collecting data and linking data from different sources. The four principles are outlined below:

- 1) Quality measures should be used for more appropriate payment, consumer engagement, and public accountability—measures should create a business case for practicing continuous quality improvement, empower consumers to identify better performing care providers, and provide a way to evaluate whether a provider group is improving the health of its attributed population.
- 2) There should be an aligned approach across payment, consumer engagement, and public accountability—there should be uniformity and consistent reporting structures across the various Medicare payment programs that interact with MIPs, maintained at a time frame necessary to allow for stability and accurate evaluation.
- 3) Reporting systems should reward both improvement and achievement—benchmarking methodologies should include aspects that incentivize historical performance as well as absolute performance.
- 4) Measures should incentivize provider groups to contribute to emerging and innovative measures—national quality standards should include efforts to diffuse best practices for quality improvement.

Thank you for the opportunity to provide this input. The Task Force sees MACRA as a pillar in advancing the adoption of value-based payment throughout the industry. We welcome the opportunity to further discuss these recommendations with you.

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

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