September 10, 2018

VIA ELECTRONIC MAIL

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

Re: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Quality Payment Program (CMS-2018-0076)

Dear Administrator Verma:

The Health Care Transformation Task Force ("HCTTF or Task Force") thanks the Centers for Medicare and Medicaid Services (CMS) for the opportunity to submit comments on CMS-2018-0076: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program ("QPP"); and Medicaid Promoting Interoperability Program ("Proposed Rule").

The Task Force is a diverse group of 43 private sector stakeholders across the industry – including providers, health plans, employers, and consumers – that support accelerating the pace of delivery system transformation. Together 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, and aspire to have 75 percent of our business in value-based payment arrangements by 2020.

The HCTTF supports the goals of the Medicare Access and CHIP Reauthorization Act ("MACRA") and QPP to reward high value, high quality providers through the Merit-Based Incentive Payment System (MIPS) and encourage adoption of Advanced Alternative Payment Models ("APMs"). The Task Force is also pleased to see various recommendations from our CY 2018 QPP proposed rule response incorporated into the 2019 proposed rule. While supportive of CMS's efforts to reduce burden and encourage broader participation in these programs, we note that some of the proposed changes in this rule would create additional complexity and will require significant bandwidth from organizations to address and fully understand the impact of the proposals as it relates to the transition to value-based payment.

I. General Comments

With the significant recent proposed changes to the Medicare Shared Savings Program ("MSSP"), Outpatient Prospective Payment System, and anticipated changes following the Stark Law and Antikickback Statute requests for information, it is difficult to assess the potential interaction with changes proposed to the Fee Schedule and QPP. This uncertainty about the overall financial impact of interdependent payment rule changes can hinder the ability for providers to decide whether to participate in voluntary Advanced APMs. As we anticipate further regulatory reform, CMS should more explicitly address the impact these changes will have on APM participants, and specifically, to address how the payment changes will be considered in the APM methodology for organizations that have voluntarily committed to multi-year contracts. **The Task Force urges CMS to engage stakeholders again after addressing the concerns about the total impact of the payment rule changes on APM participants subject to performance-based risk before issuing final guidance.**

II. Physician Fee Schedule

A. Evaluation & Management ("E/M") Billing Codes Proposal

While the Task Force supports CMS' efforts to reduce the burden of documentation, we are concerned that the specific proposal to collapse E/M codes into a single blended payment rate for new and established patients for E/M levels 2-5 could result in additional operational complexity and present challenges to care delivery that were not adequately considered in the proposal. Specifically, our members are concerned about the downstream effects of this change on Medicare payment methodologies that rely on an accurate record of patient risk through E/M documentation. For example, this proposed change could impact the way benchmarks and rates are set for MSSP and Medicare Advantage plans, respectively.

Beyond billing and payment, E/M codes also serve a critical role in population health management and delivering care management services. Providers and payers use claims data to risk-stratify patient panels and prioritize high-risk patients for care management programs, for example.[1] We are worried that there might be unintended consequences on the delivery of primary care that have not been considered in the proposed rule. **Given that this change could have implications for payers beyond Medicare and that there are important secondary uses of E/M codes outside of billing, we encourage CMS to address these concerns and allow the industry to review an interim final rule before finalizing any E/M changes as proposed.**

III. Quality Payment Program

A. MIPS Opt-In Proposal

As stated previously in our response to the CY 2018 Updates to QPP,[2] the Task Force supports extending the option for clinicians to voluntarily participate in Merit-based Incentive Payment System

[1] http://hcttf.org/2017-11-8-levers-of-successful-acos/

[2] http://hcttf.org/2017-8-21-task-force-provides-input-on-cms-proposed-rulemaking-on-cy-2018-updates-to-the-quality-payment-program/

("MIPS") for a performance score and performance-based adjustment. We support the policy as proposed to allow clinicians to opt-in to MIPS participation in Year 3 of the program.

B. Performance threshold

The Task Force supports the proposal to increase the MIPS performance threshold from 15 to 30 and the exceptional performance threshold from 70 to 80. In our prior correspondence on the QPP CY 2018 proposed rule, we expressed support for a higher threshold to incentivize full participation and provide greater opportunity for eligible clinicians performing above average to receive a positive payment adjustment. In conjunction with the additional $500 million authorized by MACRA and made available each year from 2019-2024, the threshold increase will serve as a tool to incent greater quality and cost performance.

C. Availability of Advanced Alternative Payment Models (APMs)

We support the goal of MACRA and the QPP to prepare and incentivize providers to move into Advanced APMs. It is important to continue to offer opportunities for physicians to participate in a variety of Advanced APMs which hold the most potential for accelerating the pace of value transformation. However, CMS has only introduced one new model qualifying as an Advanced APM for PY 2019 (BPCI Advanced), and providers are uncertain what models may be introduced or continued in the future. **The HCTTF urges CMS to accelerate the development of new models, and to provide a detailed vision for its value-based transformation priorities. We also urge CMMI to articulate its future direction for model development at the earliest opportunity.** Additionally, we encourage CMS to use its authority to create and implement APMs with a focus on primary care. A greater investment in primary care is essential to achieving the Medicare program's goal of delivering lower cost, higher quality, and more person-centered care.

D. Payer-initiated determination of Other Payer Advanced APMs

The Task Force is pleased to see the CMS is proposing to allow the inclusion of all payer types in the 2019 Payer Initiated Process for the 2020 performance period. However, we would like to reiterate our recommendation from our CY 2018 QPP response that **Medicaid managed care plans should be able to submit information for determination directly to CMS as opposed to through the state as a go-between.**[3] Extending this option to Medicaid managed care plans willing to submit this information would also reduce provider burden.

E. Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) demonstration

The Task Force is committed to moving our nation's delivery system away from volume-based compensation and towards payment for value and high-quality care, and therefore believes it is essential to ensure provider incentives are aligned in both traditional Medicare and MA to incent participation in risk-bearing alternative payment models. We appreciate that CMS has announced the MAQI Demonstration in the proposed rule to increase participation in Advanced APMs. MA plays a

[3] http://hcttf.org/2017-8-21-task-force-provides-input-on-cms-proposed-rulemaking-on-cy-2018-updates-to-the-quality-payment-program/

significant role in properly aligning provider incentives to support the transition from fee-for-service to value-based payment and care delivery.

****

The Task Force appreciates the opportunity to provide comments to CMS regarding the changes proposed to the Medicare PFS and QPP. Please contact HCTTF Executive Director Jeff Micklos (jeff.micklos@hcttf.org or 202.774.1415) with questions regarding this communication.

Francis Soistman
Executive Vice President and President of Government Services
Aetna

Stuart Levine
Chief Medical and Innovation Officer
agilon health

Farzad Mostashari
Founder & Chief Executive Officer
Aledade, Inc.

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

Hoangmai Pham, MD, MPH
Vice President, Provider Alignment Solutions
Anthem, Inc.

Peter Leibold
Chief Advocacy Officer
Ascension

Warren Hosseinion, MD
Chief Executive Officer
ApolloMed

David Terry
Founder & Chief Executive Officer
Archway Health

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

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

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

Rahul Rajkumar, MD
Senior Vice President & Chief Medical Officer
Blue Cross Blue Shield of North Carolina

Ann T. Burnett
Vice President
Provider Network Innovations & Partnerships
Blue Cross Blue Shield of South Carolina

John Driscoll
Chief Executive Officer
CareCentrix

Gaurov Dayal, MD
Executive Vice President, Chief of Strategy & Growth
ChenMed

Jean Drouin
Founder and Chief Executive Officer
Clarify Health

Monica Deadwiler
Senior Director, Health Care Payment Innovation
Cleveland Clinic

Susan Sherry
Deputy Director
Community Catalyst

Colin LeClair
Chief Development Officer
ConcertoHealth

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

Karen Murphy, **PhD RN**
Executive Vice President, Chief Innovation Officer
Geisinger

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

David Klementz
Chief Strategy and Development Officer
Encompass Health

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

Anne Nolon
President and Chief Executive Officer
HRH Care Community Health

Anthony Barrueta
Senior Vice President, Government Relations
Kaiser Permanente

Leonardo Cuello
Director
National Health Law Program

Debra Ness
President
National Partnership for Women & Families

Robert Sehring
Chief Executive Officer
OSF HealthCare System

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

Sree Chaguturu
Chief Population Health Officer
Partners HealthCare

Jay Desai
Founder and Chief Executive Officer
PatientPing

Blair Childs
Senior Vice President, Public Affairs
Premier

Christopher Garcia
Chief Executive Officer
Remedy Partners

Jessie Israel
Senior Director of Accountable Health
SCL Health

Richard J. Gilfillan, MD
Chief Executive Officer
Trinity Health

Martin Hickey, MD
Chief Executive Officer
True Health New Mexico

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