



September 27, 2019

**VIA ELECTRONIC MAIL**

Seema Verma  
Administrator  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, MD, 21244

Re: CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule, Quality Payment Program, and Other Changes to Part B Payment Policies (CMS-1715-P)

Dear Administrator Verma:

The Health Care Transformation Task Force (HCTTF or Task Force) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule on CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule, Quality Payment Program, and Other Changes to Part B Payment Policies ("Proposed Rule").

The Task Force is a consortium of over 40 private sector stakeholders that support accelerating the pace of transforming the delivery system into one that better pays for value. 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 better health and better care at reduced costs. Our member organizations aspire to have 75 percent of their business in 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.

**I. Medicare Shared Savings Program Requirements**

CMS seeks comment on whether the agency should alter the current quality scoring approach for Medicare Shared Savings Program (MSSP) ACOs to instead adopt the quality scoring approach used in the Merit-based Incentive Payment System (MIPS) in an effort to better align quality scoring methodologies across programs. The goals of the two programs may not lend themselves to perfect alignment. The MIPS program is specialty- and provider-specific,

making episodic measures more meaningful, whereas ACOs are responsible for beneficiaries' total cost of care and it stands to follow that those providers should be accountable for total health measures. **In sum, HCTTF does not oppose altering the MSSP quality scoring in the manner contemplated so long as there is sufficient time for MSSP ACOs to adjust to the new approach and when future changes are made.**

Efforts to pursue alignment can also be unnecessarily disruptive to existing programs. The Task Force recommends that CMS – when making any changes that would impact MSSP – allow MSSP ACOs time to adapt and transition to new measures. For example, CMS has proposed to flip the ACO-43 - Ambulatory Sensitive Condition Acute Composite measure (PQI #91) to pay-for-reporting for two years given AHRQ changes to the measure. The removal of dehydration from the scope of ACO-43 requires at least the following work from ACOs: (1) building and testing new analytics code to replicate the new measure; (2) implementing this code in scalable rules engines; (3) adapting the design & documentation for performance reports; (4) re-assessing ACO performance and specific areas of opportunity in light of the new data; (5) changing the scope & mandate of provider workgroups charged with improving performance; and, (6) re-allocating resources to focus on the new scope. Changing quality measures impacts both analytics and operations, and ACOs need time to adapt to the new scope. We support best practices such as the approach proposed for ACO-43 when the scope of measures has meaningfully changed.

## **II. Quality Payment Program**

The Quality Payment Program (QPP) was intended to accelerate the transition of traditional Medicare away from its reliance on fee-for-service payment system in part by providing incentives for physicians and other clinicians to move into Advanced Alternate Payment Models (Advanced APMs). Our members took the necessary steps and made significant investments to participate with the expectation that some of these investments would be recouped in part by the five percent Advanced APM bonus. However, while physicians and other clinicians participating in the MIPS began receiving payment adjustments January 1, 2019 for their 2017 performance, no participants have received the expected bonus to date for performance year 2017. While legitimate operational considerations exist, the reasons for a holdup of this length of time is unclear. **We urge CMS to commit to pay the Advanced APM incentive payment no later than June 30<sup>th</sup> in future years.** This ongoing delay could dissuade providers from participating in Advanced APMs in the future, or worse, be forced to make difficult budgetary choices in the short term that could hinder patient care or inhibit their ability to succeed in APMs. Timely payment of the Advanced APM incentive payment would reflect a supportive approach by CMS to the hard work that providers are doing to move toward advanced risk models.

**a. Merit-based Incentive Payment System**

We generally support the updates to this part of the Proposed Rule. We agree that the QPP has imposed administrative burdens on providers with unclear outcome benefits for patients. However, we also believe that MIPS should not only be about provider payment—it should create value for Medicare and Medicaid beneficiaries. CMS should leverage MIPS to put the focus on the patient and what consumers need to make choices and in promoting joint decision-making.

*i. MIPS Value Pathways*

CMS is proposing to create MIPS Value Pathways (MVPs) of integrated measures and activities that are meaningful to all clinicians and patients. CMS hopes that these new MVPs would remove barriers to APM participation and promote value by focusing on quality, interoperability, and cost. The Task Force appreciates that CMS is trying to better engage specialists in building capacity for taking on APMs but are concerned that the proposal would create an overly complicated mechanism to do so. The Task Force encourages CMS to engage closely with stakeholders this year to design cost measures that are specifically aligned with clinical practice, to address existing challenges around MIPS data reporting, and to ensure the program promotes movement to APMs. As part of this effort, CMS should consider how the MVP program could better align reporting requirements for MIPS and Advanced APMs.

*ii. Patient-reported outcomes measures*

CMS believes that MIPS performance measurement should focus more on patient reported measures, including patient experience and satisfaction measures and clinical outcomes measures. CMS also suggested that MVPs may include patient reported outcomes measures (PROMs), and that the Agency intends to incorporate more PROMs and patient care experience measures into MVPs. While we believe patient experience and satisfaction is important, we recommend that CMS focus more on patient outcomes. Meeting patients' expectations of their health has proven to promote better mental health and personal wellbeing beyond simply treating a condition or diagnosis. The use of PROMs may result in improvements to patient outcomes in several ways—for example, by providing patient centered information and facilitates improved communication between doctors and their patients. Patients may also feel that healthcare providers are more involved in their care because providers are showing an interest in the patient's views on their expected outcome in health and wellbeing.

**a. Advanced APMs**

*i. Aligned Other Payer Medical Home Models*

The Task Force supports separate, more flexible, nominal amount and financial risk standards for Medical Home Models. CMS is proposing to add the defined term "Aligned Other Payer Medical Home Model" to mean an aligned other payer payment arrangement (not

including a Medicaid payment arrangement) operated by another payer formally partnering in a CMS Multi-Payer Model that is a Medical Home Model through a written expression of alignment and cooperation with CMS, such as a memorandum of understanding (MOU), and meeting other designated characteristics. CMS notes that the proposal would limit this Aligned Other Payer Medical Home Model definition to other payer payment arrangements that are aligned with CMS Multi-Payer Models that are Medical Home Models because of the assurance that the structure of these arrangements is similar to the Medical Home Models and Medicaid Medical Home Models for which CMS has already made a similar determination. However, we are concerned that this definition would effectively limit the applicability of the definition to other payer participants to only CMS Multi-Payer Models. **The HCTTF recommends that CMS expand the definition to include commercial medical home models that fit the standard to give providers in these arrangements credit for participation.** Further, organizations enrolled in these models 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 organizations using the Medical Home Model Financial Risk Criteria regardless of size.

*ii. Payer Initiated Process for Determination of Other Payer Advanced APM Status*

Our members have reported difficulty with participating in the Payer Initiated Process for Remaining Other Payers. In the 2019 final rule, CMS finalized that if a payer uses the same other payer arrangement in other commercial lines of business, that payer could concurrently request that CMS determine whether those other payer arrangements are Other Payer Advanced APMs as well. Many commercial payers use the same general payment arrangement across multiple lines of business but negotiate individual arrangements with each provider based on their ability to take on risk.

CMS's approach finalized for 2019 does not recognize programs as Other Payer Advanced APMs unless all individual arrangements under the program meet the marginal risk rate standard; however, this is not reflective of how commercial payers operate advanced APM programs. Commercial payers operate APM programs with the same parameters (*e.g.*, attribution methodology) but negotiate individual rates of risk and other payment details (*e.g.*, care management fees) for each contract. We support the proposal to use the average marginal risk rates when determining whether a payment arrangement is an Other Payer Advanced APM, but the issue remains that individual provider arrangements under a given program will have varying rates of marginal risk. Without allowing payers to identify which provider arrangements meet the Advanced APM threshold under a given program and instead requiring Advanced APM qualification determination at the program level, most payers will be unable to use this option and the burden remains squarely on eligible clinicians to submit that information.

**We encourage CMS to work with commercial payers to design a process that would allow for recognition of Other Payer Advanced APM programs with negotiable rates of**

**marginal risk as long as individual provider arrangements meet minimum Advanced APM standards.** CMS should allow payers to submit a list of providers (*e.g.*, identified by TIN) that participate in the program and take on the required amount of risk-sharing to meet criteria for Other Payer Advanced APMs for that performance year. Additionally, CMS should provide additional guidance and opportunities to gain clarification about how other payers should submit the information, including information about comparable metrics. Working closely with commercial payers to improve this process will ensure that more payers participate and encourage broader APM participation.

### **III. Stark Advisory Opinion Process**

The Proposed Rule proposes several changes to the Physician Self-Referral Advisory Opinion process. Many of the proposals are designed to make the Advisory Opinion process more accessible, shorter in duration, and allow for greater reliance on final opinions, all of which are positive developments. The Task Force supports these changes.

In the context of APMs tested by the Center for Medicare and Medicaid Innovation (CMMI), the Task Force urges CMS to implement an additional process beyond advisory opinions by offering official guidance on the scope and application of regulatory waivers implemented for APMs. Waivers are an important innovation accompanying new payment models, yet often they are not used due to questions about how they will be interpreted and applied. Due to the risks associated with misuse of a waiver, a provider may decide not to participate in a particular model altogether because of the lack of clarity around a waiver's scope and application. The issuance of official guidance would go a long way to addressing these concerns and result in greater uptake of CMMI models.

Also, the Task Force has long recommended that CMMI establish a core set of waivers that would be available for any CMMI APM, and then add additional waivers as needed for a particular model. A core set of waivers subject to a consistent interpretation would also be significantly helpful for providers interested in participating in CMMI models and provide greater piece of mind about not running afoul of regulatory waivers. In lieu of common APM waivers, it is our recommendation that CMMI provide additional justification on the purpose of that waiver, including guidance on the types of activities the waiver is intended to support.

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The Task Force appreciates the opportunity to advise CMS regarding updates to Medicare Part B. Please contact HCTTF Executive Director Jeff Micklos ([jeff.micklos@hcttf.org](mailto:jeff.micklos@hcttf.org) or 202.774.1415) with questions related to this statement.

Regards,

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