September 13, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1751-P: Medicare CY Payment Policies Under the Physician Fee Schedule; and Medicare Shared Savings Program Requirements

Dear Administrator Brooks-LaSure:

The Health Care Transformation Task Force (HCTTF or Task Force) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS), Medicare Payment Policies Under the Physician Fee Schedule and Medicare Shared Savings Program Requirements (CMS-1751-P) ("Proposed Rule").

The Task Force is a consortium of 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, payers, purchasers, and patient advocacy organizations – we share a common commitment to transform our respective businesses and clinical models to deliver better health and better care at reduced costs. 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.

We appreciate the opportunity to provide input on the following topics and questions:

- *II.D: Telehealth and other Services Involving Communications Technology*
- *III.J: Medicare Shared Savings Program*
- *III.L: Medicare Diabetes Prevention Program*
- *IV: Updates to the Quality Payment Program*

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I. Telehealth and Other Services Involving Communications Technology (Section II.D.)

The Task Force shares CMS' belief in the value of telehealth for both patients and their providers, and points to the ways in which telehealth helped support the system's overall resiliency during the public health emergency (PHE). The Task Force appreciates the opportunity to comment on the following telehealth provisions in the proposed rule.

A. Revised Timeframe for Consideration of Services Added to the Telehealth List on a Temporary Basis

In response to the COVID-19 pandemic, CMS added a third category for adding services to the Medicare telehealth services list. Finalized in the CY 2021 MPFS rule (85 FR 84507), this category describes services that were added to the Medicare telehealth services list during the COVID-19 Public Health Emergency (PHE) for which there is likely to be a clinical benefit when furnished via telehealth, but for which there is not yet sufficient evidence to consider permanent additions to Categories 1 or 2. Ultimately, services in Category 3 will need to meet the criteria of Categories 1 and 2 to be permanently added to the list. CMS is proposing to retain all services previously added to the Medicare telehealth services list on a Category 3 basis until the end of CY 2023. **The Task Force agrees with this proposal. As CMS stated, this provides stakeholders with adequate time to collect the necessary evidence for Category 3 services to be considered for a permanent Category 1 or 2 status.**

B. Implementation of Provisions of the Consolidated Appropriations Act

The Consolidated Appropriations Act, 2021 (CAA) includes several provisions relating to Medicare's delivery of mental health services via telehealth, which CMS proposes to implement in this rule.

Under section 1834(m) of the Social Security Act (the Act), the statute limits the scope of mental health telehealth services to rural areas and certain originating sites. Section 1834(m)(7) modifies this to include the patient's home as a permissible originating site for telehealth services provided to a patient with diagnosed substance use disorder (SUD) or a co-occurring mental health disorder. CAA further amends the statute to allow the patient's home as a permissible originating site for telehealth services furnished for the purpose of diagnosis, evaluation, or treatment of a mental health disorder, effective on or after the end of the PHE. Relaxing the geographic restrictions around home as an originating site for telehealth services to those who have a mental health disorder provides a huge benefit to the patient. Not only does this address stigma of receiving mental health services by providing the patient with a more comfortable, private, and attentive space in which to receive mental health care, it also allows those who may struggle to travel to a mental health care facility with the opportunity to engage in counseling services via telehealth.

The CAA requires that the initial telehealth service include an in-person visit within six months. In this NPRM, CMS proposes that as a condition of Medicare payment, the billing

telehealth practitioner must have furnished an in-person service to the beneficiary within the prior 6-month period for subsequent mental health telehealth services as well.

The Task Force has significant concerns with the proposal to make the CAA six-month in-person visit a requirement for all subsequent telehealth services, both video and audio-only. We believe the six-month period is arbitrary and should be eliminated for both video and audio-only telehealth services, as it could contribute to disparities in health care access and outcomes by preventing those who cannot travel to an in-person appointment (either because of their job, a rural location, lack of childcare, etc.) from receiving needed telehealth services. Given that section 1834(m)(7)(B)(i)(I) of the Act gives the Secretary discretion to specify the times or intervals for which a subsequent in-person requirement is required, **the Task Force recommends that CMS remove the in-person visit provision.** If enforced, the in-person requirement would stifle beneficiary choice and necessitate the termination of countless existing provider-patient relationships not because the clinical quality is inferior but simply because the practitioner lacks a brick-and-mortar location. The in-person requirement also inadvertently discourages and places a moratorium on Medicare provider enrollment for behavioral health providers at a time when the demand for and ability to access behavioral health treatment has significantly increased. Studies show that within the past year the prevalence of serious psychological distress among adults older than 55 was nearly double when compared to pre-COVID levels.[1]

Further, telehealth provision of mental health services allows individuals to choose a provider that aligns with their cultural views. The in-person visit requirement will likely limit individuals' ability to choose a mental health care provider who can provide culturally congruent care depending on which provider is next available for an in-person mental health appointment.

If eliminating the six-month requirement for video and/or audio-only telehealth is not feasible, **the Task Force offers the following recommendations, to apply to both types of telehealth:**

- **Delay enforcement of the in-person requirement and announce a period of non-enforcement for one-to-two years to provide Medicare beneficiaries the broadest possible access to mental telehealth services.** By doing so, CMS could reduce the burden for providers, and barriers for patients, to receive mental health telehealth services beyond the PHE.
- **Allow the in-person visit to be furnished by any provider in the selected practice and/or ACO**, including a primary care provider or a provider of the same specialty or subspecialty
- **Waive or exempt the in-person visit requirement for beneficiaries who are unable to travel, are located in a rural area, or who have a provider who is**

[1] Psychological Distress and Loneliness Reported by US Adults in 2018 and April 2020 | Anxiety Disorders | JAMA | JAMA Network

not located within a reasonable travel distance. Specialist access is a significant concern in many communities; creating these flexibilities will help eliminate barriers to access, ensure beneficiaries are not denied treatment due to provider shortages related to the in-person visit requirement, and can accelerate the move toward integrated, coordinated care

C. Payment for Medicare Mental Health Telehealth Services Furnished Using Audio-Only Communication Technology

In regulation § 410.78(a)(3) of section 1834(m) of the Act, a telecommunications system is defined as multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and provider. During the COVID-19 pandemic, CMS has used waiver authority under section 1135(b)(8) of the Act to waive this definition and allow for payment of telehealth services using audio-only communications. CMS is now proposing to amend regulation § 410.78(a)(3) to specify that an interactive telecommunications system can include interactive, real-time, two-way, audio-only technology for telehealth services furnished for the diagnosis, evaluation, or treatment of a mental health disorder under certain conditions, including 1) The originating site is the patient's home; 2) the furnishing practitioner has the capability to furnish the service using interactive two-way, real-time audio/visual technology but instead uses audio-only because the beneficiary is unable to use, does not wish to use, or does not have access to two-way audio-visual technology; and 3) an in-person service is furnished within 6-months of the audio-only service.

The Task Force appreciates the extension of audio-only telehealth delivery of mental health services to define the originating site to include the patient's home. This is in line with recent pushes to provide more care at the patient's home and allows those who may not have reliable access to broadband to receive telehealth services more easily. However, as mentioned in response to the previous section, the Task Force is concerned with the provision requiring an in-person service to be furnished within 6-months of the audio-only telehealth service delivery of mental health care. If CMS is allowing audio-only to help those who may live in rural areas or areas with little broadband, it is counterintuitive to impose a burden on those who must travel greater distances to receive their in-person visit. The Task Force refers CMS to the recommendations above, regarding the in-person visit requirement for audio-only telehealth.

Regardless of whether the mental health services are provided via traditional telehealth, or audio-only telehealth, CMS should allow patients who are attributed to an ACO that includes the rendering providers to receive care from other providers within that ACO. The ACO provides a layer of accountability and stewardship of Medicare resources, which addresses the concerns that underlie the proposal. Specialist access is a significant concern in many communities; allowing for this flexibility will help eliminate barriers to access, ensure

beneficiaries are not denied treatment due to provider shortages related to the in-person visit requirement, and can accelerate the move toward integrated, coordinated care.

In response to the request for comment on additional documentation that should be required in a patient's medical record to support providing audio-only telehealth services for mental health, the **Task Force recommends that audio-only visits be documented in a way that is consistent with traditional in-person visits**. Additional documentation requirements should be avoided to reduce burden. However, one of the following statements would create negligible burden to establish in an electronic health record (EHR), and would both support proposed regulatory requirements for audio-only visits, and suffice in the event of an audit or claims denial:

1. "Audio-only; patient unable to use two-way audio-visual technology"
2. "Audio-only; patient does not wish to use two-way audio-visual technology"
3. "Audio-only; patient does not have access to two-way audio-visual technology"

D. Expiration of the PHE Flexibilities for Direct Supervision Requirements

In the CY 2021 MPFS rule, CMS finalized the continuation of allowing "direct supervision" as it pertains to supervision of diagnostic test, physicians' services, and some hospital outpatient services, to occur when the supervising professional is immediately available through virtual presence using real-time audio/visual technology, instead of requiring physical presence. The ability to meet direct supervision requirements using remote technology increases the ability for care teams to serve patients, especially when patients are treated outside of a clinical setting when travel time for supervision may be a limiting factor. The Task Force expressed its support for extending this flexibility permanently after the end of the PHE in response to last year's PFS rule, and **we continue to express our support for this provision, particularly where the provider is participating in a Medicare ACO, given the layer of accountability and stewardship of the Medicare payment that the ACO provides.**

II. Medicare Shared Savings Program (Section III.J)

A. Quality Measurement

i. Amending the Reporting Requirements Under the APM Performance Pathway for PY 2022 and 2023

The Task Force has always been directionally supportive of the proposed changes to MSSP's quality performance standard and reporting requirements but has had concerns with the implementation timeline. **The Task Force supports CMS' decision to extend the CMS Web Interface as a collection type for the Quality Payment Program for PY 2022 for MIPS Groups, virtual groups, and Shared Saving Program ACOs reporting under the APM Performance Pathway.** Providing ACOs with an extra year, and then a transition year (PY 2023) in which they only have to report one eCQM/MIPS eCQM measure plus the ten CMS web interface measures if they choose to not fully transition to three eCQM/MIPS eCQM measures,

reduces an ACO's burden of transitioning to a new quality reporting system in the middle of a PHE. **The Task Force is supportive of this extension of the CMS web interface collection type; however, rather than a two-year extension, we recommend CMS allow ACOs to continue reporting using the web interface until resources and solutions are widely available to allow EHRs to meet the eCQM and interoperability requirements, which may take longer than two years.**

We are also concerned with CMS' proposal to increase the data completeness threshold to 80 percent. We strongly recommend that the data completeness standard not be increased; if it moves in any direction, we recommend that it be lowered if participating practices are to meet the attainment threshold and realize any shared savings. **We urge CMS to recognize the challenge data accessibility – or lack thereof – between ACOs and their provider members**. Contractual relationships do not include ACOs having access to the data that are required to meet the completeness threshold, and will result in ACOs investing significant resources only to not recoup investments due to these data attainment requirements that do not align with how these APM arrangements are operationalized.

a. Solicitation of Comments on Addressing Health Disparities and Promoting Health Equity

CMS queried stakeholders for comments and recommendations on how ACOs can utilize their resources to ensure that all patients have access to equal care. Earlier this year, the Task Force responded to the OMB RFI on methods and leading practices for advancing equity through the government. Within this letter, the **Task Force highlighted a tool by the Center for Health Care Strategies, *Leveraging Medicaid Accountable Care Organizations to Address Health Equity: Examples from States,* which highlights how accountable care organizations (ACOs) can be a powerful tool to address health equity.** States with successful ACO programs describe formulating payment around data collection, paying for equity using value-based payment, adjusting for social risk factors, increasing member engagement, supporting non-traditional providers, increasing ACO internal capacity to advance a culture of equity, partnering with community-based organizations, and integrating the social determinants of health into care. To achieve this, **we make two recommendations**:

- Leverage the federal agency-level efforts occurring across the administration, via the Census and other data collection processes, to significantly increase the volume of demographic data available for addressing health equity.
- Provide financial support – either via reimbursement or other investments in infrastructure – to allow ACOs to collect race, ethnicity, and other demographics data and use evaluation metrics (based on outcome measures that are applicable to both primary care providers and specialists participating in the model) that can be stratified by these factors to compare different population segments and identify any existing health disparities.

CMS also seeks comment on how to bring providers who serve vulnerable populations into ACOs or other value-based care initiatives. To encourage more providers to participate in models, **CMS should broaden risk assessment criteria to accurately encompass all factors that impact equities in health care.** In addition to broadening risk assessment criteria, **CMS should apply the thought process behind the Community Transformation Track of the Community Health Access and Rural Transformation (CHART) model to providers serving vulnerable populations in ACOs.** The CHART model allocates funding to providers to invest in overall health care infrastructure, which in turns allows providers flexibility in how they treat their patients. This is the same method that was used in the ACO Investment Model (AIM) which administered up-front payments to participating ACOs for two years. Compared to similar non-AIM SSP ACOs, most AIM ACOs reduced spending, and all AIM ACOs maintained quality of care.

b. Solicitation of Comments on feasibility of TIN Level Reporting and Sampling for eCQMs/MIPS CQMs

We appreciate the opportunity to comment on CMS' proposal to allow ACO providers/suppliers to submit eCQM/MIPS CQM measures to CMS at the ACO participant TIN level, with CMS then aggregating the TIN level quality data to create an ACO level score. While the Task Force supports CMS efforts to reduce the burden on ACOs in quality reporting, our membership is concerned that the proposed method would not reduce burden for ACOs. We also have concerns that this policy, if mandatory, could create incentives for provider groups to restructure their TINS to exclude certain specialists. While the ACO participant does not have to provide data directly to the ACO, they still must get TIN level data to CMS. **Therefore, the Task Force recommends CMS not require ACO providers to submit eCQM/MIPS CQM measures to CMS at the ACO participant TIN level.** We are concerned that implementing TIN-level reporting will have the opposite effect, and will create additional burden on ACOs.

c. Comment Solicitation for Reporting Options for Specialist Providers Within an ACO

In order to address measure applicability for specialist providers, CMS is seeking comment on allowing ACO participant TINs to report either the eCQM/MIPS CQM measures in the APP measure set at the TIN level or the applicable MIPS Value Pathways, including how APP and MIPS Value pathway data reported at the ACO participant TIN level could be aggregated in order to assess ACO quality performance.

The Task Force appreciates the opportunity to comment on reporting options for specialist providers within an ACO. We support the concept of specialty-level measurement and agree that assessing quality of specialty care is important. **However, we are concerned that this proposal creates the perception that CMS is conflating MSSP with MIPS, and is moving away from the original goal of MSSP which is to assess ACOs and their participating providers as one unit or entity that is responsible for ensuring successful patient care**. There is also the operational concern that the effort to create measures for specialty providers will lead ACOs to restructure their TINs to exclude specialists.

We recommend that CMS focus on total cost of care and coordination of care, which reflect the goals of what providers are seeking to achieve with the MSSP program. If CMS continues to seek strategies for measuring specialists within MSSP, we recommend looking to the Medicare Advantage measures, and not MIPS measures, given the greater parallels between MSSP and Medicare Advantage.

ii. Shared Savings Program Quality Performance Standard

CMS has aligned the MSSP quality performance standards with the MIPS quality performance category, establishing a newly modified quality performance standard that requires ACOs to reach the 30th percentile at a minimum across all MIPS Quality performance category scores in order to qualify for shared savings. CMS now proposes to freeze the current quality performance standard at the 30th percentile across all MIPS Quality performance category scores, excluding entities/providers eligible for facility-based scoring for PY 2023. The quality performance threshold would then increase to 40% percentile in PY 2024. **The Task Force shares stakeholders' concerns that providers need time to gain familiarity with the new quality reporting requirements, as well as deal with the ongoing effects of the COVID-19 PHE. Thus, we support CMS freezing the quality performance standard at the 30th percentile for PY 2023.**

In response to stakeholders concerns regarding the lack of information on the level of quality performance that would equate to a 30th or 40th percentile MIPs quality performance category score that enables an ACO to be eligible to share in savings, CMS is seeking comment on whether publicly displaying prior year performance scores that equate to a 30th or 40th MIPs quality performance category score would address these concerns. **The Task Force does not view CMS' proposal as the optimal way to address stakeholder concerns.** Performance is volatile and the 30th (or 40th) percentile may change significantly from year to year depending upon changes in performance in MIPS. We recommend that the final rule provide clarity on the data reporting requirements overall. For example, in the proposed rule CMS notes that for CY 2022, providers who report all APP measures must reach 30 percent on one measure. But it is unclear whether the 30 percent refers to a benchmark for one specific measure, or will be calculated across all APP measures.

Publicly displaying prior year performance does not provide MSSP participants with the level of transparency they need to understand their performance and improvement targets for shared savings. **We urge CMS to provide meaningfully transparent information on not only the target that represents 30th (or 40th) percentile, but also the methodology used to calculate the benchmarks.** The standard should be published in advance, to allow ACOs to be strategic about their quality improvement efforts, thereby creating an environment in which they can successfully serve patients and meet performance goals for shared savings.

iii. Revisions to the Extreme and Uncontrollable Circumstances Policy

CMS is proposing to update the extreme and uncontrollable circumstances policy under the Shared Savings Program to be consistent with the proposal to freeze the quality performance standard at the 30th percentile for PY 2023. Therefore, for PY 2023, if an ACO is able to report quality data via the APP, CMS will use the higher of the ACO's quality performance score or the equivalent of the 30th percentile MIPS quality performance score. If the ACO is unable to report quality data and meet the MIPS quality data completeness and case minimum requirements due to an extreme and uncontrollable circumstance, CMS would apply the 30th percentile MIPS quality performance score. For PY 2024, this same logic would apply, but using the 40th percentile MIPS quality performance score. **The Task Force is supportive of this change to update the extreme and uncontrollable circumstances policy.**

B. Revisions to the Definition of Primary Care Services Used in Shared Savings Program Beneficiary Assignment

CMS proposes several changes to the primary care service codes. The department proposes to include several new codes to capture primary care services that would assign a beneficiary to a MSSP ACO including chronic care management, principal care management, a prolonged office or other outpatient evaluation and management service, and communication technology-based services. They also propose to extend the applicability of the expanded definition of primary care services in response to the PHE, and the incorporation of replacement codes into the definition of primary care services to reflect current coding. **The Task Force supports updating of the primary care services codes.**

C. Repayment Mechanisms

i. Repayment Mechanism Account Calculations

CMS is proposing to reduce the percentages used in the existing repayment mechanism account calculations. Currently, the repayment mechanism is the lesser of either 1% of the total per capita Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries for the most recent CY for which 12 months of data are available, or 2% of the total Medicare Parts A and B FFS revenue of its ACO participants, based on revenue for the most recent CY with 12 months of data available. CMS proposes to reduce these percentages to .5% and 1%, respectively. **The Task Force supports this proposed change as would lower barriers to entry for ACOs, particularly smaller or rural ACOs.**

On this topic, the Task Force recommends that CMS share its learnings regarding the repayment mechanism for MSSP with CMMI. We believe the repayment mechanism amounts for the Kidney Care Choices (CKCC) Model and the Global and Professional Direct Contracting (GPDC) Model may be higher than they are for MSSP, and that lowering them should be considered in light of how CMS describes repayment in MSSP in this proposed rule. **We appreciate CMS' transparency on this matter and suggest the agency work collaboratively with CMMI to create efficiencies in model operations.**

ii. Population of Assigned Beneficiaries Used in Calculating and Recalculating Repayment Mechanism Amounts

CMS is seeking to change how assigned beneficiaries are used in calculating and recalculating repayment mechanism amounts. The department proposes to determine the number of assigned beneficiaries used in the calculation based on more recently available assignment data, instead of using population projections based on historical data. For recalculation calculations, CMS proposes to use the number of ACO beneficiaries assigned to the ACO at the beginning of the year. **The Task Force supports both proposed changes**.

iii. Threshold for Increasing Repayment Mechanism Amounts

Finally, CMS is proposing to change the threshold for increasing repayment mechanism amounts. Under current regulation, if the recalculated repayment mechanism exceeds the existing repayment mechanism amount by at least 50% or $1,000,000 (the lesser of the two), CMS notifies the ACO that the repayment mechanism must be increased to the recalculated amount. Revising the repayment amount is burdensome to ACOs, and generally only impacts low revenue ACOs with relatively low existing repayment mechanism amounts. Further, if the above changes to the repayment mechanism account calculations are finalized, the current method will disproportionately benefit CMS. The new proposal seeks to eliminate the 50% threshold, so that only organizations of which the recalculated repayment amount exceeds $1,000,000 would have to increase their repayment amount. **The Task Force is supportive of this proposal as it aligns the recalculated repayment mechanism with the changes stated in the previous sections.**

D. Reducing Shared Savings Program Application Burden

CMS proposes to reduce the application burden on MSSP ACOs by making the prior disclosure requirement necessary only by request of the department; allowing ACOs to submit ACO participant agreement documents only by request of the department; and removing language from the statute requiring an ACO to submit an executive ACO participant agreement for each ACO participant at the time of the initial application and during renewal processes. **The proposed changes reduce the administrative burden for both the MSSP ACOs and CMS, therefore, the Task Force is supportive of these changes.**

E. Beneficiary Information Notices for ACOs with Prospective Assignment

Acknowledging that the current requirements on beneficiary notification are overly broad for ACOs that have selected prospective assignment methodology, CMS is proposing to modify beneficiary notification obligations depending on the assignment methodology selected by the ACO. However, the Task Force has a few concerns with this new approach. Next Gen ACOs that are currently required to conduct mailings incur tens of thousands of dollars in resource costs, and many of these letters are returned due to inaccurate addresses**.** Mailings waste resources that should be directed toward providing quality care to patients. Further, providers find that beneficiaries who do receive the written notice often experience confusion

about what the assignment means to their care, and do not have the ability to ask someone to clarify immediately. While we do appreciate the importance of meaningful engagement of beneficiaries, and the need for information sharing, **the Task Force recommends that beneficiary notice policy remain as it is now, whereby beneficiaries are alerted to changes by a notice in their provider's office. This method allows beneficiaries to have a face-to-face conversation with staff if there are any questions or confusion.**

However, recognizing that a mailed notification may – for some consumers – be an important communication tool to support patient-centered care delivery, we recommend CMS develop a more efficient process, including ensuring that beneficiaries' mailing information is accurate to reduce the potential for wasted resources.

F. Use of Regional FFS Expenditures in Establishing, Adjusting, Updating, and Resetting the ACO's Historical Benchmark

i. Request For Comment on Calculation of the Regional Adjustment and Blended National-Regional Growth Rates for Trending and Updating the Benchmark

The Task Force appreciates that CMS is exploring ways to update the regional adjustment and blended regional/national growth rates for trending and updating the benchmark. In terms of changes to the regional adjustment and blended regional/national growth rates for trending and updating the benchmark, the Task Force urges CMS in the final CY 2022 Physician Fee Schedule rule to remove ACO beneficiaries when calculating regional costs, i.e. address the "rural glitch." The rural glitch provision of MSSP benchmarking is systematically disadvantaging ACOs that achieve better care at lower costs, and creates a perverse incentive that disadvantages – and could be damaging – to rural ACOs. **We strongly urge CMS to take the opportunity in the CY 2022 Final Medicare Physician Fee Schedule rule to fix this problem, without further delay.**

Because CMS caps the risk adjustment for ACOs but does not cap risk adjustment for the population used to calculate the trend factor, the scenario is occurring in which some ACOs are penalized not for upcoding, but for simply operating in regions where the risk score for other beneficiaries is greater than 3 percent. For example, if an ACO and its comparison population both experience 6 percent growth in costs and 6 percent growth in risk, the ACO will have risk-adjusted cost increase of 3 percent but the comparison population will have risk-adjusted cost increase of 0 percent, simply because one is capped and the other is not. The purpose of the policy was to deter ACOs from upcoding, but the effect in practice is that savings are being systematically shifted from ACOs to CMS. In 2021, 13.6 percent of Medicare beneficiaries assignable to MSSP live in a county with a risk ratio above 1.03. This policy also creates health equity issues. Medicare beneficiaries who are dually eligible for Medicaid are twice as likely to live in a "capped-out" county as Medicare beneficiaries who only have Medicare.

In addition, the Task Force is concerned that the HCC approach is still built upon ICD-9 mapping, while the newest version is ICD-10. **We recommend that CMS update this approach**

as it will likely create challenges in getting accurate risk scores if MSSP participants rely on an outdated coding system. The Task Force is also concerned of the wide variation in risk adjustment across MSSP and numerous CMMI models such as Direct Contracting and bundled payment models. CMS needs a more consistent risk adjustment methodology across all models to promote a more aligned model portfolio.

ii. Request for Comment on the Shared Savings Program Risk Adjustment Methodology

The Task Force has concerns regarding the risk adjustment methodology, particularly in relation to how the risk adjustment cap affects ACOs that care for higher-risk patient populations, as well as taking into account the overall volume of patients to which an ACO delivers care. **Our overarching recommendation is that CMS guard against changing the risk adjustment methodology in a way that creates adverse incentives for practices to select or oppose certain beneficiaries based on their health risk status. Specific recommendations below reflect this concern:**

- Establish a risk adjustment cap that accounts for the size of the ACO's patient population, in recognition of the fact that a smaller patient panel will be more volatile in terms of utilization and costs and may not be comparable risk-wise to other ACOs in the region.
- Consider an ACO's patient break-down across dual eligible and non-dual eligible in calculating the cap.
- Consider capping the reference population risk score in the same way that the ACO population risk score is capped prior to normalizing.
- Consider the proportion of vulnerable populations a given ACO serves. For ACOs serving the most vulnerable and high-risk patients, the regional risk score is often above the three percent cap, which creates enormous financial pressure on the practice due to lower shared savings.
- Look to CMMI's methodologies for risk adjustment and apply promising practices as appropriate to the MSSP program. For example, CMMI applies a methodology for high needs Direct Contracting Entities which may be useful in addressing the concerns described above.

III. Medicare Diabetes Prevention Program (Section III.L.)

CMS is seeking comments on three proposed changes to the Medicare Diabetes Prevention Program (MDPP), including 1) elimination of ongoing maintenance sessions (year 2) from Medicare DPP for beneficiaries who start their MDPP on or after January 1, 2022; 2) redistribution of a portion of the payment from the ongoing maintenance sessions to the core and core maintenance session performance payments; and 3) waiving provider enrollment application fee for all organizations applying to be MDPP suppliers starting on January 1, 2022. **These changes are consistent with the comments the Task Force submitted to CMS last**

June, in that they are being proposed to allow beneficiaries and providers to access and support the MDPP, respectively, without creating unintentional safety or financial consequences in light of the ongoing PHE.

IV. CY 2022 Updates to the Quality Payment Program (Section IV.A.)

CMS proposes several changes to the structure of the Quality Payment Program (QPP) to reduce reporting collection and submission burden on providers, as well as to align with broader CMS initiatives, including the CMS Quality Measures Action Plan. The agency's goal is to unify efforts to adopt measures most critical to providing high quality care, accelerate strategic improvements for quality programs and measures, and support interventions and activities that drive better patient outcomes at lower costs.

A. RFI: Closing the Health Equity Gap in CMS Clinician Quality Programs

CMS seeks information on strategies to collect data on race, ethnicity, and social factors to enable improved identification and reporting of health disparities, with the goal of hospitals and providers being enabled to create actionable interventions to support patients. The Task Force supports CMS' efforts to address health disparities and agrees that accurate data are a key component to developing effective policies and programs. Further, we agree with CMS that a greater volume of data is necessary to accomplish the important work of stratifying results, and that to fully understand health disparities, data must be collected on not just race and ethnicity, but also gender identify, language preference, tribal membership, and disability status as well as other socio-economic variables.

As the Task Force noted in its comments to CMS for the Inpatient Prospective Payment System (IPPS) NPRM RFI, we have several concerns with the use of an imputation algorithm to address these data challenges. **The Task Force does not support the use of indirect estimation techniques,** due to concerns that this imprecise approach may result in data inaccuracy and misrepresentation of populations, and because of the potential for it to divert resources from improving methods of direct reporting. Instead, **we recommend CMS rapidly and meaningfully pursue efforts to improve access and exchange of directly collected race and ethnicity data through reliable and adopted data standards and sources**, including the US Core Data for Interoperability (USCDI) data classes and elements exchanged via standardized APIs. We note that eCQM reporting already requires the inclusion of race and ethnicity data of the affected populations when this information is available at the time of measure calculation. This and other requirements should be catalogued and leveraged before devoting resources to indirect estimation algorithms that are not proven to provide accurate information.

i. Updating the Complex Patient Bonus Formula

CMS seeks to reward providers who achieve better outcomes for patients with social risk factors by updating the complex patient bonus methodology to ensure it targets providers who care for high risk, complex patients, in a way that mitigates differences in provider organization resources that affect MIPS scores. **The Task Force supports CMS' proposal to revise the**

weighting of the Promoting Interoperability performance category, in recognition that small practices may not have the means to invest in infrastructure needed to track and report measures to MIPS. However, we are concerned using the median for the Hierarchical Condition Category (HCC), or proportion of duals, to determine eligibility for the complex patient bonus, could disadvantage some rural practices. Rural practices typically have lower Hierarchical Condition Category (HCC) scores due to coding (not a reflection of healthier patients). This can result in these practices not meeting or exceeding the median. It would be more equitable to set national and regional levels and use whichever is lower to determine eligibility.

B. MIPS Value Pathways

CMS proposes to begin the voluntary transition to the "MIPS Value Pathways" (MVP) model, in an effort to more effectively reward providers who are delivering high quality care, and increase opportunities for Advanced APM participation. An "MVP Participant" will be defined as an individual MIPS eligible clinician, multispecialty group, single specialty group, subgroup, or APM entity that is assessed on an MVP. CMS proposes the following introductory seven condition/care areas that would be available starting with the 2023 performance period: Rheumatology, Stroke Care and Prevention, Heart Disease, Chronic Disease Management, Emergency Medicine, Lower Extremity Joint Repair, and Anesthesia. MVP participants would be required to select only four – rather than the current six – quality measures and two medium-weighted or one high-weighted improvement activity. The MVP would also include cost measures, require reporting on measures of "Promoting Interoperability" required under traditional MIPS, and require participants to report on one population health measure. **The Task Force submits the following comments for CMS' consideration:**

- Provide additional clarification in the final rule regarding which entities are eligible for participation in the MVPs.
- The Task Force supports the underlying concept behind the MVPs, and sees tremendous value in a mechanism that will create a streamlined glidepath for providers to participate in MIPs and Advanced APMs. However, we are concerned that there is not a well-defined end-goal for the MVPs, and that the case for sunsetting traditional MIPS is not clear. We also have concerns with their implementation, and the lack of alternative payment models for physicians to transition into.
- Do not restrict the sub-group participation population to a specialty. In primary care practices there may be different specialties who will report to the MVP; restricting sub-group participation conflicts with the goal of aligning practices' participation in AAPMs.
- In the set of quality measures comprising each MVP, we strongly suggest that there be at least one mandatory outcome measure, and that the MVPs do not rely solely on process measures. For conditions in which there is no supported

outcome measure, we recommend including a priority measure that is as outcome-adjacent as possible.

- Align measures and requirements across CMS and CMMI programs as much as possible to enable practices to prepare for APMs.
- Consider offering multi-category credit for MVPs. This will serve as an incentive to report an MVP and can meaningfully reduce burden.

We urge CMS and CMMI to collaborative to ensure there are sufficient APMs available across the risk spectrum to absorb providers who take this path, to guard against physicians becoming "stranded" in MIPS. At the same time, we recommend CMS assess that MVPs are meeting their intended goals before setting a deadline to sunset traditional MIPS.

In response to CMS' request for comments regarding other aspects of patient measurement beyond the Health Affairs definition – "measures should be patient-centered and incorporate new approaches to assessing patient health status and patient experience. Such measures include assessment of clinical outcomes, patient-reported outcome measures, as well as new approaches to evaluation of patient experience." – **the Task Force asks that CMS focus on 1) supporting the collection of data necessary to assess patient experience; and 2) measures that create accountability for the extent to which the following actions are occurring**:

- Meaningful inclusion of patients and their caregivers as active partners in all aspects of health care decision-making.
- Inclusion of patients and caregivers in the design of care delivery operations that are attentive and respective of individuals' preferences, needs, and values.
- Pursuit of health equity, including initiatives to advance robust and secure data collection through an infrastructure that can be accessed by individuals, family caregivers, providers, payers, and community-based organizations.
- Access to information to support individuals' choices, including visibility into costs and outcomes.
- Provision of culturally congruent care, including the recruitment, training, and hiring of diverse staff.
- Continuous quality improvement procedures that incorporate quantitative and qualitative patient feedback and are representative of diverse populations.

Finally, **the Task Force supports CMS' propositions to 1) develop health equity measures in a way that would make them broadly applicable to the various specialties and subspecialties that participate in MIPs, but where that is not possible, to 2) recognize the value in specialty-specific health equity measures, and 3) include a required health equity measure in the foundational layer of all MVPs.**

The Task Force encourages CMS to continuously assess MIPS participants to identify and understand the effects of alternative payment models on health equity, including potential unintended consequences (on both patients and providers). These measures should be designed in such a way to provide metrics that are relevant to assessing disparate impacts to care across patient populations within a certain condition. We also urge HHS to broaden risk assessment criteria to accurately encompass all factors that impact equity in health care. Risk assessments are often focused on income and education as defining characteristics for health disparities; however, these variables do not adequately reflect the challenges inherent in addressing morbidity and mortality in conditions where these outcomes do not correlate to income or education.

We respectfully request that CMS consider the clarity of how all finalized rules are conveyed, to minimize inconsistent interpretation, all in the goal of easing physicians' glidepath toward implementing APMs.

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The Task Force appreciates the opportunity to respond to the MPFS Proposed Rule. Please contact HCTTF Executive Director Jeff Micklos (jeff.micklos@hcttf.org) with questions related to these comments.

Angela Meoli
Senior Vice President, Network Strategy & Provider Experience
Aetna, A CVS Health Company

Lisa Dombro
Senior Vice President, Innovation & Growth
agilon health

Sean Cavanaugh
Chief Commercial Officer and Chief Policy Officer
Aledade, Inc.

Shawn Martin
Executive Vice President & Chief Executive Officer
American Academy of Family Physicians

Maria Stavinoha
Payment Innovation Director, Network Optimization
Anthem, Inc.

Stephanie Graham
Vice President, Payer Innovation
Apervita

Jordan Hall
Executive Vice President, Accountable Care Operations
ApolloMed

David Terry
Founder & Chief Executive Officer
Archway Health

Patrick Holland
Chief Financial Officer
Atrius Health

Jamie Colbert, MD
Senior Medical Director, Delivery System Innovation and Analytics
Blue Cross Blue Shield of Massachusetts

Todd Van Tol
Senior Vice President, Health Care Value
Blue Cross Blue Shield of Michigan

Troy Smith
Vice President of Healthcare Strategy & Payment Transformation
Blue Cross Blue Shield of North Carolina

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

Scott Seymour
Vice President, Network Management & Provider Partnership Innovation
Cambia Health Solutions

Adam Myers, MD
Chief of Population Health and Chair of Cleveland Clinic Community Care
Cleveland Clinic

Shelly Schlenker
Executive Vice President, Chief Advocacy Officer
CommonSpirit Health

Susan Sherry
Deputy Director
Community Catalyst

Colin LeClair
Chief Executive Officer
Connections Health Solutions

Mark McClellan, MD, PhD
Director
Duke Margolis Center for Health Policy

Chris Dawe
Chief Growth Officer
Evolent Health

Frederick Isasi
Executive Director
Families USA

Zahoor Elahi
Chief Operating Officer
Health [at] Scale

Richard Lipeles
Chief Operating Officer
Heritage Provider Network

Anthony Barrueta
Senior Vice President, Government Relations
Kaiser Permanente

Jeanne DeCosmo
Senior Director, Clinical Care Transformation
MedStar Health

Nathaniel Counts
Senior Vice President, Behavioral Health Innovation
Mental Health America

Sinsi Hernández-Cancio
Vice President for Health Justice
National Partnership for Women & Families

Blair Childs
Senior Vice President, Public Affairs
Premier

Jordan Asher, MD
Senior Vice President and Chief Physician Executive
Sentara Healthcare

Kim Holland
Senior Vice President, Government Affairs
Signify Health

Jim Sinkoff
Deputy Executive Officer and Chief Financial Officer
Sun River Health

Emily Brower
SVP Clinical Integration & Physician Services
Trinity Health

Debbie Rittenour
Chief Executive Officer
UAW Retiree Medical Benefits Trust

J.D Fischer
Program Specialist
Washington State Heath Care Authority