August 21, 2017

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–5522–P
P.O. Box 8013
Baltimore, MD 21244–8013

Re: Medicare Program; CY 2018 Updates to the Quality Payment Program

Dear Administrator Seema Verma:

The Healthcare Quality Coalition (HQC) welcomes the opportunity to offer comments on the implementation of the Medicare Quality Payment Program (QPP). The CY 2018 proposed rule provides updates for program year 2, and we are pleased to provide feedback on areas where CMS requests input.

The HQC is comprised of hospitals, physicians, health systems and associations committed to value-based healthcare. Organized in 2009, the HQC supports efforts to create a sustainable Medicare system through incentivizing high-value care. We believe value-based payment policies can drive better quality, lower cost of care, and reduce overall costs for the Medicare program. The HQC strongly supports continued implementation of payment systems that reward value over volume, and we are pleased to provide comments on CMS' 2018 proposed rule on the Merit-based Incentive Payment System and Alternative Payment Models.

Merit-based Incentive Payment System (MIPS)

The proposed seeks input on the implementation of the Merit-based Incentive Payment System (MIPS) as authorized in the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. MIPS is comprised of four categories of measures: Quality, Efficiency, Advancing Care Information, and Clinical Practice Improvement Activities. Each category includes a set of performance measures generated from their respective (prior) individual programs and initiatives. The applicable percentage for payment year 2 for 2020 MIPS payment adjustment year ranges from 5% to + (5% x 3) scaling factor, and completing the increase to +/-9% in payment year 2022. Based on the proposed changes for payment year 2, 2020, we are pleased to provide responses to a number of policy areas in the MIPS program.

MIPS Structure, Participants, Reporting, and Scoring

Overall, the structure, participants, reporting and scoring provisions for program year 2 reflect most of the policies previously finalized with some modifications. CMS proposes increased low-volume thresholds, virtual groups, and facility-based clinicians

Comments:

- **Overall, the HQC supports the option to form virtual groups as a means for individuals and small group clinicians to improve quality through collaboration. For continuity, the HQC also supports using the group scoring standards for virtual groups and the lack of any geographic restrictions or size.**
- **The goal of the QPP is advance quality improvement, and increasing the number of clinicians excluded does not meet this goal. CMS should provide ways to include most Part B clinicians with opportunities for success and take caution on expanding exclusion criteria.**
- **We support the *optional* application of hospital value-based purchasing composite scoring for quality and cost measures for facility-based clinicians in the MIPS program. We also support the definition of facility-based clinicians as those providing 75% or more of services within an inpatient setting or emergency department.**

Virtual Groups

The proposed rule facilitates the establishment and implementation of a process that allows the formation of virtual groups. Virtual groups allow an individual MIPS eligible clinician or a group consisting of not more than 10 MIPS eligible clinicians to elect to form a virtual group with at least one other individual MIPS eligible clinician or group of not more than 10 MIPS eligible clinicians for a performance period of a year. Individual MIPS eligible clinicians and groups forming virtual groups are required to make the election as a virtual group prior to the start of the applicable performance period under the MIPS, and they cannot change their election during the performance year. Virtual groups are proposed to be scored under the MIPS group scoring standard with some exceptions. As proposed for 2018, there are no restrictions on size or geographic location of virtual groups.

Overall, the HQC appreciates the implementation of virtual groups. We had supported regulations to facilitate the formation of virtual group in past notice and comment cycles and are pleased that CMS proposes to implement policies for virtual groups.

Low-Volume Threshold

For the current transition year CY 2017, individual MIPS clinicians or groups are excluded if they have less than $30,000 in charges for part B or have less than 100 Part B beneficiaries. The proposed rule for CY 2018 would increase the threshold to exclude individual clinicians or groups with less than $90,000 of charges in Part B, or less than 200 Part B beneficiaries. Starting in CY 2019, MIPS clinicians are able to opt-in to MIPS if they exceed either of the low-volume threshold components:

1) Medicare revenue, or 2) number of Medicare patients. This is in conjunction with the additional proposal for CY 2019 that would allow a third opt-in item that would consist of: 3) number of Part B items and services. After all exclusions are applied, only about 37% of clinicians billing Medicare Part B services would be included in the MIPS program, which is concerning. By design and implementation, the QPP should apply to Medicare Part B clinicians to advance value-based care with opportunities to succeed.

Application to Facility-based Clinicians

The HQC has long supported the alignment across different legacy, non-alternative payment value-based programs that adjust payments on fee-for-service or diagnostic-related groups. CMS states its belief that facility-based measurement is intended to reduce reporting burden on facility-based MIPS eligible clinicians by leveraging existing quality data sources and value-based purchasing experiences and aligning incentives between facilities and the MIPS eligible clinicians who provide services there. CMS also believes that facility-based measurement under MIPS should be based on pay-for-performance programs (such as VBP programs) rather than pay-for-reporting programs that do not adjust payments based on performance.

CMS believes incorporating additional facility-based measures under MIPS by focusing on inpatient hospital measures, as the inpatient setting has a mature VBP program. CMS proposes to define facility-based clinicians as those providing 75% or more of services within an inpatient hospital setting or emergency department. CMS believes that of the three-distinct pay-for-performance programs for the inpatient hospital setting, the Hospital VBP program is most analogous to the MIPS program. CMS proposes for the 2020 MIPS payment year (2018 program year) to include all the measures adopted for the FY 2019 Hospital VBP Program on the MIPS list of quality measures and cost measures. The facility-based measurement is proposed as optional. The HQC supports the facility-based proposal.

MIPS Scoring Methodology, Thresholds and Category Weights

The CY 2018 proposed rule modifies the 2020 payment year scoring threshold, proposes to extend bonus points for rural practices, and offer additional points for care provided to complex patients.

Comments:

- **The HQC supports increasing the threshold score higher than 3 points.**
- **The HQC supports the proposed distribution of 1 to 3 bonus points to clinicians who treat medically complex patients under the Complex Patients Bonus using the Hierarchical Conditions Category (HCC) model.**
- **We support CMS's proposal for offering bonus points to small practices and the future expansion of bonus points to include practices in rural areas.**

- **The HQC opposes the proposal to weigh cost measures at 0% for CY 2018. Instead, we suggest CMS assign a 10% weight as a transition to the statutorily required 30% weight for 2019.**
- **The HQC supports incorporating performance improvement into the scoring methodology for the MIPS Quality and Cost categories. This reflects the approach in the Hospital Value-based Purchasing Program. However, we would suggest improvement be focused more on outcome measures with performance variation. Nearly half of all quality measures are deemed "topped out."**
- **At this point, the HQC supports CMS's proposal to provide additional or multiple submission mechanisms for performance categories. However, we urge caution with over-reliance on claims-based measures to drive quality improvement and scoring in future program years.**

Performance Threshold Scoring

For the CY 2018 program year, CMS proposes to increase the threshold score in MIPS from 3 points to 15 points. The threshold score is the minimum points needed to avoid any downward payment adjustment in Medicare Part B for the 2020 payment year. The exceptional performer threshold score, however, is proposed to remain at 70 points to be eligible for the $500 million bonus funds distribution. For the transition year (Year 1) of the program, submitting a single quality measure, for example, was sufficient enough to avoid any downward payment adjustment in the program.

While the HQC understands the intention of the program to bring all eligible clinicians into the QPP, we are concerned setting the threshold very low is insufficient to advance value-based care. There needs to be a balance with administrative simplification and flexibility, but by setting the standard too low doesn't reward high quality care. As such, we support the increase of the performance threshold above the current level.

Bonus Points for Small Practices, Rural Areas, and Complex Patients

CMS has proposed for the final rule CY 2018 multiple patient and clinician bonus points that will help raise MIPS scoring. These bonus points include the Complex Patients Bonus that includes distributing points to clinicians who treat medically complex patients. Another set of eligible bonus points include extra points for small practices and rural clinicians.

For the 2020 MIPS payment year, CMS proposes a complex patient bonus based on the average HCC risk score because this is the indicator that clinicians are familiar with from the VM. CMS proposes that the complex patient bonus cannot exceed 3 points, selecting this value because the differences in performance observed between simulated scores between the first and fourth quartiles of average HCC risk scores was approximately 4 points for individuals and approximately 5 points for groups. Alternatively, CMS seeks comment on using a methodology based on Medicare-

Medicaid dual eligible enrollees as a proxy for complex patients. The HQC agrees with the proposal using the HCC risk adjustment methodology as a means for applying the complex patient bonus, which is clinically stronger and familiar to providers and quality improvement professionals. We do not think utilizing dual eligibility status as a way to identify complex patients is the best method.

To receive the small practice bonus, CMS proposes that the MIPS eligible clinician must participate in the program by submitting data on at least one performance category in the 2018 MIPS performance period (the performance category does not need to be the quality performance category). CMS also proposes that group practices, virtual groups, or APM Entities that consist of a total of 15 or fewer clinicians may receive the small practice bonus. CMS believes a bonus of 5 points is appropriate to acknowledge the challenges small practices face in participating in MIPS, and represents one-third of the total points needed to meet or exceed the performance threshold (proposed at 15 points for the 2020 MIPS payment year) to receive a neutral to positive payment adjustment. CMS believes that a higher bonus might discourage small practices from actively participating in MIPS or could mask poor performance. CMS notes that this small practice bonus is intended to be a short-term strategy to help practices transition to MIPS and thus it is proposing the bonus only for the 2018 MIPS performance period (2020 MIPS payment year). CMS states that it will assess on an annual basis whether to continue the bonus and how the bonus should be structured, including extending to rural practices. The HQC supports this proposal.

MIPS Category Weights

Finalized in prior rulemaking, for the transition year of MIPS (Year 1), the weighting of the categories were as follows: Quality (60%), Cost (0%), Advancing Care Information (25%), and Improvement Activities (15%). For Year 2 (CY 2018 performance year), CMS proposes to maintain the same weights before transitioning to statutory levels in 2019.

The HQC expressed concern in last year's rulemaking cycle that setting the weight of cost at 0% was a step back—the Physician Value Modifier included cost measures prior to the enactment of the Medicare Access and CHIP Reauthorization Act (MACRA). We suggest CMS consider weighing the cost performance category at 10% for performance year 2018 as an incremental step toward the required 30% in 2019. In addition, we ask CMS to use the Physician Value Modifier cost measures, Medicare Spending per Beneficiary (MSPB) and Total per capita costs for 2018 program year.

Improvement Scoring

The CY 2018 proposed rule seeks comment on incorporating performance improvement into scoring for the MIPS program. Currently, the transition year of the program related closer to a "pay for reporting" initiative, and we urge CMS to move the program into pay for performance.

As part of the journey toward pay for performance, improvement becomes an aspect of this movement. The Hospital Value-based Purchasing program, a sibling program in Medicare Part A to the QPP, improvement is also incorporated into the total performance score for cost and quality

measures. This approach allows hospitals performing lower on quality and cost measures to obtain scoring credit for improvement. We believe this is good policy to incorporate into the MIPS program, and we support this inclusion for cost and quality measures. As we noted, the inclusion of improvement scoring may help clinicians that are underperforming against the benchmark, but we also understand nearly half of all quality measures are considered topped out. Moving toward outcomes should be complemented with an improvement scoring option.

MIPS Performance Category Measures

While much of the proposed rule maintains the transition year program, CMS proposes some modifications. Specifically, the proposed rule addresses quality measures deemed "topped out," reporting periods, episode-based cost measure development, advancing care information exclusions, and potential changes to improvement activities.

Comments:

- **The HQC continues to urge CMS to focus on quality measure development, endorsement, and implementation of those measuring patient outcomes. We are concerned that nearly half of the quality measures in the MIPS program are within a "topped out" status.**
- **We are concerned regarding a 3 year removal period for topped out measures. We suggest CMS consider 2 years for removal so long as outcome measures are included. Outcome measures can potentially replace the estimated 70% of process-based measures that are topped out.**
- **Our coalition is concerned with longer delays with cost measures development. While we understand issues exist with cost measure reliability, we ask CMS to make cost measure development at the episode or global level a high priority. We appreciate that CMS is proposing to make stakeholder outreach a high priority for this category. We ask CMS to adopt a 10% weight for CY 2018 performance period for cost measures, and include those in the previous physician value modifier program. We also suggest improvements for cost measures to incorporate incentives for keeping patients healthy.**
- **The HQC supports the proposed exclusions in the ePrescribing and Health Information Exchange domains of the Advancing Care Information Category. We are still concerned this category maintains an element of "all or nothing" scoring as part of the base score.**
- **We appreciate additional options for meeting the Improvement Activities category, including Appropriate Use Criteria and activities that align with advancing care information.**

Quality Measures

Representing 60% of the program weight, hundreds of quality measures can be selected by individual clinicians and groups to meet the requirements of the program. There is still a strong reliance on process-based quality measures. We recommend CMS prioritize outcome measures that are both narrowly-focused and broad-based to incorporate the quality of medical care practice and to incent keeping patients healthy.

As CMS noted, nearly half (45%) of all quality measures offered in the program are at or greater than a 95% median. This includes approximately 70% of claims-based measures, 10% of EHR measures, and 45% of Registry/QCDR measures. This means that more than half of clinicians reporting those measures are achieving nearly 1:1 performance. The lack of variation suggests these measures are already embedded into the fabric of patient care processes and care delivery. Given the abundant options available, we ask CMS to consider removing these measures within a two-year time frame, especially process-based measures, rather than after three years.

Cost Measures

As finalized in last year's rule, the cost performance category was assigned a 0% weight. As noted earlier in this letter, we are asking CMS to finalize a 10% weight for CY 2018 program year. We urge CMS to use the cost measures previously included in the Physician Value-based Payment Modifier program: Medicare Spending per Beneficiary and Total Per Capita Costs.

While these measures are not perfect, we believe providing a transition to 30% weight as required in statute in 2019 is better suited than a 0% to 30% weight increase. We also ask CMS to rapidly work toward inclusion of National Quality Forum (NQF) endorsed measures of cost and a plan to apply them in an episode-based and/or global-based approach. For example, the Quality category includes a global based population measure as a separate element to the quality performance category. The cost domain may be better suited to include a separation of cost measures that are either episode or service specific, and those that are broader, more global based. The strength of resource use measures lies in a set of cost measures that carry a counter balance with measures of quality and we ask this principle be used moving forward.

As part of this process to improve cost measures, we believe CMS's attribution methodology must take into consideration when a clinician first begins to care for a patient and reward physicians for keeping patients healthy, and not only when an episode "trigger" occurs. At the global level, clinicians and group practices should not be penalized for seeing patients with high risk scores or for keeping patients out of the hospital. If a provider has a record or patients declare that a provider is their primary care physician, Medicare should extract that data and count it in the physician's score even if a beneficiary doesn't use services for a given time period. As efforts to move toward population health management continue, CMS must recognize these efforts with keeping patients healthy—a win-win outcome for providers, payers, and our communities.

Improvement in attribution will help the balance with patients that are very healthy with those that need more coordinated care. If attribution is not done correctly, physicians will be dis-incentivized from coordinating care. Spending from other physicians and the associated costs could be attributed to their own cost score if they became involved to a level where they would meet the current CMS threshold for attribution to that patient. In addition, healthy patients who need limited or no services during a performance period also should be attributed to physicians. Physicians who keep their patients well should be rewarded for that care.

Advancing Care Information

The CY 2018 Advancing Care Information (ACI) category primarily continues as finalized for CY 2017. For 2018, clinicians may use either the 2014 or 2015 CEHRT, with a one-time bonus for using the 2015 version, with a minimum reporting period of 90 days. The ACI category modifications include reporting to public registries; clinicians will need to report to a different registry to achieve bonus points than what was used in the performance category. If a MIPS eligible clinician cannot fulfill the Immunization Registry Reporting Measure, then the clinician could earn 5 percentage points in the performance score for each public health agency or clinical data registry to which the clinician reports for the following measures up to a maximum of 10 percentage points.

Beginning with the 2017 performance period, CMS proposes to establish an exclusion for the e-Prescribing and Health Information Exchange measures. Specifically, MIPS eligible clinicians who wish to claim this exclusion would select "yes" to the exclusion and submit a null value for the measure. This change would allow the clinician to fulfill the requirement to report this measure as part of the base score. For the Health Information Exchange Objective, CMS proposes additional exclusions because some MIPS eligible clinicians are unable to meet the measures required for the base score because they do not regularly refer or transition patients fewer than 100 times during the performance period. The HQC appreciates the proposed exclusions and supports this proposal.

Improvement Activities

For the 2018 program year, there is proposed to be no changes to the activities needed to achieve full credit for the category. For the 2018 year, CMS is adding Improvement Activities to the category, including Appropriate Use Criteria and those that align with the ACI category. In addition, CMS is asking for input on increasing accountability for meeting the activities in the category. For example, CMS is asking for feedback on creating thresholds to successfully attest to performing the activity, especially for group reporting. Under the regulations, a single eligible clinician can attest to the activity for a group to receive entire credit. As part of this transition, CMS is proposing that designated patient centered medical homes (PCMH) must be certified or recognized in 50% of the sites of care to be counted for full improvement activity credit. Overall, the HQC supports the proposed additional improvement activities in the category. It is important to align, to the extent practical and possible, measures and activities across all the domains of the MIPS program.

Alternative Payment Models

Alternative Payment Models (APMs) are approaches to paying for health care that incentivize quality and value. As defined by MACRA, APMs include CMS Innovation Center models (under section 1115A, other than a Health Care Innovation Award), MSSP (Medicare Shared Savings Program), demonstrations under the Health Care Quality Demonstration Program, and demonstrations required by federal law. To be an Advanced APM, a model must meet the following three requirements: Requires participants to use certified EHR technology; Provides payment for covered professional services based on quality measures comparable to those used in the MIPS quality performance category; and Either: (1) is a Medical Home Model expanded under CMS Innovation Center authority OR (2) requires participants to bear a more than nominal amount of financial risk. In order to qualify for a 5% APM incentive payment, model participants must receive a certain percentage of payments for covered professional services or see a certain percentage of patients through an Advanced APM during the associated performance year.

CMS expects APM enrollment to increase approximately double from 2017 to 2018. The 5% bonus payment for qualified participation in advanced APMs is estimated between $590 to $800 million in 2020. The CY 2018 proposed rule makes modifications to the alternative payment models option in the QPP, including: nominal risk standards, qualifying participant determination for all-payer models, attestation from other payers on meeting APM parameters, and changes to MIPS APM scoring standards.

Comments:

- **We remain concerned the minimum Medicare Part B requirement of advanced APMs, even with the all-payer option, is a deterrent for widespread adoption of advanced APMs. We ask for CMS to remain flexible, make a priority of, and consider necessary waiver authority to create additional pathways for advanced APMs.**
- **To recognize flexibility and differences in APM models, the HQC supports the advanced APM qualifying professional standard determined at either the individual or entity level.**
- **For Medical Home Models, the HQC supports the proposed modifications to the nominal amount risk standard. Also, the HQC also supports the proposed exemption of more than 50 clinicians from the Medical Home model and believes this policy should be made permanent and available for new medical home participants.**
- **We support the proposed payer and/or clinician-initiated process for verifying advanced alternative payment model information from non-Medicare sources. We caution that the information submitted should only be necessary for purposes of determining eligibility for advanced APM qualifying participation status.**
- **The HQC supports the proposed modifications to the MIPS APM scoring standard for CY 2018 program year.**

Determining advanced APM QP Status

CMS proposes that QP determinations under the all-payer combination option would be performed at the individual eligible clinician level only (not at the physician group or APM entity level). CMS says that there will be significant challenges in making these determinations at the group level. However, the HQC believes this decision should be made by the APM entity as to whether determinations be made at the group and/or individual level. Furthermore, in order to determine whether the individual clinician is a QP under the all-payer combination option, CMS suggests that it would need to receive all of the payment amount and patient count information attributable to the clinician through every other payment advanced APM and for all payments or patients (except excluded payer types) made or attributed to the clinician in the performance period.

Modified MIPS APM Scoring Standard

Under the proposed rule, CMS seeks to maintain the Marginal Risk and Minimum Loss Rate requirements for purposes of meeting the parameters for advanced APMs. In addition, the proposed rule adds a revenue-based nominal amount standard for total risk of 8%. This standard would be an additional option (in addition to the previously finalized expenditure-based standard) and would only apply to models in which risk for APM Entities is expressly defined in terms of revenue. The HQC agrees with this proposal.

Patient-Centered Medical Home APM

A Medical Home Model is an APM that:

- Includes participants in primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services
- Empanelment of each patient to a primary clinician; and
- At least four of the following additional elements:
    - Planned coordination of chronic and preventive care
    - Patient access and continuity of care
    - Risk-stratified care management
    - Coordination of care across the medical neighborhood
    - Patient and caregiver engagement
    - Shared decision-making
    - Payment arrangements in addition, or substituting for, fee-for-service

In addition to removing exclusion for enrollees with more than 50 clinicians for round 1 participants, the proposed rule modifies the nominal risk standard of estimated average total Parts A and B revenue for CY 2018:

- 2.5% in 2017 to 2% in 2018
- 3% in 2017 to 3% in 2018
- 4% in 2018 to 4% in 2020
- 5% in 2020 to 5% in 2021 and after

The HQC supports the proposed rule modifications to patient-centered medical homes regarding risk and eligibility. In addition, we support a permanent policy regarding the removal of the 50 clinician or greater exclusion.

Payer and Clinician-initiated process for APM verification

We support CMS's proposal to have both a payer-initiated process and an APM entity or clinician-initiated process to become an advanced APM. Under the proposed rule, CMS would allow either the plan or the APM entity or clinician to submit a form describing an all-payer advanced APM arrangement. The APM entity submission pathway option will be critical to the successful implementation of all-payer models, particularly because under MACRA the bonus is paid directly to the clinicians and not to health plans or other payers. As part of the submission, CMS indicates in the proposed rule that it would also like to collect supporting documentation, including copies of contracts and other underlying materials. The HQC recommends that CMS limit its requests for information to that information that supports the model's qualifications as an advanced APM (quality, CEHRT, and risk).

Conclusion

On behalf of the HQC, we appreciate the opportunity to provide comments on the implementation of the QPP. We urge CMS to work together with physicians, groups, hospitals, associations, and coalitions to ensure value-based payment programs are working in tandem to achieve the goals of better quality and lower cost. Thus far, we have been very pleased with the outreach and engagement from CMS officials and we hope this can continue. We look forward to continuing to provide feedback on the implementation of the new payment programs in the QPP.

If you have any questions or need clarification, please feel free to contact us.

Sincerely,

The Healthcare Quality Coalition