



June 27, 2016

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphry Building, Room 445-G
200 Independence Avenue SW
Washington, DC 20201

Re: Response to CMS-5517-P, Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed Rule

Dear Acting Administrator Slavitt:

HealthInsight appreciates the opportunity to respond with our comments and recommendations regarding the above-referenced Proposed Rule. MACRA is implementing major culture change in America by transforming the way physician services are delivered and paid for. We laud these efforts. We also recognize the scope, depth and intensity of resistance to these much needed changes as evidenced by the fact that some 558,000 physicians currently are penalized 2% of the Medicare reimbursement fee schedule because they are not reporting PQRS quality measures.

HealthInsight is a private, non-profit, community-based organization dedicated to improving health and health care, that is composed of locally governed organizations in four western states: Nevada, New Mexico, Oregon and Utah. HealthInsight is the Medicare Quality Improvement Network- Quality Improvement Organization in these four states. HealthInsight enterprise holds additional contracts and grants, and is certified, in key areas of health care improvement. We operate Nevada's statewide community based health information exchange enabling doctors, hospitals, laboratories, imaging centers, clinics, and other health care professionals to easily access patient health records quickly, securely, and accurately at the point of care to improve the timeliness, quality and coordination of care. As the Regional Extension Center designated by the Office of the National Coordinator in Utah and Nevada and as a major subcontractor in New Mexico, we assisted more than 1,500 providers through hands-on, one-on-one customized assistance in selecting and effectively using their electronic health records to improve patient care. HealthInsight New Mexico is certified as a Qualified Entity by CMS to combine Medicare and private insurance data to provide comprehensive, useful reports on provider performance. HealthInsight Utah operates Utah Health Scape web site displaying quality of care and patient experience survey results for providers, health plans and the public. HealthInsight Nevada is one of seven organizations across the nation selected by CMS to lead the initiative to reduce avoidable hospitalizations among nursing facility residents. The HealthInsight End Stage Renal Disease Alliance is composed of HealthInsight, the Northwest Renal Network 16 (serving Alaska, Idaho, Montana, Oregon and Washington) and Network 18 (serving Southern California), along with stakeholders in both regions. The alliance brings

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together the strengths of all partners to ensure broader impact and the best quality health care for ESRD beneficiaries. The alliance serves more than 55,000 patients with ESRD in 569 dialysis facilities. And we are members of the Network for Regional Healthcare Improvement extending into 25 states across the country.

We offer our comments and recommendations below to strengthen the Quality Payment Program.

Provider and Patient Engagement

Beginning in six months, failure to report quality measures will double current penalties followed by increasing financial penalties for those providers who fail to adapt to the new culture of value based payment systems.

We believe we must pull out all stops to assure every eligible clinician currently being penalized knows and understands urgent first steps necessary to survive and possibly thrive in the new value based payment systems. Consider including check stuffers in explanations of payments sent by CMS fiscal intermediaries to these providers that offer links to web sites that list contact information for currently available resources for free technical assistance and for certified reporting entities available to them (Qualified Clinical Data Registries, Electronic Health Records, Qualified Registries, CMS web interfaces, etc.). Make it easy for eligible clinicians to connect with tools and resources available from practice transformation networks, support and alliance networks, Regional Health Improve Collaboratives, Quality Improvement Networks- Quality Improvement Organizations, and other support entities.

Create “surround sound” messaging especially from those who physicians and clinicians trust and depend on - other clinicians and their own patients. The word is out that those small practices (who provide the majority of office based care) and psychiatrists who already are relatively undercompensated will likely have negative pay adjustments under MIPS while procedural specialists will likely experience more positive pay adjustments. Give many examples and contact information to small practices and psychiatrists who have learned how to succeed.

Offer clear and frequent messages on what’s in it for patients and physicians and other eligible clinicians to spend the time, effort, and expense to meet the reporting burden of MIPS. Inform them how fast they will receive actionable performance feedback and options for closing care gaps and improving efficiencies. Explain how independence minded clinicians can be sure that capital rich administrators and conveners of alternate payment models do not skim excessive administrative fees off the top of payments sent to these APMs before payments for direct care are processed. How is CMS assuring that “medical loss ratio” (direct care expenses) are at least 85% of payments to APMs so that patients benefit more than administrators and business people?

Offer explanations directly and through your contracted agents regarding how participation in alternate payment models assures appropriate payment to those providers delivering value while reducing the coding and compliance burdens that waste resources that could be better applied to improving clinical, financial and satisfaction outcomes. Offer evidence and stories demonstrating that value based payments enable effective team based care that reduces burnout and returns joy to the work of clinical practice. Structure listening sessions with practicing clinicians and beneficiaries to hear and heed observations and recommendations of those experiencing the results of the evolving value based payment systems. Publish and widely circulate evidence that certified alternate payment models are actually saving money, saving lives, reducing health risk scores, and improving the functional status of those being served. Make patients and their physicians real believers that this culture change is really worth the cost and difficulties of the transitions. Help rebuild trust with providers who feel betrayed after participating in shared savings and other alternative payment models only to learn they must still do onerous MIPS reporting rather than benefiting from their APM participation. Clinicians remember unkept promises.

Engage Medicare beneficiaries as allies to help convince their attending physicians to participate in value-based care delivery systems. Enable them to know the name and contact information of the attending physician to whom they are

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attributed. For instance, beneficiary explanation of payment statements could include the name and contact information of their attributed attending physician- “Our records indicate your attending physician is Doctor Smith.” Explain to beneficiaries what’s in it for them to receive care from clinicians focused on improving quality, safety, satisfaction, and cost. Advise patients to ask their physicians and eligible clinicians what they are doing to improve care and health of their patients. They mostly trust Medicare to take good care of them. Perhaps the office offers handouts or web sites describing some of their quality improvement activities and results.

Consider delaying the 2017 accumulation period of new penalties for nonparticipating clinicians until proof has been collated demonstrating that they are aware and have decided to ignore the information and offers of help.

Remove Barriers

Eligible clinicians and beneficiaries do not have ready access to comparisons of total allowed payments (total cost of care) and relative value scores of various drugs, devices, procedures, specialists, episodes of care and care bundles in the marketplace. Thus it is virtually impossible for clinicians to make informed decisions about best prescriptions, referrals, and other services to advise for their patients consistent with the values of the patients. And patients must largely depend on the advice of their attending physicians to choose providers and services to pursue. CMS is the logical entity to lead, encourage, and incentivize public transparency of comparisons of prices paid, results achieved, patient reported outcomes, and value delivered.

Before certifying electronic health records and other data reporting tools required by CMS for MIPS reporting, guarantee that they actually have the capability to report the required performance measures and that certified electronic health records are interoperable with local and regional health information exchanges. This enables eligible providers to accomplish better coordination of care and communication through interoperable connectivity with electronic records of other practitioners.

Since provider consolidation and market power raises costs, reduces the impact of clinician and patient input, and reduces competition for delivering highest value services, implement performance requirements and audits of cost management and resource allocation within such advanced payment models to assure “integration” truly delivers better results than competing physician led networks.

Reduce administrative and policy barriers to using telemedicine and telehealth technologies to improve customer service and offer more rapid access to needed medical advice and care both for urban dwellers and for rural medically underserved populations.

Enable policy and administrative changes to allow emergency services paramedics responding to 911 non-emergency calls to be compensated for delivering these callers to more appropriate lower levels of care to meet their needs. They usually are paid only when they transport 911 patients to overcrowded, expensive emergency departments.

Separate actuarial population risk from provider performance risk when applying risk adjusted experience data to determine prospective global, bundled, and episode payments for procedures and conditions. Clinicians should not be held accountable for behaviors and choices they do not significantly influence.

Assign relatively higher performance scores to incentivize documenting pledges signed by both the patient and her attending physician defining the individualized personal care plan based on their shared decisions for scheduled and expected care visits, consultations, tests, preventive services, procedures, medication fills and whether those are accomplished as planned. These do not require unaffordable electronic reporting systems and they drive better patient and provider engagement in coordinating and accomplishing important prevention and care interventions that reduce illness burden.

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Assure that reimbursements and payments within advanced payment models are distributed in accordance with value delivered in returning patients to better function without avoidable complications consistent with the values of the patients served.

Lead, encourage, and incentivize convening of local and regional community health boards (joint operating committees) with representation of payers including CMS (Medicare, Medicaid), employers, and insurers as well as QIN-QIOs, Regional Health Improvement Coalitions, public health, social services, federally qualified health centers, acute and post-acute care providers, primary and specialist physicians, and other key stakeholders to determine local health and well-being priorities and steps to accomplish measured improvements in cost, quality, safety, and health. Lead by example. Demonstrate that CMS, ONC, CDC, AHRQ, SAMHSA, and Aging and Disability Services collaborate and coordinate their interventions as models of collaboration and coordination in communities.

Rapidly expand the availability of Qualified Entities throughout the US. They can appropriately combine Medicare, Medicaid, and Commercial claims and clinical performance information to enable continuously improving reliability and risk stratification of costs, value, and outcomes to drive better decisions and interventions.

Performance Measures

Consider reinstating cross-cutting measures and geriatrician specialty measures such as falls prevention, adult immunizations, delirium prevention, reducing antipsychotic medication prescriptions, reducing unwarranted polypharmacy prescribing, assuring medication reconciliation, and reducing avoidable hospital transfers.

Consider weighting patient reported outcomes more heavily for performance scores including measures of shared decision making between physician and patient/ caregiver.

Move toward specialty and sub-specialty specific core measures to enable easier apples to apples comparisons. Be careful about allowing providers to cherry pick performance measures on which they excel while avoiding reporting core measures that deserve attention.

As clinicians increase their capabilities to prove they are delivering higher value care and services either through MIPS reporting or APMs, reduce the quantity of onerous reporting and coding workloads that engender perceptions they are not trusted and respected. These reporting burdens also do little to improve health.

Add validated health risk scoring tools for lifestyle choices and chronic conditions to outcomes performance measures to monitor whether relevant accountable units (practitioners, teams, practices, medical groups) are reducing total health risk burdens and improving functional status of patients they serve.

Reward both excellence compared to benchmarks and per cent improvement over baseline.

Continuously remove topped out low value measures and replace them with measures of important high value interventions.

Consider raising the threshold for base scores of advancing clinical information from one patient to 5% of patients in 2019.

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Continue to improve the ease of navigation and access to individual level provider performance information on Physician Compare.

Alternate Payment Models

To advance team-based care through new payment models, encourage developing a risk adjusted global budget for a population served by the entity. Inside that global budget, advise

- The accountable provider teams to have a main “quarterback” (person on point) to coordinate the interventions.
- Covering estimated cost of outliers using stop loss insurance;
- Making the quality and cost measures transparent to those involved;
- Including adequate payment for care coordination services above that provided by the clinicians in the quality payment; and
- Having the local entity (team members) determine the distribution of payments.

Since sustained patient engagement in self-management of their chronic conditions in partnership with their attending clinicians is critical to success, alternate payment entities should be allowed to apply financial and non-financial incentives for patient adherence to shared decision based individualized care plans. In some cases they should have the flexibility to help their poor high risk patients with high social needs with durable medical equipment, transportation, ramps, etc. that could substantially improve their functional status and coping skills.

To help assure that clinicians are not forced out of business by taking on excessive risk for which they are not prepared, they should only be contracted as groups to manage risks they can control (performance risk, not actuarial/ outlier risk).

- They should follow evidence based guidelines/ pathways with proven track records.
- The infrastructure costs to accomplish the pathway steps should be taken into account.
- The served patients should be risk stratified (behavioral, social, baseline medical and pharmacy claims, geographic variables, predictive modeling risk factors, and outlier reinsurance cost).
- Total payments should periodically be adjusted in accordance with actual performance and experience.

To help assure that hospital systems are not forced out of business by inadequate patient service volumes to support medical education and professional training, payments for these community needs should be separated from payments for clinical services. As in hospital service volume goes down and value of outpatient clinical services improves, the savings should be applied at least partially to needed continuing work force development.

Assure that standards for granting certified alternate payment model status are transparent and that appropriate risk adjusted data are used for developing the payments and that medical necessity controls are in place to avoid excessive volume of unnecessary bundles.

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Conclusion

We appreciate the opportunity to comment on this important and valuable rulemaking process. We look forward to working with CMS to further Triple Aim goals for Medicare beneficiaries and the communities we serve.

Sincerely,



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