

June 27, 2016

Andy Slavitt  
Acting Administrator  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

**RE: 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**

Dear Acting Administrator Slavitt:

Thank you for the opportunity to provide input on the design and implementation of the physician payment programs created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Pacific Business Group on Health (PBGH) is a not-for-profit organization that leverages the strength of its 60 members – who collectively spend \$40 billion a year purchasing health care services for more than 10 million Americans – to drive improvements in quality and affordability across the U.S. health system.

PBGH has long recognized that the existing fee-for-service payment model encourages volume and complexity in health care services and drives up health care costs. It provides little incentive for the robust care coordination and high quality care that patients, especially the most vulnerable, deserve. A high-value health care system requires value-driven payment arrangements and we are encouraged by the opportunities MACRA has created to expand the footprint of value-based purchasing. The approach of the Quality Payment Program to pay clinicians based on the value and quality of care is an important step forward in transforming our nation's health care system. Such value-based payments should result in better health outcomes, improved care coordination and patient experience of care, and decreased costs. We applaud CMS for designing the Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) paths with the intention of moving toward the Triple Aim while supporting multi-payer alignment and innovation.

Below we highlight a few aspects of the design of the MACRA Quality Payment Program that are critically important to purchasers.

## **Meaningful delivery system transformation**

We strongly support payment models that reward value rather than volume and are pleased to see CMS accelerate the movement towards APMs. Value-driven models of care must not only increase efficiency but also improve the delivery of care, such as through greater care coordination, more shared care planning and partnership with patients at all levels of care, and better patient experience of care.

### Financial Risk

Models with two-sided risk or population-based payments—not just models that slightly alter payment arrangements—reward clinicians who adopt practices that have been shown to increase value to a range of stakeholders including consumers and purchasers. This financial accountability model is at the heart of the transformation of a payment arrangement from fee-for-service into a value-driven model. In tandem with this financial model, there must be the opportunity for clinicians to practice medicine and deliver care in innovative ways as they work to improve patient experience, quality, and efficiency. APMs must provide meaningful rewards to high-performing clinicians who accept accountability for the quality, patient experience, and cost of the services they provide. We support CMS’s definition that Advanced APMs must include downside financial risk and agree that model designs should take precedence for other requirements.

The proposed Advanced APM criteria exclude many existing APMs including most ongoing Medicare bundled payment initiatives. Though this may appear to be in conflict with CMS’s stated goal of promoting participation in Advanced APM models, we support the proposal because it establishes a high bar for clinicians to receive the APM incentive payment. Rather than adjusting the Advanced APM criteria to increase the number of qualifying APM participants immediately, we urge CMS to make changes to the existing APM program designs as quickly as possible. For example, the Bundled Payments for Care Improvement and Comprehensive Care for Joint Replacement programs should be updated to meet the health IT requirements for Advanced APMs for any new or renewed contracts, and participants should be given the opportunity to update contracts before the end of the current contract period to address this change. Similarly, in the Medicare Shared Savings Program, to facilitate more rapid progression toward two-sided risk models, CMS should enable Track One ACOs to move up to risk based contracts after any performance year. We note that without a policy change, early adopting MSSP ACOs that decided to pursue a second three-year contract in Track One will lack a mechanism to advance to higher tracks until the conclusion of their contract period until 2019. To prevent this unintended delay, we recommend that CMS allow clinicians participating in all current ACO contracts to move quickly into a two-sided risk model.

### Assessment of APMs

Cost savings and the transition to value-based payment models cannot be the lone goals of health care transformation. Meaningful transformation requires that the transition to APMs also result in improved delivery of care (e.g., greater care coordination, use of shared care planning and partnership with patients at all levels of care; demonstration of improved patient care experience). We strongly recommend that as entities take on financial accountability for quality performance and cost, assume financial risk, and move towards capitation-like payment models, these entities must likewise be able to demonstrate that they promote and support sustainable, effective, evidence-based, accessible, and patient- and family-centered care models.

In the same vein, we need performance information that is comparable to the prevailing system (i.e., MIPS) to know whether APMs are succeeding as intended. We support the proposal that APMs require at least one outcome measure. Ultimately, though, the Advanced APMs' quality measures will only be as strong as the underlying models' requirements. Currently, there is no consistency across models in obtaining stakeholder feedback on the quality measure sets or other model design features. We strongly recommend this be a standard part of the process. One way to operationalize this is to obtain the feedback through the Measure Applications Partnership.

In addition to using consistent performance metrics in APMs and MIPS, we urge CMS to monitor the impact of these programs on the broader market. The full impact of the Quality Payment Program on small practices/solo practitioners, specialty providers, and primary care remains to be seen as the market responds to this new program. At the same time, the focus on a few Advanced APM models may unintentionally increase provider consolidation that may lead to abuses of market power, including higher prices for the private sector. CMS should monitor such changes in the market in the short-term and quickly make improvements to the programs to support effective participation of these providers while maintaining robust value purchasing programs.

### Primary Care Foundation

For much of the health system, meaningful delivery system transformation requires a strong foundation of primary care. The special consideration given to medical home models as Advanced APMs acknowledges the critically important role of primary care in improving the quality of health care overall, reining in high medical costs, and improving patient experience of care. We support the separate financial standards for medical home models and appreciate CMS's attention to placing a high-value on the provision of primary care. However, with regards to the requirements around medical home models, we urge CMS to go further and require medical home models seeking to qualify as Advanced APM to meet all seven of the domains

listed in the proposed rule's definition of a medical home model. No one of these domains could be acceptably missing from a high-quality medical home.

In addition to requiring all seven criteria, we suggest that CMS reframe the shared decision-making domain to focus on shared care planning, of which shared decision-making is an integral part. While shared decision-making may be tied to a singular episode of care, shared care planning captures and occurs across a patient's lifespan. We encourage CMS to move toward measuring whether meaningful shared decision-making and care planning has occurred, specifically through PROMs.

#### Clinical Practice Improvement Activity (CPIA) Performance Category

Many state-based or regional multistakeholder improvement initiatives can accelerate CMS's intended delivery system transformation. In fact, a multistakeholder approach is more likely to effectively engage and support clinicians in practice redesign. In contrast, multiple unaligned improvement initiatives from multiple payers or sponsors interrupt progress at the practice site.

We recommend that CMS include participation in a regional health improvement collaborative (RHIC) as a CPIA. MACRA directs the Secretary to consider, in establishing CPIAs, the circumstances of small practices and practices located in rural areas and health professional shortage areas. As Congress recognized when identifying RHICs as appropriate entities to provide technical assistance to small and rural practices, RHICs' regional focus and multistakeholder governance structure allow them to engage small practices in a way that others cannot. We note that many of the proposed CPIAs that center on QCDR participation and Quality Improvement Organization (QIO) technical assistance could be expanded to include assistance that providers obtain through RHICs.

As an example, as the preeminent multistakeholder improvement organization in California, the California Quality Collaborative (CQC) brings together major payers with medical groups and clinics to set and support improvement priorities statewide. CQC assists providers and plans to meet the demands of the current environment across all business lines. Importantly, all of CQC's activities incorporate the fundamental belief that systemic changes are needed at the organizational level and building capacity is necessary to sustaining unprecedented transformation. We recommend that CMS expand the activities that qualify as CPIAs beyond the Transforming Clinical Practice Initiative to include all programs offered by CQC. Similarly, we recommend that CMS raise the weight of participation in the Bridges to Excellence program from medium to high to reflect the program's robust approach to practice improvement that incorporates the major tenets of the Quality Payment Program: meaningful measurement, increased value, and aligned incentives.

### All-Payer and Other Payer Advanced APMs

A typical provider in the United States must collect and coordinate revenue from multiple public and private payers. Each has its own rules for payment and separately negotiated contractual standards. Coordination among payers is discouraged or illegal. The cumulative effect is to emphasize the economic and administrative status quo and reduce the ability of providers to innovate with improvements that benefit patients and populations. Myriad payment programs have the potential to conflict with one another, or fail to provide large enough incentives to undertake certain activities or invest in the infrastructure needed for improvements. In contrast, successful multi-payer alignment can amplify the impact of payment and delivery system reforms by sending consistent incentives to health care providers and aligning performance measurement. As the Advanced APM path evolves, it is critical that CMS incorporate Other Payer and All-Payer APMs that drive the market in a consistent direction without competing or contradictory incentives. We support CMS's proposed approach to define Other Payer Advanced APMs similarly to the Medicare Part B Advanced APMs.

### **Glide path**

We support CMS's proposed Intermediate APM option to serve as a glide path from MIPS to Advanced APMs. Moreover, we support streamlining requirements for Intermediate APMs to create consistency with the goals of Advanced APMs and reduce barriers to becoming an Advanced APM. This glide path helps CMS maintain a high bar for Advanced APMs. However, we urge CMS to include a quality score for the Intermediate APMs beginning in the first year—these models include payment based on quality, and those measures can offer information to help compare the performance and impact of the Intermediate APM path to the MIPS and Advanced APM paths.

### **Performance measures**

To truly support high-value care and value-based purchasing, performance measurement must be meaningful to all stakeholders, useful not only for quality improvement but also to distinguish between providers who deliver excellent, average, or poor care. We applaud CMS for identifying and emphasizing the types of measures that offer the most value to consumers and purchasers: measures of outcomes, appropriate use, patient safety, efficiency, patient experience, and care coordination.

Critically, however, we urge CMS to redesign the reporting requirements for the Quality Performance Category of the MIPS program. We are disappointed that CMS proposed a continuation of the menu selection approach used in PQRS that only requires clinicians to report

on a small number of self-selected measures. This is problematic for multiple reasons: the PQRS and proposed MIPS measure sets include low-value documentation and process measures that offer little value to consumers or purchasers; reporting only a small number of measures is unlikely to reflect the spectrum of patients and conditions treated by the clinician; and by self-selecting the measures, clinicians could potentially give an inaccurate picture of his/her practice. We acknowledge that the proposed rule aims to give providers flexibility to report on those measures most relevant to their practice, but that flexibility must not come at the cost of meaningful and actionable information for consumers, purchasers, and other stakeholders. We urge CMS to redesign the MIPS Quality Performance category by establishing core sets of measures by specialty or subspecialty. A core set approach using high-value measures would enable direct comparison between similar clinicians, and would provide assurance that the comparison is based on a consistent and sufficiently comprehensive set of quality indicators. This, in turn, supports informed choice and the ability to design value-based networks. We also support providing additional incentives to encourage reporting on other priority and innovative measures. The measure sets in the proposed rule and existing efforts to define core measure sets are a good starting point. Over time, core measure sets should be updated as better measures become available.

Beyond the need for core measure sets, the performance measures and reporting requirements for MIPS leave room for improvement.

- We urge CMS to further prioritize patient-reported outcomes (PROs) and PRO-based measures (PROMs) in the Quality performance category and among CPIAs. While outcomes are proposed as priority measures, this group typically refers to clinical outcomes rather than PROMs. PROMs and other measures using patient-generated data assess issues that are important to patients and are a key element of patient-centered care, enabling shared decision-making and care planning.
- We need performance information at the individual clinician level to support quality improvement, value-based purchasing, and informed choice. CMS should request information about all of the MIPS performance categories as well as from APM participants at the most granular level possible, enabling assessment of clinician performance at the individual level as well as aggregating performance to the group, practice, APM entity, or other level as appropriate.
- CMS should require a standard patient experience survey from all MIPS clinicians in groups of two or more. Patient experience of care is a key tenet of a person-centered health care system, and patient experience measures are critical for quality improvement, consumer choice, and value-based purchasing.
- We support the proposal to use all-payer data for quality measures, recognizing that this data will create a more comprehensive picture of an EC's performance. Specifically, we

support all-payer data for the Qualified Clinical Data Registries, qualified registries, and EHR submission mechanisms. We also support all-payer data for patient experience surveys.

- In addition to measuring the proposed aspects of resource use, we strongly encourage CMS to move rapidly towards including Part D costs as these costs represent a substantial portion of total cost of care.

### **Advancing Clinical Information**

The robust use of health IT and health information exchange is fundamental to achieving the foundational goals of MIPS and Advanced APMs created by MACRA to incentivize high-quality, efficient practices, coordinated care and improved health outcomes. The proposed requirements for health IT adoption and use in both the MIPS and APM tracks are not sufficient to drive system transformation, and we are disappointed that the proposed rule does little to build on the Meaningful Use program. Particularly problematic is the “one patient” threshold for the measures in the base score of the Advancing Clinical Information category. We strongly urge CMS to increase the threshold for the base score measures to five percent as quickly as possible, and by the 2019 measurement year at the very latest. In addition, we recommend reducing the weight of the base score relative to the performance score to reward those clinicians who invest in effective use of health IT.

For more detail about these recommendations and comments on other components of the proposed rule, we refer you to the comments from the Consumer-Purchaser Alliance.

Thank you again for the opportunity to provide comments on this important program. Please contact me should you require any additional information or clarification.

Sincerely,



William E. Kramer  
Executive Director for National Health Policy  
Pacific Business Group on Health