



Working Together for an Affordable Future

November 17, 2015

Andrew Slavitt  
Administrator  
Center for Medicare and Medicaid Services (CMS)  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building, Room 445-G  
200 Independence Avenue, SW  
Washington, DC 20201

**Re: Request for Information Regarding Implementation of the Merit Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models**

Dear Administrator Slavitt:

I write to share the National Coalition on Health Care's response to the Request for Information regarding implementation of the core Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) provisions of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

NCHC is a coalition of health care stakeholder organizations committed to promoting an affordable, high-quality health system in the United States. As the nation's oldest and most diverse group working to achieve comprehensive health reform, we represent more than 85 member organizations, including health care providers, purchasers, payers, and consumers. Collectively, our organizations represent, as employees, members, or congregants, more than 100 million Americans.

The current fee-for-service (FFS) payment model in health care encourages volume and complexity in health care services and drives up health care costs across the United States. It

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provides little incentive for the robust care coordination and quality care that patients, especially the most vulnerable, require. Building a high-quality health system we all can afford will require both expanding alternatives to fee-for-service and improving existing payment systems like Medicare's physician fee schedule.

Toward those ends, we recommend the following:

- CMS's approach to quality measurement should move toward a parsimonious set of high-quality core outcome measures, endorsed wherever possible by a multi-stakeholder process – while acknowledging the continuing need for high-quality process and structure measures for certain specialties and populations.
- CMS must ensure that providers receive more timely and frequent reports on quality and resource use, provided, at a minimum, on a quarterly basis.
- To offer an on-ramp to more advanced APMs, CMS should provide additional credit under the clinical practice improvement category, and potentially other categories, to those MIPS eligible providers (EPs) who actively participate in robust APMs but who may be ineligible for the 5% APM bonus or exemption from MIPS because those APMs do not meet requirements related to risk.
- Medicare policy related to APMs should both a) encourage progression among the subset of Medicare providers who participate in APMs currently and b) actively seek to increase the percentage of providers participating in APMs and the proportion of patients relying on their care.
- To support APM participation, particularly in advanced APMs like the capitated physician payment models used in MA, CMS should, at a minimum, allow advanced APM participation in MA to count toward the Medicare payment threshold option and the Medicare portion of the combination all-payer and Medicare payment threshold option.

Below, we offer specific comments addressed directly to the questions raised in the RFI.

## **MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)**

### **3a: Reporting Mechanisms for the Quality Performance Category**

NCHC has identified several key principles that we believe can help CMS' quality measurement activities drive improvements in quality, provide meaningful information for consumer decision-making, and provide useful information for value-based payment and purchasing by CMS and other purchasers.

**We recommend that CMS consider the following principles:**

- 1. Over time, quality measures should move toward a parsimonious set of core outcome measures, with a focus on patient-reported experience and functional outcomes.**
- 2. Wherever possible, such measures should be endorsed by a multi-stakeholder process to ensure they are evidence-based and meet the needs of all stakeholders.**
- 3. Incentives should be provided to providers who utilize the highest-value measures. One constructive approach would be to adopt modest additional “pay for reporting” incentives for use of the following measure types:**
  - a. more advanced registry or EHR-based quality outcome measures, and;**
  - b. patient reported outcome measures (PROMs), addressing patient experience, the level of functional restoration or improvement, and quality of life.**

We also recognize that non-core measures will remain necessary. For example, measures will be needed that specifically address the unique needs of vulnerable groups, including children, patients with functional and cognitive limitations and serious mental illness, who may not be appropriate patients for providers who do not typically serve such populations. We appreciate that it may be difficult to identify, in every specialty, high-quality outcome measures for which individual clinicians have sufficient numbers and the ability to affect results. For this reason, process and structure measures will continue to be needed – if those measures are to remain relevant to clinicians and useful for quality improvement. In selecting such measures, CMS should emphasize those structure and process measures which are most directly related to outcomes.

We note that non-Medicare payers can and should rely on core measures of limited relevance to Medicare, such as those needed for pediatric or obstetric care, and certain measures important to Medicare populations, such as those related to falls, may be of limited use to some non-Medicare payers serving different populations.

Within the Medicare program, however, broad reporting of certain core outcome measures (for example, preventable hospitalizations or readmissions) remains important – even if those measures can and should not always be tied to payment for all eligible providers. As MedPAC has pointed out, stakeholders and policymakers need to understand the performance among MA, ACOs, and traditional fee-for-service providers, in and across regions and within and between particular populations.

## **5: Clinical Practice Improvement Categories**

Implementation of MIPS should do more than promote incremental practice improvement. It should incentivize MIPS EPs to invest in their practice’s progression toward more advanced alternative payment models. Without such an incentive, the leap toward advanced risk-based

models will appear too daunting to many providers, and they will simply remain on the treadmill of volume-based, fee-for service medicine.

We note that MACRA provides full credit under Clinical Practice Improvement category to MIPS EPs in practices that are certified as patient-centered medical homes, and at least 50% of the maximum possible score under Clinical Practice Improvement for participation in an Alternative Payment Model, as defined in section 1833(z)(3)(C)).

But in our view, CMS should take additional steps to support practice progression. **CMS should provide 100% credit under the clinical practice improvement category to those MIPS EPs who participate in and show active engagement in certain robust alternative payment models but who may be ineligible for the 5% APM bonus or exemption from MIPS because those APMs do not meet requirements related to risk.**

After all, participants in alternative payment models that do not require repayment to CMS, such as track 1 ACOs, are still taking steps toward risk and beginning care coordination activities, and those steps should be recognized – even if the providers are found ineligible for the APM 5% bonus. MIPS EPs participating in these APMs should receive credit under the Clinical Practice Improvement Category.

Additionally, when such APMs' requirements are similar to the quality performance and certified EHR requirements of MIPS, CMS should also consider providing credit under these categories – provided that it can be ascertained that EPs are engaged in meeting those quality and EHR requirements.

In this way, MIPS EPs would be credited for these activities associated with certain robust APM models, without facing duplicative reporting or performance requirements. And MIPS requirements would better align with and support the Secretary's stated goal of achieving 50% Alternative Payment Model participation by 2019.

## 7. Other Measures

*What types of measures and/or clinical practice improvement activities (new or from other payment systems) would be appropriate for these EPs?*

As noted above, it may be difficult to identify high-quality outcome measures in all specialties for which individual clinicians would have sufficient numbers and the ability to affect results. This is particularly true for non-patient facing EPs.

In their case, as elsewhere, high-quality process and structure measures will continue to be appropriate for payment purposes. In selecting such measures, CMS should emphasize those structure and process measures which are most directly related to outcomes.

### ***11. Public Reporting***

Publicly available performance information is central to understanding value-based performance. It drives quality improvement, accountability, and consumer choice. Consumers find individual-level provider quality information extremely valuable when selecting physicians and other providers, therefore we strongly advocate not only for group-level and individual clinician-level measurement but also individual clinician-level public reporting – provided the reported data is valid, accurate, and reliable.

We also encourage CMS to require public reporting of quality measurement at higher levels of aggregation in order to be as transparent as possible and inform decision-making by other stakeholders and policymakers.

### ***12. Feedback Reports***

Quality and Resource Use Reports are essential in gauging progress and identifying challenges as clinicians strive to improve. It is vital that CMS do everything possible to provide such reports as frequently as possible and to minimize the lag between the conclusion of the time period measured and the delivery of the report. Timely provision of performance data enables clinicians to identify poor or sub-par performance and address it, while spotting successful approaches and replicate them. **At a minimum, we urge CMS to ensure they can provide such reports on a quarterly basis and provide even more frequent reports for claims-based measures that are calculated by CMS.**

## **ALTERNATIVE PAYMENT MODELS**

### ***1a: QPs and Partial Qualifying APM Participants***

The RFI states that APMs must have a certain threshold of their Part B covered professional services furnished through the APM entity to qualify for the 5% bonus. Beginning in 2021, the statute allows eligible APMs to include “all-payer” revenue, including Medicare Advantage, in the risk threshold calculation. However, the statute requires that 25% of an entity’s Medicare Part B payments be attributable to an alternative payment model under the all-payer threshold.

This discussion appears to imply that an eligible provider who is paid through a capitated or global payment through Medicare Advantage cannot qualify for an APM bonus unless he or she is

also participating in an APM within traditional Medicare – even if a majority of the provider’s revenue is in a risk-bearing arrangement in MA.

Excluding MA APMs from the calculation of the 25% requirement would put the brakes on capitated arrangements currently used by leading MA plans to pay providers. Congress established the 5% bonus to accelerate progress toward more advanced alternative payment models, not to slow it down. **To support APM participation, particularly in advanced APMs like the capitated models used in Medicare Advantage, CMS should, at a minimum, allow advanced APM participation within MA to count toward the Medicare portion of the combination all-payer and Medicare payment threshold option.**

### ***1d: Nominal Financial Risk***

- *What is the appropriate type or types of “financial risk” under section 1833(z)(3)(D)(ii)(I) of the Act to be considered an EAPM entity?*
- *What is the appropriate level of financial risk “in excess of a nominal amount” under section 1833(z)(3)(D)(ii)(I) of the Act to be considered an EAPM entity?*
- *What is the appropriate level of “more than nominal financial risk if actual aggregate expenditures exceed expected aggregate expenditures” that should be required by a non-Medicare payer for purposes of the Combination All-Payer and Medicare Payment Threshold under sections 1833(z)(2)(B)(iii)(II)(cc)(AA) and 1833(z)(2)(C)(iii)(II)(cc)(AA) of the Act?*
- *What are some points of reference that should be considered when establishing criteria for the appropriate type or level of financial risk (e.g., the MIPS or private-payer models)?*

NCHC’s member organizations have differing perspectives on the appropriate types and level of financial risk, and, as a coalition, we have not achieved consensus on a definitive answer to these questions. However, we can outline an overall approach that can serve as a useful point of reference.

**Medicare policy related to APMs should both a) encourage progression among the subset of Medicare providers who participate in them currently and b) actively seek to increase the percentage of providers participating in APMs and the proportion of patients relying on their care.** We agree with CMS and other stakeholders that charting a path toward greater assumption of performance risk by providers is a policy goal of significant importance. In pursuit of this goal, however, it is vital to balance two objectives: encouraging practices to progress toward greater risk and expanding the proportion of practices that are on that path in the first place.

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On another, related matter, we would like to call attention to a potential misalignment that could arise between implementation of this provision of MACRA and the Medicare Shared Savings Program regulations finalized earlier this year.

CMS has offered the option of a second 3-year contract under track one, recognizing that many ACOs may not be ready to advance to higher-risk tracks. We understand that ACOs are currently engaged in deciding whether to pursue this new option. It also appears that providers in these track 1 ACOs could be denied the 5% bonus and face MIPS reporting requirements, depending on how rulemaking defines “more than nominal risk” under MACRA.

We note that MSSP ACOs that decide to pursue a second three-year contract in the coming months will lack a mechanism to advance to higher tracks– at least until the conclusion of their contract period.

This potential misalignment between the MACRA incentives and ACOs’ ability to act in response to those incentives could harm the Medicare Shared Savings Program, discouraging eligible providers from participating in MSSP ACOs and leading some ACOs to drop out of the MSSP altogether.

### ***1e: Medicaid Medical Homes or other APMs under State Medicaid Programs***

*What criteria could the Secretary consider for determining comparability of state Medicaid medical home models to medical home models expanded under section 1115A(c) of the Act?*

CMS should carefully evaluate Medicaid payment models for their similarity to medical home models that are expanded under section 1115a. At a minimum, health home or medical home models that either require performance risk or rely on upside-only shared savings (similar to the approach used in the Comprehensive Primary Care initiative) should count toward the Combination All-Payer and Medicare Payment Threshold Option requirements

*Which current Medicaid alternative payment models – besides Medicaid medical homes – are likely to meet the criteria for comparability of state Medicaid medical homes to medical homes expanded under section 1115A(c) of the Act and should be considered when determining the all-payer portion of the Combination All-Payer and Medicare Payment Threshold Option?*

We note that many Medicaid programs are exploring ACO and bundled payment models. Provided they meet the same standards required of private payers, they should also count toward the Combination All-Payer and Medicare Payment Threshold Option requirement.

We also note that Medicaid payment rates in most states lag substantially behind Medicare and private payers. Under an APM threshold based on the percentage of all-payer revenue attributable to APMs, it is possible that an EP who is participating in a Medicaid APM might be denied the 5% bonus that would have been attributed available to them, had their Medicaid APM been paid at Medicare or private market rates. This could have the effect of reducing provider participation in Medicaid APMs.

To account for Medicaid’s typically low payment rates and to promote provider participation in Medicaid APMs, CMS should consider the advantages and disadvantages of weighting payment under these Medicaid APMs differently than that of other payers.

## ***2. Quality Measures***

**NCHC recommends that CMS consider the following principles:**

- 1. Over time, quality measures should move toward a parsimonious set of core outcome measures, with a focus on patient-reported experience and functional outcomes.**
- 2. Wherever possible, such measures should be endorsed by a multi-stakeholder process to ensure they are evidence based and meet the needs of all stakeholders.**
- 3. Incentives should be made available to providers who utilize the highest-value measures. One constructive approach would be to adopt modest additional “pay for reporting” incentives for use of the following measure types:**
  - a. more advanced registry or EHR-based quality outcome measures, and;**
  - b. patient reported outcome measures (PROMs), addressing patient experience, the level of functional restoration or improvement, and quality of life.**

In applying these principles to the implementation of MACRA’s APM provisions, CMS should take care to consider the implications beyond the Medicare program.

Although NCHC supports moving toward a parsimonious number of core outcome measures - recognizing, as noted above, that measures outside the core set will remain necessary -we note that non-Medicare payers often rely on core measures of limited relevance to Medicare , such as those needed for pediatric or obstetric care. Non-Medicare APMs should have the flexibility to place such measures at the center of their quality measurement regime, and eligible providers participating in those APMs should receive credit for participation under the Combination Medicare and All-payer Threshold option – even if the private APM’s core measure set differs from that used by Medicare APMs.

Similarly, a core measure related to falls may be judged to be a core outcome metric in Medicare APMs, but less relevant to APMs focused on ambulatory adults and children. Private APMs should have the flexibility to exclude that metric without denying eligible providers in that APM credit toward the Combination Medicare and All-payer Threshold Option.

NCHC appreciates the opportunity to offer these comments now and looks forward to working with CMS as implementation of MACRA proceeds. Should you or your staff have questions regarding these comments or other issues, please do not hesitate to contact myself at [jrother@nchc.org](mailto:jrother@nchc.org) or NCHC's Policy Director Larry McNeely at [lmcneely@nchc.org](mailto:lmcneely@nchc.org).

Yours truly,



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