National Business Group on Health®

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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

August 21, 2017

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

RE: CMS-5522-P: Medicare Program; CY 2018 Updates to the Quality Payment Program

Dear Administrator Verma:

The National Business Group on Health (the "Business Group") appreciates the opportunity to comment on CMS' proposed rule to modify the Quality Payment Program (QPP), Year 2, originally implemented as part of the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA).

The National Business Group on Health represents 415 primarily large employers, including 73 of the Fortune 100, who voluntarily provide group health and other employee benefits to over 55 million American employees, retirees, and their families. Being mostly self-funded, our employer members as well as many other employers have a vested interest in more effective, efficient health care and promote health plan designs that encourage delivery of the right care at the right time and in the right place; an emphasis on promoting health in primary and preventive care; improving value while reducing the cost of care; and, delivering services to the highest level of customer satisfaction.

At a high-level, we support efforts to continue refining payment systems to improve the quality of care patients receive, reduce the inefficient use of care, and increase the value of care provided. These objectives are best achieved by focusing on payment models that reward improved patient outcomes and quality enhancements, as well as transform health care delivery to promote integrated, coordinated, and accountable care. To that end, we applaud this proposed rule as a sign that CMS and HHS are continuing the path to moving away from the legacy fee-for-service system that bases payment on volume and utilization, to payment models that increasingly reward value and performance.

In fact, the Business Group has consistently supported CMS's efforts to reform and refine payment policies focused on rewarding value, performance and quality, especially including those outlined within MACRA, the hospital quality improvement program, and the move to alternative payment

models. CMS's efforts complement that of many large employers who are working either directly with providers or with their commercial health plan partners to implement alternative payment and delivery models such as accountable care organizations (ACOs), patient-centered medical homes (PCMHs) and bundled payments for their employees because of their potential to improve health care quality, value and efficiency.[1]

We appreciate that the agency is committed to continuing to ramp up the QPP by establishing special policies for Program Year 2 aimed at encouraging successful participation in the program while reducing measurement and reporting burdens, and preparing clinicians for the calendar year (CY) 2019 performance year.

While we are largely supportive of the proposed rule and reduced burden on providers, we also caution CMS to continue with a progressive path forward while it seeks to simultaneously simplify the program for small, independent, and rural practices that may not yet be ready for participation. The attached addendum further details the following areas where we have offered suggestions for additional focus:

- We urge the agency to consider keeping the original proposed step up of 10% in the weighting of cost in the overall composite score, in 2018.
- However, while we do not support delaying the weighting of cost within the composite score, we believe that the 10% should only be reallocated to the quality component of the composite score so that it has greater weight, to the extent that this provision of the proposal is finalized.
- We are concerned with the broad flexibility being extended to virtual groups to determine their composition and believe that reasonable limits should be adopted.
- We believe it is critically important for CMS to closely monitor the ways in which solo practitioners and groups with 10 or fewer eligible clinicians form virtual groups, and consider establishing guidelines or a limit on the number of TINs that may form a virtual group in future rulemaking as necessary.
- We encourage the agency to consider ways to ensure that clinicians coming together to form a virtual group have bona-fide clinical reasons to collaborate and demonstrate them.
- We are concerned that the formation of virtual groups could create further incentives for provider consolidation, which can increase both Medicare and private-sector spending without necessarily improving quality.
- While we are supportive of increasing the low-volume threshold, we encourage the agency to consider additional outreach opportunities to small and rural practices, to make it easier for them to report through MIPS and receive composite scores, thereby eliminating the need to establish additional or future upward modifications to the low-volume threshold.
- We encourage the agency to modify the low-volume threshold opt-in proposal relative to the number of patients, beginning in 2019, which would allow clinicians to voluntarily report if they exceed one of the measures within the low-volume threshold.

[1] National Business Group on Health. Large employers' 2015 health plan design survey. 2014. https://www.businessgrouphealth.org/pub/b4c900ee-782b-cb6e-2763-0aa2f9563309

- We encourage the agency to continue to consider a hybrid approach to the proposed facility-based reporting approach, in which MIPS eligible clinicians would be measured based on both the performance of the facility with which they are connected and their individual performance.
- We support the bonus for complex patients' adjustment of up to 3 bonus points to clinicians based on the medical complexity of the patients they treat, to address the impact patient complexity may have on final scores.
- While the agency has proposed that MIPS eligible clinicians must submit data on at least one performance category in the 2018 MIPS performance period for the small practice bonus, we believe the requirement should be to submit data on at least two performance categories. Further, while the agency has also described that the MIPS eligible clinicians would not need to meet submission requirements for the quality performance category to receive the bonus, we believe at least one of the submissions should be required to be within either the quality or cost category.
- While we are supportive of the flexibility outlined in the current proposal for advanced APMs and believe it appropriately considers market barriers to successful participation in these models, we additionally caution the agency to avoid continued or prolonged implementation delays.
- Finally, we strongly support the implementation of an alternative path to qualifying as a successful participant in an A-APM and avoiding any MIPS payment adjustment by defining what it means to be a qualified provider through the "all payer combination option."

We look forward to continuing to work with you to transform the nation's health care system into one that is renowned for high-quality and high-value care, through improvement initiatives which pursue a broader system of linked goals. Again, thank you for the opportunity to comment. Please contact me or Steven Wojcik, the National Business Group on Health's Vice President of Public Policy, at (202) 558-3012, if you want to discuss our comments in further detail.

Sincerely,

Brian Marcotte
President and CEO

Addendum

Composite Scoring Composition

In general, we are supportive of the proposals the agency has put forth on the overall composition of the composite score, especially those related to quality, advancing care information and improvement activities. We believe the agency has made substantial effort to incorporate stakeholder feedback and reduce the reporting burden for clinicians, making participation more attractive and compliance easier. Over time, we encourage the agency to continue to seek opportunities to sustain movement away from category measures that over-reward process while paying little attention to outcomes or quality. While we appreciate that improvements in process are important to overall improvement of outcomes, it is important to ensure an appropriate balance and that physicians are not being unduly compensated for improvements focused only on process. To that end, we encourage the agency to rigorously evaluate process improvement for consideration as part of those measures which are considered "topped-out," so that, eventually, the focus of the composite score is on improvements in outcomes and costs. Below, we make additional comments related to composite scoring.

Cost

We urge the agency to consider keeping the original proposed step up of 10% in 2018. By maintaining the current weighting of 0% of the composite performance score in 2018 and instead reweighting the quality weighting to 60%, we believe that the agency is removing an important accountability lever within the program and a measure of performance that is critical to employers, insurers, and the Medicare program itself.

It is critically important that costs factor into the overall composite score. Eligible clinicians who deliver more efficient, high quality care, and demonstrate more judicious resource use should be recognized for their efforts to do so, and we applaud CMS for establishing a mechanism by which to focus on cost and reward efficiency. Additionally, we support the increased value weighting for cost over time, eventually making up 30% of the MIPS composite score. Ultimately, this provision will lead to an increased accountability for healthcare spending in value-based purchasing and APMs and reduce waste in the system.

However, while we do not support delaying the weighting of cost within the composite score, we believe that the 10% should be allocated to the quality component of the composite score so that it has greater weight, to the extent that this provision of the proposal is finalized. While we feel it is critically important that cost be a factor in determining payment, a temporary redistribution of that weighting to the quality component is the best redirection for sustained focus on improving patient care and overall population health.

Improvement Scoring for Quality and Cost

We strongly support the implementation of improvement scoring in the quality and cost categories. Consistent with our comments above, we support refining payment systems to improve the quality of care patients receive, reduce the inefficient use of care, and increase the value of care provided. Focusing on an enhanced reward system relative to quality and cost, as

the primary measurements of care efficiency, and increasing clinicians' incentive to drive improvements in these categories could boost the success of the underlying programmatic objectives of MACRA. They also enable clinicians who already score well on quality and cost the opportunity to strive for additional improvement and be rewarded for their success. Increasing incentives in these categories also supports the continued transition away from traditional FFS by making FFS increasingly unattractive while simultaneously increasing the attractiveness of the program.

Implementing virtual groups

We support, with some caveats described below, the implementation of virtual groups, an option for MIPS participation previously included within the original MACRA legislation, but not yet implemented. We believe there may be potential positive side-effects of joining a virtual group, including encouraging a greater focus on population health and allowing for increased collaboration and coordination among physicians who may have found it difficult to come together if this option were not available. Because the physicians would be assigned to one tax identification number (TIN) and measured accordingly, some of the measurement disparities for individual physicians who may not have patient populations large enough to effect meaningful change on quality measures for any given metric could be eliminated. In addition, as a group, the physicians would be able to focus on clinical quality measures where, collectively, they can impact change and improve quality. We know that challenges in patient population sizes make it unlikely to clearly identify high-value or low-value solo providers through MIPS scoring and thus, limit the program's utility for beneficiaries to select high-value clinicians or for clinicians themselves to figure out where they need to improve their performance. Therefore, an additional positive associated with virtual groups is the potential for increased availability of more meaningful and comparable scoring data.

However, we are concerned with the broad flexibility in the proposed rule for virtual groups to determine their own composition. While the underlying statute does not limit the number of TINs that may form a virtual group, we encourage the agency to consider appropriate limits and to continuously reevaluate virtual group composition in advance of future rulemaking. We agree with the concern previously expressed by both CMS and the MedPAC that virtual groups of too substantial a size (for example, 10 percent of all MIPS eligible clinicians in each specialty or sub-specialty) may make it difficult to compare performance between and among clinicians.

We believe it is critically important for CMS to closely monitor the ways in which solo practitioners and groups with 10 or fewer eligible clinicians form virtual groups, and consider establishing virtual group composition guidelines or a limit on the number of TINs that may form a virtual group in future rulemaking, as necessary.

For virtual groups to be measured reliably, we believe that CMS should establish parameters on the size and structure of these groups. Reliability of measurement is an issue because some clinicians are much less likely to have a sufficiently sized population of beneficiaries attributed to them. We support MedPAC's proposal related to virtual groups, which suggests that "CMS could set measure-specific case sizes and, in this way, implicitly require clinician groups to join with other specialties so that they would

have a sufficiently large number of attributed patients for each measure."[2] Further, we also encourage rulemaking that would establish a unified selection of metrics on which the group will report, to allow for meaningful measurements overtime.

Additionally, we encourage the agency to consider ways to ensure that clinicians coming together to form a virtual group have a bona-fide clinical reason to collaborate and demonstrate it. This requirement becomes particularly important in an environment where there are no proposed checks on the composition of the groups, either in size or specialty. We are concerned that this lack of structure around composition may lead to cherry-picked self-selection of virtual groups, formed in a manner that does not advance the spirit of the program. Instead, we encourage the agency to set requirements that a virtual group must demonstrate their clinical collaboration and a commitment to improving quality within virtual groups that is otherwise infeasible without this option.

Finally, we are concerned that the formation of virtual groups could create further incentives for provider consolidation, which can increase both Medicare and private-sector spending without necessarily improving quality. Establishing requirements to demonstrate bona-fide reasons to form a virtual group and demonstrate the benefits will help minimize this concern. In addition, CMS should also monitor to ensure that providers who financially integrate under virtual groups do not form to exercise market power, but rather that they do so to improve cost or quality performance.

Increasing the low-volume threshold to less than or equal to $90,000 in Medicare Part B allowed charges (from $30,000) or less than or equal to 200 Medicare Part B patients (from 100 patients)

With some caveats below, we support CMS's proposal to increase the low volume threshold to exclude individual MIPS eligible clinicians or groups with ≤ $90,000 in Part B allowed charges or ≤ 200 Part B beneficiaries during a determination period that occurs during the performance period or a prior period. We share CMS's opinion that increasing the low-volume threshold will reduce the burden on individual MIPS eligible clinicians and groups practicing in small practices and designated rural areas. Finally, we understand that this change would exclude approximately 134,000 additional clinicians from MIPS from the approximately 700,000 clinicians that would have been eligible based on the current 2017 low volume threshold, which means that sixty-five percent of Medicare payments would still be captured under MIPS compared to 72.2 percent of Medicare payments under the 2017 QPP final rule.

However, while we are supportive of this expansion of the low-volume threshold, we think it is important to stress a continued drive toward overall improved population health, as well as a sustained focus on moving away from traditional FFS type payment and treatment mindset, to one that focuses on improved patient outcomes. To that end, we encourage the agency to continue to seek private and public payer alignment and simplify reporting by maintaining consistent reporting requirements across practices. Continuing to expand exemptions creates payer uncertainty, potential lack of performance information for a greater number of patients, as well as potential health care disparities for patients. While we appreciate that small and rural practices face unique challenges, we

[2] Report to the Congress: Medicare and the Health Care Delivery System, p. 156. June 2017. Medicare Payment Advisory Commission (MedPAC). Accessed July 12, 2017 via: http://www.medpac.gov/docs/default-source/reports/jun17_ch5.pdf?sfvrsn=0

also believe that all patients deserve the same quality of care. Fundamentally, we have supported efforts to reform payment policies because of their impact on improving the quality of patient care. Thus, long-term or permanent exemptions for these practices may have the impact of creating long-term differences in the quality of care patients served in these areas receive. ***We encourage the agency to consider additional outreach opportunities to small and rural practices, to make it easier for them to report through MIPS and receive composite scores, thus eliminating the need to establish additional or future upward modifications to the low-volume threshold.***

Finally, we also encourage the agency to modify the opt-in proposal relative to the number of patients, beginning in 2019, which would allow clinicians to voluntarily report if they exceed one of the measures within the low-volume threshold. While we support the opt-in policy relative to cost, given that one complex patient can quickly trigger the threshold, we do not support the opt-in policy relative to the number of patients. If a MIPS eligible clinician triggers this portion of the low-volume threshold exemption, he or she should be required to participate in the program.

Facility-Based Measurement

Apart from the suggestion below, we are generally supportive of allowing facility-based clinicians who perform at least 75% of their covered professional services in the inpatient hospital setting or emergency department, to voluntarily select an optional facility-based scoring mechanism based on the Hospital Value Based Purchasing Program. We agree with the agency's desired goal to reduce the 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. We also support the agency's position that facility-based MIPS eligible clinicians contribute substantively to their respective facilities' performance on facility-based measures of quality and cost, and that their performance may be better reflected by their facilities' performance on such measures. Finally, we are encouraged that allowing facility-based reporting may also increase and improve the coordination of care delivered by clinicians and hospitals.

However, we are concerned that allowing MIPS eligible clinicians to be paid based solely on facility scores may create a "free-rider" mentality. On the flip side, there will also be physicians who are working very hard to improve quality, who may get "dinged" by being associated with facility-based scores. We appreciate that the agency has considered the best way to roll this into the program, and has laid out an approach within the proposed rule that would look at phasing this in, focus on certain inpatient procedures, and align with already existing pay-for-performance payment systems. ***However, we encourage the agency to continue to consider a hybrid approach to the proposed facility-based reporting approach, in which MIPS eligible clinicians would be measured based on both the performance of the facility with which they are connected and their individual performance.***

One potential approach could be to only allow the physicians to use facility-based scores that are relevant to their patient populations. As an example, an endocrinologist should likely not receive a payment adjustment for a facility score improvement in orthopedic-related conditions or some other conditions that have little to no bearing on their own performance even though they qualify for the facility-based measurement option.

Complex Patient Bonus

We support the adjustment of up to 3 bonus points to clinicians based on the medical complexity of the patients they treat, to address the impact patient complexity may have on final scores. This approach will protect access to care for complex patients and avoid placing MIPS eligible clinicians who care for complex patients at a potential financial disadvantage.

Small Practice Bonus

Our members appreciate that eligible clinicians and groups who work in small practices are a crucial part of the health care system and they encourage competition that benefits patients. We also appreciate that these types of clinicians and groups face unique challenges related to financial and other resources, environmental factors, and access to health information technology.

We recognize the factors that have led the agency to support an adjustment to the final score for MIPS eligible clinicians in small practices, to account for these barriers and to incentivize MIPS eligible clinicians in small practices to participate in the program. However, we recommend a change in the approach the agency has described for MIPS eligible clinicians to qualify for the small practice bonus. ***While the agency has proposed that MIPS eligible clinicians must submit data for at least one performance category in the 2018 MIPS performance period, we believe the requirement should be at least two performance categories. Further, while the agency has also described that the MIPS eligible clinicians would not need to meet submission requirements for the quality performance category to receive the bonus, we believe at least one of the submissions should be required to be within either the quality or cost category.***

Again, consistent with our previous comments, our members are acutely focused on cost and quality measures, as we believe that driving improved efficiency in these categories improves the overall efficiency and value of the care provided. Moreover, because this is a bonus category, we also believe that raising the accountability bar is appropriate in this instance.

Performance Threshold/Payment Adjustment

We strongly support increasing the composite performance score from 3 points to 15 points. This significant increase means that in 2018 it will no longer be possible to avoid a negative payment adjustment by reporting just one measure. Increasing mandatory reporting to two or more categories is a positive step toward reaffirming the agency's commitment to a transition away from FFS clinician payments, as well as improving the quality of care provided.

Advanced APMs

In general, we support the proposed changes to the A-APMs portion of the QPP. Although the agency has proposed to relax certain provisions (extending the nominal amount standard, exemptions for certain models, and adjustment of minimal risk), we appreciate that the spirit of the program has remained intact. We are supportive of CMS's flexibility to adjust and adapt based on market experience with A-APMs, while maintaining a commitment to the program and continuing to make the program an attractive option for participation, which furthers the movement away from FFS. We also recognize that physicians and hospitals are just beginning to understand the new requirements and practice arrangements. Looking forward, we urge the agency to sustain its commitment to A-APMs in

future rule-making. ***While we are supportive of the flexibility outlined in the current proposal and believe it appropriately considers market barriers to successful participation in these models, we additionally caution the agency to avoid continued or prolonged implementation delays.*** Ultimately, improved care coordination, increased efficiency and enhanced quality in care delivery must be achieved, to maintain the affordability and sustainability of heath care long term.

All-Payer Combination Option

We strongly support the implementation of an alternative path to qualifying as a successful participant in an A-APM and avoiding any MIPS payment adjustment, by defining what it means to be a qualified provider through the "all payer combination option." Requiring clinicians who participate in A-APMs with CMS to also participate in an APM with "another payer," the agency is sending a clear signal that it values payment alignment across both the public and private payer markets.