



June 27, 2016

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5517-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Proposed Rule for the Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models (CMS-5517-P)

Dear Acting Administrator Slavitt:

The National Business Group on Health appreciates the opportunity to comment on CMS' proposed rule to implement the payment reform provisions of the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA). Consistent with many of our recent comments to the agency, we once again applaud and commend CMS' leadership and its commitment to reforming payment models under Medicare, leaving an antiquated and inefficient fee-for-service (FFS) model in the past. Each incremental step forward under new payment models improves the quality of health care delivered to beneficiaries because eligible clinicians are increasingly encouraged to combine evidence-based approaches to medicine with value-based decision making, and payments are increasingly tied to improved patient outcomes. We are encouraged by the provisions within the MACRA proposed rule and urge CMS to sustain and amplify its commitment to transforming the payment for and delivery of care, and continue to streamline reporting, enhance quality of care, and implement policies to encourage cost-effectiveness.

We provide expanded comments within the attached addendum, which further develop the following statements of support, as well as offer suggestions for additional focus:

- Encouraging private and public payer alignment and simplify reporting by requiring the use of the core quality measures that private payers already utilize;
- Increasing or decreasing a physician's FFS reimbursement in the Merit-Based Incentive Payment System (MIPS), tied to composite scores;

- Creating four categories of MIPS eligible clinician performance measurement, which are focused on cost, quality, clinical practice improvement activities, and advanced care information;
- Consolidating three currently disparate Medicare quality programs into MIPS: 1) the Physician Quality Reporting System (PQRS); 2) the Value-Based Modifier (VBM) Program; and, 3) the 'Meaningful Use' of electronic health records, starting with CY2017 performance year; and
- Implementing new Clinical Practice Improvement Activities (CPIA) measures.

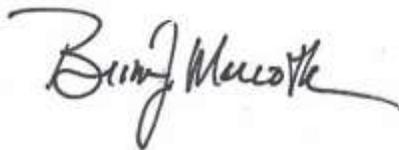
We encourage the agency to give additional consideration to the following elements of the current proposal:

- Ensuring that clinician self-selection of six quality measures within the MIPS performance reporting allows for appropriate comparisons by consumers and plans;
- Strengthening the intent of cross-cutting quality measures;
- Enhancing the focus on measures of efficiency; and,
- Requiring additional outcome or high quality reporting measures as part of the overall composite score.

The National Business Group on Health represents approximately 425 primarily large employers, including 72 of the Fortune 100, who voluntarily provide group health plan coverage and other health programs to over 55 million American employees, retirees and their families.

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,

A handwritten signature in black ink that reads "Brian Marcotte". The signature is written in a cursive, flowing style.

Brian Marcotte
President and CEO

Addendum

Payer Alignment

Notably, the proposal would enact important incentives for synergies between private and public payers, which is a critical step forward for the private payer and employer communities. Specifically, we commend the agency's effort to align with the private sector as related to quality reporting metrics, which will have the added consequence of reducing the reporting burden by including the quality measures that private payers already use. While we would rather see a more comprehensive transition to alternative payment models, we believe the proposed MIPS equation is a step in the right direction, in terms of weaning eligible clinicians off of the FFS model, and that CMS has identified the right reporting measures.

With the exception of concerns related to the self-selection of quality metrics, which we outline in greater detail below, we believe the components identified to comprise the composite score strike the appropriate balance to advance improvements in the quality of health care. By creating a composite score predominately comprised of quality metrics, the MIPS payment model moves reimbursement closer to achieving the "Triple Aim," or 1) improving the individual experience of care 2) improving the health of populations; and 3) reducing the per capita costs of care for populations. Taken together, performance measured in the four categories – quality, resource use, health information technology (HIT) use, and clinical practice improvement – we expect MIPS to have a positive result for Medicare beneficiaries, patients in private plans, employers and other payers, as CMS continues its transition to a payment system under which eligible clinicians will be rewarded for delivering high-quality, cost-effective care and encouraged to shift toward alternative payment models.

An additional important synergy is related to the use of clinical registries. Registries, which are already in use by ACOs, are an important measure of performance for their constituents, including individual practices, sites and providers. Registries serve numerous functions, including adding to the evidence base for care improvement, informing participants on where they need to focus their organization's efforts, highlighting performance areas for improvement, and identifying which patients require interventions. In this way, registries are foundational to population health management. Under the proposal, eligible clinicians may use data they are already submitting to a clinical registry or to an ACO, and this will suffice as quality reporting. We support this distinction because 1) it enhances the importance of registries which are already seeking to deliver high quality and high value care, and 2) it additionally streamlines reporting requirements for eligible clinicians.

Cost Category

Costs directly contribute to prices and thus, it is critically important that costs factor into the overall composite score. Eligible clinicians who deliver more efficient, high quality care, and demonstrate the most equitable 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 are supportive of 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.

Measurement Consolidation & Payment Adjustments

We support consolidating reporting of quality data into one program down from three separate programs. By doing this, MACRA can substantially ease the burden of provider reporting, and simplify compliance mandates. Additionally, consolidating these programs will provide a better and more consistent signal to eligible clinicians with respect to their performance, thus better reinforcing rewards for quality and improvement. Finally, this action will accelerate the movement to alternative payment models by the nation's largest payer, which will certainly have an impact on provider behaviors as a whole, thus enhancing a population health approach to care delivery. This is a positive development for employers, who have long been supportive of accountable care organizations and other value-based health care payment models.

Beyond consolidation and simplification of reporting requirements, we additionally support the proposal to specifically measure eligible clinician performance through the MIPS composite scores. Assessing how well eligible clinicians deliver quality patient care, and adjusting payments respectively is a central element to providing high quality and efficient care. While Medicare has been measuring physician quality through a patchwork of programs over the last several years, the current proposal to streamline this reporting and also meaningfully adjust payments to eligible clinicians, while keeping clinician flexibility in tact transitions to a dual function of both measuring and – importantly – rewarding success and penalizing poor performance.

Self-selected Quality Metrics

In partnership with CMS and other stakeholders, The Business Group participated in the Core Measures Collaborative (the Collaborative). As the agency knows, The Collaborative is a multi-stakeholder effort working to define core measure sets of various specialties, promoting alignment and harmonization of measure use and collection across both public and private payers. We were gratified to be part of this process, and to work with the agency in developing evidence-based measures to help drive the health care system toward improved quality, decision-making, and value-based payment and purchasing. These core measure sets are also designed to be useful to patients, consumers, and physicians, as they embark on selecting appropriate care.

Within the menu of MIPS quality measures from which eligible clinicians may select to self-report, included are 58 measures which were recommended by The Collaborative. We would urge CMS to consider adding language to make it mandatory to report on these particular measures, when available within appropriate categories and when clinically relevant to their practice area.

We appreciate the agency's stated desire to build in a significant amount of provider flexibility with regard to self-selecting the quality metrics on which they will be paid. However, we also encourage the agency to carefully consider the difficulty that too much flexibility may add to understanding quality differences between eligible clinicians. Specifically, we have some

concern that the unified scoring system, as outlined within the proposal, may not allow consumers and payers to make meaningful comparisons across MIPS eligible clinicians. When considering the variety and types of practices, along with the varied reporting options, it may also be challenging to ensure sufficient reliability and validity of overall MIPS composite scores for eligible clinicians, given that the denominators will differ greatly.

Additionally, we are concerned that providing too much flexibility to eligible clinicians may lead to cherry-picking of quality reporting, opening the door for eligible clinicians to report only on metrics on which they are performing well and withholding information about practice areas that need improvement. We ask that the agency be sensitive to ensuring that composite scores meet high standards, promote transparency, and enable meaningful comparisons of providers' performance for specific services.

We encourage the agency to consider ways to simplify available data to enable consumers, patients and caregivers to assess meaningful differences among eligible clinicians when making health care decisions. In general, our members would support a unified scoring system that would provide sufficient incentive for MIPS eligible clinicians to invest in and focus on certain measures and activities that meet high priority goals such as improving beneficiary health, improving care coordination through health information exchange, or encouraging APM participation, while allowing for the ability to easily compare performance.

CMS should consider paring down from the list of over 250 quality metrics a provider may self-select for quality reporting, and instead focus on the creation of a smaller number of clinically relevant measures, particularly including additional patient outcome measures where available, and where they measure separate and distinct outcomes. Additionally, as CMS embarks on future iterative changes to the QPP, we encourage the agency to continue to rely on multi-stakeholder and consensus driven feedback loops, such as The Collaborative, to inform additional core measure sets, where such measure sets are useful and promote the appropriate comparisons.

Additionally, with regard to the "cross-cutting" measures, as currently drafted, we feel there is a great deal of opportunity to improve the selection of available options. Of the ten currently proposed, only one measure is focused on an "intermediate outcome," one measure is focused on "patient engagement/experience" and the remaining eight measures are focused on measuring "process." The measures currently included focus largely on qualities our members feel strongly should be considered a baseline for medical practice, and they should not be included as part of an overall performance measurement which would dictate a higher payment to a provider. For example, one measure which could be selected would require that eligible clinicians report on "documentation of current medications in the medical record." This is a practice behavior which should be substantially integrated as a foundation of care, and we do not support inclusion of this measure as a marker of exceptional performance, nor do we support higher payment for services based on this documentation. Similarly, the other nine measures speak to elements of practice which we would consider standard of care. Thus, we would encourage CMS to consider alternative cross-cutting measures, which would have a more meaningful impact on the overall quality of care.

Further, within the bucket of measures which can be self-selected, 58 of the more than 250 metrics focus on outcomes and 192 focus on process. Only 9 focus on efficiency. We encourage CMS to conduct additional research around efficiency measures that could be added to the overall menu of measures and, where available and clinically relevant to practice areas, eligible clinicians should be required to report on an efficiency measure.

Finally, with regard to specialty measure sets, we recommend that MIPS eligible specialists be required to select a minimum number of quality metrics from within their appropriate specialty measure set. We recognize that there may be eligible clinicians whose services overlap in one or more specialty areas, and that flexibility is necessary. But, we feel strongly that, in order for payers and patients to have a clear understanding of comparators, the ability to distinguish providers on like-metrics is critical. To that end, we also urge CMS to continue to explore specialty-specific measure sets for additional specialty and subspecialty areas, to enhance and refine meaningful comparisons over time.

Outcome Measures

It is critical that performance measures and quality reporting focus not only on processes, such as whether a person with diabetes had their hemoglobin A1C measured, but that they also provide some insight into the provider's provision of care. As a bottom-line litmus test, the measure should answer one key question: did the care result in an optimal health outcome? Measures of quality should feel like logical extensions of good healthcare. Continuing with the example, rather than quantifying the percentage of people with diabetes who had their hemoglobin A1C measured, a quality metric should focus on the percentage of people with diabetes who effectively control their disease and complications.

With this in mind, we would encourage the agency to further evaluate the use of more than one measure which must be an outcome measure or a high quality measure, when more than one measure exists and each measures a distinct and different health outcome. If an applicable outcome measure is not available, consideration of another high priority measure (appropriate use, patient safety, efficiency, patient experience, and care coordination measures) in lieu of an outcome measure should be considered. Thus, we are proposing consideration be given to requiring two (or more) outcome or high quality measures, as a component of the composite score, when available.

We concur with CMS that outcome measures are more valuable than clinical process measures and are instrumental to improving the quality of care patients receive. And, we commend the agency's plan to increase the requirements for reporting outcome measures over the next several years through future rulemaking, as more outcome measures become available. We encourage the agency to consider accelerating the implementation of additional outcome or high quality measures. To this end, we would also be supportive of additional bonus points awarded to eligible clinicians for reporting additional outcome or high quality measures.

Clinical Practice Improvement Activities

We support the innovative new section of MACRA that will roll out clinical practice improvements. Specifically, we believe the clinical practice improvements outlined in the proposal will increase eligible clinician engagement with patients. The subcategories defined in rule, which would encourage expanded practice access, population management, care coordination, beneficiary engagement, patient safety and practice assessments, participation in APMs, and the promotion of health equity and continuity, are efforts private ACOs have implemented with great success.

We applaud the agency for establishing this performance category and look forward to working with our members and the agency to continue to refine subcategory requirements in future rule-makings. While we generally place a greater priority outcomes measures as a better measure of improved quality, we also recognize that quality improvement is an additional critical aspect of improving the health of individuals and the health care delivery system overall. Additionally, we recognize this effort as another great opportunity for public and private payer alignment.