

August 21, 2017

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

Dear Administrator Verma,

Thank you for the opportunity to comment on *Medicare Program; CY 2018 Updates to the Quality Payment Program (CMS-5522-P)*.

Our organization, the American Health Quality Association (AHQA), represents the Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) and their quality improvement partners throughout the United States, Puerto Rico, the Virgin Islands, and the outer Pacific islands. Our association's goal is to make health care better, safer, and available at a lower cost.

As Medicare-funded organizations charged with working with providers, beneficiaries, families, and stakeholders to improve quality for our nation's Medicare beneficiaries, QIN-QIOs are keenly interested in the provisions of the proposed rule.

Below are our comments regarding selected elements included in the NPRM:

Quality Payment Program (QPP) Year 2 Performance Threshold

We support the proposal to set the QPP Year 2 performance threshold at 15 points. In an effort to encourage continuous performance improvement and participation in MIPS, we believe strongly that such an increase will achieve the intended goal. Additionally, seeking a higher level of performance from clinicians will promote engagement and collaboration as clinicians seek out ways in which to meet the required threshold and likely will be able to achieve a greater number of performance points than 15.

However, it should be noted, specifically as it relates to quality measures, that many specialists (eg. nephrology, psychiatry, acute rehabilitation) find it extremely difficult to identify quality measures that relate to their given patient populations. This makes participation difficult and

will make meeting the increased threshold more challenging for these provider groups. For future years of rulemaking, we urge CMS to consider increasing the number of specialty specific quality measures that are available to these groups.

### Low-Volume Threshold Exclusions

In response to the proposed changes to the low-volume threshold values, we believe that although increasing the threshold will indeed result in the exclusion of a larger percentage of small and rural clinicians from participation, exclusion itself will put these clinicians at a significant competitive disadvantage.

Over the past year, our members have heard from many of the solo, small, and rural practitioners to whom they have provided MIPS education and support that there are requirements within MIPS that make their participation preclusive. While their current exclusion from reporting may alleviate the immediate pressures they feel as they plan for quality measure selection, improvement activity operationalization, and contemplate EHR implementation, we have seen that exclusion also often results in the unintended consequence of these practices lagging behind other practices in regards to quality improvement and technology utilization.

Rather than excluding these clinicians from reporting to MIPS, we recommend providing them with the requirement to report under a continuation of the 'Pick Your Pace' program. Providing solo, small, and rural clinicians with the opportunity to track and report quality measures and implement improvement activities will allow them to better engage their vulnerable patient populations and provide them with a push towards begin using a certified EHR. Most importantly, these activities will enhance engagement with and motivation within a group that may otherwise stagnate. Additionally, providing an opportunity for these clinicians to earn even a small positive payment adjustment may be incentive enough to encourage increased participation.

In addition, we believe that CMS should strengthen its technical assistance and expand focused support for practices below the current low-volume threshold. This support could be offered through an expansion of the QPP-SURS program or implemented through the QIO infrastructure.

AHQA also has concerns about the potential addition of a third component of the low volume threshold rooted in the number of Part B items and services. Under the newly proposed low volume thresholds, approximately 570,000 clinicians will be excluded from participating in the QPP. However, it is not clear why there would need to be an additional exclusionary criteria based on the number of services provided and doing so could potentially severely limit the expansion of health transformation. One such example is with chiropractic services. Under the

current Medicare Part B physician fee schedule, only 3 services provided by chiropractic physicians are reimbursable. If the low service threshold is set at 4 services, it will exclude all chiropractic physicians from participation in the QPP, effectively excluding the third-largest provider group in the country from participating in incentives to drive healthcare transformation. Given the high potential impact of increasing both the payment threshold and patient volume threshold for the low-volume exclusion, little would be gained, and much lost, by including a third exclusionary criteria based on the number of services.

#### Bonus Points for Improving Score for Quality Performance Category

AHQA supports the proposed methodology to utilize the 30% floor for calculating achievement for those that had less than 30% of the score attained in the transitional year. Unlike the band methodology, the proposed methodology easily reconciles the size of bonus to the amount of progress, thereby appropriately incentivizing the lower performers to improve performance.

AHQA also supports the proposal to award improvement bonus points at the performance category level rather than the individual level to allow providers to change measures based on changes in practice workflow, achievement of optimal performance in certain areas, or simply due to a change in priority focus areas. We recognize and appreciate CMS' willingness to ensure incentives earned by individual providers are paid even when there are changes in group composition or new elections to report as part of a group. Based on our experience assisting providers, we believe that this flexibility will allow them to make decisions based on achieving full participation in the program and their desire to leverage efficiencies of scale, rather than making decisions based solely on needing to maintain revenue in the short-term.

We also applaud the flexibility that the shift in policy to recognize achievement based on reconciling a single identifier for two will allow. Flexibility will be significantly increased compared to what we have seen previously and a contrast to the strict NPI/TIN combination reconciliation we have experienced through the PQRS program. QIN-QIOs have helped mediate payment and reporting issues for providers with mid-year or between year TIN changes (due to ACO closings, solo practices changing tax designations, etc). We anticipate that that a more flexible reconciliation may make it easier for providers who have unexpected or unanticipated TIN changes from year to year to receive their earned improvement recognition points and positive payment adjustments.

However, we do have one question around which we would appreciate additional clarification in the final rule: Does the more flexible assessment of improvement achievement also extend to the assignment of both positive and negative payment adjustments based on the same NPI, TIN, or NPI/TIN reconciliation, or does this only apply to the calculation and assignment of bonus points? As ours is a dynamic healthcare environment and providers continue to evaluate

various operational adjustments and direction in order to sustain success, we support the more flexible approach of matching either NPI, TIN or NPI/TIN combination.

Lastly, due to the increased complexity of this process, we recommend continuing to engage contractors already working in this area, such as the QIN-QIOs, to assist with education, outreach, and mediation of perceived reporting issues in order to extend CMS' capacity and align with the service delivery approach already in place across the QPP.

#### Scoring the Cost Category

AHQA supports the proposal to utilize the same scoring methodology as the shared savings program. We also support the proposal to calculate improvement scores at the individual measure level for all of the reasons articulated in the rule. However, we do have some concerns regarding the measure benchmarks. The rule indicates that these benchmarks will be created throughout the performance year and therefore not available until after the performance period is completed. Based on our experience with providers during the MIPS transitional year who are calculating quality measures without known or identified benchmarks, this will likely be a significant challenge for providers. Calculating a benchmark based on the year prior to the performance period, and publishing them at the beginning of the performance period, may better incentivize or provide direction for meaningful improvement efforts. Additionally, we strongly encourage CMS to identify and publish future, episode-based cost measures as soon as possible to allow providers adequate preparation time to evaluate and make practice level changes that may impact success within these measures.

We also have concerns about the jump from 0% to 30% for PY2021. Additionally, without a defined measure set or any frame of reference by which to evaluate preparedness, we would argue that providers cannot adequately assess their performance with a 0% to 30% jump after year two. We encourage CMS to consider the originally planned, phased-in approach, with the cost category accounting for 10% of the total performance score in year 3 of the program; 20% in year 4, and 30% in year 5. Practice level feedback on new episode-based cost measures will not be available until summer of 2018. Only when practices are able to view where they stand in comparison to standards will they be able to forecast their success, and the proposed timeline seems like a relatively short turnaround time to prepare for a 30% impact. Adjusting costs, utilization measures, and workflow take time to develop, test, and implement, and success is more attainable under a phased approach.

Finally, we wanted to note that cost measures seem to be the most difficult for providers to assess and then react to in terms of improvement or decline. Eligible clinicians need to understand how to evaluate the impact of cost measures. However, we find that providers have not had a great deal of incentive to focus on cost containment priorities, referral management, care coordination, or minimizing unnecessary transitions. Continued delays in including cost as

a required performance category have shifted provider focus away from adequately addressing these interventions and workflow enhancements. We strongly encourage CMS to provide additional technical assistance and focused support around cost measures from providers already engaged in this type of work in the field, such as the QIN-QIOs. Provision of the feedback report and other episode-based cost measures early in the 2018 performance period will provide leverage for QIN-QIO contractors to provide real time assistance with cost improvement activities.

#### Facility Based Measurement

AHQA agrees and fully supports the notion that facility based measure performance is as much an accomplishment of the medical staff providing services within the institution. The proposal to allow facility based providers to use their facility based performance score for participation in the MIPS program serves to further align multiple programs and operationalizes the goal of “reduced burden” , “report once for multiple programs” and creates efficiencies that will serve to improve efforts around facility performance improvement. Further, we support the proposal to align MIPS and facility reporting ONLY for those programs where payment is based on performance and not reporting.

We believe that this level of transparency reconciles the “competitive disadvantage” in which facility based providers have been previously, namely required participation in a reporting/performance-based program that was designed for the ambulatory setting. For examples, facility based providers seem to be the most challenged in determining how to succeed within PQRS and MIPS because many of their activities align more with inpatient/ED care than ambulatory care, but MIPS measures were designed for ambulatory care. The current proposal will level the playing field between ambulatory and facility based providers.

Finally, we do not believe that lengthy HVBP performance periods (i.e. 36 months) should override the desire to use the HVBP performance. However, there should be some consideration to whether the eligible clinician was employed at the facility whose score they are electing to use for a minimum portion of the performance period, rather than just being currently employed, but not having contributed to the performance period success.

#### Improvement Activities

AHQA strongly supports the provision of standard documentation to survive an audit. There is much concern over documentation as a simple attestation process is being utilized to report. In order to be prepared for an audit, practices need clarity regarding the documentation standards to accompany the improvement activities. Practices are struggling with whether a particular activity or workflow will satisfy the requirements of an improvement activity because many are worded ambiguously. In some cases, the descriptors actually create confusion. For example, does participating in an antimicrobial stewardship program with the QIN-QIO count to

satisfy IA\_PSPA\_15 although the specific diagnoses in the measure are upper respiratory infection in children, pharyngitis, or bronchitis in adults? We would also like to suggest bundling improvement activities around areas of affinity for future consideration. Once developed, these standards should be posted clearly on the CMS QPP Website and distributed widely through the QIN-QIO quality improvement infrastructure.

#### Calculating and Operationalizing the MIPS Final Score

We applaud CMS efforts to align the Quality, ACI, and Cost reporting, however the MIPS composite score is complex and difficult to monitor throughout the year. Clinicians need a mechanism to monitor performance close to real time in order to improve performance across all MIPS categories. Concrete quality and cost feedback is imperative to clinicians' success in the Quality Payment Program. While we support the use of mid-year and annual QRUR reports for data that may not be otherwise available, we encourage more timely data through the use of technology-driven reports. QIN-QIOs have a deep understanding of clinicians' needs and have a longstanding history of positively supporting clinicians in attaining CMS goals. Based on this relationship and success, we believe QIN-QIOs are in the best position to provide direct support and common tools to help clinicians understand their current and projected MIPS performance scores. In order to provide adequate support, QIN-QIOs must also have access to these reports and data.

Specifically, in response to proposed scoring methodology, we propose and suggest the following. While "Pick Your Pace" was a successful and necessary step for the first year, we believe the threshold should gradually increase to ensure success of the QPP. We believe that 15 is an adequate, neutral payment threshold for the second year. We support the proposal to keep a 3 point floor for scoring quality measures without benchmarks and the use of a 1 point floor for measures that don't meet data completeness requirements; we agree care complexity is not the same across care settings.

However, if the overall goal is increased information flow and continuity of care, then clinicians in rural areas must be held equally accountable for quality. We believe the focus should be on finding innovative solutions that are reasonable and affordable for small and rural practices rather than excluding them. In lieu of complicating the scoring methodology with separate benchmarking systems, we support the allowance for bonus points for clinicians practicing in CAHs, SURS, and those who meet certain other criteria. We support the bonus for complex patient care, the use of facility reporting, and multiple reporting options to include continued use of 2014 certified EHR technology. We recommend expanding the definition of "facility" to include settings beyond inpatient and emergency to include LTACHs, IRFs, etc. Improvement scoring supports the goal of continuous improvement, however it complicates scoring and performance monitoring. This could be alleviated with appropriate feedback mechanisms and resources provided throughout the performance year. The QPP portal is a well-designed

resource that could house some of these resources. We implore CMS to continue the user-friendly design of these resources and ask that additional tools be added as resources. Several QIN-QIOs have developed MIPS estimators or calculators which could be considered for addition.

### Virtual Groups

In response to the proposal for the creation of virtual groups, we believe this is a valuable option for solo and small practice clinicians to take advantage of. However, we believe that this option should not be made available until all of the details of participation have been completely defined. There is tremendous concern from clinicians over the specifics of the participation agreement that is required and how interested clinicians and groups will work through all of the necessary details under a very restricted timeline. Specifically, it is important to note that contractual agreements between clinicians and practices often take several months, at least, to negotiate and finalize. Although sub-regulatory guidance will be provided on the virtual group agreement in September 2017, we do not believe this will allow adequate time for interested clinicians and groups to make informed decisions on participation. It would be helpful to have the virtual group agreement template available for review and comment in advance. A clear understanding of the repercussions for a clinician or group that signs a participation agreement and fails to report as part of the virtual group should also be provided.

It appears the expectation is for virtual groups to aggregate the data. However, we do not believe that this will decrease burden on the groups, but will rather create an additional step that may be more complex than what is required for standard groups. We believe this will be a potential barrier for participation and recommend that alternative submission methods also be considered.

Lastly, we have a several questions related to virtual groups that we hope can be clarified in the final rule:

- Will registry vendors recognize virtual groups for reporting and will this be reflected in how the registry vendors charge for their services?
- Will virtual groups be given the allowance to use multiple reporting mechanisms within a performance category as is proposed for other eligible clinicians?
- How will technical assistance be executed as the groups may be comprised of clinicians from multiple states, specialties, and EHR systems? [It should be noted that contractors providing technical assistance will need access to TIN level information for groups.]

Thank you for the opportunity to comment on proposed updates for the second and future years of the Quality Payment Program. We believe our observations, comments, and recommendations are aligned with and in support of CMS' intent, as well as the long history

and demonstrated successes of the QIN-QIOS in partnering with CMS to achieve substantive improvement in health care quality.

Regards,

A handwritten signature in black ink, appearing to read "Alison Teitelbaum". The signature is fluid and cursive, with the first name "Alison" written in a larger, more prominent script than the last name "Teitelbaum".

Alison Teitelbaum, MS, MPH, CAE  
Executive Director