

September 10, 2018



Ms. Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1693-P
P.O. Box 8013
Baltimore, MD 21244-8013

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Dear Administrator Verma,

Thank you for the opportunity to comment on *Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program (CMS-1693-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 notice of proposed rulemaking (NPRM):

Increasing Performance Threshold and Exceptional Performer Bonus

We are in favor of the progressive increase to the Merit-based Incentive Payment System (MIPS) performance threshold, with 2019 increasing to 30 MIPS points. The gradual implementation of the program, with increasing reporting requirements each subsequent program year, demonstrates both the willingness to ease eligible clinicians and organizations into program participation, as well as the expectation for increased performance and engagement.

Additionally, we believe that by increasing the exceptional performer bonus, providers and groups must achieve a high level of performance to be eligible for these additional funds, which could result in some clinicians striving to achieve higher performance. It would be helpful to receive fact sheet on how the bonus is added to the positive payment adjustment and to get the scaling factor to achieve budget neutrality ahead of time in order for eligible providers to calculate their return on investment.

However, we anticipate that it will become more difficult for clinicians and groups to achieve 80 MIPS points in future years due to the following reasons:

- Quality measure performance is increasing each year, which leads to higher benchmarks and more topped out measures, which will make it difficult for practices to score well in the quality category in future years.
- With higher benchmarks and more topped out measures, practices may not have sufficient electronic health record (EHR) functionality to be nimble with measure selection.
- In 2018, there were only 54 EHR measures to select from, and most EHRs are not certified to all measures. This leaves clinicians choosing to submit quality measure data via their EHR with few choices and forces them to report on the measures that are available to them, including topped out and process measures. Even with high performance, a topped out measure earns minimal points for a practice.
- As the Promoting Interoperability category is proposed to move to a performance-based score in 2019, this creates a more challenging road to achieve a high performance score of 80 or greater.

We want clinicians to report on Meaningful Measures, regardless of the possible points that can be earned. We are concerned that increasing the exceptional performance bonus to 80 MIPS points may cause clinicians to report on the measures that bring the most points, rather than ones that bring the most value to their practice. We believe that clinicians should be allowed to align the Quality Payment Program (QPP) quality measures with the processes that are of importance to their patients and practice, because this will result in the best outcomes for patients.

A significant concern is the impact this will have on the ability of small clinics with limited administrative and support resources to explore and model the best combination of measures to achieve the highest score. Many specialists in small practices struggle with PCP focused EHR systems in order to meet the measures. They especially struggle with EHR functionality to meet the 80 points for exceptional performance. We prefer an approach that incentivizes their time and effort on purposeful activities. Following this model will assist towards improving quality measure performance and achieving better patient outcomes. Encouraging small practices to focus the most appropriate measures for their patient population would limit the attention and time paid on just achieving the highest score possible.

Low-volume Threshold Opt-in Option

One of the proposed changes would, beginning with the 2021 MIPS payment year, provide clinicians the opportunity to choose to opt-in to MIPS reporting, given an eligible clinician or group meets or exceeds at least one or two, but not all, of the low-volume threshold determinations (including as defined by dollar amount (less than or equal to \$90,000), number of beneficiaries (200 or fewer), or number of covered professional services (200 or fewer)). This proposed change functions as a flexible and versatile option for anybody interested in

participating in the program despite not meeting initial, actual program requirements and offers opportunities for a larger array of clinicians and practices.

However, there is one related to this new opt-in feature, where additional clarification would be highly beneficial: How will inclusion of an unknown volume of additional participants impact the spread of final participant payment adjustments based on the budget neutrality of the program, as indicated? Our recent experience with the provider community is that many are disappointed regarding lower-than-anticipated positive payment adjustments for the 2017 reporting year, due to the high level of overall program participation (+2.02% for those earning 100 MIPS points). Therefore, we are concerned that the proposed opt-in option could be considered a possible hindrance to active participation. Could this potentially dilute the amount of money available for positive payment adjustments?

Low-volume Threshold Exclusion

The administration's continued efforts to slowly ease clinicians and groups into QPP participation are admirable and certainly demonstrate an understanding of the external forces clinicians face daily, such as competing priorities and tight resources, that might make participation challenging. However, we remain concerned about the continued exclusion of many clinicians from the program.

CMS estimates show that about 60% of otherwise eligible clinicians are excluded from MIPS from the 2018 performance year based on the existing participation threshold. LVT excluded 32.5% in 2017. In 2017 45.5% of the clinicians excluded were in a practice size 1-9.

Given the initial 2017 low-volume threshold, the significant increase to the current 2018 low-volume threshold, and now, the proposed inclusion of a third low-volume threshold criteria that will invariably exclude another portion of the eligible clinicians from participating in MIPS in 2019, we have significant concerns about the impacts of exclusion on those clinicians over time. As we have seen, the program criteria continue to get more stringent with increased performance thresholds and additional performance categories. However, for those clinicians and groups that have been excluded, some for the entirety of the program, we wonder if they are continuing to prepare for reporting or not preparing and falling farther behind the curve.

Many of the small and rural practices do not have the resources (human or infrastructure) to implement a certified EHR system if they are not receiving incentive payments from programs such as MIPS (or previously Meaningful Use). Without a certified EHR or other reporting mechanism, these clinicians and practices will not be able to meet the participation requirement of 30+ MIPS points. We are concerned this could result in their exclusion for the duration of the program; if so, that raises additional concerns. It will be incredibly difficult for these practices to achieve interoperability or establish efficient communication channels with fellow clinicians or service providers without the continued emphasis on quality reporting or care coordination programs like those in alternative payment models (APMs).

We applaud the deliberate efforts to slowly transition into the full MIPS program. However, we believe more needs to be done to address keeping those clinicians who are excluded—or not yet eligible—engaged in the critical work that is being done and preparing them for when they are required to report.

Changes to Score Calculation for Promoting Interoperability

We appreciate the changes to the Promoting Interoperability performance category and believe that the proposed reduction in objectives and measures will assist clinicians and groups in furthering their endeavors towards full interoperability. We also believe these revisions better align MIPS measures with the Medicare Promoting Interoperability (PI) Program for Eligible Hospitals and Critical Access Hospitals (CAHs). Additionally, we greatly appreciate the two opioid-related measures and believe that they are timely and appropriate as the country continues to work towards combatting the opioid epidemic. We also support the phased inclusion of these e-prescription measures, which allow bonus points for the Query of the Prescription Drug Monitoring Program (PDMP) and Opioid Treatment Agreements in 2019 and then require the measures for 2020. This phased implementation will allow clinicians and groups to develop workflows and practices to support the measures over time.

However, we are concerned about the shift away from the scoring methodology that provided points for the base required measures and additional points for performance and bonus measures. This significant change will likely result in many clinicians and groups achieving fewer MIPS points for their performance in the Promoting Interoperability category than in the past. With each measure equating to a maximum number of points and the score being derived from the clinician's or group's performance on each measure (numerator/denominator), there will likely be lower performance scores across the performance category.

While lower performance is not a reason to adjust the scoring methodology, we believe that many clinicians and groups may not fully understand how the category will be scored or be aware of the continued requirement for completing the security risk analysis (SRA), as it is not a listed measure. With any subsequent improvements/updates to the QPP Portal and QPP webpage, we would recommend ensuring that the scoring methodology for this performance category and all requirements are clearly represented.

Move from Base and Performance Measure Points

We support the proposed change to move from base and performance measures to measures and objectives. We believe this change better aligns MIPS measures with the Medicare PI Program for Eligible Hospitals and CAHs and may eliminate confusion between the two programs. Moving away from the base measures and performance measures may cause confusion for some clinicians. Adequate clinician education about program changes will be important to ensure a successful transition.

Potential New Measure: Health Information

Health information exchange across the continuum of care can be difficult for small and rural practices. There are added difficulties when beneficiaries receive health care at multiple sites

that may include multiple states and regions. The electronic exchange of information requires knowledge of direct address for health care organizations, and currently there are not reliable resources, such as directories, from which to easily obtain this information. We support the desire to move toward electronic information exchange; however, we are concerned that there is not yet sufficient infrastructure to support this requirement.

Reducing Provider Burden Recommendation

We appreciate and support that reducing provider burden is included in the proposed rule. Provider burden and burnout are unfortunately quite common, as evidenced in a 2016 poll by the NEJM Catalyst, which found that more than 30% of physicians reported knowing other physicians who are 50%–100% burned outⁱ. Unfortunately, however, the proposed rule does not include any information about how provider burden will be measured. We would appreciate further clarification about how CMS plans to measure provider burden.

Furthermore, it is now widely known that provider burden, burnout, and lack of joy in practice are major considerations that must be accounted for when considering quality reporting or other regulatory programs. The introduction of the Meaningful Measures and Patients Over Paperwork initiatives are tremendous steps towards ensuring that clinicians find value in their quality measure reporting and are less burdened from required documentation; however, these steps do not address the issue of provider burnout and lack of joy in practice.

Bodenheimer and Sinsky (2014)ⁱⁱ suggest that joy in practice be added to the Triple Aim to become the Quadruple Aim, noting that to achieve high quality care, safety, and patient satisfaction, clinicians must also be satisfied and not burned out. While it is outside the Annual Call for Improvement Activities nomination period, we believe that it is imperative for organizations to be encouraged to measure their efforts to address provider burden and lack of joy in practice. Therefore, we recommend the addition of an Improvement Activity that would include the implementation of at least an annual assessment of clinician staff by using a statistically significant provider burden/burnout tool.

For the assessment, we recommend the use of a tool such as the Physician Well-Being Index (PWBI; available from <https://www.mededwebs.com/well-being-index>), which is a 7- or 9-item tool that has shown to be of benefit in evaluating self-reporting of medical errors, quality of life, suicidal ideation, fatigue, satisfaction, and intent to leave practice. We believe this tool can assess the necessary aspects of physician burnout and satisfaction and that it is not overly cumbersome or time consuming to complete. Furthermore, this tool has national benchmarking data available for physicians and is slated to include advance practice providers and nurses in the coming months.

If organizations are interested in a more comprehensive assessment, we would recommend the use of a tool such as the Maslach Burnout Inventory – Human Services Survey (MBI-HSS; available from <https://www.mindgarden.com/117-maslach-burnout-inventory>), which is a 22-item survey that evaluates individuals for emotional exhaustion, depersonalization, and a low sense of personal accomplishment. This survey has been shown to have strong correlation to

physicians that demonstrate burnout and associated patient outcomes, such as medical errors, as well as suicide and turnover rates. Due to the longer length of this survey, an abbreviated two question version was developed and has also demonstrated the same strong correlation. The abbreviated survey utilizes two questions: #8 – “I feel burned out from my work” and #10 – “I have become callous towards people since I took this job.”

We believe that by enabling organizations to identify and receive credit for the work that they are undertaking to address burden, burnout, and lack of joy in practice, that there will be a progressive shift towards improving the quality of life for providers, which will directly and positively impact patient outcomes and quality of care. As a component of this Improvement Activity, we recommend that organizations be expected to implement the utilization of the PWBI or MBI-HSS tool on at least an annual basis and then utilize the data to inform strategies to address physician well-being. With strong leadership engagement and support, system-level initiatives will begin to make a positive impact on this growing issue within the health care environment.

Addition of New Provider Types

The proposed rule includes the addition of the following clinician types to the definition of MIPS eligible clinicians, beginning with the performance period in 2019: physical therapists, occupational therapists, clinical social workers, and clinical psychologists.

We support the inclusion of additional provider types and welcome the levels of flexibility taken into consideration for these clinicians as provided under the Promoting Interoperability category.

However, given the type of services rendered by these new provider types, we believe that targeted education on program requirements will be critical for program participation and success. Services are often not delivered within the realms of regular medical practice environments, which would potentially limit the applicability of certain Quality Measures and Improvement Activities. This distinction and significant difference in service delivery ought to be taken into consideration for eligible clinicians falling into this newly eligible “pool.”

All Payer Combination

We support the proposal to increase flexibility for the All-Payer Combination Option and Other Payer Advanced APMs for non-Medicare payers to participate in the Quality Payment Program. It is a change that has the potential to reduce provider burden and reduce redundancy between payer programs. Additionally, increasing the number of non-Medicare patients seen under an APM has many benefits to the health of entire communities.

We also agree with the proposal to determine comparable measures between Medicare APMs and Other Payer Advanced APMs to reduce confusion and provider burden so that one set of measures applies.

Finally, we support offering the ability to provide information on the length of agreements between providers and APMs to reduce the need for annual applications to participate in the All-Payer Combination, as this may provide administrative relief.

However, there are a few aspects of the proposed changes to the All-Payer Combination option around which we would appreciate further clarification:

- How does CMS plan to verify the volume and means by which non-Medicare patients were seen by a provider? As CMS is trying to encourage private carriers to adopt Alternative Payment Models that involve a quality component, policing and tracking seem incredibly challenging.
- Additionally, we anticipate that complications may arise for providers that meet early thresholds (i.e., 25%) and become part of an Advanced APM. As thresholds increase, providers may find that not all commercial payers participate as an Advanced APM, which could mean the provider would no longer meet the criteria to participate in the All-Payer Combination. In these instances, would the provider be required to report MIPS data, even though they no longer meet the increased threshold under the Advanced APM? If so, we are concerned that providers may see this as a deterrent to participation in the Quality Payment Program. Additionally, dropping providers from the Advanced APM method of participation may be detrimental and unnecessarily penalize providers for lack of payer participation.

Claims-based Submission

We support the proposal to allow in small practices the ability to use Medicare Part B claims submission at the individual and group level. This will allow providers in the most vulnerable, underserved areas to participate in MIPS. We believe that continuing to allow small, rural, and underserved providers and groups to utilize claims-based reporting will enable them to participate in the program fully, which otherwise would have been preclusive due to lack of EHR or resources to obtain access to a qualified registry for Quality measure reporting. With the possible addition of claims-based reporting for groups, we are curious about what claims-based measures would be made available for groups. Additionally, the spring 2017 enhancements to the QPP Portal allowing clinicians to review their performance on claims-based Quality measures were tremendously helpful, and we request that this be made available again.

Cost Performance Category

We support a full calendar year for the Cost performance category, as this allows for a larger number of cases to be included for each measure, which will ideally lead to a higher rate of performance.

We also support a gradual increase in the Cost category of 5% per year until the full 30% is realized in the 2022 performance year, provided groups and clinicians are proactively given a complete list of all beneficiaries attributed to them for each measure. We do not believe groups and clinicians should be held accountable for cost if they are not given sufficient information to effectively identify opportunities for improvement. Without visibility into beneficiaries

attributed to them and the costs incurred by those beneficiaries, groups and clinicians have limited or no data to guide effective improvement efforts. Holding groups accountable for cost when they have insufficient data does not promote a sense of fairness and collaboration in driving down health care costs from CMS. It only serves to increase the perceived burden of the MIPS program and engenders animosity towards collaborating on CMS's Triple Aim.

We support CMS continuing to provide fact sheets and information about the Cost performance category measures. Currently, there is very little information in the Performance Feedback report on how each item in the Cost measures is derived and calculated. An enhanced description of how costs are derived in an easily understandable fashion would be very beneficial for provider and groups. We recommend including detailed reports with Cost measure calculation breakdowns with the annual Performance Feedback report. Providers have expressed to us that they do not yet have enough information to build models in their EHRs to help them track and address costs throughout the performance year. Currently providers and groups only have enough information to review cost data internal to their practices or organizations. The much larger concept of being held accountable for costs across all providers and health care settings for attributed patients is a very new and unfamiliar area for clinics not yet exposed to accountable care organizations (ACOs) or APMs. Determining and executing interventions to reduce costs for attributed patients will require a learning curve for all.

We are concerned about the uneven distribution of the Cost category across specialties. As the Medicare Spending per Beneficiary (MSPB) measure is weighted towards hospital-based providers and the Total Per Capita Cost (TPCC) measure is weighted towards primary care providers, which will result in these provider types almost certainly having a Cost category score. Meanwhile, specialties not represented in the eight new episode-based measures will likely not have a Cost score and will have their Cost performance category weight added to the Quality performance category. While we believe that clinicians have more flexibility and ability to positively influence the Quality category compared to the Cost category, this situation could be viewed as unfair towards primary care and hospital-based providers.

We are also concerned about the lack of inclusion of services and costs provided as part of an All Inclusive Rate (AIR) by Rural Health Centers (RHC). Some small Critical Access Hospitals have associated RHCs as well as skilled nursing facilities billing under their Taxpayer Identification Number (TIN). In such scenarios, their Medicare Part B service claims typically cover only ER services and care for nursing home patients. Thus, the overall Cost category profile shows a far higher cost for the TIN than what is really being provided. The lower cost, ambulatory care is covered under the AIR and is not included with the high cost of ER and nursing home patient care. This disproportionately affects rural providers with abnormally high cost values which results in a very low Cost category score.

Alignment of Determination Periods

We appreciate the effort to align determination periods to reduce confusion and provide clarity, and fully support a determination period which matches the federal fiscal year (10/1 through 9/30 of the following year). We believe that the alignment of determination periods for

low-volume threshold determination could further streamline and simplify the definition of eligibility. Using a determination period of the last three months and two years preceding the performance year through the first nine months of the year preceding the performance year would be sufficient to determine eligibility.

One concern we have with the proposed determination period alignment is the fifteen-month gap between the end of the determination period and the end of the performance year for eligible clinicians in group practice who qualify for a group final score and will have a modified determination period that starts with the second 12-month determination period. There will be significant clinician movement from one TIN to another in this time span. To alleviate this issue, we recommend CMS allow groups to report providers both individually and/or as a group for all providers who have assigned billing rights to the TIN during the performance year regardless of Taxpayer Identification Number–National Provider Identifier (TIN-NPI) eligibility for their TIN. Allowing successful MIPS reporting under any TIN to meet eligibility under all TINs to which the provider has assigned billing rights would address this and similar concerns.

Thank you for the opportunity to comment on proposed updates for the third and future years of the Quality Payment Program. We believe our observations, comments, and recommendations are aligned with and in support of CMS’s intent, as well as reflect 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".

Alison Teitelbaum, MS, MPH
Executive Director

ⁱ Swensen, S., Shanafelt, T., Mohta, S. (2016). Leadership survey: Why physician burnout is endemic, and how health care must respond. Retrieved from <https://catalyst.nejm.org/physician-burnout-endemic-healthcare-respond/>.

ⁱⁱ Bodenheimer, T., Sinsky, C. (2014). From Triple to Quadruple Aim: Care of the patient requires care of the provider. *Annals of Family Medicine*. 12(6): pp. 573-576.