UnityPoint Health

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August 17, 2017

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

Submitted electronically via *http://www.regulations.gov*

Dear Ms. Verma:

UnityPoint Health ("UPH") appreciates the opportunity to provide comments on the Proposed Rule related to the Quality Payment Program published in the Federal Register on June 30, 2017. UPH is one of the nation's most integrated healthcare systems. Through more than 30,000 employees, our relationships with more than 280 physician clinics, 33 hospitals in metropolitan and rural communities, and home care services throughout our 9 regions, UPH provides care throughout Iowa, Illinois and Wisconsin. On an annual basis, UPH hospitals, clinics and home health provide a full range of coordinated care to patients and families through more than 4.5 million patient visits. In addition, UPH is actively engaged in numerous initiatives which support population health and value-based care. UPH participates in CMMI contracts under the Bundled Payment for Care Improvement Model 2 and the Medicare Care Choices Model. In addition, UnityPoint Accountable Care (UPAC) is the ACO affiliated with UPH and has value-based contracts with multiple payers, including Medicare. UPAC is the largest ACO participating in the Next Generation ACO Model with roughly 80,000 beneficiaries attributed to this program. UPAC has providers that have participated in the Medicare Shared Savings Program as well as providers from the Trinity Pioneer ACO, which achieved two years of savings.

We appreciate CMS' outreach to the stakeholders, including the provider community, as it seeks to implement these provisions. We respectfully offer the following comments.

QUALITY PAYMENT PROGRAM RESTRUCTURE

Instead of providing a technical review of the Proposed Rule, UPH would like to express our general concern about the direction of the regulatory (and statutory) path that is guiding the future of medical practice and Part B reimbursement. The Quality Payment Program is the outcropping of the Sustainable Growth Rate (SGR), the failed effort to control healthcare costs specifically targeting Part B Medicare expenses. It is not debatable that the 21% reduction in Part B payments through the cumulative delays of SGR would have financially crippled healthcare professionals. Therefore, it is no surprise that healthcare professionals rallied around MACRA as a means to repeal SGR and to encourage healthcare value over volume. What has been surprising is the added complexity, administrative burden, and infrastructure cost associated with CMS' rules combined with the agency's willingness to increasingly narrow the professionals to whom these rules apply, thus greatly diminishing the impact intended by the statute. This trend is underscored in the Proposed Rule's continued delay of the cost measure, without which "value" is meaningless and not impactful; and its continued reliance on an ever-increasing and unmanageable pool of quality measures that emphasize reporting compliance and process over patient outcomes. The proposed structure and the thinning of the provider base does little to differentiate and reward high performers and may, in fact, alienate high performers. We believe that the mandatory, complex and expensive QPP mechanism to earn Part B payment adjustments should be revisited in favor of a voluntary, straight-forward incentive program to reward provider outcomes and risk-bearing on a tiered basis. In the spirit of recent requests for information on CMS flexibilities and efficiencies, we suggest that the QPP be restructured as follows:

- **Merit-based Incentive Performance System (MIPS) should be greatly simplified and preferably eliminated.**
  - **MIPS implementation is continuing down a regulatory path that emphasizes reporting compliance, documentation and increasing regulatory burden over patient care.** Despite the Annual Burden Estimates[1] which indicate a slight burden reduction in recordkeeping and data submissions, the administrative burden and complexity of MIPS for providers is increasing and, for most, was already unmanageable. While CMS forecasts a 1.4% decrease in overall program hours and labor costs, the percentage of eligible MIPS clinicians have decreased from 46.5% to 37.8%, equating to a greater burden on each participating clinician. MIPS increasing complexity is also evidenced by the proliferation of TA resources, software and reporting vendors, etc. that are intended to assist MIPS clinicians. These facts do not support a statement that regulatory burden is reduced. Additionally, annual burden estimates do not include the HHS budget for regulatory oversight of the QPP.
  - **CMS should expand, not contract, the pool of MIPS-eligible clinicians under the QPP.** If the purpose of the QPP is to tie reimbursement to value-based service

[1] N. Summary of Annual Burden Estimates – Page 30230 - Impact reductions are related to expanded provider exclusions, which are indicated to be temporary in nature. – 1.4% reduction in both hours and labor costs.

delivery, then this policy should apply to an increasing number of providers and quickly all providers, with exclusions being the exception and not the rule. Unless MIPS is eliminated, the only exemption from MIPS reporting should be qualifying participation in an A-APM track.[2] Rather than tightening exemptions in the second year of MIPS implementation, the Proposed Rule expands the number of providers that avoid MIPS scoring to exclude nearly two-thirds of Part B clinicians (Table A). The largest exclusion category (37.8%) is the expanded low-volume threshold, whose definition is at the Secretary's discretion. We understand CMS' desire and we support reducing the regulatory burden on providers, but we believe CMS should go significantly further by determining a path to effectively eliminate/nullify MIPS while simultaneously encouraging Congress to legislatively eliminate it altogether. In 2018, only 36% of Part B clinicians will be subject to MIPS reporting and scoring. This transition strategy is questionable policy reminiscent of SGR delays – excluded provider categories are not encouraged to transition from volume to value, to make investments in reporting infrastructure, or to seek technical assistance.

Table A. Estimated number/percentage of MIPS exclusions – 2017 vs. 2018.

		2017[3]		2018[4]	
	Part B clinicians	1,380,209	100%	1,548,022	100%
Exclusions	Ineligible types	199,308	14.4%	233,289	15.1%
	Newly enrolled	85,288	6.2%	81,954	5.3%
	Low volume	383,514	27.8%	585,560	37.8%
	AAPM	70,000	5.1%	74,920	4.8%
	MIPS eligible	642,099	46.5%	572,299	37.0%

- **MIPS funding construct fails to significantly incentivize quality.** As set forth in statute[5], the structure of the MIPS payment adjustments is based on funding neutrality – i.e. the net amount of positive adjustments must equal the net amount of negative adjustments. MIPS negative payment adjustments should be eliminated because:
  - Merit-based incentives should not be punitive. The term "merit-based incentives" implies the ability to earn rewards based on performance. "Merit-based incentives" does not imply penalties for inaction or failure to participate in MIPS. This should be a voluntary program outside of which payment is flat-lined, not downgraded, for an election to not participate;
  - Negative adjustment thresholds will not incentive behavior change. CMS states that potential reductions are a "small percentage" of their total Medicare Part B paid charges and would "rarely" result in losses in excess of

[2] MACRA statute q(1)(C)(ii) excludes A-APM participants, qualifying partial A-APM participants, and eligible clinicians meeting low-volume thresholds.
[3] Table 57—Projected Number of Clinicians Ineligible For or Excluded From MIPS in CY 2017, By Reason, Vol 81, No. 214 Federal Register Page 77517 (Friday, November 4, 2016).
[4] Table 85—Projected Number of Clinicians Ineligible For or Excluded From MIPS in CY 2018, By Reason, Vol 82, No. 125 Federal Register Page 30235 (Friday, June 30, 2017).
[5] MACRA reference insert here

3% of their total revenues. When potential revenue loss is compared to MIPS reporting burden as well as infrastructure costs, the economic incentive to participate is negligible at best; and

- Offsetting funding infuses uncertainty into the rewards (positive adjustment) system. If MIPS reporting is revised to promote value, the flaws of this funding structure are exposed as CMS provides more exclusions (presumably narrowing the negative adjustment total pool), which reduces the total pool for positive adjustments and adds an unnecessary element of reimbursement unpredictability. The number of providers that will receive the maximum positive adjustment of 5% in 2020 will be minimal, with the vast majority of providers receiving neutral or slightly positive adjustments. The most harm from this zero-sum game will be the alienation of MIPS clinicians who engaged in partial or full MIPS reporting with expectations of financial reward. With two-thirds of providers excluded, there is a high probability that MIPS simply pushes larger, already high-performing groups, into another burdensome compliance activity that takes time and resources from truly improving patient care. For MIPS to promote value, measures need to change and MIPS reporting should support engaged clinicians without the level of support being dependent upon clinicians who choose not to play/report.

- If A-APM status is the end game, **Part B payment incentives should be aligned to encourage participation in the A-APM track**. Ending MIPS and moving all bonus dollars to be used as incentives for entering MSSP Track 1+ and other entry level A-APMs, including small incentives for MSSP Track 1 participation, would seem to incentivize the action and learning that needs to take place to truly drive more value for patients.
  - All MIPS clinicians should receive the across-the-boards, standard Part B reimbursement adjustment to encourage access to care; however, Part B bonuses or incentives should be reserved to encourage high performers to participate in A-APM tracks, not to remain in the MIPS track. Current methodology theoretically permits MIPS base payment adjustments to exceed the 5% A-APM bonus. In 2018, the maximum MIPS adjustment is 5% and progresses to 9% in 2020 without incentive for those clinicians to transition to the A-APM track. While we would recommend no positive payment adjustment for the MIPS track, any positive adjustments that exist should be limited in time with an intent to prepare clinicians for transition to an A-APM.
  - The MIPS exceptional performance pool should be eliminated to encourage a glide path to transition high performers from MIPS status and redirected to entrance into risk-bearing models, including lower risk bearing A-APMs like MSSP Track 1+. This is the place providers will learn to work with data, build the analytic systems necessary to manage populations, and truly increase value. The Proposed Rule narrative indicates that this MIPS exceptional performance category "should only be available to those clinicians with very high performance on the MIPS measures and activities," yet CMS estimates

that between 76.8% and 77.1% of eligible MIPS clinicians will meet this standard.[6] As structured to provide funding to three-fourths of MIPS clinicians, this exceptional performance pool has been hijacked to fund positive payment adjustments for average and above performance, while at the same time significantly diluting their impact.. Even if this funding source was limited to truly exceptional performers (within the top 5-15%), this pool does little to encourage a glide path to A-APM participation aside from being limited in time.

- **MIPS performance category requirements should be reduced or eliminated in favor of minimum standards based on safety concerns, rather than best practices**. While measurement categories were established in statute, CMS took this to the "nth" degree and has developed a labyrinth of quality and performance improvement measures. In an effort to satisfy every specialty group, the QPP website offers **271** quality measures and **92** performance activities. This Proposed Rule would add to these measures/activities lists. Instead of streamlining the process, QPP has added reporting and scoring complexity and established a system with too much measurement choice, topped out measures, and few outcome measures. The result is a system that will not drive improved patient outcomes or significantly differentiate and reward high performers. We envision a much different system to incentive quality care. An entry level quality program should focus on a small number of easily measured outcomes. Since QPP performance is linked to Part B reimbursement, cost measures should be prioritized, appropriately weighted, and not further delayed (although we believe that redirection of incentives toward A-APMs and away from MIPS will have a more measurable impact on cost than further delay of cost measures in MIPS). Any required quality measures should be limited to outcome-based measures. Performance improvement activities should be concentrated in number and related to CMS initiatives, voluntary in nature, and result in flat bonus payments. Overall, our preference is to have best practices and performance improvement activities that are dictated by market demand, professional or licensing/credentialing associations, employment relationships, and patient-specific situations.

For the reasons above, we believe that restructuring MIPS is warranted and reasonable. We would suggest that CMS analyze alternative value-based funding schemes with detailed economic impact for Congressional consideration. These impacts should take into account costs of regulatory burden as well as federal compliance infrastructure.[7] From an administrative perspective, the simplest alternative would be a set/fixed payment adjustment for all eligible clinicians. Any positive adjustments should be earned through voluntary participation, limited in

[6] Proposed rule, pages 30149 and 30240.
[7] CBO analysis of HR 2 did not include impact of appropriations; Proposed Rule do not include compliance / enforcement costs for related agencies.

time, and involve milestones to prepare clinicians for transition to an A-APM. It should be noted that, if there is no negative adjustment, newly enrolled Medicare providers and other Part B providers do not need to be exempt from MIPS participation.

- **Advanced Alternative Payment Models (A-APMs) should be voluntarily encouraged and incentivized**. It is projected that approximately 4.8% of Part B clinicians will participate in A-APM tracks in 2018. As the largest ACO participating in the Next Generation ACO model, UnityPoint Accountable Care has a keen interest in assuring that QPP requirements both recognize A-APM providers for their commitment to voluntarily assume heightened risk and support A-APM delivery system flexibility needed to drive innovation and high quality care.

  - **Participation in an A-APM track should be the only MIPS exemption**. To create a guide path, there should be no exceptions.

  - **Potential A-APM financial rewards should match or exceed potential MIPS financial rewards**. A-APM clinicians should receive, at minimum, the highest MIPS payment adjustment in the form of a lump-sum payment. The bonus should be limited in time, the amount of which would be relative to their risk-bearing structure and their tenure within A-APM entities. This Part B payment adjustment would be in addition to any incentives earned for participation in the A-APM model.

  - **A-APM participation thresholds for Medicare-only revenue or patient count should be eliminated altogether or kept at 2017 and 2018 performance year levels.** The Proposed Rule maintains the MACRA thresholds which progressively increase the revenue percentage for QPs within A-APMs from 25% to 50% (starting in 2019) to 75% (starting in 2021) and the patient counts from 20% to 35% to 50%. We are concerned with the graduated schedule of heightened thresholds. These drastic percentage increases over a short period of time will not only discourage further Advanced APM participation, but also jeopardize clinicians that may have achieved Advanced APM status in the past. Instead of MACRA thresholds, A-APM status should ride on the back of underlying eligibility requirements for those A-APM demonstrations or programs appearing on the QPP website list[8]. If thresholds are not eliminated, we would suggest that revenue threshold remain constant at the 25% revenue or 20% patient count Medicare-only thresholds with one caveat – Medicare-only should also recognize MA revenue or patient count as needed for MA relationships that share "more than nominal risk" with clinicians. These percentages are sufficiently steep and recognize that A-APMs exist in local markets in which there are insufficient levels of risk arrangements outside Part B Medicare. As participation in A-APMs increases, CMS can re-evaluate these thresholds to encourage greater migration to value-based arrangements.

[8] https://qpp.cms.gov/docs/QPP_Advanced_APMs_in_2017.pdf.

- **QP determinations should be at the TIN level of the A-APM entity**. To simplify and reduce administrative burden, we support the methodology to collectively assess the participation of individual providers within an A-APM. The proposed group determination recognizes that A-APMs contain a variety of professionals that are working together to promote access, increase quality and contain costs. It is through the collective, and not individuals, that results will be achieved in these programs. The proposed group determination permits implementation flexibility and enables the APM Entities to establish clinician relationships based on population health needs. It is the APM Entity that will provide a guide path for willing clinicians to learn and master the use of EHR technology, payments linked to quality outcomes and assumption of financial risk.

- **A-APM quality measures should be outcome based only**.

- **Establishment and continued improvement of A-APM entities should be further encouraged** through incentive dollars moved from the MIPS exceptional performers pool. These dollars should be tied to the A-APM Entity TIN, which will permit the APM to distribute funds pursuant to contractual arrangements that drive performance. We support the development of new models by the CMS Innovation Center that encompass a hierarchy of risk-bearing opportunities. The Innovation Center should clearly differentiate new models from current A-APMs and consider whether there are sufficient benefits in heightened risk-bearing models to maintain an elevated level of commitment or instead whether models with reduced risk will introduce migration of early innovators to lower risk models. We encourage the Innovation Center and the CMS QPP implementation team to collaborate in the development of new models to issue spot program overlap and alignment/attribution concerns. Of particular importance is to understand how new models and QPP requirements encourage and/or discourage a transition to A-APMs and enhance and/or detract from A-APMs that serve total populations.

- Aligned with our recommendation to eliminate all thresholds or freeze current Medicare-only participation thresholds, **All-Payer Combination Model should be eliminated or the recognition of Other Payer A-APMs should be limited to CMS programs and/or initiatives**.
  - As mentioned above, we are supportive of MA revenue and patients being applied to the Medicare-only thresholds for MA plans that meet A-APM requirements. After review of the proposed two-tiered process for Other A-APM Determinations, we are hesitant to support inclusion of any other payors. The proposed determination process is highly complex, resource intensive, and targeted at the individual NPI level. Not only will this be highly burdensome for individual providers, the CMS resources required to implement and monitor these processes and the volume of requests will likely outweigh any benefit.

As we have commented in the past[9], we support the multipayer concept in theory; however, we have concerns related to the willingness of commercial payers to support value-based arrangements with A-APMs and this proposal does not alleviate those concerns. Omitted from the proposal is a CMS mandate to commercial payers share full claims data sets to allow providers to manage risk and their patient population. In the absence of a mandate, we fear that commercial payers will have no motivation to provide timely or complete claims data sets to providers. Given the lead time on such data integration, the prospect of successful all payer models is de minimis at best.

We appreciate the opportunity to provide comments on the direction of the Proposed Rule and its impact on our integrated health system and our patients. To discuss our comments or for additional information on any of the addressed topics, please contact Sabra Rosener, Vice President and Government Relations Officer, Public Policy and External Affairs at Sabra.Rosener@unitypoint.org or 515-205-1206.

Sincerely,

Aric Sharp, MHA
Vice President
UnityPoint Accountable Care

Sabra Rosener, J.D.
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[9] UPH comments to CMS–5517–P, submitted June 27, 1916, via www.regulations.gov