September 24, 2019

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1715-P
Submitted electronically to: http://www.regulations.gov

Re: CMS-1715-P Medicare Program; CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations

Dear Administrator Verma:

On behalf of the Premier healthcare alliance serving approximately 4,000 leading hospitals and health systems, hundreds of thousands of clinicians and 175,000 other provider organizations, we appreciate the opportunity to submit comments on the Centers for Medicare & Medicaid Services (CMS) Physician Fee Schedule proposed rule. Premier healthcare alliance, a 2006 Malcolm Baldrige National Quality Award recipient, maintains the nation's most comprehensive repository of hospital clinical, financial and operational information and operates one of the leading healthcare purchasing networks. Our comments primarily reflect the concerns of our hospitals and health systems, their employed physicians and independent physicians aligned with them. Premier runs the largest population health collaborative in the country, the Population Health Management Collaborative, which has worked with well over 200 ACOs and is currently comprised of more than 70 ACOs.

TELEHEALTH SERVICES

CMS proposes to add three services to the Medicare telehealth services list. These services have been deemed by the agency to be sufficiently similar to services currently on the telehealth list. Premier continues to believe that telehealth services offer the ability to enhance consultations between patients and providers, enable remote monitoring, and generally improve communication and education between primary and specialty care providers, particularly in rural and underserved areas. **The Premier health alliance supports CMS' proposed expansion of the services on the telehealth list.**

CARE MANAGEMENT SERVICES

Chronic Care Management Services

For CY 2020, CMS aims to increase utilization of care management services. Responding to stakeholders' suggestions, CMS proposes refinements to transitional care management (TCM) and chronic care management services and proposes new codes for principal care management (PCM) services. First, to address suggestions that the time-increments for non-complex CCM services performed by clinical staff need to recognize finer time increments, CMS proposes to adopt two new G codes to define the clinical staff time based on 20 minute increments (GCCC1 for the initial 20 minutes of time and GCCC2 for each additional 20 minutes of time). These two G codes would be used instead of CPT code 99490 which describes 20 minutes or more of clinical staff time. Second, to address concerns that the CPT code codes for chronic care

management (99487 and 99489) require the establishment or substantial revision of the comprehensive care plan, CMS proposes to adopt two new G codes (GCCC3 and GCCC4) to explicitly indicate that the comprehensive care plan needs to be established, implemented, revised or monitored and does not need a substantial revision. **Premier supports CMS efforts to increase utilization of care management services**.

CMS also proposes two new G codes for PCM services which describe care management services for one serious high-risk chronic condition that would be expected to last between three months and a year, or until the death of the patient, may have led to a recent hospitalization, and/or place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. **Premier supports CMS expansion of care management services to include patients with one serious high-risk chronic condition and its proposals not to apply any restrictions on either the specialties that could bill for PCM, including the patient's primary care practitioner or the number of PCM services a patient can simultaneously receive from different specialties**.

Chronic Care Remote Physiologic Treatment Monitoring Services

Chronic care remote physiologic monitoring treatment management services involve using the results of remote physiological monitoring to manage a patient under a specific treatment plan. Management of a patient can include clinical staff having interactive communication with the patient and/or caregiver working under the supervision of a physician or other qualified healthcare provider. These services currently require direct supervision. **Premier supports separate payment for services provided through remote physiologic monitoring and agrees with CMS' proposal to designate these services as care management services and be furnished under general supervision.**

MEDICARE SHARED SAVINGS PROGRAM

Changes to the Web Interface Measure Set

CMS proposes to remove *ACO-14 (NQF #0041) Preventive Care and Screening: Influenza Immunization*, replacing it with *ACO-47 (NQF N/A) Adult Immunization Status*. In addition to influenza immunization, the new composite measure includes tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap); zoster; and pneumococcal. **Premier does not support removing ACO-14 because we believe that the yearly influenza immunization is an important annual preventive healthcare service and should not be included with other adult immunization that are not annual immunizations.** Given the significant complications resulting from the yearly influenza season, a separate measure should remain to focus on this immunization. In addition, although these immunizations have been supported by the CDC, several are not covered by Medicare as preventive health services (e.g. tetanus) and we do not think it is appropriate to measure ACOs' performance on these immunizations. **We support CMS' proposed modifications to ACO-14 to reduce data collection burden and request CMS allow the patient's reported year of vaccination to satisfy the measure criteria.**

CMS proposes modification to new measures: ACO-17 and ACO-43. The modifications to *ACO-17 (NQF #0028) Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention* are designed to align the measure with clinical guidelines and to reporting reduce burden. Because CMS cannot rely on historical data to benchmark this measure, CMS designates this measure as pay-for reporting for the 2018 performance year. CMS expects it will be able to establish an appropriate 2019 benchmark and proposes this measure as pay-for-performance for the 2019 and subsequent performance years. **Premier supports the changes in the measure specification but given the impact of measure specification changes, we believe that the modified measure should be pay-for-reporting for both the 2018 and 2019 performance years, consistent with the requirements in §425.502(a)(4).**

The proposed modifications for ACO-43 (AHRQ PQI #91) incorporate changes to the measure specification. The measure currently assesses the risk adjusted rate of hospital discharges for acute Prevention Quality Indicator (PQI) conditions with a principal diagnosis of dehydration, bacterial pneumonia and urinary tract infection. The updated measure will include only bacterial pneumonia and urinary tract infection. CMS considers this a substantive change to the measure and proposes to redesignate ACO-43 as pay-for-reporting for 2020 and 2021. **Premier supports this change and the**

proposal to redesignate ACO-43 as pay-for-reporting for two years. We reiterate that a two-year pay-for-reporting period should also apply for ACO-17.

Late Notification of Quality Measure Specification Changes

During the 2018 and 2019 performance periods, CMS notified ACOs of quality measure specification changes close to the end of the performance year or in some cases after the performance year closed and reporting started. These late notifications result in significant burden for ACOs due to the enormous amount of time required to adjust abstraction and data collection. Additionally, when measure specification changes are substantial, late notification of these changes can result in poor performance on the measure due to clinical workflows not being adjusted in advance of the changes to appropriately capture the necessary data for the measure. Premier supports CMS' proposal for changing the specifications for the smoking cessation quality measure, ACO-17, but we urge CMS to solicit stakeholder feedback on proposed changes and provide ample notification of such changes in the future. **This notification must be provided in the form of a widespread, clear communication to ACOs about the quality measure specification changes through multiple communications (such as publication in the ACO Spotlight Newsletter, updates in the ACO-MS, etc.). Additionally, when such changes result in substantial changes to the measure, we request CMS revert to pay-for-reporting only status for such measure for two performance years as required in §425.502(a)(4).**

Aligning the MSSP Quality Score with the MIPS Quality Score

CMS seeks comments on how to potentially align the MSSP quality performance scoring methodology with the MIPS quality performance scoring in order to reduce ACOs' reporting burden and allow ACOs to more effectively target their resources for improving care. **Premier urges CMS not to align the MSSP quality scoring methodologies with the MIPS quality score; this alignment would increase ACO reporting burden and require resources that would be better directed to improve care. Instead, CMS should focus on working with ACOs to refine current measures and develop the most appropriate measures for groups of providers accountable for the total cost of care and quality of the care provided collectively for the population aligned to the ACO.**

In the proposed rule, CMS outlines several different approaches to better align scoring methodologies across the MSSP and MIPS. One approach would replace the MSSP quality score with the MIPS quality performance score. CMS would continue the current policy which considers ACOs in the first performance year of their agreement period to have met the quality performance standard based solely on pay-for-reporting. Another approach would replace the MSSP quality score with the MIPS quality performance score but remove the pay-for-reporting year provided currently to ACOs in their first year of their first agreement. Under this option, all ACOs would be measured on all measures as pay-for-performance measures in all program years. CMS also considers requiring a quality performance score at or above the fourth decile across all MIPS quality performance category scores in order to be eligible to share in savings generated by the ACO. For this purpose, CMS would use the MIPS quality performance score converted to a percentage of points earned out of the total points available as the ACO's MSSP quality score. As a comparison, ACOs are currently required to meet minimum attainment levels, defined as the 30th percentile benchmark for pay-for-performance measures, on at least one measure in each domain to be eligible to share in any savings generated. **This approach would immediately hold ACOs to a considerably higher standard than is currently required in the MSSP and one that is based upon measures that were not derived nor tested for ACO use.**

CMS also is considering an alternative in which CMS would determine MIPS quality performance category scores for all MSSP ACOs as it currently calculates MIPS quality scores for non-ACO group reporters using the CMS Web Interface. This would allow ACOs to receive a score for each of the measures they report and zero points for those measures they do not report. As a comparison, the current methodology requires ACOs to report all Web Interface measures in order to satisfy the MSSP's complete and accurate quality reporting standard. Under this option, CMS also considers using MIPS administrative claims measures for ACOs. ACOs are currently evaluated on claims-based quality measures ACO-8, All Conditions Readmissions; ACO-38, Acute Admissions Rate for Patients with Multiple Chronic Conditions; and ACO-43, Ambulatory Sensitive Conditions Acute Composite. In this rule, CMS considers instead to evaluate ACOs on administrative claims measures used in MIPS, the MIPS 30-Day All Cause Hospital Readmissions Measure and possibly the Multiple Chronic Conditions measure.

Additionally, CMS would continue to assess ACOs on the CAHPS for ACOs survey, but quality performance would be calculated by MIPS methodologies used in calculating the CAHPS for MIPS survey score. The scoring and benchmarking approach for the CAHPS for MIPS survey is to assign points based on each summary survey measure (SSM) and then average the points for all the scored SSMs to calculate the overall CAHPS score. In contrast, ACOs currently receive up to two points for each of the ten SSMs for a total of 20 points.

Finally, CMS discusses an approach using the MIPS quality improvement scoring methodology as an alternative to the current MSSP quality improvement process. Under current MSSP rules, ACOs not in their first performance year can earn a quality improvement reward in each of the four quality domains. Under the MIPS approach, improvement points are awarded if a MIPS eligible clinician has a quality performance category achievement percent score for the previous performance period and the current performance period, fully participates in the quality performance category, and submits data under the same identifier for two consecutive performance periods. Additionally, under MIPS, improvement is evaluated at the performance category level rather than the individual measure level. The MIPS quality improvement score is equal to the absolute improvement divided by the previous year's quality category percent score prior to bonus points, then multiplied by 10. Up to 10 percentage points are available for improvement.

Premier believes the significant fundamental differences between providing healthcare in an uncoordinated fee-for-service payment system and an ACO, where providers are accountable for the total cost of care and quality of the care provided collectively for the population enrolled in the ACO, requires methodologically different quality programs.

We do not support CMS' option to use a MIPS quality scoring approach that would hold ACOs to a higher minimum attainment standard by requiring a quality performance score at or above the fourth decile across all MIPS quality performance category scores in ordered to be eligible to share in savings generated by the ACO. **Premier is concerned that this option to raise the minimum attainment level would be detrimental to ACOs**. In addition, we are concerned the MIPS quality scoring methodologies could result in narrow bands for measures with clustered performance, resulting in inequitable scores for very small differences in performance especially when extrapolated from a small sample. As an example, if one ACO scored 84.9 percent on a particular measure it would earn 9.9 points for the measure. If another ACO scored 84 percent, it would earn 9.76 points. This small change in actual percentage score can add up quickly but is relatively unbalanced in the actual quality of care provided as it can mean the difference of one or two patients in a sample. Rather, percentile rankings are more meaningful because they provide the larger context and help appropriately adjust the weighting of the actual score.

Additionally, Premier is concerned that CMS' option to remove the pay-for-reporting year provided currently to ACOs in their first year of their first agreement would have significant repercussions for new ACOs. Providing ACOs in their first contract year with 12 months to assess performance, understand measure specifications, and implement workflow and IT changes necessary to capture data to document quality performance as specified by the measure steward is a vast undertaking requiring significant resources. In addition, this time is crucial to educate clinicians and support staff to incorporate processes to implement the quality measure in practice and establish buy-in and support among staff. Given that ACOs are responsible for over 20 quality measures, each with its own measure specifications, exemptions and requirements, time is necessary for new ACOs to educate physicians and staff on the measure specifications and begin tracking performance. Therefore, a pay for reporting year is critical for the success of new ACOs. **Premier believes that removing this pay for reporting year would harm ACOs new to the program and we oppose such a change**. We urge CMS to maintain the current approach of providing all ACOs one pay for reporting year in the first year of their first contract.

Additionally, in this rule CMS also proposes major overhauls to the current MIPS structure by applying a new MIPS Value Pathways (MVP) framework beginning with the 2021 MIPS performance year. CMS has not yet completely established the MVP framework and CMS proposes to apply this framework beginning with the 2021 performance period so it can obtain feedback on the details of this framework and address additional details of this methodology in subsequent rulemaking cycles. **Premier is concerned that any consideration of aligning MSSP quality scoring methodologies with the MIPS quality score when CMS is also beginning significant modifications to the MIPS program**

introduces a great deal of uncertainty regarding how the quality scoring methodology may also change in future years under the proposed MIPS Value Pathways approach and how these changes would ultimately affect ACO quality scoring. As such, Premier does not believe that the MIPS administrative claims measures would be appropriate for ACOs. Introducing such uncertainty and raising quality standards at a time when ACOs are still evaluating the most sweeping program changes made to the MSSP with the introduction of the MSSP Pathways to Success would be ill advised. As was demonstrated recently when small measure specification changes took place late in 2018 to the smoking cessation quality measure, very small changes in quality measures can result in potential losses totaling tens of thousands of dollars to ACOs who have invested heavily in quality performance improvement.

We believe this is not the appropriate time to align methodologies in both programs and develop one set of quality measures for both programs. ACOs are responsible for both the quality and total cost of care for the population, and CMS must use a different approach in evaluating ACOs as compared to individuals or groups reporting quality measures in MIPS, who are not participating in a total cost of care model. **Instead, CMS should focus on working with ACOs to refine current measures and develop the most appropriate measures for groups of providers accountable for the total cost of care and quality of the care provided collectively for the population enrolled in the ACO.**

ACOs are high quality performers. Providing high quality should not serve as a reason for CMS to overhaul the quality performance assessment approach for the MSSP. **Instead, we urge CMS to work with Premier and stakeholders to make changes to the current quality measure set for ACOs.** The MSSP measure set should reflect that ACOs are responsible for total cost of care. Accordingly, **CMS should work to align the ACO measure set with measures used to assess Medicare Advantage plans**. While there is some alignment between the two programs' quality measure sets, it could be enhanced by testing MA measures for use in ACOs. Specifically, CMS should explore employing measures that assess care over multiple years; a majority of an ACOs population remains aligned to the ACO year over year. To reduce burden, CMS should also begin testing eCQMs for ACOs. While ACOs are challenged with aggregating data across numerous EHRs, the information in the clinical record should be leveraged in assessing the quality of care ACOs provide. Recognizing the significant challenges, CMS must devote resources to a thoughtful testing approach. We would welcome the opportunity to engage with the agency to implement this strategy to identify the next generation of quality measurement within the existing ACO program structure and methodology.

QUALITY PAYMENT PROGRAM

Merit-based Incentive Payment System (MIPS)

MIPS Value Pathways (MVPs)

Context for the MVP Initiative

Embedded in the proposed rule is a Request for Information (RFI) about a wide-ranging initiative that CMS is terming the *MIPS Value Pathways* (MVPs). CMS expresses substantial concern that MIPS as currently structured has yet to produce performance data that effectively supports clinicians to achieve better outcomes or that readily aids beneficiaries to make informed decisions about their healthcare. CMS attributes the lack of actionable data in part to having purposefully emphasized flexibility throughout the MIPS framework, inadvertently leading to an overly complex program that does not produce the desired information for patients and clinicians. CMS further notes that the payment landscape of the QPP continues to evolve and will add to the near-term challenges facing the MIPS program. The major payment changes are driven largely by statutory requirements including increasing the MIPS adjustment range to 9 percent; raising the weight of the MIPS Cost category to equal that of the Quality category in the final MIPS scoring; and mandating use of the mean or median final score as the MIPS performance threshold. Statutory changes to the APM Incentive portion of the QPP also will pressure the MIPS portion, since rising payment and patient count thresholds to achieve Qualifying APM Participant (QP) status – and thereby receive a payment bonus or a higher fee schedule update -- will push some clinicians from being QPs to being subject to MIPS

CMS concludes that the history of the MIPS program combined with the shifting payment landscape mandates making transformative changes to MIPS to deliver a program that accelerates Medicare's transition to value-based care,

increases feedback to clinicians while reducing reporting burden, and empowers informed beneficiary care choices. CMS believes that transforming MIPS to this desired future state will require restructuring MIPS in a more standardized and somewhat less flexible fashion. CMS anticipates convening public forums, listening and office hours sessions, webinars, and other opportunities to gather stakeholder input, in addition to that provided through responses to the MVP RFI.

T**he Premier healthcare alliance commends CMS for being willing to openly and critically analyze the results to date of the QPP, especially its MIPS component.** Premier finds the MVP RFI to be far-reaching and thought-provoking, while targeting goals that are important to all healthcare stakeholders. **Premier looks forward to collaborating with CMS as the design and operational details of the MVP initiative are further developed.**

Initial Response to the MVP RFI and to Related Proposed Rulemaking

As expected with transformative change, the RFI poses innumerable strategy, design, and implementation questions about the MVP initiative as part of the extensive MVP discussion in the proposed rule.[1] The RFI specifically seeks answers to all aspects of the following: 1) how to construct MVPs; 2) how to select measures and activities; 3) how to determine MVP assignment; and 4) how to transition to from the current state of MIPS to MVPs. Premier does not believe that thoughtful and meaningful answers can be provided quickly in a single comment letter to all of the questions raised. Rather than hastily attempting to do so today, we instead will focus our responses on some key features of the MVP initiative and the limited number of formal proposals made by CMS. **The Premier healthcare alliance looks forward to additional opportunities to offer expanded input to CMS.**

MVP Definition

CMS proposes to define a MIPS Value Pathway as "a subset of measures and activities specified by CMS." CMS adds that the measures and activity sets would share a foundation of Promoting Interoperability (PI) performance category measures and administrative claims-based population health measures. The foundational measures would be layered with condition/specialty-specific clinical quality measures, allowing for simplified and more standardized reporting. CMS also provides guiding principles for use in defining each MVP:

- Limiting the MVP to measures and activities that are meaningful to clinicians;
  - Limitation would reduce measure selection burden, simplify scoring and enhance data generation.
- Requiring the inclusion of measures and activities that would provide comparative clinician performance data to support informed choices by patients and caregivers;
- Targeting the inclusion of measures that encourage performance improvement in high-priority areas; and
- Adopting measures from APMs where feasible and that link cost and quality measurement;
  - APM measure adoption into MIPS would reduce barriers to future APM participation.

CMS notes that MVP creation will require significant clinician and specialty society input.

The Premier healthcare alliance supports the definition of a MIPS Value Pathway as proposed. Premier agrees entirely with not stipulating the allowable number of measures in total or by performance category type to be included in an MVP, preserving some flexibility in MVP construction, especially in the early years of MVP implementation. We support increasing alignment among measures by adopting APM measures into the MVPs, contingent upon modifying and testing the measures specifically for MVP use. Consideration should be given to pay for reporting in the initial year or two of new measure usage, as is done in other CMS programs. Premier fully concurs with CMS that clinician and specialty society input will be essential for successful MVP creation, and we encourage CMS to involve a broad range of stakeholders whenever feasible.

MVP Framework Features

CMS intends for the MVP framework to connect the quality, cost, and improvement activities performance categories. Overarching MVP framework features identified by CMS would include organization around a clinician specialty or health condition; equity across MVPs (e.g., reporting burden and scoring are similar for all MVPs); choosing measures with room for improvement; and substantial alignment and correlation among the quality and cost measures and the improvement activities (IAs) that are bundled together in each MVP. CMS also has provided several draft MVP examples to help

[1] See 84 FR 40730 through 40745.

stakeholders envision a format for how an MVP might be described and displayed. To support MVP development, CMS proposes that MIPS quality measure stewards must link their measures to related, existing cost measures ad IAs whenever feasible, beginning with the 2020 Call for Measures process.

Premier believes that the key features outlined above are consistent with the goals and principles of the MVP initiative as articulated by CMS in the rule; we view establishing and maintaining equity across the MVP inventory of MVPs as essential. **The Premier healthcare alliance supports that quality measure stewards be asked to identify cost measures and IAs that link to their quality measures. However, related to our concerns about the proposed timeline for rollout of MVPs (discussed below), Premier believes that measure stewards should not be penalized for failing to identify linked measures during the Call for Measures process, at least for 2020 and 2021, since the feasibility of linking measures in this way is largely unknown at present.**

MVP Measures: Composition, Collection Types, Scoring Methodology
CMS states that the number of performance measures and activities available to clinicians for reporting would be reduced. CMS anticipates that MVPs could include, but would not be limited to the following measure types: administrative claims-based population health; care coordination; patient-reported (e.g., outcomes or experience of care); and specialty or condition-specific measures. Many and perhaps all PI measures would be uniform across all MVPs. All four MIPS performance categories would be represented in each MVP. CMS initially describes retaining all of the current MIPS measure collection types but later adds that related details remain to be worked out and would be addressed during rulemaking for 2021. Similarly, CMS initially indicates retention of current approaches to scoring cost and quality measures but later mentions plans to propose scoring changes in future rulemaking. CMS further describes using a single benchmark for each measure that would be applicable to all clinicians and groups in the associated MVP. Special scoring and bonuses would be eliminated since clinicians would be required to report all measures and activities contained within their MVPs. Improvement scoring for quality and cost measures would be aligned to allow comparison year-over-year at the measure level. However, no formal proposals are made.

The Premier healthcare alliance recognizes that future transformative change cannot be adequately and definitively characterized by a few simple proposals. Premier appreciates the candor shown by CMS in combining a commitment to MIPS stability with flexibility and openness about changes that will inevitably be necessary to implement MVPs. We welcome opportunities to engage with CMS as the MVP initiative evolves. However, we also believe that the current level of uncertainty about key MVP operational details suggests that the transition to MVPs will require more than one rulemaking cycle to enhance the likelihood of early success for beneficiaries, clinicians, and CMS.

MVP Examples
Premier greatly appreciates the MVP examples provided by CMS in Table 34 of the rule and their associated MVP diagrams. Our review of the examples, however, has created some discomfort for us about them, if they are emblematic of future MVPs. First, we are concerned about the potential overuse of administrative claims-based quality measures, as these make up most of the quality measures in the example MVPs. In response to such measures included in previous QPP proposals made by CMS, we and others have questioned measure reliability and applicability, minimum case size, attribution, risk adjustment, application level (clinician or group), and yield of actionable feedback for clinicians. We further question whether data from this class of measures would in fact be likely to aid beneficiary decision-making. Patients and caregivers typically are interested in clearly-defined and focused outcomes achieved by an individual practitioner when treating other patients with the same conditions or diseases as themselves, rather than more generic population health statistics. Premier recognizes that the standardization sought by CMS for MIPS through MVP implementation would be facilitated by administrative claims-based measures, but we believe balance should be sought by also including other types of quality measures in most if not all MVPs. **We also believe that Qualified Clinical Data Registries (QCDRs) could serve as a robust source of quality measures that would provide relevant and actionable feedback to clinicians and allow sufficient specificity to yield information desired by patients and caregivers in making healthcare choices.**

Second, Premier is concerned about the breadth of disease covered under each example MVP. For example, how will a single MVP for all of “Preventive Health” or “Major Surgery” translate to specific, relevant, and actionable information for use in beneficiary decision-making? Further review of the example MVPs raises another potential challenge. The use of

episode-based cost measures appears to be limited to MVPs that include procedures (Major Surgery and General Ophthalmology). These more focused measures may in fact produce results sufficiently granular for beneficiary decision-making but CMS' goal of parity across MVPs is unlikely to be realized if such measures are applied only to procedure-related MVPs rather than to the entire MVP inventory. **Finally, Premier is wary of further changes to the PI performance category, since a major redesign was just implemented for performance year 2019 and experience with the revised category is just now being accrued**. We also note that the PI category has been reweighted to zero for several clinician subsets, so we are unclear at this point about how the requirement for some PI measures to apply to all clinicians in all MVPs would be reconciled with current reweighting policies.

MVP Assignment
Clearly, a key feature of MVP implementation would be the process for linking MVPs and clinicians, termed "MVP assignment" by CMS. How to determine MVP assignment is one of the four primary questions around which the MVP RFI is organized. CMS anticipates having at least one relevant MVP for virtually all clinicians and several MVPs applicable to some; the latter circumstance would almost certainly be true for multispecialty groups. CMS states a strong preference for controlling MVP assignment, so that CMS would identify and assign in advance the relevant MVP(s) for MIPS eligible clinicians and would require each clinician or group to report on their assigned MVP(s). CMS indicates actively considering assigning MVPs to clinicians and groups starting with the 2021 MIPS performance period and states a plan to propose the MVP assignment process during rulemaking for 2021. Clinician specialty as indicated on Part B claims or in the Medicare enrollment database could be used to inform MVP assignment. CMS invites input on situations in which clinicians and groups would be permitted to select an MVP other than the one assigned to them by CMS, and specifically questions whether self-assignment to MVPs should be employed for the first year of MVP implementation with assignment by CMS for subsequent years. CMS makes no formal proposals about MVP assignment.

The Premier healthcare alliance recognizes and has supported the flexibility that CMS has heretofore offered to clinicians in selecting MIPS measures that they will report. We understand that CMS intends to standardize MIPS reporting through the MVP initiative, but we also recognize the significant philosophical and operational change that MVP assignment by CMS would represent for clinicians accustomed to measure self-selection from extensive inventories. Premier urges CMS to pursue a balance between imposing MVPs on clinicians and allowing self-selection for the long-term, particularly when many features of the MVP initiative are not yet established. We are concerned that MVP assignment by CMS would be viewed as inappropriate and disruptive by many clinicians, thereby posing a significant threat to successful MVP implementation. **Premier recommends that CMS consider how to actively incorporate QCDRs in developing MVPs that will resonate with clinicians and might facilitate blended assignment by CMS and clinician self-selection.**

MVP Implementation Timeline
CMS proposes to apply the MVP framework to future QPP proposals beginning with the 2021 MIPS performance year and expects to have several MVPs created and finalized by that time. CMS indicates choosing the 2021 proposed timeline rather than proceeding with the MVPs for 2020 to allow sufficient time for seeking public input on the methodology and process details of the transformational MVP initiative. Although not explicitly stated, CMS appears to anticipate a phased approach to MVP implementation that would begin with clinician assignment to all applicable MVPs that are finalized during 2020 rulemaking. The remaining clinicians would continue to follow the current MIPS processes until being assigned to relevant MVPs once such become available. CMS acknowledges that numerous issues remain to be resolved prior to implementing any MVPs but appears to believe that stakeholder input gathered through the MVP RFI will support the proposed 2021 timeline.

The Premier healthcare alliance appreciates that CMS desires to proceed rapidly with transforming MIPS through the MVP initiative to realize as soon as possible the potential improvements in performance data projected to accrue for beneficiaries, clinicians, and CMS. **We are uncertain whether the proposed 2021 timeline is achievable and are concerned that a premature launch could produce unintended negative consequences that outweigh the advantages of the time gained.** We find the MVP examples provided in this year's rule conceptually helpful but not yet ready for actual clinician use. We concur with CMS that development of sufficient MVPs that would be applicable to most clinicians will not be ready for rollout in 2021 due to the magnitude of the work remaining to be done and to the timelines inherent to PFS rulemaking. **Premier believes that QCDRs and their associated specialty societies could be leveraged effectively to drive MVP development that is rational and likely to engage clinicians.**

Premier also is not entirely comfortable with a phased, multi-year, implementation of the MVP initiative. We are significantly concerned that clinicians who are required to transition to MVPs in 2021 may inadvertently be substantively disadvantaged or advantaged compared to those clinicians who, through reasons beyond their control, would remain in the current MIPS structure. Certainly, clinicians who continue participating in pre-transformation MIPS would not experience the burden of learning the requirements of MVP-based MIPS and may be able to score better with less effort than if assigned to MVPs. While parity across MVPs might be possible, parity between MIPS with and without MVPs included seems unlikely.

Premier believes that clinicians must be given sufficient time to implement and adapt to the MVP initiative in their practices and their clinical workflows. **We urge CMS to consider deferring MVP implementation until MIPS performance year 2022 or until MVPs have been finalized that are applicable to 90 percent or more of MIPS eligible clinicians, whichever comes later.** This alternative timeline should better accommodate the successful buildout of multiple MVPs by CMS, allow time for extensive clinician education and outreach, permit updating of EHRs and clinical workflows to MVP-ready status, and facilitate an MVP launch that is far more likely to be successful. Premier is ready to work with CMS to design a timeline and processes designed to optimize MVP rollout.

Subgroup Identifier
CMS suggests that MVP implementation could offer a solution to the challenge of subgroup reporting under MIPS. Premier and others previously have noted the need to allow reporting by TIN subgroups within larger, multispecialty TINs. Subgroup reporting would more accurately capture clinician performance using measures relevant to their practices, resulting in more useful information being made available to beneficiaries and enhancing the ability of clinicians to compare themselves to their peers. **The Premier healthcare alliance appreciates the continued attention that CMS has allocated to the challenge of subgroup reporting. Our clinicians would greatly appreciate a workable solution. Premier looks forward to engaging further with CMS in this effort.**

MVP Section Summary
In summary, Premier commends CMS for being willing to innovate within the QPP and especially the MIPS part of the program. The MVP initiative as described in the proposed rule appears to have both great promise and substantial challenges. Much more information about the MVP framework is needed for meaningful stakeholder input. Striking an appropriate balance between standardization and flexibility will be essential for MVP success. We appreciate this opportunity to provide initial responses to selected portions of the MVP RFI and the related proposals brought forward by CMS as part of rulemaking for 2020. Finally, the Premier healthcare alliance looks forward with enthusiasm to an ongoing, robust dialogue with CMS about the MVP initiative.

Promoting Interoperability (PI) Requirements for MSSP ACOs
The Premier healthcare alliance appreciates the burden reduction that has resulted from CMS having implemented an annual attestation process by which MSSP ACOs can provide evidence that they are meeting requirements for usage of certified electronic health record technology (CEHRT). We ask that CMS apply a similar solution to a parallel challenge that exists for ACOs related to meeting PI requirements. The timeline of QP status notifications to ACOs does not allow their clinicians to know whether they meet QP thresholds in time to avoid reporting MIPS PI measures. As a result, those ACOs participating in MSSP tracks that are considered Advanced APMs must have their clinicians submit all required PI measures, engage in ongoing education to support this reporting, and be prepared on very short notice to review and provide their data to CMS. The substantial regulatory burden thereby imposed upon ACOs and their clinicians is unfair to groups that have come together voluntarily to advance value-based care delivery. **In keeping with efforts by CMS to reduce clinician reporting burden, the Premier healthcare alliance strongly recommends that for clinicians belonging to ACOs on MSSP Advanced APM tracks, CMS implement either 1) an exemption from PI reporting for all such clinicians and give them full credit for PI category scoring; or 2) a simple attestation process through which such clinicians would be credited with having provided evidence of meeting all PI performance category requirements.**

Alternative Payment Model (APM) Incentive Program

Generally Applicable Advanced APM Nominal Amount Standard

Expected Expenditures for Advanced APMs

In determining whether a CMS-sponsored payment arrangement constitutes an Advanced APM, CMS utilizes three criteria: 1) CEHRT usage by a specified percentage of APM participants; 2) conditioning participant payment on specified quality measures equivalent to those used for MIPS quality scoring; and 3) bearing financial risk for more than nominal monetary losses. APMs other than medical home models must satisfy the generally applicable nominal amount standard to qualify as Advanced APMs. For CMS-sponsored APMs, the nominal amount standard for which an Advanced APM may be liable is set at either 8 percent for revenue-based APMs or 3 percent for expenditure-based APMs. Determining the actual amount at risk is based upon the difference between the APM's actual expenditures and its expected expenditures. CMS has defined expected expenditures to mean the beneficiary expenditures for which an APM Entity is responsible under an APM (e.g., benchmark or target price).

While managing an expanding and diverse APM portfolio, CMS has become concerned that an APM can be compliant with the nominal amount standard but not face substantial financial risk. This situation can occur when the model's expected expenditures are set higher than the likely range of actual expenditures, and may reflect non-representative data or flawed assumptions used when establishing benchmarks or target prices. High expected expenditures increase the likelihood that actual expenditures will fall below the benchmark or target price, resulting in little risk of money loss for the APM. To strengthen the nominal amount standard so that it ensures meaningful risk-bearing by Advanced APMs, CMS proposes to revise the definition of expected expenditures. The revised regulation would stipulate that, for purposes of assessing financial risk for Advanced APM determinations: 1) the expected expenditures under the terms of the APM should not exceed the Medicare Part A and B expenditures for a participant in the absence of the APM; and 2) if the expected expenditures exceed the Medicare Part A and B expenditures that an APM Entity would be expected to incur in the absence of the APM, such excess expenditures would be disregarded during the Advanced APM determination process.

The Premier healthcare alliance does not support the proposed revisions to the definition of expected expenditures as applied to determine whether a payment arrangement meets the criteria to be considered an Advanced APM. Premier does not believe that CMS has convincingly demonstrated that the current nominal risk standard is insufficiently rigorous. The proposed changes are likely to discourage participants to join Advanced APMs. Actual data and examples of inadequate risk-bearing under the current standard, and the undesirable consequences for beneficiaries that resulted, should be provided by CMS before adopting the revised standard. Further, if CMS were to finalize the proposed revision for 2020, APMs that are anticipating being Advanced APMs for performance year 2020 would have little time after the publication of the final rule and before the start of the performance year to make any structural adjustments needed to meet the revised standard or, more likely, would not qualify for Advanced APM status. Changes to the available Advanced APM list just before the beginning of the 2020 performance year would be enormously disruptive for the beneficiaries served by those APMs as well as for their clinicians and health systems. **Premier strongly recommends that CMS maintain the current definition of expected expenditures and the existing generally applicable nominal amount standard for performance year 2020.** Reconsideration during future rulemaking should not be undertaken until CMS is prepared to cite actual examples and data that clearly and convincingly demonstrate the problem to be solved by regulatory revision.

Generally Applicable Other Payer Advanced APM Nominal Amount Standard

Expected Expenditures for Other Payer Advanced APMs

Citing concerns similar to those described above for CMS-sponsored Advanced APM determinations, CMS also proposes parallel changes to the definition of expected expenditures and generally applicable nominal amount standard as applied during Other Payer Advanced APM determinations. **The Premier healthcare alliance opposes the proposed revisions to the Other Payer APM generally applicable nominal amount standard for performance year 2020.** Our objections parallel those already stated for the proposed regulatory revisions regarding risk bearing by CMS-sponsored Advanced APMs. Further, revisions to the Other Payer Advanced APM standard would discourage participation by payers other than CMS and impede the transition to value-based care. Finally, if CMS were to finalize the proposed changes to expected expenditures as defined for the generally applicable nominal amount risk standard for Other Payer Advanced APMs for

2020, affected APMs who anticipated Advanced status for 2020 would not meet the financial risk criterion and fail to qualify as Advanced. This outcome would be highly disruptive for the clinicians, patients, and other providers of the affected APMs, Those APMs would not be above to rectify their status determinations for an entire performance year. At the very least, **Premier strongly recommends that other payer arrangements built upon CMS-sponsored Advanced APM frameworks be stipulated as meeting the revised standard.**

Marginal Risk for Other Payer Advanced APMs

The financial criterion for CMS-sponsored Advanced APMs incorporates nominal amount standards that define losses in terms of APM Entity revenue or total expenditures, depending upon the model's design. The financial criterion for Other Payer Advanced APMs incorporates similar nominal amount standards but also sets standards for additional risk parameters: total potential risk of at least 4% of expected expenditures and a marginal risk rate of at least 30%. The marginal risk rate is defined as the percentage of the amount by which actual expenditures exceed expected expenditures for which an APM Entity is responsible under the terms of its APM.

Under the terms of some APMs, the marginal risk rate varies depending on the amount by which actual expenditures exceed expected expenditures. For APMs with variable marginal risk rates, current regulations require that the marginal risk rate set for each level of total loss be 30% or higher. Having gained experience with assessing whether Other Payer APMs meet criteria to be termed Advanced, CMS proposes to revise the regulations pertaining to marginal risk, requiring instead that the APM's overall average marginal risk rate meet the 30% standard. The average marginal risk rate would be calculated in a two-step process as illustrated in Table 58 of the proposed rule: 1) take the sum of the marginal risk for each percent above the Total Cost of Care (TCOC) benchmark to determine the participant losses, then 2) divide the participant losses by the percentage above the benchmark. Current regulations that create marginal risk rate exceptions for very large and very small losses would remain in force without modifications. CMS believes that the proposed revision would not lower the marginal risk rate standard but rather would allow for a new demonstration of how the standard could be met, and thereby facilitate continued innovation in the value-based care marketplace. **The Premier healthcare alliance supports the proposed revision to the Other Payer Advanced APM marginal risk rate standard. Premier commends CMS for demonstrating flexibility that should encourage payers other than CMS to seek Advanced APM status for their payment arrangements and thereby enhance clinician opportunities to reach QP status under the All-Payer Combination option.** Premier requests, however, that CMS provide additional illustrative examples in the final rule if the marginal risk regulation revision is to be finalized.

Application of Partial Qualifying APM Participant (QP) Status

Clinicians whose Advanced APM payments or patient counts approach but fail to meet the QP thresholds of the Medicare and All-Payer Combination options during a QP performance period may still meet one of the Partial QP status thresholds for that year. Partial QP status does not result in an APM incentive bonus payment or in a positive adjustment to future Medicare Part B payments for professional services, but the partial QP clinician is given an option to be exempt from MIPS reporting and related payment adjustments. Currently, CMS applies a partial QP clinician's election to be MIPS-exempt to all of the TIN/NPI combinations containing that clinician. Therefore, a partial QP clinician whose performance could have earned a positive payment adjustment under MIPS in a TIN other than the one resulting in partial QP status, relinquishes that positive adjustment by choosing to be MIPS-exempt. In response to stakeholder concerns that being forced to forfeit a positive MIPS adjustment discourages Advanced APM participation by clinicians, CMS proposes for 2020 and subsequent years to apply partial QP status only to the TIN/NPI combination(s) through which a clinician reaches partial QP status. The partial QP clinician thus could choose to be MIPS-exempt under one TIN/NPI but remain eligible to receive any MIPS adjustment(s) earned under other TIN/NPI combinations.

The Premier healthcare alliance supports the intended result of the proposed change, giving a partial QP clinician control over how a MIPS exemption is applied. However, CMS does not provide operational details for the revised policy, and we have concerns about increasing burden for Partial QP clinicians who choose to retain eligibility for MIPS payment adjustments under one or more TIN/NPI combinations. Premier strongly encourages CMS to refine its partial QP implementation processes to be easily accessible and user friendly by clearly presenting all available options and their payment consequences to Partial QP clinicians while requiring minimal effort from those clinicians to transmit back their preferences for MIPS exemption, or not, to CMS for each of their TIN/NPI combinations.

Clinicians should be able to choose from all available options as individuals may differ in their perceptions about what is most "advantageous" (MIPS exemption or a positive MIPS payment adjustment) and the same clinician's perception may differ depending upon the TIN/NPI combination. For example, the process for electing MIPS exemption should begin with CMS contacting the clinician rather than depending upon the clinician to query the QPP participation status tool, and the notification about options should be linked to a single submission form that provides CMS with all information necessary to implement the partial QP clinician's preferences for all applicable TIN/NPI combinations. **The Premier healthcare alliance recommends that operational details and illustrative examples should be provided by CMS in the final rule and accompanied by an opportunity for stakeholder comment (e.g., interim final), or the proposed change should be deferred to future rulemaking.**

APM Early Termination

Current policy dictates that if the APM Entity group terminates, voluntarily or involuntarily, from the Advanced APM before the end of the QP performance period (August 31), the groups' clinicians would forfeit their QP or Partial QP status and would become subject to MIPS reporting and payment adjustments for that year. CMS has observed that the terms of some Advanced APMs allow their entities to terminate their model participation after the end of the QP performance period without having borne any financial risk for the year. While CMS acknowledges that such termination options may be appropriate at the APM Entity level under some models, CMS does not believe that the clinicians of an early-terminating APM Entity, having borne no financial risk, should be permitted to reach QP or Partial QP status. CMS, therefore, proposes to revise current regulations to state that a clinician is not a QP or Partial QP for a year in which the clinician's APM Entity terminates voluntarily or involuntarily from the Advanced APM prior to bearing financial risk. The current regulation precluding QP or Partial QP status for clinicians whose APM Entity terminates prior to the end of the QP Performance also would remain in force.

The Premier healthcare alliance does not support the regulatory revision as proposed. Premier notes that most early terminations by APM Entity groups occur in late June or late August and usually create considerable pressure on the groups' clinicians who then must hurry to select appropriate MIPS measures for which they can collect, analyze, and submit the required data during the upcoming MIPS submission period. The required MIPS data typically overlap only partially with the data already collected by the APM Entity, as the latter data are tailored to the design of the APM rather than the MIPS framework. Termination by an APM Entity group after the end of the QP performance period exacerbates the pressure on clinicians by further compressing the time available for MIPS data collection and submission. Measures chosen in haste are less likely to meaningfully represent clinician performance and data collected in haste are more prone to contain errors. Premier also notes that the termination decision is made at the APM Entity level and may not represent clinician consensus. We further observe that the clinical behaviors and care patterns up to the point of termination are those of practitioners who believed their group was bearing risk, and that they should remain eligible for QP or partial QP status.

The Premier healthcare alliance strongly urges CMS not to finalize the revised APM early termination policy and to retain the current regulations. The revised policy will serve as a deterrent to clinician participation in Advanced APMs. If CMS persists in making revisions, Premier strongly recommends that when an APM Entity group terminates from a model after the end of the QP Performance period without having borne risk, the groups' clinicians should be provided the option to be considered MIPS-exempt for that performance year, particularly when the early termination is voluntary and not linked to patient safety or program integrity issues. CMS is also proposing analogous early termination regulation revisions for clinicians participating in more than one APM Entity group, one or more of which terminates prior to bearing risk. CMS proposes that the clinicians would be assessed for QP or Partial QP status as individuals based on all risk-bearing entities in which they participated for the year but excluding all performance, payment, or patient count data generated through the terminating APM Entity. **Premier also opposes this revised APM early termination policy for reasons similar to those already outlined.**

Aligned Other Payer Medical Home Model

The All-Payer Combination Option for reaching APM Qualifying Participant (QP) status first became available to eligible clinicians beginning with the 2019 QP performance period. The option allows clinicians the opportunity to earn the APM

incentive bonus payment (in payment year 2021 and thereafter through 2024) for care delivered through a combination of CMS-sponsored Advanced APMs and models sponsored by other payers. CMS proposes to expand the available other payer model types by adding the Aligned Other Payer Medical Home Model to the APM Incentive Program starting with the 2020 QP performance period. Consistent with its general approach to Other Payer APMs, CMS proposes to base the new model type's definition on those already established for the CMS-sponsored Medical Home and Medicaid Medical Home Models. Requirements proposed for a financial arrangement to meet the definition of an Aligned Other Payer Medical Home Model are as follows:

- Be operated by a payer other than Medicare or Medicaid;
- Execute a written expression of alignment and cooperation between the other payer and CMS, such as a memorandum of understanding;
- Participate in a CMS Multi-Payer Model that meets the definition of a Medical Home Model (e.g., Comprehensive Primary Care Plus model); and
- Demonstrate the characteristics of a medical home model (see §414.1305).

Conceptually, Premier healthcare alliance supports the addition of the Aligned Other Payer Medical Home Model type **but we oppose limiting it to CMS Multi-Payer Models. The stipulation that the other payer arrangement must be part of a CMS Multi-Payer Model that also satisfies CMS' definition of a Medical Home Model to be overly prescriptive, particularly since multi-payer models, much less those that are also medical homes, comprise a very small fraction of the CMS Advanced APM portfolio**. CMS states that the multi-payer model stipulation is necessary to prevent gaming by other payers. Premier believes that this stipulation instead will discourage participation in the APM Incentive Program by other payers who operate medical home models, hobbling the expansion of high-value primary care and creating barriers for clinicians to reach QP status under the All-Payer option. Finally, adding this stipulation for other payers' models but not CMS-sponsored models represents a departure from the strategy previously established by CMS of designing and implementing policies for other payer arrangements that are parallel to arrangements operated solely by CMS. Premier supports the application of the existing Other Payer Advanced APM criteria to an Other Payer Medical Home model, if an appropriate definition of the latter model type were to be brought forward by CMS in future rulemaking.

CONCLUSION

In closing, the Premier healthcare alliance appreciates the opportunity to submit these comments on the CY 2020 Medicare Physician Fee Schedule proposed rule. If you have any questions regarding our comments or need more information, please contact Aisha Pittman, vice president, policy, at aisha_pittman@premierinc.com or 202.879.8013.

Sincerely,

Blair Childs
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Premier healthcare alliance