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Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Re: CY 2018 Updates to the Quality Payment Program (CMS-5522-P)

Dear Administrator Verma:

AMDA – The Society for Post-Acute and Long-Term Care Medicine appreciates the opportunity to provide input pleased to offer our comments to the Centers for Medicare & Medicaid Services (CMS) on the 2018 Quality Payment Program (QPP) proposed rule.

The Society is the only medical specialty society representing the community of over 50,000 medical directors, physicians, nurse practitioners, physician assistants, and other practitioners working in the various post-acute and long-term care (PA/LTC) settings. The Society's 5,500 members work in skilled nursing facilities, long-term care and assisted living communities, continuing care retirement communities (CCRC), home care, hospice, PACE programs, and other settings. In serving this population, these clinicians care for the most high-risk and costly group of beneficiaries covered by Medicare and Medicaid programs.

The Society, working with many other specialty societies continues to be engaged with CMS as the Agency continues to implement the QPP. We support many of CMS' proposals that aim to improve patient care while reducing the burdens on PA/LTC clinicians. Specifically, we appreciate that CMS is taking steps forward on recommendations to ensure the QPP is an equitable system that rewards clinicians for taking care of the most vulnerable and costly population, including those at the end-of-life. Specifically, we strongly support proposals that include incentives (e.g., bonus points) for clinicians who see complex patients as well as those with increased social risk factors and dual eligibility status in CMS' risk adjustment methodology.

Likewise, we appreciate CMS' willingness to listen to the concerns we have express about the implementation of the Merit-Based Incentive Payment System (MIPS) to allow PA/LTC and allow another transition year a clinician continue to prepare their practices to meet new reporting requirements.

We remain committed to working with CMS to provide feedback on the QPP and highlight ways to improve successful participation. Working in PA/LTC we work with patients and their families who require care that not only prioritizes evaluation and management activities but person-centered care that attempts to elicit the values and goals of the patient and their family, understand the true needs of the individual that will help to maintain health stability including community based services and supports, and work to establish care networks that will avoid hospitalizations and support these individuals in low cost environments. PA/LTC clinicians do not want to abandon this high need and often high cost population. The Society wants to work with CMS that these individuals continue to have access to appropriately trained physicians, nurse practitioners and physician assistants. Thus, we urge CMS to continue to think of ways to ensure the QPP program follows the following principles:

- Streamline and harmonize reporting requirements for clinicians who practice in multiple settings including ambulatory, skilled nursing facility, long-term acute care hospital, home health and other settings in the post-acute care continuum;
- Provide a robust Alternative Payment Model (APM) pathway that can support clinicians who want to make the transition to new delivery and payment models;
- Accommodate the needs of clinicians in rural, solo, or small practices in order to enhance their opportunities for success and avoid unintended consequences; and
- Develop a model that attracts and retains qualified clinicians who have the specialized knowledge and skills required to care for these vulnerable, chronically-ill, and acutely-ill patients.

While we believe CMS has taken steps forward on all of these points, we believe more work is necessary to ensure that any quality reporting program adequately compare clinicians who take care of similar populations. Simply put, more work needs to be done on risk adjustment models and specialty comparison groups to ensure equity in the system. Accordingly, the Society has submitted an application for a specialty code designation for clinicians who practice in the PA/LTC setting. We believe rapid resolution of this matter would allow clinicians to be compared on a more equal scale. Additionally, the Society has adopted an official position statement asking CMS to clearly define risk stratification indices and develop a cost to risk algorithm. This algorithm should be based on previous utilization data and should incorporate specific, patient-level characteristics, including functional status, age, and frailty, to accurately evaluate clinicians' performance. We strongly urge CMS to monitor implementation of these programs to ensure that they do not dis-incentivize clinicians from providing care for the most clinically complex and frequently the costliest patients who are often cared for in the post-acute and long-term care sector. A recent study in the Journal of the American Medical Association (JAMA) found that the value-based programs hurt clinicians who see high-risk patients.[1] Therefore, we continue to stress that it is vital that the Administration consider not only physician specialties, but also the place of service (POS) of their encounters and their patient mix, including factors related to health status, stage of disease, comorbidities, functional status, local demographics, and socioeconomic status.

General Comments

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[1] Chen LM[1], Epstein AM[2], Orav EJ[2], Filice CE[3], Samson LW[4], Joynt Maddox KE[5]. Association of Practice-Level Social and Medical Risk With Performance in the Medicare Physician Value-Based Payment Modifier Program. JAMA. 2017 Aug 1;318(5):453-461. doi: 10.1001/jama.2017.9643.

Stability in Program Reporting Requirements

We strongly urge CMS to provide as much stability in the reporting requirements throughout QPP as possible. As this program continues to be implemented, physician practices need time to transition their practices to meet these requirements. Unfortunately, that has been very difficult given the constant changes in many of the program requirements. Starting with the legacy programs, the number of measures, minimum patient thresholds and many other details of the program have continued to change year to year. That does not allow for practices to build a sound strategy as they seek to implement changes in their practice. Likewise, it is difficult for specialty societies to develop plans for measure development when the number of measures and other requirements continuously change. Further, this would allow the agency to conduct a valid data analysis that truly reflects performance over a period and provide the necessary feedback practices require to make improvements in their workflow. While we appreciate that the rulemaking process only addressed the 2018 program, we strongly urge CMS to keep requirements constant for a period of time as clinicians adjust their practices.

In addition to these general comments we also offer more specific comments on the proposals:

I. MIPS

Low Volume Threshold

We support policies that seek to hold more practices, particularly those in small and rural areas, harmless from penalties. Therefore, we support the expansion of the low-volume threshold to individuals and groups that have Medicare Part B allowed charges less than or equal to $90,000 or that provide care for 200 or fewer Part B-enrolled beneficiaries. However, the program should not seek to exclude anyone who wishes to voluntarily submit data and participate in the program. Given the instability in the program, practices may have already been gearing up to participate and it would be unfair not to allow those practices to participate and earn potential earnings to offset the cost they may have already invested to participate. Therefore, we strongly urge CMS to allow an ***opt-in option*** for those practices that wish to participate. While we understand that CMS may have administrative challenges to allow for a full opt-in for the 2018, performance period but given that the performance payment adjustments do not occur until 2020, CMS would have time to work on its administrative challenges.

Reporting Period

CMS is proposing different reporting periods for the MIPS categories—90 days for both the Advancing Care Information (ACI) and improvement activities (IA) components and a year for quality reporting. We believe CMS should strive to be both flexible and uniform in its approach. We have heard from many of our clinicians that a full calendar year reporting period can create significant administrative burden while not necessarily improving the validity of the data. Given that the regulations are not finalized until November, it is very difficult for practices to develop a sound reporting strategy by January 1 of the following year. We also believe that these different time frames may create confusion and add to the complexity of the MIPS program. To better align the MIPS categories, we urge CMS to allow physicians to choose a shorter reporting period for the quality reporting period. This would permit reporting on a full

calendar year for those physicians who believe it is more appropriate for their practice. A MIPS participant would also have the flexibility to select a 90-day quality period if they preferred to harmonize their MIPS reporting periods. We believe this flexibility would also resolve problems that may occur if a physician updates or switches their EHR during the performance year.

We understand that CMS' systems and some vendors may have challenges in using a shorter reporting period or multiple reporting periods. We, however, urge the agency to work with physicians to develop options and a specific plan to provide accommodations where possible. For example, CMS could allow physicians to select from one of four reporting periods: 90 days, 180 days, 270 days, or 360 days. This option could alleviate some of technical challenges while still providing flexibility to participants.

Low Performance Threshold

CMS seeks comment on the minimum reporting threshold for the 2018 reporting period. As we stressed previously, it is vital that the QPP program remain as stable as possible to allow for clinicians to adjust to the requirements and for CMS to have valid data over a period of time. Therefore, we strongly urge CMS to set the performance threshold for the second program year at six points. The pick-your-pace program in the first reporting period provided an opportunity for an adjustment period while holding practices harmless. Significantly increasing the threshold would put many practices at risk for penalties. We simply do not have data on how well proposed new bonus points and other changes will impact clinicians who see complex patients in PA/LTC settings. Holding as many of these practitioners as possible harmless will allow CMS to collect data and provide more meaningful feedback to these practices. One of our overarching principles that we have stated previously is that under no circumstances should any payment model penalize clinicians who care for the most vulnerable patients in our country. Keeping the program stable and minimizing potential harm would ensure that principle is met.

Bonus Points for Complex Patients and Risk Adjustment

CMS is proposing to include several different bonus opportunities, including additional points for small practices and providers who see complex patients. The Society strongly supports awarding bonus points for clinicians who see more complex patients. As we have stated, these clinicians have previously been disadvantaged in this program and this would take steps to resolve that issue. However, we remain unclear how the weight of the bonus points is assigned. For instance, why does seeing complex patients (1-3 bonus points) matter less than being a small practice (5 points)? These differences are not explained in the proposed rule and appear to create biases. To simplify MIPS scoring and to avoid arbitrarily awarding points, we recommend that these additional bonus points be equal and are significant enough so that these adjustments provide a more equitable program. CMS should also strive to be clear and transparent with its methodology so that we gain and understanding and dialogue with the agency on these matters.

CMS seeks comment on proposals to include accounting for social factors, HCC scores and dual eligibility. The Society believes that this is the one of the most important proposals in this rule. Without proper risk adjustment in the program, clinicians who see complex patients in PA/LTC settings will continue to be disadvantaged, which flies in the face of goals of the entire program. We support CMS' proposal to include Hierarchical Condition Category (HCC) and dual eligibility adjusters. We strongly urge CMS to adopt ***both*** adjusters and both play a key role. As we have argued previously, we also strongly urge CMS to look to place of service (POS) codes [POS 31 SNF; POS 32 NF) to provide further granularity in complexity of clinicians' patient population.

Another important adjuster to consider is frailty. There is increasing evidence that frailty plays a key role in adjusting for patient mix, as it correlates with morbidity, mortality and cost. CMS needs to study this issue carefully and provide more data and explanations of how risk adjustment will be incorporated into measures that reflect clinician practices. We remain concerned that current commonly available risk adjustment measures are insufficient and additional measurement development and collection is needed to fully account for functional abilities, physical and cognitive frailty, and psychosocial limitations that impact health, costs, and place of service. We stand ready to work with the agency to develop appropriate risk adjustment in the program.

Reweighing Categories

In the 2017 QPP, CMS elected to reweigh any "zeroed" out category to the quality category. We do not support this rigid one-size-fits-all approach. It may be that for facility-based clinicians, the improvement activities (IA) category removes administrative burden, aligns their efforts with that of the facility, and reduces the inequity created by improper risk adjustment in the quality category. For instance, the newly proposed "Physician Participation in Partnership to Improve Dementia Care" as an IA is one that our member physicians have already had extensive experience with and would align well with CMS' goals of measure harmonization and alignment. Thus, we do not agree with CMS' concerns that since this category is new, clinicians would lack experience in reporting. Therefore, we support CMS' alternative option to more evenly distribute the performance category weights. We further urge CMS to consider increasing the amount of weight it would add to the IA category to 20 percent (for a total of 35 percent in IA and 65 percent in quality).

Facility-Based Measurement

CMS proposes to adopt a new scoring option for the quality and cost performance categories that allows facility-based MIPS eligible clinicians to be scored based on their facility's performance. The Society has and continues to support the voluntary option to elect a facility-based score for their MIPS performance. We understand that currently CMS can only adopt this proposal for hospital-based physicians given that there are no value-based programs in existence at other sites of care. However, we urge CMS to study the experience of hospital-based physicians and design facility-based measurement options for physicians that practice in PA/LTC settings. SNF Value-Based Purchasing (VBP) is in its early implementation phase and could provide a framework by which interested nursing home clinicians could utilize these data.

Definition of Facility-Based Clinician

Currently, CMS defines a facility-based clinician only as those who practice in hospital settings. That creates challenges when dealing with hardship exemptions in the program such as the one for facility-based clinicians under the Advancing Care Information (ACI) category. However, as the healthcare system moves toward value-based care and population management, clinicians increasingly practice in different sites of care. These definitions, however, assume that the system is still siloed by setting of care. Thus, we strongly urge CMS to expand its definition of facility-based clinician to other sites of care and specifically PA/LTC settings based on place of service [POS 31 SNF; POS 32 NF]. This would achieve the goal of reducing administrative burden and ensure alignment for hardship exemptions within the program.

Virtual Groups

The Society continues to support efforts to reduce administrative burden for small practices participating in the program. Thus, we support agency's proposals to establish the ability for small practices to create virtual groups. For PA/LTC small practices the burden and lack of electronic health records (EHRs) interoperability between physician practices and facilities they serve, make it particularly challenging task to comply with reporting requirements. In many instances, there may not be many small groups in rural areas that practice PA/LTC medicine. Therefore, we urge CMS to have as much flexibility in establishing virtual groups as possible.

Accordingly, CMS should not establish a limit on the number of Tax Identification Numbers (TINs) that may form a virtual group. CMS is concerned that virtual groups may become so large that it makes comparison of performance among individual clinicians difficult; however, it is unlikely this will occur given the significant administrative and contractual requirements to become a virtual group. Allowing physicians to form virtual groups, particularly in PA/LTC settings, without restriction simplifies an already complicated program.

CMS should also not arbitrarily limit the number of virtual groups that can be approved each year. As CMS notes in the proposed rule, there is unlikely to be a flood of virtual groups in 2018 given the brief time between the release of the rule and the start of the performance year.

Setting limits on the establishment of virtual groups, including the maximum number of groups, size of groups, geographic proximity, or specialty, could have a chilling effect on the formation of virtual groups. Such limitations could harm practices with limited resources and administrative support, who would benefit most from being in a virtual group, because they might elect not to utilize their resources to attempt to establish a virtual group if there were a chance the request would be denied based on limits.

Quality Category Measure Reporting Requirements

We strongly urge CMS to maintain the reporting requirements consistent from the 2017 reporting period. As we have mentioned, keeping stability in the program is vital to clinicians' ultimate success. Therefore, we strongly urge CMS to maintain the number of measures at 6 and maintain the data completeness threshold at 50 percent. CMS has not released data on how many clinicians elected to report the minimum required data under the pick-your-pace option. Our anecdotal data suggest that many PA/LTC practices took advantage of this option and are still working to change their practices to accommodate and phase in more complete reporting. Increased thresholds will only increase anxiety and burden on these practices that are looking at current requirements as their target. CMS should not increase any requirements for a period of time and do a thorough analysis of clinician readiness for participation, as this may drive physicians to opt out of this parameter, which would be likely to have a negative impact on the quality of patient care. Worse yet, it may drive clinicians away from caring for this vulnerable population and/or complex care settings. This would only further exacerbate existing workforce concerns of inadequate well-trained, competent post-acute and long-term care clinicians.

Make Outcome/High Priority Measures Optional

One of the biggest challenges in 2017 reporting period for PA/LTC clinicians was the requirement to report at least one outcome measure among the six measures. The unintended consequence of that

requirement was that clinicians had to report on a diabetes measure, Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%), that was benchmarked for an ambulatory setting and was not generally applicable to the PA/LTC population.[2] [3]This was an example of how a new requirement that did not exist in the legacy programs created an unforeseen hardship, inequity in the program and had the potential to place beneficiaries' health at risk. While the Society continues to work with various measure stewards to ensure that the measure in the program are appropriately specified, we urge CMS to build as much flexibility into the program as possible and allow clinicians to report quality measures that are most appropriate to their practice and their patient population. We simply gain nothing by arbitrary requirements that force clinicians to report on measures that are not appropriate. It hurts their practice and their patients, and runs counter to goals of this program in addition to giving CMS misleading and virtually meaningless data. The Society is willing to work with CMS to develop more meaningful measures in PA/LTC.

Remove CAHPS Requirements from Group Reporting

No PA/LTC practice can successfully report under the current measure reporting requirements for GPRO Web Interface. Given that they must report on all measures, including CAHPS measures, these practices are unable to satisfy the requirements. CAHPS surveys are not designed for, and are inappropriate for, skilled nursing facility-based clinicians because in many situations the source of the information is not reliable due to mental status of the patients being surveyed or other issues outside the control of the clinician including extraordinary administrative burden. The web interface option is a popular option for large group practices, and we urge CMS to create a more reliable and accurate pathway for reporting for PA/LTC based practice groups.

While not part of this rule, CMS has also been made aware of this issue in Accountable Care Organization (ACO) reporting for entities that face the same challenges for their PA/LTC population.

Reporting New Measures

To encourage reporting on new measures, CMS should institute protections to ensure that physicians are not penalized for reporting on new measures. Under the current scoring criteria, CMS does not create a benchmark or provide associated achievement points on a measure until after receiving first-year data. If CMS cannot create a benchmark because less than 20 physicians report on the measure, the maximum amount of points a physician can earn for reporting on the measure is three achievement points. The Society is working to create new measures, but we are concerned that clinicians would not want to report on these measures even if they are more relevant to their practice due to these policies. CMS appears to have some internal inconsistency in its statements because on the one hand, it caps achievement points on "topped-out" measures at six points to encourage reporting on new measures; however, a physician may potentially only earn a maximum of three points for reporting on a new measure. This creates a clear disincentive to utilizing new measures and may discourage innovation and the development of more clinically relevant and appropriate measures in this population. To encourage reporting on new measures, we recommend that CMS automatically award maximum achievement points for reporting on new measures as long as the clinician meets CMS' data integrity requirements.

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[2] Sussman JB[1], Kerr EA[1], Saini SD[1], Holleman RG[2], Klamerus ML[2], Min LC[1], Vijan S[1], Hofer TP[1]. Rates of Deintensification of Blood Pressure and Glycemic Medication Treatment Based on Levels of Control and Life Expectancy in Older Patients With Diabetes Mellitus. JAMA Intern Med. 2015 Dec;175(12):1942-9. doi: 10.1001/jamainternmed.2015.5110.

[3] Lipska KJ[1], Ross JS[2], Miao Y[3], Shah ND[4], Lee SJ[5], Steinman MA[5]. Potential overtreatment of diabetes mellitus in older adults with tight glycemic control. JAMA Intern Med. 2015 Mar;175(3):356-62. doi: 10.1001/jamainternmed.2014.7345.

Cost Category

The Society appreciates CMS' decision to not apply the cost category for the second year of the program. We believe this category needs to remain at zero until such time as CMS has completed its work with the MACRA episode-based cost measure development project contracted to Acumen and has collected significant and valid data on those measures. We stress that the 2017 MACRA proposed rule exempted skilled nursing facility (SNF, place of service [POS] 31) patients from cost attribution, and should this category be applied in future years of this program, we strongly urge CMS to continue this exemption because these patients are automatically going to create high costs—they have just come out of an acute hospitalization and are felt to be too ill, or too functionally and/or cognitively impaired, to be discharged to home—and clinicians who choose to work in this setting with this population should not be penalized for their decision to work with this needy and vulnerable group of Medicare beneficiaries.

The Society is participating in the MACRA episode-based measure development and we believe it needs more work, more time, making it unlikely to be ready for implementation in the 2019 reporting period. For these reasons are working with other societies on potential legislative solutions to this issue.

Advancing Care Information Category

Many PA/LTC physicians are taking advantage of currently available hardship exemptions. We have commented in the 2017 rule and in previous rules on the meaningful use (MU) program that meeting requirements for PA/LTC clinicians is extremely difficult. We strongly urge CMS to adopt the facility-based definition that we explained earlier, and apply it to this category to allow for ***automatic*** hardship exemptions, and only have it scored if they elect to do so (opt-in). Currently, hospital-based clinicians, ambulatory surgical center (ASC) clinicians, and other specialties such as pathology and radiology have automatic exemptions. To reduce administrative burden and to align policies in the program the same process needs to be established for PA/LTC based clinicians.

We are aware that groups are now trying to meet requirements due to gradually increasing availability of certified technology (CEHRT) in PA/LTC. However, even those that may try to meet these requirements are unable to do so due to e-prescribing measure requirements. In the legacy e-prescribing incentive program, PA/LTC clinicians had an exemption for this requirement, but this exemption has not carried over into ACI. Exempting prescriptions by prescribers in the SNF/NF setting from all denominators for 'prescribing' would eliminate a significant barrier to meeting the ACI category for those that elect to do so.

Hence, we request consideration of an automatic hardship exemption from ACI for PA/LTC clinicians (those who make most of their visits in the SNF or NF place of service). For those who opt in to ACI reporting, there should be an ability to exempt e-prescribing from the reporting requirement for those clinicians who do not have that service available with the nursing home dispensing pharmacies.

Improvement Activities Category

The Society appreciates CMS' proposals to expand measures in the IA category. Specifically, we were pleased that several of our proposed measures are being considered for inclusion. Many of our members are already quite active in their facilities' Quality Assurance and Performance Improvement (QAPI)

programs. However, we remain unclear how the "Physician Participation in QAPI" will be included in the proposed rule. We urge CMS to clarify and provide more educational material on how clinicians can document their participation in these programs and earn credit for this category.

As we have stated in our previous comments, we believe that inclusion of these activities is very important for PA/LTC based clinicians for the purposes of aligning various quality-based programs. Within these programs clinicians are working with their facilities to report on quality measures similar to those in the quality category. Therefore, we feel that this category deserves consideration for higher weight. We stand ready to work with CMS to help develop QAPI IA details.

II. Alternative Payment Models

The Society appreciates CMS' proposal to score "Other MIPS APMs" (that is, MIPS APMs that are not required to report through the CMS Web Interface) on quality. Given the lack of available Advanced APMs for PA/LTC based clinicians, many are participating in MIPS APMs such at the Bundled Payments for Care Improvements (BPCI) Initiative. This proposal helps to remedy the scoring structure applied to Other MIPS APMs in the 2017 performance year, in which ACI was weighted at 75 percent, while IA was weighted at only 25 percent. As stated throughout these comments, we continue to encourage CMS to distribute weight among the categories in a manner that reflects CMS' intent to create a holistic program.

III. Advanced APMs

While we appreciate changes in the MIPS APM scoring, we strongly urge CMS to expand the number of Advanced APMs (AAPMs) by providing more flexibility on what it defines as an advanced APM. Currently, there are ***no*** APMs in the Advanced APM category that would allow clinicians who practice in PA/LTC setting to qualify. The Bundled Payment for Care Initiative and the Initiative to Reduce Hospitalizations Among Nursing Facility residents are APMs, but they do not qualify as an Advanced APM in their current form. Both programs have shown significant quality improvement and cost savings primarily driven by incentives in PA/LTC practice changes. Given that these are the only two APMs focused on the PA/LTC population, we strongly urge CMS to work to establish a process to allow these models to be modified so that they can qualify and allow flexibility to allow participants to qualify in the first year of the program. Other programs, such as CPC+, should be considered for their application the PA/LTC population. Current quality measures used in the program do map to SNF residents and yet they are not included in the model. Palliative care models currently under consideration by the Physician Technical Advisory Committee (PTAC) may also hold some possibility for PA/LTC clinicians in some work settings, and we encourage CMS to consider those as well. We believe CMS should work closely with CMMI to address how these models account for institutional patients.

The Society has also worked with other specialties and CMS to design a physician-focused APM. However, the strict timelines and funding for such development remains unclear. We strongly urge CMS to pay particular attention to APMs around the medically complex population, which constitutes a significant proportion of the PA/LTC patient population.

Clinicians in PA/LTC play a critical role in building post-acute networks and are key partners in reducing rehospitalizations and reducing cost. However, in many instances, that requires physicians to make more frequent face-to-face visits that might trigger them as outliers, with concerns about meeting the "medical necessity" requirements for Evaluation & Management coding of these visits. This may trigger Program

Integrity audits that are costly, burdensome and discourage clinicians from participating in these models. CMS must therefore ensure that clinicians have the capability to have gain-sharing arrangements in the APMs so that they can be appropriately reimbursed for the care they provide, and that clinicians not be penalized for keeping a close watch on the very ill post-acute patient population.

Likewise, we urge CMS to consider start-up and overhead cost to the practice in its definitions of "risk." Practices are spending a great deal of capital including new EHR systems in order to be able to participate in these models. Given the uncertainty of the PA/LTC market, these decisions are financially difficult. CMS must analyze existing data and consider these cost in the total risk calculations.

We stand ready to work with CMS and the PA/LTC stakeholders to develop such models within both existing and new APM models.

Conclusion

We appreciate your consideration of our recommendations, and your continued endeavors to improve the quality of medical care Medicare beneficiaries receive. We are committed to working collaboratively and constructively with CMS and others as final regulations are prepared and the agency works to implement these welcome and much-needed reforms.

Sincerely,

Heidi White, MD
President