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November 17, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: CMS-3321-NC: Request for Information Regarding Implementation of the Merit-based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models

Dear Acting Administrator Slavitt:

Thank you for the opportunity to provide input on the design and implementation of the physician payment programs created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) in response to your Request for Information (CMS-3321-NC). The Pacific Business Group on Health (PBGH) is a non-profit organization that leverages the strength of its 60 members—who collectively spend $40 billion a year purchasing health care services for more than 10 million Americans—to drive improvements in quality and affordability across the U.S. health system. Below we highlight a few critical issues to purchasers for consideration in the implementation of MACRA.

Advancing two-sided risk models and population-based payments. MACRA is a major step forward, and it has the potential to improve the quality and affordability of health care for Medicare beneficiaries. It will also have an impact on the entire health care system by encouraging providers to also participate in alternative payment models with other payers. The success of this effort, however, will depend on how alternative payment models (APMs) are defined and what is considered more than "nominal risk". If these models don't move off of the traditional fee-for-service "chassis", we will miss the opportunity to reap the full rewards of value-based payment and care models. Within the framework laid out by CMS in 2014, we support the use of Category 4 models as well as Category 3 models with two-sided risk that could include a range of different payment strategies.[1] Models with two-sided risk or population-based payments -- not just models that slightly alter payment arrangements -- incentivize providers to adopt practices that have been shown to increase value to a range of stakeholders including consumers and purchasers. Moreover, the five percent bonus should require a meaningful shift in payment design structured on measurable quality outcomes and efficiency gains.

Incent new models of care and payment approaches. MACRA provides incentives for clinicians to move from fee-for-service into APMs. However, it is expected many clinicians will choose the Merit-based Incentive Payment System (MIPS), a primarily fee-for-service model, and will be accountable through the MIPS approach for some time to come. The statute already includes some key activities and incentives that will help providers achieve APMs, such as promoting increased patient and family engagement and creating standardized measurement and transparency for continuous quality improvement. The clinical quality

[1] Rajkumar R, Conway PH, Tavenner M. CMS--engaging multiple payers in payment reform. JAMA. 2014 May 21;311(19):1967-8. Accessed November 2015 from http://jama.jamanetwork.com/article.aspx?articleid=1864086.

improvement activities in MIPS encourage providers to advance towards APMs and to adopt models of care that are suitable for new payment approaches. These activities should be weighted more heavily to motivate providers to dedicate more resources to moving to value-based payment and away from fee-for-service.

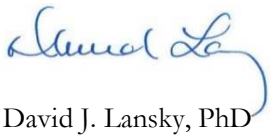
Meaningful measures. Furthermore, both the MIPS and APM payment tracks need a strong foundation of performance measures that assure the public that they're getting value for their spending. Given that the APM criteria require the use of measures comparable to MIPS, the importance of starting MIPS from the get go with more meaningful measures has much broader implications. Understanding how the new payment (and delivery) models in APMs impact quality is critical to an evolving health care system that is striving for higher quality, person-centered care. We strongly support measure sets that focus on outcome measures -- both clinical and person-reported -- coordination and transitions of care, patient experience, and appropriate use.

Advancing better quality measures and patient-reported outcomes. The clinical quality improvement activity category in MIPS can also be used as a vehicle for getting better measures in use by clinicians. We urge CMS to add a subcategory that supports continuous quality improvement within a practice via the use of patient-reported outcome (PRO) tools and corresponding collection of PRO data in a systematic way. CMS should provide guidance on acceptable PROs and require data reporting back to CMS that supports measure development efforts. Such data collection could significantly improve the use of PROs in clinical practice and future development of PRO measures which is frequently hindered by too few providers using a given PRO tool or by barriers to data access. We also encourage CMS to provide additional incentives for using more advanced performance measures that capture important outcomes and patient experience.

Multi-payer alignment with private sector. Finally, designing MACRA implementation with the private sector in mind is paramount to both the program's success and to achieving overall system transformation. Multi-payer alignment benefits everyone – patients, providers, and purchasers. The law already encourages alignment by including a provision on contracting with other payers besides Medicare. CMS can further support alignment by creating efficiencies between Medicare and private sector requirements for APMs. PBGH and its members have been successful in using new delivery and payment models to improve health outcomes and the value of care; we would be happy to share lessons learned from these initiatives.

CMS plays a vital role in how physicians will be paid through its direct oversight of large public programs and its influence of and collaboration with the private sector. We applaud the agency's leadership in this area and ask for continued strong leadership; now is the time to accelerate quality improvement, care coordination, and cost savings. For additional comments on the overall direction and specific implementation recommendations, please see the comment letter from the Consumer-Purchaser Alliance.

Sincerely,



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