FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

August 21, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5522-P
P.O. Box 8013
Baltimore, MD 21244-8013

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

Dear Administrator Verma,

Families USA appreciates the opportunity to offer comments on the proposed rule for CY 2018 Updates to the Quality Payment Program (CMS-5522-P). Families USA is a national, non-partisan, non-profit consumer advocacy organization dedicated to the achievement of high quality, affordable health care and improved health for all. As such, we are supportive of the transition to a more value-based health care system. We are also committed to ensuring that payment and delivery reform efforts meet the needs of consumers and their families, account for the many factors that impact a person's health, including the social determinants of health, and drive reductions in health care disparities.

We are supportive of the underlying goals of the Quality Payment Program (QPP) to continue to transition Medicare into paying for value instead of the volume of services and to incentivize providers to participate in alternative payment models (APMs). We believe CMS has made several improvements to the QPP with this proposed rule. We are pleased to see CMS giving particular attention to the additional challenges faced by clinicians who serve patients with complex health and social needs through its continued study of approaches to risk adjustment and the availability of bonus points for clinicians who serve patients with complex needs. However, we see clear opportunities for the QPP to better incentivize reducing health disparities.

Families USA is also very concerned by CMS's proposal to continue some of the transition year policies finalized previously and to exempt such a large number of clinicians from MIPS by raising the low-volume threshold. Though we understand that small and independent practices may need additional assistance to participate successfully in the QPP, exempting 64% of clinicians from MIPS entirely slows the transition to value, creates a widening gap between the MIPS and APM tracks, and will make successful participation in the QPP more abrupt and therefore more difficult for these providers in future years, as some currently waived requirements will be statutorily required in future years.

We also want to underscore how important it is for the Center for Medicare and Medicaid Innovation to both maintain and expand existing models that qualify for the Advanced APM track and to design and test new models that can later be added to this track. Creating new opportunities for providers to gain the Advanced APM bonus is important for incentivizing more providers to join APMs under MACRA, and to help drive higher quality and lower cost care throughout the health care system, as other payers learn from the testing of these models.

In order to further expand these opportunities, we also encourage CMS to carefully consider how to develop and/or restructure similar programs and incentives in Medicaid and the marketplaces that will align with the policies of the QPP, such as better aligning HIT requirements and incentivizing quality measurement and improvement activities. This will help reduce reporting burdens on providers, and will also help ensure that providers who serve a population with relatively few Medicare patients, such as community health centers, are not left behind or disadvantaged in this transition to more value-based care.

We make the following additional comments on the proposed rule:

MIPS Program Details

MIPS Eligible Clinicians

Low-Volume Threshold

Families USA understands that small practices and those in rural areas may face additional barriers to successful participation in the QPP that larger practices do not experience. Providing some flexibilities for these clinicians, such as different weighting for the "improvement activities" category and special exemptions for insufficient internet connectivity, in addition to technical assistance from CMS, is necessary to ensure that such providers are not unfairly disadvantaged. However, simply excluding these providers from MIPS by increasing the low-volume threshold is not an adequate solution and we do not support CMS raising this threshold to $90,000 in allowed Medicare Part B charges and 200 Medicare Part B beneficiaries. Such a policy sends the message that small and rural practices should not be a part of the transition to a more value-based health care system and by exempting 64% of clinicians, the patients of these clinicians will not benefit from the improvements incentivized by the QPP. We strongly recommend that CMS not finalize this higher low-volume threshold.

Virtual Groups

As the concept of virtual groups is untested, we are concerned that such an arrangement may have serious implications for reporting and achieving higher quality care, reducing costs, and reducing health care disparities. We strongly encourage CMS to first test this approach as a pilot

with a smaller group of MIPS eligible clinicians to learn more about how this approach will work and what additional limits or safeguards may be necessary.

MIPS Performance Period

We support CMS maintaining a full calendar year as the reporting period for the quality and cost performance categories in payment year 2020 and in future years. A reporting period that spans the entire performance year is important for ensuring continuity in the quality of care delivered to beneficiaries and can help make sure that quality measurement and any processes undertaken to improve care delivered to beneficiaries are fully integrated into clinical workflows. For these reasons, we also encourage CMS to increase the reporting periods for the advancing care information and clinical practice improvement activities from 90 days to a full year that aligns with each performance period.

MIPS Performance Category Measures and Activities

Performance Category Measures and Reporting

Submission Mechanisms

We agree with CMS that allowing MIPS eligible clinicians to submit measures and activities via multiple submission mechanisms will lead to more providers having the minimum number of required measures available and applicable to them. As we want to see more providers participating in the QPP and participating in a robust way, we are supportive of allowing submission via multiple mechanisms. We do have some concerns that allowing providers to submit the same measure via multiple mechanisms and only counting the higher of the two scores may lead to some providers "gaming" their scores, and we recommend that CMS and HHS OIG closely monitor this to ensure this is not happening.

Quality Performance Criteria

In order to drive improvement, quality reporting must measure what is clinically meaningful to patients, and not just care processes. For this reason, we applaud CMS for requiring MIPS clinicians to report on at least one outcome measure. As more outcome measures become available in future years, we strongly support increasing the required number of outcome measures and the overall number of high priority measures that eligible clinicians must report.

Quality measurement should also be used to drive the reduction in health care disparities. We strongly encourage CMS to work towards a QPP that supports and incentivizes quality measures being stratified, as much as possible, by demographic characteristics such as race, ethnicity, gender, gender identity, sexual orientation, primary language, and disability status. This type of stratification is essential both to accurate quality measurement and to the identification and ultimately the reduction of disparities in care and health outcomes and is foundational to

transforming our health care system into one that provides high quality care to historically underserved communities.

To do this, we encourage CMS to prioritize for future measure development and inclusion in MIPS those measures that are "disparities-sensitive." The National Qualify Forum (NQF) identifies these measures based on the following criteria: 1) a condition's prevalence among populations with social risk factors; 2) the size of the disparity; 3) the strength of the evidence linking improvement on a measure with improved outcomes for people with social risk factors; and 4) how actionable the measure is among the population with social risk factors. In its recently released draft report, "A Roadmap to Reduce Health and Healthcare Disparities through Measurement" NQF has compiled measures that are disparities-sensitive across different domains of health equity, as well as measurement gaps across these domains. We encourage CMS to refer to this draft report and the forthcoming final report to help identify measures for future inclusion and development.[1]

Submission Criteria for Quality Measures for Groups Electing to Report Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey

Hearing directly from patients is critical for ensuring that care is being delivered in a way that meets patients' real needs and helps them meet their own care goals. Patient-reported outcomes measures (PROMs) allow patients to have a direct role in evaluating the care they receive, and we encourage CMS to further develop and incentivize the use of robust PROMs.

PROMs can also be an important tool for advancing health equity as they can help identify when patients are not receiving culturally competent care or other challenges faced by individuals who often encounter discrimination within the health care system. Therefore, we urge CMS to not remove the SSM entitled "Between Visit Communication" from the CAHPS for MIPS survey. Though related to two other SSMs ("Care Coordination" and "Courteous and Helpful Staff"), these measures do not entirely overlap, and poor communication between visits can have serious consequences. Between visit communication is itself a central building block toward moving health care beyond a "visit and procedure" reimbursement model. Additionally, though we understand and generally support the desire to align quality reporting under MIPS with reporting under Advanced APMs, such as the Medicare Shared Savings Programs, we do not believe the lack of inclusion of the "Between Visit Communication" SSM from the CAHPS for ACOs Survey is a sufficient enough reason to justify its removal from CAHPS for MIPS.

We are very supportive of expanding the patient experience data available for the CAHPS for MIPS survey to include a "patient narrative" via the addition of open-ended questions. Presenting this information can make data on the quality of care more accessible and useful for many patients and their caregivers. As beta testing of these additional questions is ongoing, we encourage CMS and AHRQ to ensure that these questions are being tested among a diverse

[1] http://www.qualityforum.org/Disparities_Project.aspx

sample of patients to ensure that the questions and resulting data will be useful for all beneficiaries.

Data Completeness Criteria

We encourage CMS to maintain the proposal it finalized in the CY 2017 Quality Payment Program final rule to increase the data completeness threshold to 60 percent in 2018 for quality measure data submitted via QCDRs, qualified registries, EHR, or Medicare Part B claims. We understand CMS's concern that increasing this threshold too quickly will hamper providers' ability to participate in MIPS. However, other aspects of this proposed rule still provide ample opportunities for even inexperienced providers to participate and succeed in MIPS (e.g. still receiving 1 point for submitted measures below the completeness threshold, a 3 point floor for submitted quality measures that do meet completeness criteria, and a lower MIPS threshold score). We are very concerned that finalizing an additional year of a 50% data completeness threshold contributes to a QPP that does not establish a meaningful ramp from the transition year to full implementation and will continue to create a misalignment between the MIPS and Advanced APM tracks.

Cost performance category

Weighting the Final Score

Improving the value of health care is important for ensuring appropriate and efficient use of services, not just for the overall sustainability of the health care system, but also for beneficiaries who must bear cost-sharing requirements for these services as well. We strongly urge CMS give the cost performance category a weight of at least 10 percent in the final score, as this is best for both providers' future success in MIPS and for the care delivered to beneficiaries.

With the cost performance category accounting for 10 percent of the final score in performance year 2018, providers will be incentivized to pay attention to and try to improve their performance, making them prepared for the following year when it is statutorily required to make up 30 percent of the final score. With such a substantial portion of the final score, it will be difficult for providers to succeed in MIPS overall if they are unprepared for and unaccustomed to being measured and evaluated in this category. Additionally, we are concerned about potential negative impacts on beneficiaries whose providers are not prepared for costs to figure so much into their final score, as this unpreparedness may lead to inappropriate delivery of care. Finally, weighting this category at 10 percent of the final score for payment year 2020 is appropriate given that many providers have some exposure from the VM program to both the total per capita cost and MSPB measures that would be used to calculate their cost performance category score.

Episode-Based Measures

Though we support the use of episode-based measures, we strongly encourage CMS to also incorporate total per capita cost measures for populations with specific conditions. Families USA

urges CMS to change the cost criteria in future years to include the four total cost of care measures for condition-specific groups from the VM program in addition to the total cost of care, MSPB measures, and episode-based measures. We do not support measuring performance for condition-specific groups solely through episode-based measures of care. By doing so, CMS misses a critical opportunity to capture the full breadth of cost for chronic diseases with high incidence in the Medicare population. Without accurately capturing the full scope of care for individuals with specific conditions beyond acute care interventions, providers cannot accurately assess their performance in consistently delivering high-quality, high-value care to these individuals. Additionally, a focus on episode-based costs, rather than an emphasis on total cost of care, runs counter to the goals of value-based alternative payment models and may fail to ensure that MIPS providers are appropriately prepared to succeed in the Advanced APM track.

Furthermore, primary care has a central role in the long-term management of chronic disease to prevent progression. Without accurate measures to capture the full scope of resources necessary to manage chronic disease, inclusive of primary care, we cannot ensure that beneficiaries are receiving the right care for their needs. As such, we urge CMS to incorporate more total cost of care measures into the cost performance category in future rulemaking.

Finally, CMS must engage a broader group of stakeholders as it develops new measures for the cost performance category. We appreciate that CMS has consulted with over 50 clinician specialty societies, but it is important that CMS hear especially from providers who are located in HPSAs and who serve populations with a high rate of SES risk factors. These providers face unique challenges reducing the cost of care and their patients are receiving too little care in many cases, making them more vulnerable to cost performance measures that are designed without taking their needs into account.

Improvement Activity Criteria

Families USA is very supportive of CMS's decision to focus in this category on incentivizing the use of telehealth and on connecting patients to community-based services. There is ample evidence that these types of interventions can have significant, positive impacts on people's health and experience of care, and they can be powerful tools for addressing disparities. We believe there are additional steps CMS can take to further incentivize activities that are more likely to help achieve health equity. These could include: giving particular focus to developing new activities for the Achieving Health Equity subcategory, assigning a high weight to all activities in this subcategory, and, after enough additional activities have been added to this subcategory, requiring all clinicians and groups to perform at least one activity from this subcategory.

<u>Submission Mechanisms</u>

We are supportive of establishing a minimum threshold of clinicians that must perform a practice improvement activity in order for the entire group to receive credit in its final score. For MIPS

eligible clinicians who choose to report at the group level, it is important that the final score awarded to that group, and the resulting payment adjustments, be reflective of care delivered by the group as a whole, and not simply of one or a few high-performing providers. Practice transformation is likely to be more successful in those practices where more providers are working to drive improvement. Establishing a minimum threshold also ensures that more individual clinicians are participating in MIPS in a robust manner. We would be supportive of setting this minimum threshold at 50 percent for the 2018 QPP performance year, but we encourage CMS to gradually raise this threshold in future years, particularly for larger groups.

Submission Criteria

Similarly, we also support the proposal that to receive full credit under this category as a patient-centered medical home, at least 50 percent of the practice sites within the TIN must be recognized as such, and we also encourage CMS to explore raising this threshold in future years, particularly for TINs that contain a large number of practice sites. As with requiring a minimum percent of providers to perform an activity for the group to receive credit, scores for this category should reflect the overall delivery of care received by all patients served by the reporting group. Without such a minimum threshold, we are concerned that those practice sites who are not currently recognized as a PCMH will not perform any improvement activities and will have no incentive to do so.

Required Period of Time for Performing an Activity

For the clinical practice improvement activities reporting period, we reiterate our comments from above that the reporting period for all MIPS performance categories should be the full performance year. A full-year reporting period would better align this category with the quality and cost categories, and this is important for MIPS to be implemented and experienced by providers and their patients as a unified program, rather than four separate reporting programs.

Improvement Activities Inventory

Families USA applauds CMS for the inclusion of the new activity entitled "Provide Clinical-Community Linkages", including utilization of community health workers. There is significant evidence that community health workers (CHWs) can improve the experience of care and health outcomes, while producing cost savings. Community health workers are also a powerful tool for reducing health care disparities, and we would support this activity's inclusion in the "Achieving Health Equity" subcategory rather than the "Population Management" subcategory. Given the large evidence-base supporting the integration of CHWs, we strongly encourage CMS to reweight this to a highly weighted activity.

We recommend that CMS update the description of this activity in the CPIA inventory to also include "*promotoras/es de salud*, community health representatives (CHRs), and other frontline public health workers." Though "community health worker" is often understood as an umbrella term for these frontline public health workers, we believe it is important that providers

understand that workers filling a CHW-type role, no matter their official title, could be used to carry out this activity. The inclusion of *promotoras* and CHRs is especially important, as these terms are the preferred and most commonly used terms in the Latinx and American Indian communities, respectively, for the individuals that are performing these crucial roles in their communities.

Given the major impact that adverse social factors have on a person's health, we believe that CMS should further incentivize the screening of all patients for SES risk factors by reweighting the activity "Participation in a QCDR, demonstrating performance of activities for use of standardized processes for screening for social determinants of health such as food security, employment and housing" as a highly-weighted activity.

In considering the addition of new activities to the improvement activities inventory, we encourage CMS to engage directly with providers, researchers, and other stakeholders who are implementing and studying interventions that have been shown to be effective in communities of color and among other groups with adverse social factors. This will help make sure that providers serving these under-resourced communities are able to participate successfully in the QPP and will not be financially penalized, which would only further exacerbate these resource challenges, and will incentivize more providers to engage in activities that can directly address health disparities. As one example, we recommend CMS consult the various resources and guides compiled by the Disparities Solutions Center.[2]

CMS Study on Burdens Associated with Reporting Quality Measures

Families USA looks forward to reviewing the results of the CMS study on burdens associated with reporting quality measures. As the types and number of providers who will be study participants are selected, CMS should consider factors in addition to practice size and rural or urban location, including practices and clinicians located in both urban and rural HPSAs and providers who serve a high proportion of low-income patients and patients of color. Ensuring the experiences of these particular providers are represented in the study will be important for assessing how these clinicians and groups may be disadvantaged by certain reporting requirements.

Advancing Care Information Performance Category

The robust use of health IT and health information exchange is fundamental to achieving the foundational goals of the QPP to incentivize high-quality, efficient practices, coordinated care and improved health outcomes. Health information technology can also be an empowering tool for consumers by allowing them to track, manage, and assert preferences for their own care.

[2] https://mghdisparitiessolutions.org/guides/

Reporting Periods

In order for the QPP to drive the use of HIT to improve care delivery and the patient experience of care, we strongly encourage CMS to require a full-year reporting period for this category. The reporting requirements in this category can go a long way in supporting clinicians' successful performance in both the quality and cost categories, and by increasing the reporting period for the ACI category to a full year, CMS would be further aligning these performance categories.

Eligibility Changes

We are concerned with the number of clinicians who will be essentially exempt from the requirements of the ACI performance category under the current proposal to reweight the category to zero for:

- Non-patient facing clinicians;
- Hospital-based clinicians;
- Ambulatory surgical center-based clinicians;
- Nurse practitioners (NPs), physician assistants (PAs), Certified Registered Nurse Anesthetists (CRNAs) or Clinical Nurse Specialists (CNSs);
- Clinicians facing a significant hardship;
- Clinicians using decertified EHR; and
- Small practices (15 or fewer clinicians and solo practitioners).

We understand the need to construct a realistic on-ramp for clinicians, but to achieve our shared goals of a high-quality, patient-centered health care system, we need more clinicians using certified health IT in ways that improve patient care, not fewer. Delaying the inevitable transition to health IT will only further disadvantage these clinicians in the long run. Similarly, we are concerned by the proposal to not apply the five-year limit to significant hardship exceptions (e.g., clinicians who lack internet connectivity). While it is important to acknowledge circumstances outside of the provider's control, it does not seem necessary to grant these hardship exceptions in perpetuity.

Certification

We are similarly disappointed in the delayed transition to the 2015 Edition certification requirements. Consumers need digital health technologies that advance their ability to access, contribute, and share health information. The 2015 Edition includes new and significant patient-facing functionalities as well as in certification standards and implementation specifications designed to improve interoperability, designed to support the following:

- Accessing health information via Application Programming Interfaces (APIs)
- Patient-generated health data
- Non-clinical data (i.e., social determinants of health)
- Incorporate / accept summary of care record
- Stratification of data by demographic characteristics

The proposed delay further postpones our shared vision for a more connected, interoperable health care system. We support the proposed bonus for clinicians that report ACI objectives and measures using only 2015 Edition technology to encourage clinicians to upgrade their systems and begin to use these more innovative and priority functions but would prefer that the transition to the 2015 Edition certification requirements proceed as planned previously.

Scoring

We strongly support the base and performance score categories and urge CMS to maintain this structure, which simultaneously encourages adoption and use of health IT by new clinicians while rewarding performance on measures that have the greatest impact on patient and family engagement, care coordination and interoperability.

We continue to believe that ACI measures should evolve in future performance years to emphasize these innovative, person-centered uses of health IT that support health system transformation and the nation's health imperatives. We encourage CMS to consider the following for future performance years:

- Increasing the weight of the performance score relative to the base score;
- Establishing thresholds for performance measures; and
- Over time, adding additional patient-facing measures to the base score.

We support the proposed bonus points to encourage important clinician behaviors, such as adopting 2015 Edition technology, reporting to registries, and leveraging health IT in improvement activities. However, CMS should use this approach cautiously so that clinicians continue to make progress on more innovative performance category measures and not rely on the availability of bonus points to improve their overall ACI performance score.

MIPS Final Score Methodology

Policies Related to Scoring Improvement

Families USA is supportive of incorporating improvement into a clinician's score in both the quality and cost performance categories. This ensures that providers who make large gains in their performance can be rewarded, and it incentivizes a commitment to continuous quality improvement, even for the highest performers. We appreciate that CMS is structuring the improvement score to be layered on top of the achievement score so that both elements are incorporated. However, the challenges with scoring improvement at the measure level in the quality performance category underscore how the flexibility afforded to providers to choose from a potentially large menu of quality measures to report on, and to change the measures they report on each year, makes it difficult to accurately assess providers' improvement over time. We

encourage CMS to continue to study how this could be addressed in future years, such as by the possible use of core measure sets.

Scoring the Quality Performance Category for Data Submission via Claims, Data Submissions via EHR, Third Party Data Submission Options, CMS Web Interface, and Administrative Claims

Assigning Points Based on Achievement

We recommend that in the second QPP performance year CMS lower the floor for scored quality measures to less than 3 points. Though it is understandable that such a floor was put in place for the transition year, it is necessary to move providers forward in the second year to fuller participation in MIPS. Keeping such transition year policies in place for another year does not incentivize providers to commit fully to quality improvement, particularly for providers who would fall below such a floor, who are in the most need of improvement.

We are also supportive of establishing a cap on the score of topped-out measures, as providers should not be rewarded for achieving a top score in the quality performance category by reporting solely or mostly on measures on which most clinicians are already performing highly. Given how many measures are currently topped out, we are supportive of implementing a 6-point cap for the 2018 performance year, but we encourage CMS to lower this cap in the future as topped out measures are removed.

Facility-Based Measures Scoring Option for the 2020 MIPS Payment Year for the Quality and Cost Performance Categories

We agree with CMS that clinicians practicing in facilities, such as hospitals, do contribute to that facility's overall performance in other value-based payment programs, and that for some clinicians, using the facility's score as their MIPS score might be a reasonable option. However, we are concerned that for some providers, based on the amount or type of practice they perform in a facility, a facility's score is not an accurate assessment of that provider's performance. Given that opting in to the facility-based scoring option would likely be most attractive to providers whose scores would otherwise be lower than that of the facility, we are especially concerned that this option may be used to mask poor performance. Instead of making this scoring option available to all who qualify, we strongly recommend that CMS use the 2018 performance year to pilot such an option with a small subset of providers selected based on their largely facility-based practice.

Calculating the Final Score

Considerations for Social Risk

We applaud CMS for its consideration of how best to account for social risk factors in the QPP, and we agree that it is a delicate balance between not unfairly disadvantaging clinicians whose patients have more social risk factors that influence outcomes, and not masking such differences

in outcomes or accepting a lower standard of care for these patients. For these reasons, Families USA is very supportive of CMS's decision to apply bonus points to final scores based on the proportion of patients with more adverse social factors affecting their care. We encourage CMS to utilize the 2018 QPP performance year and the use of this temporary approach to accounting for these risk factors as an opportunity to test, capture data on, and refine different approaches for accounting for these factors. For example, we recommend that CMS calculate an eligible clinician's bonus points based on both proposed measures to better understand the effectiveness and appropriateness of each, and to consider scoring the measure that would give a clinician or group a larger bonus.

MIPS Payment Adjustments

Establishing the Performance Threshold

We are pleased that CMS has raised the performance threshold above the 3-point threshold of the 2017 performance year. However, Families USA would encourage CMS to increase this threshold above 15 points. For payment year 2021, by statute, this threshold must be set at either the mean or median of performance scores, and this will likely be a significantly higher threshold than 15 points, meaning that there would be a sharp increase between one year and the next on what providers must achieve in order to avoid a negative payment adjustment. Again, Families USA is aware of the challenges some clinicians may face in participating in MIPS, but we do not believe that continuing so many transition year policies is setting these providers up for success in the future. Instead, we support CMS's alternative proposal of setting this threshold at 33 points, as this would require participation in both the improvement activities and quality performance categories for providers to be able to avoid a negative adjustment.

Overview of Incentives for Participation in Advanced Alternative Payment Models

Overall, Families USA is supportive of the direction CMS is moving with respect to promoting the adoption of Advanced APMs, and we are pleased that more providers will have an opportunity to participate in an Advanced APM through re-opening of applications to participate in existing Advanced APMs. We offer the following overarching comments for the Advanced APM incentive:

Greater opportunity for consumer engagement in the design of APMs: Broadly, we recommend that CMS consider how to increase transparency and opportunities for public input into the development of APM models in the future. The relative success of Advanced APMs at driving improvements in care delivery and health outcomes is largely dependent on the underlying care delivery models that are certified under this program. Patients, caregivers, and consumers bring a critical perspective as to how our health care system needs to be reformed to truly meet their needs. They should be seen as key partners in developing new care models, advancing health equity, and improving patient-centered care. We urge CMS to consider

developing formal opportunities for public and stakeholder input into the development of future models, such as establishing an advisory committee of patients and consumer advocates to consult in developing new models.

We have particular concerns about consumer involvement when the Other Payer option will contribute to a provider's eligibility for the Advanced APM bonus. We think it is critical that there is some foundational transparency regarding the types of other payer models that are approved by CMS. We urge CMS to engage with stakeholders outside of providers and plans, including consumer groups, in both developing and implementing plans to designate other payer Advanced APMs.

Establish an adequate floor of quality measure requirements to ensure that all Advanced APM models, particularly Other Payer APMs, put adequate emphasis on care and quality improvements: Clinical quality measurement is a fundamental part of distinguishing APMs from simply shifting risk onto providers and pressuring them to reduce needed care. We are concerned that the current quantitative standard for the requirement that Advanced APMs tie payment to quality measures is inadequate to ensure that APMs incentivize quality improvement and do not incentivize stinting on care in order to achieve savings. We are particularly concerned about applying such a loose standard to Other Payer APMs, as there is little to no guarantee of public oversight or opportunity for public input in the design of these models. While we believe a more rigorous CQM standard is warranted for all Advanced APMs, at a minimum, we recommend that CMS consider establishing a more rigorous requirement for Other Payer APMs that more closely mirrors the scope of quality measures that payment is currently tied to under Medicare Advanced APMs. We believe it is warranted for CMS to consider more rigorous standards specifically for Other Payer Advanced APMs given that the agency has less involvement in the design or oversight of these APMs.

Require all Medical Home Models seeking to qualify as Advanced APMs to meet all seven of the domains listed in the rule's definition of a Medical Home Model: There is a risk that the Medical Homes option under APMs will function as a major loophole in the APM standards. Moreover, each criterion is important for comprehensive, patient-centered care. Medical Homes and Medicaid Medical Homes should be striving to meet all of these criteria in the future, and we believe that these broad criteria represent the direction of good clinical practice.

Remove or broaden practice size restrictions on Medical Home Models: As we stated in previous comments, we are concerned that the size standard of 50 clinicians creates a steep cliff for the financial risk criterion applied to qualified participants. We are concerned that the marginal difference in resources between an entity hiring 49 and 51 clinicians may not translate to the ability of that entity to take on a higher financial risk standard- this may be especially true for Medicaid Medical Homes. We strongly recommend that CMS monitor the impact of this

policy on medical homes and consider increasing the size standard above 50 clinicians in future years.

We look forward to continued work with CMS on implementing these provisions and other payment and delivery reform efforts. If you have any questions about our comments and recommendations, please contact Ellen Albritton, Senior Policy Analyst, at ealbritton@familiesusa.org.

Sincerely,

Ellen Albritton,
Senior Policy Analyst
Families USA