wellcentive

June 27, 2016

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

Re: Medicare Program: Merit-Based Incentive Payment System and Alternative Payment Model Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models Proposed Rule (CMS-5517-P)

Administrator Slavitt and staff,

Wellcentive supports providers and clinicians delivering care within health system, physician practice, IDN, FQHC, hospital, employer, and more recently, payer settings.

These thousands of MIPS and APM-eligible clinicians currently perform value-based care and population health management within MSSP, PQRS, PCMH, meaningful use, Medicaid Delivery System Reform Incentive Payment (DSRIP) and multiple private-payer quality programs.

Wellcentive appreciates the opportunity to submit comments regarding the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. Wellcentive applauds the Centers for Medicare & Medicaid Services (CMS) on taking the steps to advance quality and align reporting programs with similar goals.

Timeframe

Although Wellcentive intends to be fully ready to support our partner clinicians on day one of the first performance year, we have also heard significant concern from our partners about the speed of implementation. While final tallying, submission and completion of the 2016 PQRS program is taking place, which requires a large amount of focus, clinicians are expected to roll out a significantly new program (MIPS) at the same time. This causes many clinicians concern that they are being set up for failure in the first year of MIPS as there will not be adequate time to prepare and implement the new program successfully.

Additionally, we believe the traditional (PQRS) and proposed (MIPS) timeframe between publishing final measure specs and implementation of the specs should be greater. In many cases, with the publishing of final measure specs in November, for implementation beginning January 1st, it leaves very little time to build, test and publish all available measures to allow clinicians to interpret and begin tracking their progress beginning the first day of the performance year. This leads to lost time and little opportunity to make course corrections to ensure compliance and performance.

Sample Size

Wellcentive has heard significant concern from clinicians about the minimum reporting requirements and the significant increase that has been proposed from PQRS (50% of Medicare Part B beneficiaries, vs. 90% of all patients in MIPS, regardless of payer). With such a large increase in expected reporting, along with a short implementation timeframe for MIPS, Wellcentive requests that there be a period where the reporting requirements are phased in over the course of 2-3 performance years. This will allow clinicians to better prepare to report on the expanded patient base without overwhelming them with a sudden sharp increase.

Scoring on Physician Compare Website

Wellcentive requests, on behalf of our partner clinicians, that scores reported on the Physician Compare website show how each provider's Composite Score is calculated. Clinicians may be providing outstanding quality of care, but that care may be more expensive than their peers for various reasons. For example, it should be easily visible to the general public that the provider does deliver high quality care and that the reason for a potentially lower Composite Score is related to a higher cost, for example. In other words, ensure all category scores are visible on Physician Compare, and not just the final Composite Score.

Ambiguous Scoring

Wellcentive and our represented clinicians believe that the method for how scoring will be handled in large TIN's remains ambiguous in the Proposed Rule. We request that CMS clarifies how scoring will be handled across large Groups (TIN's) whose practices perform different activities. For example, in a TIN that has 10 practices, but only 5 are PCMH certified

- How would scoring be handled in the Clinical Practice Improvement Activities category?
- Will all providers in the TIN get full credit because some of the practices are certified?
- Will other practices need to perform their own activities to get full credit? If so, will the practices all be able to report individual activities that then roll up to a full category score?

Questions like these need to be answered so groups can identify gaps they may have and determine if group reporting is appropriate for their composition. There are similar questions with the Advancing Care Information category where practices may choose to perform different activities under different measures and we seek to understand how that will be attested and whether those disparate activities will roll up into a full group score.

Comments Sought by CMS

"We seek comments for future rulemaking on whether we should propose requiring health IT vendors, QCDRs and qualified registries to have the capability to submit data for all MIPS performance categories." – Wellcentive agrees with this and is fully intent on supporting all MIPS Submission categories. We believe that only working through a single vendor will provide a clinician with a full picture of their overall performance in the MIPS program.

"We seek comment on our proposal to allow reporting of specialty-specific measure sets to meet the submission criteria for the quality performance category, including whether it is appropriate to allow reporting of a measure set at the subspecialty level to meet such criteria, since reporting at the subspecialty level would require reporting on fewer measures." – Wellcentive supports the reporting of Measure Sets as meeting the full requirements of reporting in the Quality Category. Specialty Clinicians struggle to meet many other measures outside their domain and should not be penalized for not going outside their specialty by having to find additional measures to report that may not be appropriate for the care they provide.

"We seek comment on whether or not to include 0 percent performance in the benchmark." – Wellcentive proposes that 0 percent performance be included ONLY in the case of "Inverse Measures" where lower performance is better.

"Finally, we seek feedback on whether to score improvement where MIPS eligible clinicians do not have the required case minimum for measures to be scored." – Wellcentive encourages participation in MIPS even if the minimum thresholds are not met. Clinicians attempting to participate, even if they are unable to meet the minimum case requirements, should still be acknowledged for making the attempt, especially if they are showing year-over-year improvement. As noted above, the new proposed minimum threshold may cause many providers to be unable to fully participate and we feel that threshold should be re-evaluated.

"For all of these reasons, we are not proposing to have performance follow the TIN, but rather have performance follow the NPI; however, we seek comment on this option." – Wellcentive agrees with this stance. Performance should follow the Clinician/NPI and the overall TIN not be impacted.

"We could set the performance threshold based on policy goals to ensure a minimum number of points are earned before an eligible clinician is able to receive a positive adjustment factor and potentially an additional adjustment factor for exceptional performance. We seek comment on the policy options for setting the performance threshold." – Wellcentive requests that CMS keep in mind the timeframe that clinicians are being asked to implement such a large program, and the overlap it has with the preceding program (PQRS) when it proposes the first Performance Threshold. Many clinicians will likely struggle in year 1 due to the short implementation period of MIPS and its overlap with PQRS.

"We plan to coordinate with third party intermediaries such as health IT vendors and QCDRs as MIPS evolves to enable additional feedback to be sent on the resource use, advancing care information and CPIA performance categories. We seek comment on this for future rulemaking." – As a QCDR and Qualified Registry, Wellcentive supports more frequent feedback, especially in categories where CMS is the sole source of calculating performance (ex: Resource Use Category). This will enable clinicians to better evaluate performance throughout the year and make adjustments as necessary.

Wellcentive thanks you for your time and consideration on this important topic. Please do not hesitate to contact Wellcentive if you or your colleagues have any questions regarding our comments.

Jim Costolo

Strategic Program Manager

Greg Fulton

Industry & Public Policy Lead