June 24, 2016

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

RE: CMS–5517–P: Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models

Dear Acting Administrator Slavitt:

The Health Care Incentives Improvement Institute (HCI3) has long been committed to implementing, measuring, and advocating for reforms that improve health care quality and affordability. We applauded when, under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the Sustainable Growth Rate was replaced with a framework for rewarding clinicians for value instead of volume.

HCI3 has reviewed the proposed regulations for implementing the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) incentives and has concluded that changes to the rule are necessary to achieve the law’s full potential and intent. Indeed, we are concerned that without important revisions the rule may slow progress in the implementation of a powerful tool for aligning payment with quality: bundled payments.

Of particular note, global payments for episodes of care—which are now commonly referred to as bundled payments—are being widely implemented by private sector payers; employers; several state Medicaid programs, including New York’s; and the Centers for Medicare and Medicaid Services (CMS). If these programs are not designated as an Advanced Alternative Payment Model, there is a real risk that the national movement toward value-based payment will be set back. Please consider our recommendations for supporting bundled payments, described in our comments below.

Adjust Criteria for Bundled Payment Programs to Qualify as Advanced Alternative Payment Models

Under the rule, Comprehensive Joint Replacement (CJR) implementations and Bundled Payments for Care Improvement (BPCI) efforts—operating under CMS’s own initiatives—will not qualify as Advanced Alternative Payment Models. At the same time, Accountable Care Organizations participating in two tracks of the Medicare Shared Savings Program have a clear route for qualification. We know from available research that bundled payment programs show more promise than ACOs for achieving CMS’s mission of lower cost and higher quality care.
In fact, recent research published in the New England Journal of Medicine suggests that the ACO and Comprehensive Primary Care programs—the two programs that the rule has identified as being advanced APMs—have failed to significantly improve affordability and quality of health care, whereas CMS’s justification for mandating the Comprehensive Joint Replacement was that early results from the BPCI have shown savings. In light of these findings, we propose a rule change to correct the disparity between ACOs and bundled payments—CJR and BPCI programs, in particular—under the proposed regulations.

We understand that to be recognized as an Advanced APM, an APM (other than certain medical home models) must require its participants to use certified EHR technology, provide for payment based on acceptable quality measures, and require that its participants bear financial risk. It appears from Table 32 of the NPRM, at 81 Fed. Reg. 28312 (2016), that CJR and BPCI both meet the financial risk criterion, but that according to CMS neither meets the use of certified EHR criterion, and the BPCI also does not meet the quality measures criterion. We propose that additional reporting requirements be added to the CJR and BPCI programs that will satisfy the certified EHR criterion, and that steps be taken to enable BPCI entities to include quality measures that will satisfy the quality criterion.

Rejecting these models as Advanced APMs would not only miss an opportunity to promote further adoption of promising payment approaches, but may also disrupt the focus of current participants in BPCI and CJR. Instead, bundled payments deserve CMS’s robust support.

We recommend this robust support take the following form:

- Allow CJR and BPCI programs to qualify as Advanced Alternative Payment Models
- Construct a set of evidence-based, reliable, and valid quality measures for clinicians who participate with CJR and BPCI programs. Select measures that require a lower reporting burden than the MIPS model, but that provide meaningful insight into performance.
  - There are a number of measures that have already been identified by the American Academy of Orthopedic Surgeons for joint replacements and these are being applied in many programs across the United States, including implementations facilitated by HCI.
  - Additionally, in the broad and deep bundled payment programs undertaken for Medicaid programs (for which CMS has granted waivers) in Arkansas, New York, Ohio, and Tennessee, quality measures are tied to the episodes of care. These bundled payment programs have produced examples in the field that Medicare could use to refine its rules and allow BPCI and CJR to qualify as Advanced APMs
- Demand evidence from participating clinicians that they have and use certified EHRs

Accept Participation in Bundled Payments or Bridges To Excellence as Evidence of Clinical Practice Improvement Activities (CPIA) under MIPS

Under the proposed rule, physicians who do not qualify for incentive payments under Advanced Alternative Payment Models are evaluated under a second system, the Merit-

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Based Incentive Payment System (MIPS). Under MIPS’s Clinical Practice Improvement scoring category, health care professionals can earn substantial credit for participating in APMs. HCI\(^3\) considers important bundled payment work to be devalued in this category as well, as CJR and BPCI participation does not, under the proposed rule, produce any credit in this category.

- We recommend rewarding clinicians with CPIA credit—on par with credit for qualifying ACO participation—for participating in CJR and BPCI programs that satisfy the Advanced APM criteria as we have described above
- We also recommend a change in the CPIA Inventory (summarized in Table H in the proposed regulation). The proposed regulation assigns a Clinical Practice Improvement Activities scoring weight of “medium” to participation in Bridges to Excellence, the quality improvement program operated by HCI\(^3\). Because the program has for more than a decade fostered better, smarter, and healthier care—the regulation’s description of the goal of the CPIA measure—we respectfully request that participation in Bridges To Excellence earns a scoring weight of “high.”

**In Conclusion**

HCI\(^3\) feels strongly, and our research bears out, that bundled payment programs trigger meaningful clinical practice improvements, as referenced in our recent case study on Horizon Blue Cross Blue Shield’s bundled payment program.\(^2\)

In general, the bundled payment framework is the kind of model that can help CMS, and the health care industry at large, achieve the goal of better and more affordable care. For these alternatives to achieve widespread adoption, however, it is essential that they can qualify under the MACRA’s Quality Payment Program.

Sincerely,

Francois de Brantes
Executive Director

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