

June 27, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-5517-P, Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician Focused Payment Models, May 9, 2016.

Dear Mr. Slavitt:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule implementing the physician quality payment program (QPP) mandated by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Starting with calendar year (CY) 2019 physician fee schedule (PFS) payments, clinician payment will be tied to performance in one of two QPP tracks – the default Merit-based Incentive Payment System (MIPS) and a track for clinicians participating in certain advanced alternative payment models (APMs). CY 2019 payment adjustments will be based on clinician performance during CY 2017.

The implementation of the MACRA's QPP will have a significant impact, both on physicians and the hospitals with whom they partner. According to the AHA Annual Survey, hospitals employed more than 249,000 physicians in 2014, and had individual or group contractual arrangements with at least 289,000 more physicians. Hospitals that employ physicians directly will help defray the cost of the implementation of and ongoing compliance with the new physician performance reporting requirements under the MIPS, as well as be at risk for any payment adjustments. Moreover, hospitals may participate in advanced APMs so that the physicians with whom they partner can qualify for the bonus payment and exemption from the MIPS reporting requirements.



The AHA supports a number of the flexibilities CMS proposes to provide under both the MIPS and APMs. With respect to the MIPS, we support CMS's proposal to reduce the number of quality measures that MIPS-eligible clinicians and groups would be required to report, and believe it is a good first step toward achieving greater focus in quality improvement efforts. We also appreciate that CMS has taken steps to introduce greater flexibility in meeting meaningful use requirements in the advancing care information (ACI) performance category of the MIPS. Lastly, we support the flexible, group-based approach CMS proposes for calculating the amount of care provided through an APM. We agree that the agency should consider both patient counts and payment amounts when assessing APM participation.

However, the AHA urges significant changes to other proposals that may impinge upon the ability of hospitals and physicians to successfully participate in the QPP. In particular, we urge CMS to:

- Expand its definition of advanced APMs to include other models where the downside risk comes from the substantial investments that must be made to launch and operate an accountable care organization;
- Offer a quality and resource use measure reporting option in which hospital-based physicians can use CMS hospital quality program measure performance in the MIPS;
- Incorporate socioeconomic adjustment into the calculation of performance as needed; and
- Ensure alignment between the hospital meaningful use program and the ACI category of the MIPS, and recognize the considerable complexity of achieving the proposed ACI requirements by offering a reporting period of 90 days for the ACI category in CY 2017.

Finally, hospitals have expressed concern about the short timeframe between the expected issuance of the QPP final rule (i.e., potentially as late at Nov. 1, 2016) and the proposed start of the performance year for CY 2019 payment adjustments (i.e., Jan. 1, 2017). Hospitals and their physician partners have many operational and strategic issues to consider in responding to the QPP, including quality measure reporting mechanisms, whether to pursue participation in advanced APMs, and necessary improvements to electronic health records, to name a few. **The AHA urges CMS to monitor ongoing feedback about the readiness of the field to implement MACRA, and to be willing to consider additional flexibility in its timeline and other requirements such as quality measure data completeness.**

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Our detailed comments follow. We thank you for the opportunity to provide input on this proposed rule, and look forward to continuing to work with CMS to ensure the MIPS and APM realize their potential to support the ongoing transformation of health care delivery. If you have any questions, please contact Melissa Jackson, senior associate director of policy, at mjackson@aha.org, or Akin Demehin, director of policy, at ademehin@aha.org.

Sincerely,

/s/

Thomas P. Nickels

Executive Vice President

**American Hospital Association
Detailed Comments on the MACRA Physician Quality Payment Program
(QPP) Proposed Rule**

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) sunsets three existing physician quality performance programs – the physician quality reporting system (PQRS), Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals and the value-based payment modifier (VM) – and consolidates aspects of those programs into the MIPS. The MIPS will be the default QPP track for eligible clinicians. The MIPS must assess eligible clinicians on four performance categories – quality measures, resource use measures, clinical practice improvement activities (CPIAs) and advancing care information (ACI, a modified version of the historical “meaningful use” program). For all four categories, the Centers for Medicare & Medicaid Services (CMS) proposes to use calendar year (CY) 2017 as the “performance period” for CY 2019 MIPS payment adjustments. Based on their MIPS performance, eligible clinicians will receive incentives or penalties under the Medicare physician fee schedule (PFS) of up to 4 percent in CY 2019, rising gradually to a maximum of 9 percent in CY 2022 and beyond.

The AHA urges the adoption of a MIPS that measures providers fairly, minimizes unnecessary data collection and reporting burden, focuses on high-priority quality issues, and promotes collaboration across the silos of the health care delivery system. To achieve this desired state, we believe CMS should adhere to the following:

- Streamline and focus the MIPS measures to reflect national priority areas;
- Allow hospital-based physicians to use their hospital’s quality reporting and pay-for-performance program measure performance in the MIPS;
- Employ risk adjustment rigorously – including sociodemographic adjustment, where appropriate – to ensure providers do not perform poorly in the MIPS simply because of the types of patients they care for; and,
- Move away from an “all-or-none” scoring approach for the ACI category, and ensure that programmatic changes for eligible clinicians are aligned with those of the EHR Incentive Program for eligible hospitals.

The AHA agrees with several CMS proposals that are aligned with these recommendations, including a reduction in the number of required quality measures. However, we urge significant changes to other proposed policies to reduce unnecessary burden, address technical problems, and maximize the ability of the MIPS to compare performance fairly.

MIPS ELIGIBILITY AND EXCLUSIONS

The AHA supports a number of CMS’s proposed eligibility and exclusion criteria for the MIPS. As required by the MACRA, CMS proposes that for CY 2019 payment adjustments, the MIPS will apply to physicians, physician assistants (PAs), nurse practitioners (NPs), certified registered nurse anesthetists (CRNAs) and clinical nurse specialists (CNSs). In addition, CMS proposes to exclude from the MIPS those eligible clinicians and groups who qualify for the advanced APM track. CMS also would continue to allow eligible clinicians to participate as individuals or as part of group practices, a policy the AHA supports. However, we encourage CMS to consider providing additional flexibility to allow clinicians to submit group rosters to CMS to define a MIPS reporting group. This approach allows a large, multispecialty group under one tax identification number (TIN) to split into clinically-relevant reporting groups, or multiple TINs within a delivery system to group report under a common group.

CMS also proposes to exclude eligible clinicians and groups falling below a low-volume threshold, which the agency would define as Medicare Part B billing charges of \$10,000 or less, *and* providing care for 100 or fewer Medicare Part B enrolled beneficiaries during a performance period. **The AHA supports the concept of using a combination of billing charges and the number of beneficiaries to define the low-volume threshold. However, we urge CMS to provide additional analysis to support the proposed numerical standards.** For example, it would be helpful to know how many clinicians and groups may be excluded using this standard, as well as their characteristics (e.g., urban versus rural, specialty type, etc.). In addition, it is not clear whether the low-volume threshold accounts for the minimum number of cases needed to report on certain quality measures. We believe CMS should model whether having 100 patients or \$10,000 of billing would ensure a sufficient number of patients to be able to report on a sampling of frequently used quality measures, and adjust the low-volume threshold accordingly.

Furthermore, critical access hospitals (CAHs) and other low-volume providers have expressed concern about their readiness to participate in the MIPS. While some have participated in the pay-for-reporting PQRS program, they have not yet fully participated in the pay-for-performance VM program. Indeed, low-volume providers will be held harmless under the VM until CY 2018. Thus, the AHA also recommends that CMS consider a higher low-volume threshold in the first year of the MIPS program (e.g., 200 patients and \$20,000 of Part B charges), and then adjust the threshold in subsequent years. This approach would allow additional time for low-volume providers to prepare for the MIPS.

The AHA also urges CMS to address data capture issues for CAHs that may be required to participate in the MIPS. As is the case with the current PQRS program, CMS proposes that the MIPS would apply to CAHs billing under Method II whose clinicians have reassigned their billing rights to the CAH. Under Method II, CAHs bill and are paid for facility services at 101 percent of reasonable cost, and for professional services at 115 percent of such amounts as would otherwise be paid if such services were not included in outpatient [CAH] hospital services. CMS believes these professional services constitute “covered professional services” under the PFS, and notes that CAH professional service payments are based on the PFS.

However, some CAHs have reported issues with capturing full information about eligible clinicians from the institutional billing form used by CAHs (UB-04/CMS-1450). Under existing billing rules, CAHs may bill one CMS-1450 per day. The claims from multiple providers are combined into one. However, the claims often do not include all national provider identifier (NPI) numbers and, as a result, not all of the clinicians on the bill would receive credit for participation. Thus, we ask CMS to examine whether there are mechanisms for better capturing information on eligible clinicians from the CMS-1450 form.

MIPS QUALITY CATEGORY

Number of Required Measures. **The AHA applauds CMS's proposal to reduce the number of quality measures required for reporting from nine measures in the current PQRS to six measures in the MIPS.** This proposal would apply to all MIPS measure data reporting mechanisms except for the CMS web interface used by group practices. The AHA believes the implementation of the MIPS is a critically important opportunity to streamline and refocus physician quality measurement efforts so they align with concrete national priority areas for improvement across the entire health care system. CMS's proposal is a good first step toward achieving greater focus in measurement efforts.

However, significant work remains to ensure measurement efforts across the health care system are focused on the most important quality issues. As described in the next section, we believe CMS has additional opportunities to streamline measurement and promote focus through implementing a MIPS reporting option for hospital-based physicians. We also stand ready to work with CMS to better align Medicare hospital quality measures with those used in the private sector. We applaud CMS's recent work with private insurers and physician groups to reach agreement on common sets of physician quality measures that can be used in both CMS and private payer pay-for-performance programs. CMS proposed many of the measures from these common measure sets for the MIPS. Physicians and hospitals alike spend significant resources reporting on multiple versions of measures assessing the same aspect of care to meet the differing requirements of CMS and individual private payers. Greater alignment of measures across public and private payers would reduce unnecessary data collection burden and free up additional resources for improving patient care.

Lastly, we believe CMS must ensure that the quality measurement requirements for *all* providers share a common set of goals and objectives. Indeed, the significant improvement in outcomes and health that patients expect and deserve is best achieved when *all* parties in the health care system are working toward the same objectives. Without a common framework, quality measure data requirements proliferate without a strong link to national priorities, resulting in data collection requirements that often add burden without adding value to quality improvement or transparency efforts.

We continue to urge CMS to use the recommendations of the National Academy of Medicine's (NAM) 2015 *Vital Signs* report to identify the highest priority measures for development and implementation in the MIPS. The *Vital Signs* report notes that progress in improving the quality of health care has been stymied by discordant, uncoordinated measurement

requirements from CMS and others. To ensure that all parts of the health care system – hospitals, physicians, the federal government, private payers and others – are working in concert to address priority issues, the *Vital Signs* report recommends 15 “Core Measure” areas, with 39 associated priority measures. These areas represent the current best opportunities to drive better health and better health care, based on a comprehensive review of available literature. Each stakeholder would be measured on the areas most relevant to their role in achieving common goals and objectives. While we caution against using the core measure areas to assess providers on aspects of care that may be beyond the scope of their operations, the NAM report provides an important uniting framework that will help make all stakeholders more accountable and engaged in measurement and improvement.

Use of Hospital Quality Measures for Hospital-based Clinicians. The AHA urges CMS to implement a CMS hospital quality program measure reporting option for hospital-based clinicians in the MIPS as soon as possible. We believe using hospital measure performance in the MIPS would help physicians and hospitals better align quality improvement goals and processes across the care continuum, and reduce data collection burden.

A provision in the MACRA allows CMS to develop MIPS-participation options for hospital-based clinicians so they can use their hospital’s quality and resource use measure performance for the MIPS. While we are disappointed that the agency does not formally propose such an option for the CY 2019 MIPS, we look forward to working with CMS and other stakeholders in the coming months to make hospital-based physician reporting in the MIPS a reality. In the interim, we comment on several implementation issues.

Attribution of Hospital-based Clinicians to Hospitals. **The AHA recommends that CMS allow hospitals and clinicians to self-designate whether they qualify as hospital-based.** CMS could allow physicians to self-designate hospital-based status through a process that is similar to how physician group practices currently self-designate for the PQRS program. Hospitals also would be asked to confirm this relationship. If needed, the agency could set parameters that ensure a strong relationship between a physician and hospital. For example, CMS could require active membership on the medical staff or an employment contract. The agency could utilize claims data elements, such as inpatient and hospital outpatient department place of service codes, to validate the relationship.

The AHA recommends against the mandatory attribution of hospital-based clinicians to hospitals. While we believe there is considerable value in allowing hospital-based clinicians to use CMS hospital program measures in the MIPS, we recognize that such an option may not be appropriate for all hospitals and all hospital-based clinicians in the MIPS. The use of a self-nomination process would ensure that there is sufficient mutual interest between clinicians and hospitals to warrant the use of hospital measure performance.

CMS Hospital Measures to Use. **Nearly all measures from CMS’s hospital quality reporting and pay-for-performance programs should be available for use in hospital-based physician reporting options.** The agency should consider measures from the inpatient quality reporting (IQR), outpatient quality reporting (OQR), value-based purchasing, readmissions reduction and

hospital-acquired conditions (HAC) programs for inclusion in the reporting option. This approach would help ensure that a wide variety of specialties would have the ability to use the option. To ensure that both clinicians and hospitals agree on which specific measures would be used in the reporting option, clinicians could indicate which measures they intend to use as part of a self-designation process. Hospitals could then confirm their agreement with the selected measures.

Claims-based Population Measures and Risk Adjustment. The AHA opposes the adoption of the three proposed claims-based population measures unless and until their risk adjustment approach is improved. For groups of 10 or more eligible clinicians, CMS proposes to calculate up to three Medicare claims-based measures reflecting avoidable hospital admissions and readmissions:

- *Acute Condition Composite.* Combines the rates of potentially preventable hospital admissions for dehydration, urinary tract infections and bacterial pneumonia.
- *Chronic Condition Composite.* Combines the rates of potentially preventable hospital admissions for diabetes, heart failure and chronic obstructive pulmonary disorder (COPD).
- *All-Cause, All-Condition Hospital Readmission Measure.* Assesses the rate of hospital readmissions among the group practice's population.

These measures would be calculated in addition to the measures collected and submitted by groups, and included in a group's MIPS quality score. Groups would receive a score only on the measures for which they have attributable patients and meet the minimum case volume. The AHA agrees with the goal of reducing preventable readmissions as a way to improve care coordination and reduce costs.

However, the AHA is concerned that the lack of any risk adjustment in the acute and chronic condition composite measures will cause providers caring for more complex patients to score poorly on the measures. It is a known fact that patient outcomes are influenced by factors other than the quality of the care provided. In the context of quality measurement, risk adjustment is a widely accepted approach to account for some of the factors outside the control of providers when one is seeking to isolate and compare the quality of care provided by various entities. As noted in the National Quality Forum's 2014 report on risk adjustment and sociodemographic status, risk adjustment creates a "level playing field" that allows fairer comparisons of providers. Without risk adjustment, provider performance on most outcome measures reflect differences in the characteristics of patients being served, rather than true differences in the underlying quality of services provided.

Furthermore, we strongly urge that all three measures be assessed for the extent to which sociodemographic factors impact measure performance. Sociodemographic adjustment should be incorporated as needed. The evidence continues to mount that sociodemographic factors beyond providers' control – such as the availability of primary care, physical therapy,

easy access to medications and appropriate food, and other supportive services – influence performance on outcome measures. For example, in January 2016, NAM released the first in a planned series of reports that identifies “social risk factors” affecting the health outcomes of Medicare beneficiaries and methods to account for these factors in Medicare payment programs. Through a comprehensive review of available literature, the NAM’s expert panel found evidence that a wide variety of social risk factors may influence performance on certain health care outcome measures, such as readmissions, costs and patient experience of care. These community issues are reflected in readily available proxy data on socioeconomic status, such as U.S. Census-derived data on income and education level, and claims-derived data on the proportion of patients dually eligible for Medicare and Medicaid. The agency also recently proposed to adjust several measures in the Medicare Advantage Star Rating program for sociodemographic factors. Yet, to date, CMS has resisted calls to incorporate sociodemographic adjustment into the quality measurement programs for physicians, hospitals and other providers.

Unfortunately, failing to adjust measures for sociodemographic factors when necessary and appropriate can harm patients and worsen health care disparities by diverting resources away from physicians, hospitals and other providers treating large proportions of disadvantaged patients. It also can mislead patients, payers and policymakers by blinding them to important community factors that contribute to poor outcomes. Physicians, hospitals and other providers clearly have an important role in improving patient outcomes and are working hard to identify and implement effective improvement strategies. However, there are other factors that contribute to poor outcomes. If quality measures are implemented without identifying sociodemographic factors and helping all interested stakeholders understand their role in poor outcomes, then the nation’s ability to improve care and eliminate disparities will be diminished

Data Completeness Standards. **The AHA urges CMS to adopt a more gradual increase of its proposed data completeness standards.** CMS proposes that eligible clinicians and groups using the registry and EHR reporting options must report data on at least 90 percent of the patients that meet the criteria for inclusion in a measure’s denominator. The agency also proposes that individual clinicians using the claims reporting option report on 80 percent of eligible patients. However, these data completeness thresholds are significantly higher than the 50 percent required in the current law PQRS program. Moreover, the 50 percent threshold in PQRS actually is a decrease from prior years, in response to concerns from the field.

The AHA agrees with the value of data completeness standards and believes they can help ensure the reliability and accuracy of measure data. However, a 30 to 40 percentage point increase in the standard from one year to the next is far too aggressive, especially given that the implementation of the MIPS marks a significant change for the field. Therefore, we recommend that CMS maintain the 50 percent threshold for the CY 2019 MIPS program and phase in increases of data completeness in subsequent years. Indeed, we note CMS has adopted a similar approach in the quality reporting programs for other providers, such as its recently adopted data completeness standards for post-acute care quality reporting programs.

MIPS RESOURCE USE CATEGORY

To assess performance in the resource use category, CMS proposes to calculate two overall cost measures currently used in the VM program – total cost per capita and Medicare spending per beneficiary (MSPB). In addition, CMS proposes a list of over 40 clinical condition and treatment episode-specific cost measures. CMS would score eligible clinicians and groups on all of the measures for which they have at least 20 cases. A clinician or group's overall resource use score would be the average of all of the resource use measures for which they have sufficient data.

The AHA strongly urges that CMS assess the impact of sociodemographic factors on performance for each measure and incorporate sociodemographic adjustment as necessary.

As described in the MIPS Quality Category section of this letter, a lack of sociodemographic adjustment for outcomes like cost and readmissions can lead to providers scoring worse on measures simply because they care for poorer patients.

Moreover, the AHA strongly urges CMS to retain both the specialty adjustment and the current minimum case threshold of 125 cases in the MSPB measure. The specialty adjustment in MSPB is intended to account for differences in specialty mix that can affect the costs of care. In proposing to remove specialty adjustment, CMS suggests that it is “unclear” whether the adjustment helps to account for cost differences by specialty. However, the agency does not provide an analysis to demonstrate this finding. We are concerned that without specialty adjustment, certain clinicians will have inferior performance on the measure because they provide care that is inherently more expensive. Moreover, CMS raised the minimum case threshold for MSPB to 125 cases just last year, suggesting that a threshold of 20 cases was not sufficient to ensure reliable measure results. We do not believe the measure has materially changed in such a way that it achieves reliable results without the higher case threshold.

Lastly, the AHA recommends that CMS consider a resource use measure reporting option for hospital-based clinicians in which they may use their hospital's results from the CMS quality reporting and pay-for-performance programs in the MIPS. The CMS quality reporting and pay-for-performance programs for hospitals include a number of cost and resource use measures that we believe some hospital-based physicians could use. To operationalize this approach, we refer the agency to our earlier comments on the “Use of Hospital Quality Measures for Hospital-based Clinicians.”

MIPS CLINICAL PRACTICE IMPROVEMENT ACTIVITY (CPIA) CATEGORY

Given the novelty of the CPIA category, the AHA appreciates the flexibility that CMS has attempted to provide for meeting this category's requirements. The MACRA requires that CMS establish a MIPS performance category that rewards participation in activities that improve clinical practice, such as care coordination, beneficiary engagement and patient safety. We appreciate that CMS proposes a list of over 90 CPIAs from which clinicians can select to fulfill this category. Clinicians generally would need to participate in more than one activity to receive the highest score in the category. We also appreciate CMS providing numerous ways for reporting participation in such activities, such as attestation or the use of a registry.

However, we urge CMS to reconsider assigning differential weights to CPIAs for the first two performance periods of the MIPS (i.e., CYs 2017 and 2018). CMS proposes to assign weights of “medium” or “high” to CPIAs on its proposed list. A “medium” weight CIA would be worth 10 points, while a “high” weight CIA would be worth 20 points. Eligible clinicians and groups would then select from among the list to achieve up to 60 possible points.

We agree that some CPIAs may have a greater value in improving care than others. However, we believe CMS should conduct a fuller assessment of the relative impact of particular CPIAs on practice quality – as well as the effort required to participate in particular activities – before assigning differential weights to them. Moreover, the MACRA only requires two types of CPIAs to receive higher credit towards the CIA category score. Clinicians participating in certified patient-center medical homes must receive 100 percent of the highest score for the category, and participants in certain APMs must receive at least 50 percent of the highest CIA score. Thus, we believe the agency has the flexibility to adopt uniform weights for CPIAs for at least the first two performance years of the MACRA. For example, the agency could simply ask that practices participate in any two CPIAs during the performance period, with each CIA receiving 30 points towards the score.

The AHA also urges CMS to award participants in APMs the highest possible score in the CIA category. As noted above, MACRA simply requires that CMS award *at least* half of the highest score in the CIA category to APM participants, providing CMS with the flexibility to weight APM participation even higher. Moreover, we believe this weight would more effectively recognize the significant investment of resources that is required for clinicians to participate in APMs.

ALTERNATIVE SCORING FOR APM PARTICIPANTS

As noted later in this letter, CMS’s proposed criteria for the “advanced APM” track severely limit the clinicians and groups that would qualify as an advanced APM. As a result, most Medicare APM participants would be required to participate in the MIPS. In the proposed rule, CMS acknowledges that Medicare APMs generally assess participants’ cost and quality, and require participation in improvement activities – in other words, the same areas captured in the MIPS’s performance categories. For this reason, CMS proposes to adopt alternative MIPS scoring standards for certain APMs – termed “MIPS APMs” – in an effort to reduce duplicative reporting requirements and ensure that APM participants are not assessed in different ways for performing the same activities.

The AHA appreciates the intent of CMS’s alternative MIPS scoring standards for Medicare APM participants. However, we urge CMS to make several changes that would more appropriately reward those clinicians and groups who have made significant investments to transform care through Medicare APMs. Most notably, we urge CMS to include participants in the Comprehensive Care for Joint Replacement (CJR) initiative in the APM track. While the CJR places hospitals at risk for payment rather than clinicians, clinicians are able to enter into gainsharing arrangements that allow them to take on some risk

for performance under the model. We believe it is appropriate to recognize that risk by including CJR participants under such arrangements in the MIPS APM scoring standard. The AHA also encourages CMS to consider the inclusion of physicians participating in Models 2, 3 and 4 of the Bundled Payments for Care Improvement model.

Moreover, we urge that MIPS APM participants receive the highest possible score in the CPIA category. As noted in the MIPS CPIA section of this letter, the MACRA statute should provide CMS with sufficient flexibility to award the highest CPIA category score to MIPS APM participants. Moreover, we believe this scoring would help recognize the significant investment of resources needed to participate in an APM. Finally, this approach would help MIPS APM participants focus on the care transformation efforts necessary to succeed in an APM, rather than fulfilling MIPS requirements.

MIPS ADVANCING CARE INFORMATION CATEGORY

CMS proposes a new framework for the Medicare EHR Incentive Program for MIPS eligible clinicians. Renamed advancing care information (ACI), performance in this category is proposed to represent 25 percent of the MIPS composite score. The AHA appreciates the move toward flexibility in the ACI category. We believe that the technology readiness for use in providing care is central. However, we also believe that the ACI category, as proposed, contains a high degree of complexity and a bar for success that remains too high. Additionally, we believe CMS has set forth an insufficient time for preparation for a full year of reporting.

The AHA recommends that CMS simplify the ACI requirements by permitting eligible clinicians to use objectives and measures derived from the EHR Incentive Program Modified Stage 2 objectives and measures to meet the ACI requirements and report for a 90-day reporting period. We also recommend that CMS delay the introduction of objectives and measures derived from EHR Incentive Program Stage 3 until a date no sooner than CY 2019. Finally, the AHA recommends that CMS address the misalignment of the ACI proposal and the EHR Incentive Program requirements for hospitals and CAHs.

Use the Modified Stage 2 Objectives and Measures for the ACI Category. For the ACI base score, CMS proposes reporting on objectives and measures derived from the EHR Incentive Program in a methodology that includes a score for participation and reporting – a base score – and score for performance at varying levels on several measures – a performance score. CMS also proposes an additional score based upon one additional measure – a bonus point. The proposed objectives and measures are derived from the EHR Incentive Program Stage 3.

CMS proposes that eligible clinicians would report 10 required and four optional measures within six objectives for the base score. CMS also proposes that eligible clinicians have an alternative and report on objectives and measures derived from the EHR Incentive Program Modified Stage 2. In this scenario, CMS proposes that eligible clinicians would report on 11 required measures within eight objectives for the base score. CMS also proposes an alternative number of objectives and measures to be reported for the base score using either the Stage 3 or

Modified Stage 2. Rather than four options to meet the ACI base score, **the AHA recommends that the ACI requirements be simplified to require the reporting of objectives and measures derived from Modified Stage 2 and continue the use of 2014 edition certified EHRs.**

CMS's proposal, in the alternative to the base score derived from Modified Stage 2, would require eligible clinicians to report on 16 measures within 10 objectives. **The AHA supports this reporting proposal for Modified Stage 2 base score measures because it includes the option to report computerized provider order entry (CPOE) and clinical decision support (CDS).** We believe it is important to focus on enabling the EHR capability while giving providers time to optimize the tool in care delivery. The AHA also supports the continuation of the concept of active engagement with public health agencies or specialized registries; however, **we recommend that CMS require eligible clinicians to report one public health measure rather than three measures in the base score.** Experience to date indicates that variation exists in the availability of specialized registry reporting options and the opportunity of clinicians to use certified EHRs to electronically report to state public health agencies.

The use of Modified Stage 2 objectives and measures for the performance score reporting would result in the availability of six measures for five objectives. Unlike the base score, CMS proposes that eligible clinicians meet high levels of performance based on numerators and denominators for each measure that would be assigned a number of points for each measure in the performance score. We believe the demonstration of success in the performance score will require the availability of more than six measures. The experience to date from Stage 2 thresholds indicates that eligible clinicians would not score a sufficient number of points in the performance score if a limited number of measures are offered. **The AHA recommends that CMS expand the number of objectives and measures from Modified Stage 2 available for performance score reporting to include measures from the e-prescribing, CPOE and public health objectives.** In the case of public health measures, we recommend that CMS offer the maximum number of points for electronic submission of data to a public health agency or specialized registry and half of the maximum number of points for active engagement with a public health agency or a specialized registry, as the EHR Incentive Program offers these two options to meet the public health measure reporting requirements.

In addition, the AHA also recommends that CMS revise the scoring methodology for the ACI composite score. The expansion of objectives and measures available in the performance score would eliminate the need for a bonus point in the ACI composite score and the performance to date in the EHR Incentive Program Modified Stage 2 supports reconsideration of the total points required for the ACI composite score. **The AHA supports an approach that makes clear that attainment of 70 percent of the objectives and measures afford full credit for the ACI composite score. Additionally, we recommend that CMS study the 2016 experience in the Medicare EHR Incentive Program and the first year of the ACI reporting to inform future requirements for the ACI category.**

The use of objectives and measures derived from the Modified Stage 2 also will provide time for the adoption and safe implementation of 2015 edition certified EHRs. Experience to date

indicates that the transition to new editions of certified EHRs is challenging due to lack of vendor readiness, the necessity to update other systems to support the new data requirements, mandatory use of standards that may be immature, and a timeline that frequently is too compressed to support successful change management. The receipt of a new edition of a certified EHR initiates a 19-month process from software assessment, installation, implementation and training to building of performance before the required reporting period.

Provide a 90-day Reporting Period for Reporting Requirements that Utilize Certified EHRs. The proposed rule includes a full calendar year of reporting for the ACI category. **The AHA recommends that CMS finalize a shorter, 90-day reporting period for the ACI category and for any provisions in the final rule where an eligible clinician would use a certified EHR to meet a program requirement.** Even if the MACRA rule is finalized in the fall, providers will have very little time to understand the changes, work with their vendor and prepare to meet the revised requirements.

Delay the Start of Stage 3 Requirements to a Date No Sooner than 2019. CMS proposes that eligible clinicians use their 2015 edition certified EHRs to report on objectives and measures derived from the EHR Incentive Program Stage 3 for a base score, a performance score and one bonus item. The EHR Incentive Program made reporting Stage 3 optional in CY 2017 with a 90-day reporting period. **The AHA disagrees with the proposal to accelerate the reporting of Stage 3 requirements through inclusion in the ACI category for 2017. We recommend that CMS delay the introduction of objectives and measures derived from EHR Incentive Program Stage 3 until a date no sooner than CY 2019.** We believe that at least 75 percent of eligible clinicians should attain the Modified Stage 2 before moving to objectives and measures derived from Stage 3. Additionally, the Stage 3 requirements to make the patient's health information available for access by any app of the patient's choice that is configured to interface with the clinician's EHR has the potential to introduce unacceptable security vulnerabilities to the clinician's information technology. Given the recent, sharp increases in cyber attacks on health care, clinicians must be allowed to exercise appropriate control over their information systems.

Align EHR Incentive Program Requirements for Hospitals and CAHs with Those of Eligible Clinicians. The AHA supports changes to the EHR Incentive Program for physicians that begin to offer flexibility in how physicians and other eligible clinicians are expected to use certified EHRs to support clinical care. As these changes are implemented, it will be essential to ensure that program requirements are aligned across all participants, including physicians, hospitals and CAHs. This alignment is essential to ensuring the ability of providers to share information and improve care coordination across the continuum. **The AHA urges CMS to accelerate efforts to ensure that requirements for the use of certified EHRs and the exchange of health information are aligned across all providers by also providing additional flexibilities to hospitals and CAHs under the Medicare and Medicaid EHR Incentive Program.**

ADVANCED ALTERNATIVE PAYMENT MODELS (APMs)

DEFINITION OF ADVANCED APMs

The AHA is extremely disappointed that few of the models in which hospitals have engaged will qualify as advanced APMs; we urge CMS to adopt a more inclusive approach. Specifically, we are concerned about CMS's proposed generally-applicable financial risk standard, under which an APM generally must require participating entities to accept significant downside risk to qualify as an advanced APM. We urge CMS to expand its definition of financial risk to include the investment risk borne by providers who participate in APMs, and to develop a method to capture and quantify such risk. We also urge the agency to update existing models, such as the Bundled Payments for Care Initiative and the CJR, so that those models would qualify as advanced APMs.

Financial Risk Standard. **CMS's proposed approach fails to recognize the significant resources providers invest in the development of APMs.** For example, to successfully implement an APM, providers must acquire and deploy infrastructure and enhance their knowledge base in areas, such as data analytics, care management and care redesign. Further, one metric for APM success – meeting financial targets – may require providers to reduce utilization of certain high-cost services, such as emergency department visits and hospitalizations through earlier interventions and on-going supports to meet patient needs. However, this reduced utilization may result in lower revenues. Providers participating in APMs accept the risk that they will invest resources to build infrastructure and potentially see reduced revenues from decreased utilization, in exchange for the potential reward of providing care that better meets the needs of their patients and communities and generates shared savings. This risk is the same even in those models that do not require the provider to repay Medicare if actual spending exceeds projected spending.

Although the clinicians participating in shared savings-only models are working hard to support CMS's goals to transform care delivery, under CMS's proposal they will not be recognized for those efforts. We fear this could have a chilling effect on experimentation with new models of care among providers that are not yet prepared to jump into two-sided risk models. CMS has attempted to provide a glide path to APMs that falls short of advanced APM status through the MIPS APM designation. However, we are skeptical that the benefits offered to the MIPS APMs go far enough, since providers who fall into that designation will be required to split their efforts and resources between successful MIPS reporting and undergoing the care transformation efforts necessary to succeed in an APM. Given limited resources, providers are likely to focus on achieving the successful performance required to avoid negative payment adjustments through the MIPS, leading to the unintended consequence of reduced interest in APMs.

It is important to note that Track 1 accountable care organizations (ACOs), which are shared savings-only ACOs, make up 95 percent of ACOs in the Medicare Shared Savings Program (MSSP). CMS has proposed that clinicians participating in these ACOs would receive no incentives to reward their pioneering efforts to transform care. Many Track 1 ACOs began performance periods Jan. 1, 2016, either as new entrants to the MSSP or by renewing for a

second performance period. These ACOs were not aware of CMS's proposed financial risk definition when they began on Jan. 1, 2016, but are now locked into three-year contracts under which participating clinicians would receive no credit for APM participation. Further, providers evaluating whether to enter into the MSSP face tight deadlines to assess potential participation in context of this proposed rule and build the necessary provider networks. **We urge CMS to extend the deadlines for 2017 MSSP participation to allow more time for interested providers to evaluate their options.**

CMS also proposes an alternative financial risk standard applicable to medical homes. Under this standard, medical homes would not be required to accept downside risk. Instead, the financial risk criterion would be satisfied if the medical home model potentially withholds payment for services; reduces payment rates; requires repayment to CMS; or eliminates the right to all or part of an otherwise guaranteed payment(s) if either actual expenditures for which the entity is responsible exceed expected expenditures, or the entity's performance on specified performance measures does not meet or exceed expected performance. CMS proposes that beginning in 2018, this more-lenient standard would not apply to medical homes if the owner organization has more than 50 clinicians. **The AHA opposes the proposal to limit application of the medical home financial risk standard to organizations with 50 or fewer clinicians, and we urge the agency not to finalize the proposed threshold.** This proposal would preclude clinicians participating in hospital-driven medical homes through the recently announced Comprehensive Primary Care Plus (CPC+) model from receiving credit toward MACRA APM incentives for their efforts, which could make it more difficult for hospitals to engage clinicians to partner in the CPC+ model.

EHR and Quality Criteria. In addition to the financial risk criterion, the MACRA requires that advanced APMs require APM entities to use certified EHR technology and to condition payment on quality measures comparable to those in the MIPS quality category. **The AHA appreciates that CMS recognizes that different approaches may be appropriate for different APMs, and has proposed to build in some flexibility to accommodate a variety of models.**

CMS proposes that advanced APMs would meet the certified EHR technology requirement if certain thresholds for use of certified EHR technology are met. For CY 2017, the model must require at least 50 percent of eligible clinicians who are enrolled in Medicare (or each hospital, if the hospital is the APM participant) to use the certified health information technology (IT) functions to document and communicate clinical care with patients and other health care professionals. This threshold would increase to 75 percent of eligible clinicians beginning in 2018. **We urge CMS to provide flexibility so that the model meets this criterion if it allows APM clinicians working in a facility possessing certified EHR technology – such as a hospital – to be deemed to be “using” certified EHR based on the facility's usage.** CMS could establish an attestation process to confirm that clinicians are, in fact, utilizing certified EHR technology, either on their own or within the facilities in which they are caring for patients.

We note that the CJR bundled payment model is excluded from being deemed an advanced APM because it lacks a certified EHR requirement. Therefore, physicians who partner with hospitals that were mandated to participate in the CJR would not receive credit toward APM incentives

based on their participation in CJR episodes of care. **We are dismayed that CMS designed and mandated participation in the CJR without ensuring that the model would meet the MACRA's requirements. We urge the agency to revisit the CJR model and incorporate an EHR measure that would allow CJR to qualify as an advanced APM and, thus, clinicians who have engaged with hospitals on CJR episodes of care would receive credit toward APM incentives.**

We support CMS's proposal that the quality measurement criterion is satisfied if a model incorporates quality measure results as a factor when determining payment to participants under the terms of the APM. Further, we support the proposal that an APM must require reporting on one outcome measure, if an appropriate measure exists, in addition to one measure that has an evidence-based focus and is reliable and valid. This approach provides flexibility and appropriately acknowledges that different measures may be appropriate for different payment models.

ADDITIONAL ADVANCED APM PROPOSALS

CMS has estimated that only 30,000 to 90,000 clinicians would qualify for APM incentives under its proposals, out of an estimated 800,000 clinicians who would be impacted by the MACRA. Further, as we have stated, we expect that few hospital-driven models would qualify as advanced APMs, which means that clinicians aligned with those hospital models would not qualify for APM incentives. CMS should focus on the Secretary's goals to promote participation in APMs by making sure that its proposals actually incentivize movement toward APMs rather than having the opposite effect of chilling experimentation. However, we acknowledge that the details of implementation are important, and appreciate that CMS has attempted to take a flexible approach in many cases. We offer the following comments on aspects of advanced APM implementation:

- *Calculating APM Participation.* The statute gives CMS the authority to consider either payment amounts or patient counts when determining whether a clinician is a qualifying professional (QP) by virtue of having met the statutory threshold for advanced APM participation. The agency proposes to calculate a threshold score using both methods and apply whichever method is favorable to the applicable clinician or group of clinicians. **The AHA is pleased with this approach, which we had urged the agency to adopt in our feedback to a 2015 MACRA Request for Information, although, as noted above, we urge CMS to ensure its thresholds are aligned with the quality measure reporting requirements.**
- *Group Determinations.* CMS proposes to make QP determinations at the group level. Specifically, it would calculate a collective threshold score for all clinicians in an APM entity. If the threshold score meets the relevant advanced APM threshold, the QP determination would apply to all clinicians who are identified as part the APM entity. For instances where a clinician participates in more than one advanced APM and no one single APM entity meets the appropriate threshold, CMS would assess whether the individual clinician meets the threshold, using combined information for services

provided by the clinician across all advanced APMs. **The AHA supports the proposal to determine QP status at the group level, as it would allow for recognition of all clinicians who participate in the APM entity and further its goals, but whose care may not be used for attribution. Further, we support the proposal to evaluate QP status of clinicians who participate in more than one model but do not qualify under any one APM entity, as this would more fully recognize clinicians who are immersed in APMs.**

- *Other APM Documentation.* For the all-payer APM option (which CMS calls the “other payer APM”) CMS proposes to require that APM entities or eligible clinicians submit certain information on their APM arrangements with Medicare Advantage plans, state Medicaid agencies, and private payers so that CMS may assess whether the APM arrangements meet the applicable requirements and to calculate the threshold score. The information would be provided by either the APM entity or the clinician. **As CMS considers what information to require, we urge the agency to be mindful of the need to limit potential burden on clinicians and APM entities.**

INFORMATION BLOCKING AND EHR SURVEILLANCE

The AHA concurs that interoperability is a national objective. We also strongly support the creation of an efficient and effective infrastructure for health information exchange that facilitates the delivery of high-quality, patient-centered care across health care settings. Providers have an obligation to share health information needed for care and to engage patients; hospitals and health systems are working to build systems for that purpose. Despite the shared goal of having health information follow the patient to inform care, hospitals and health systems report that many EHRs do not easily share information and providers do not universally have access to efficient exchange networks and other infrastructure. In addition, the cost and complexity of the many interfaces needed to connect systems today are simply not sustainable.

The AHA is concerned that CMS’s proposals that physicians attest to not participating in information blocking – and cooperate with EHR surveillance activities – do not focus on the core issues at hand. **The AHA recommends that CMS work with the Office of the National Coordinator for Health IT (ONC) to consider the extent to which we have the standards, technology and infrastructure in place to facilitate information exchange with a focus on mechanisms to ensure the availability of efficient and effective trusted exchange in practice, and robust testing of products used to support exchange.** Without those building blocks in place, providers are challenged to efficiently and effectively exchange and use health information. Data have shown that we do not currently have a sufficiently robust infrastructure to support exchange. For example, in the 2015 Health IT Supplement to the AHA Annual Survey, 51 percent of more than 3,500 respondents (unweighted data) indicated that they face challenges exchanging data across different platforms, suggesting a lack of standardized approaches. In addition, 52 percent (unweighted data) reported that they have difficulty locating the address of a desired recipient, due to the lack of widely available provider directories. These are just two of the infrastructure items that must be in place for providers to effectively exchange and use

electronic health information. Another missing infrastructure item is a unique patient identifier or other national solution that allows providers to know with confidence that shared information is about the same individual.

Given these challenges with today's technology and the existing infrastructure, **the AHA recommends that CMS keep only one of the three proposed attestations about information blocking – that hospitals and CAHs participating in the meaningful use program and clinicians participating in the Medicare quality program attest that they have not “knowingly and willfully taken action (such as to disable functionality) to limit or restrict the compatibility or interoperability of their certified EHR.”**

We note that of the three proposed attestations, this is the only one that is required in statute. The other two go beyond the statutory requirement and ask providers to attest broadly to items that are redundant with other regulations and may not be possible given today's health IT technology and infrastructure. We urge CMS to remove its other two proposed attestations (below):

- The technology is implemented to conform with standards, allow patient access and support secure and trusted bi-directional exchange of structured health information with other health care providers, including unaffiliated providers, and with disparate certified EHR technology and vendors.
- Hospitals, CAHs or physicians responded in good faith and in a timely manner to requests to retrieve or exchange electronic health information, including from patients, health care providers and other persons, regardless of the requestor's affiliation or technology vendor.

The certification process is intended to ensure that technology conforms with standards, as defined by the ONC. Given that meaningful use, MIPS and advanced APMs all require providers to have certified EHRs, this requirement is unnecessary and redundant. Furthermore, the term “trusted bi-directional exchange” is not well defined, creating uncertainty for providers as to what they are attesting to, and is generally not widely feasible given the challenges noted above.

With respect to the attestation on responding to requests for information sharing, both the MIPS and meaningful use contain specific requirements to share information with patients and with other providers, making this attestation redundant. Furthermore, the broad scope of the attestation does not take into account the limits of the current technology and infrastructure noted above. Finally, this attestation makes no reference to privacy concerns and could expose providers to significant penalties if they were to respond to requests for information that do not comply with the myriad federal, state and local privacy laws.