American Hospital Association

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November 17, 2015

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-3321-NC, Request for Information Regarding Implementation of the Merit-based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models (Vol. 80, No. 190), Oct. 1, 2015.

Dear Mr. Slavitt:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Request for Information (RFI) on the implementation of the Merit-based Incentive Payment System (MIPS) and alternative payment models (APMs). The MIPS and APMs constitute the two "tracks" of the new physician payment system mandated by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, and will affect Medicare physician fee schedule (PFS) payments beginning in 2019.

The implementation of MACRA will have a significant impact not only on physicians, but also on the hospitals with whom they partner. Indeed, according to the AHA Annual Survey, hospitals employed nearly 245,000 physicians in 2013, and had individual or group contractual arrangements with at least 296,000 more physicians. Hospitals that employ physicians directly will bear the cost of the implementation of and ongoing compliance with the new physician performance reporting requirements, as well as be at risk for any payment adjustments. Moreover, hospitals may be called upon to participate in APMs so that the physicians with whom they partner can qualify for the APM track. For these reasons, the AHA has initiated discussions with our membership to identify the most important policy and operational implications of the MIPS and APMs for hospitals. We look forward to sharing additional insights with CMS in the coming months. In the interim, we offer several overarching recommendations on implementing the MIPS and APMs.

MIPS Implementation. **The AHA urges CMS to adopt a system that measures providers fairly, minimizes unnecessary data collection and reporting burden, focuses on important quality issues, and promotes collaboration across the silos of the health care delivery system.** We recommend CMS:

- Streamline the number of measures required for reporting;
- Consider reducing the number of measure data reporting mechanisms over time;
- Employ risk adjustment rigorously – including sociodemographic adjustment where appropriate – to ensure providers do not perform poorly in the MIPS simply because they care for more complex patients;
- Allow hospital-based physician specialties to use their hospital's quality reporting and pay-for-performance program measure performance in the MIPS; and
- Provide flexibility in how group practices identify themselves for the purposes of the MIPS.

APMs Implementation. **We urge CMS to provide the greatest opportunity possible for physicians who choose to become qualifying APM participants.** Specifically, we suggest CMS:

- Consider both the patient population served by a physician and the payments made through an APM when determining whether a physician meets APM thresholds;
- Cast a wide net when capturing physician participation in APMs; and
- Define "financial risk" in a manner that acknowledges the significant investment providers make to participate in APMs.

Lastly, the AHA applauds CMS for seeking early input from the field on the design of the MIPS and APMs. We strongly encourage the agency to provide as much opportunity as possible for ongoing stakeholder input. To that end, we are pleased CMS is willing to receive comments outside of the RFI comment period. The agency also may wish to consider sharing more fully formulated policy approaches in advance of issuing a proposed rule using RFIs or other informal mechanisms, such as the Healthcare Payment Learning and Action Network and focus groups. This RFI does an admirable job of identifying the policy issues CMS is grappling with, but understandably, does not yet articulate specific policy approaches. Providing stakeholders with specific policy ideas to react to using additional RFIs or other avenues could help CMS identify and address potential shortcomings of policies before they are proposed.

Our detailed comments follow. Thank you for the opportunity to comment. We look forward to working with CMS to ensure the MIPS and APMs realize their full potential to support the transformation of health care delivery. If you have any questions, please contact Melissa Jackson, senior associate director for policy, at (202) 626-2356 or mjackson@aha.org, or Akin Demehin, senior associate director for policy at (202) 626-2365 or ademehin@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development

American Hospital Association
Detailed Comments on Request for Information Regarding Implementation of the MIPS and APMs

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

An approach to streamline and focus MIPS measures. **The AHA urges CMS to use the implementation of the MIPS as an 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.** There are more than 250 individual measures in the current-law Physician Quality Reporting System (PQRS) and Value-based Payment Modifier (VM) programs that affect payment for calendar year (CY) 2017. While the volume of measures stems partially from the need to have measures relevant to the variety of specialties participating in these programs, we are concerned that measures have proliferated without a well-articulated link to specific national priorities or goals. Regardless of the specialty, 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 towards the achievement of the same objectives.

The AHA has repeatedly urged CMS to identify concrete, actionable national goals for quality improvement, and to use those goals to select a small number of reliable, accurate and care-setting appropriate measures to ensure each relevant part of the health care system contributes to the overall goals. For this reason, we again strongly urge CMS to consider adopting the recommendations outlined in the Institute of Medicine's (IOM) *Vital Signs* report for streamlining and focusing national quality measurement efforts. If adopted, the report's recommendations would facilitate better use of quality measures by all stakeholders to advance health care.

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. Hospitals and other care providers spend significant resources interpreting measure specifications, training staff on reporting requirements and collecting data. Resources spent on these activities are not available to engage in important opportunities to improve care. 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. Each stakeholder would be measured on the areas most relevant to their role in achieving common goals and objectives. These core areas could be updated over time, "retiring" areas where sufficient progress has been achieved, and replacing them with new core areas that address emerging issues.

To be clear, the IOM *Vital Signs* report is intended to provide measurement priorities for *all* health care stakeholders, and not just physicians. Thus, we caution CMS against using the

IOM list to measure providers on aspects of care that may be beyond the scope of their operations. For example, in applying measures of cost and resource, CMS must ensure it is focused on the provider being measured, and not the entirety of the delivery system. CMS also should ensure measures are appropriately adjusted for factors beyond the control of providers that can affect performance, such as sociodemographic factors. Nevertheless, the *Vital Signs* report provides an important uniting framework that will help make all stakeholders more accountable and engaged in measurement and improvement.

MIPS Measure Data Reporting Options. **The AHA urges CMS to consider reducing the number of measure data reporting options over time.** The current-law PQRS includes seven different measure reporting options. Eligible professionals (EPs) participating as individuals can report measure data using claims, qualified registries, qualified clinical data registries (QCDRs), and electronic health records (EHRs). Group practices using the group practice reporting option (GRPO) can use qualified registries, QCDRs, EHRs, and a "GPRO web interface" portal. The proliferation of PQRS reporting options stems from a well-intentioned desire to provide a multitude of ways for physicians to report data, thereby avoiding payment penalties. To minimize disruption to physicians, the agency may find it desirable to retain most or all of the existing PQRS measure reporting options for the first year or two of the MIPS, but we encourage CMS to move to fewer reporting options over time.

We are concerned that over time the wide variation in reporting options will impinge on CMS's ability to compare performance accurately. With the existing-law PQRS and VM programs, the entire field has been challenged to understand whether national performance benchmarks for cost and quality are comparable for individuals, for groups and across the various physician quality reporting mechanisms. However, there are clear indications that even when reporting on the same quality measures, measure results may vary across the different reporting mechanisms. For example, CMS began to calculate separate performance benchmarks for physicians and groups reporting measures using EHRs due to concerns that EHR-derived measure results differ from other data collection modes. Given that the MIPS must *compare* the performance of all participating providers in order to determine rewards and penalties, CMS must take steps to ensure consistency of measure data.

One effective way to improve consistency is to limit the number of ways that providers can submit data. Indeed, the CMS quality reporting programs for hospitals and other facilities generally use only one measure data submission mechanism. We certainly recognize the variation in physician practices might make using only one data submission mode impossible in the short term. Nevertheless, we encourage CMS to undertake further study to determine which submission modes most appropriately balance data accuracy and provider burden.

Risk Adjustment. **The AHA strongly urges CMS to employ risk adjustment – including sociodemographic adjustment where appropriate – to ensure providers do not perform poorly on MIPS simply because they care for more complex patients.** 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. 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.

We encourage CMS to look beyond its approach to clinical risk adjustment in the current-law VM program, as we are concerned it does not adequately account for clinical factors that affect outcomes. CMS currently provides a mechanism to modestly increase the VM scores of groups that care for significant numbers of high-risk patients. CMS measures the risk of patients using hierarchical condition category (HCC) scores. HCC scores are a proxy for measuring the clinical risk factors of patients – the higher a group practice's HCC score, the more complex its patients are.

Despite CMS's adjustment for groups treating significant numbers of high-risk patients, the results of the 2015 VM program show that group practices caring for patients with more clinical risk factors are significantly more likely to receive negative VM adjustments. Indeed, over 30 percent of groups in the top HCC quartile (i.e., the most complex patients) received a negative VM payment adjustment, while only 7.4 percent of groups in the lowest HCC quartile received negative adjustments. Moreover, no groups in the top HCC quartile received a positive payment adjustment, while over 22 percent of patients in the lowest HCC quartile received a positive payment adjustment. (See Table 1.) To the extent CMS uses the same measures in the MIPS as it has in the VM, the agency should carefully assess the adequacy of the risk adjustment of the individual measures.

Table 1: Distribution of 2015 VM Results for Groups by Clinical Risk as measured by HCC Scores

	Lowest HCC Quartile	Second HCC Quartile	Third HCC Quartile	Top HCC Quartile
Positive VM Payment Adjustment	22.2 %	19.2 %	11.1%	0.0 %
Neutral VM Payment Adjustment	70.4 %	80.8 %	85.2 %	69.2 %
Negative VM Payment Adjustment	7.4 %	0.0%	3.7 %	30.8 %

Source: CMS, *2015 Value-Based Payment Modifier Program Experience Report*, June 16, 2015.

Furthermore, the AHA strongly urges CMS to examine the impact of sociodemographic factors on performance measures used in the MIPS, and incorporate sociodemographic adjustment when necessary and appropriate. As demonstrated in a growing body of research, sociodemographic factors – such as the availability of primary care, physical therapy, easy access to medications and appropriate food, and other supportive services – significantly influence performance on outcome measures like readmissions, mortality and resource use. 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. Yet, to date, CMS has resisted calls to incorporate sociodemographic adjustment.

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, as a growing body of research demonstrates, there are other factors that contribute to poor outcomes. If quality measures are implemented without identifying other critical 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.

Develop a MIPS Participation Option for Hospital-based Physicians. The MACRA includes a provision allowing CMS to develop MIPS participation options for hospital-based physicians to use their hospital's CMS quality and resource use measures in the MIPS. The AHA has long supported PQRS and VM participation options for hospital-based physicians where their reporting and performance is based on measure data from the hospital quality reporting and pay-for-performance programs. **For hospitals and physicians alike, greater integration represents the potential to better align goals and processes across the care continuum.**

The AHA recommends that CMS allow physicians and groups to self-designate whether they qualify as hospital-based. CMS could allow physicians to self-designate hospital-based status through a process similar to how physician group practices currently self-designate for the GPRO in PQRS. 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 potentially validate the relationship using claims data elements, such as inpatient and hospital outpatient department place of service codes.

Identifying EPs and Group Practices for the MIPS. The RFI solicits comment on how CMS should identify EPs and group practices for the purposes of determining eligibility, participation and performance under the MIPS. CMS asks whether it should create a unique "MIPS Identifier," or rely on current mechanisms to identify EPs and group practices. For the existing PQRS program, CMS identifies EPs using a combination of Taxpayer Identification Number (TIN) and National Provider Identifier (NPI), where each unique combination of TIN and NPI is treated as an individual EP. A group practice with multiple NPIs can self-register to participate in PQRS as a group, but can only do so under one TIN. Thus, a group practice comprised of multiple TINs cannot participate in PQRS or the VM as a single group.

The AHA urges CMS to provide as much flexibility as possible in how EPs and group practices identify themselves for participation in the MIPS, including the ability to form group practices comprised of multiple TINs. Indeed, some group practices, even those

comprised of a single specialty, may be comprised of more than one TIN, making it burdensome to report data separately for each TIN. Such groups may find it beneficial to report as a single group. In addition, some multispecialty group practices comprised of a single TIN may find it helpful to have subsets of its group report on different measures. Allowing multi-TIN groups to come together – or a single TIN to report separately – could help providers report data in a way that aligns best with their particular circumstances.

Given that there would likely be administrative burden associated with a unique MIPS identifier, we encourage CMS to explore whether its existing mechanisms for identifying group practices would achieve the goal of maximum flexibility before creating a unique MIPS identifier. For example, CMS could adopt a policy whereby the default identifier is the existing TIN/NPI combination, and that only those practices that choose to self-register would be assigned a unique identifier.

EHR Incentive Program Requirements and Performance in the MIPS. **The AHA urges CMS not to score the MIPS's EHR Incentive Program category using an "all or nothing" approach. That is, CMS should not require EPs to meet all of the meaningful use objectives and measures in order to receive points in the category**. Instead, we recommend that attainment of 70 percent of the objectives and measures in meaningful use afford an EP with full credit under this category. Additionally, to the extent CMS modifies the definitions, structure and reporting requirements of the EHR Incentive Program in the development of metrics for the MIPS and APMs, the AHA recommends the agency apply such modifications in a consistent manner for all EHR Incentive Program participants – EPs, eligible hospitals and critical access hospitals

ALTERNATIVE PAYMENT MODELS (APMS)

The MACRA provides incentives for physicians who demonstrate significant participation in APMs. **Indeed, the AHA supports accelerating the development and use of alternative payment and delivery models to reward better, more efficient, coordinated and seamless care for patients.** Many hospitals, health systems and payers are adopting such initiatives with the goal of better aligning provider incentives to achieve the Triple Aim of improving the patient experience of care (including quality and satisfaction), improving the health of populations and reducing the per capita cost of health care. These initiatives include forming accountable care organizations (ACOs), bundling services and payments for episodes of care, developing new incentives to engage physicians in improving quality and efficiency, and testing payment alternatives for vulnerable populations.

Despite the progress made to date, the field as a whole is still learning how to effectively transform care delivery. There have been a limited number of APMs introduced so far, and existing models have not provided participation opportunities evenly across physician specialties. Therefore, many physicians may be exploring APMs for the first time. **As a general principle, the AHA urges CMS to implement the APM provisions of the MACRA in a broad manner that provides the greatest opportunity for physicians to become qualifying APM participants.** Particularly in the early years of MACRA implementation, the agency

should take an expansive approach that encourages and rewards physicians who demonstrate movement toward APMs.

Patient Approach to Meeting the APM Threshold. The MACRA gives CMS the authority to determine whether a physician meets the applicable threshold of APM participation based on either patient counts or the percentage of payments attributable to an APM. **The AHA urges CMS to examine both metrics for each physician and to apply the higher number, thereby allowing the most physicians possible to meet the APM threshold.** For example, a physician may meet the APM threshold with respect to patient counts but not payments (or vice versa). CMS should examine both metrics and deem a physician to be a qualifying APM participant if that physician satisfies the threshold with respect to either metric.

This approach provides the greatest flexibility and may reduce unintended consequences inherent in either metric. For example, hospitals participating in the Medicare Shared Savings Program (MSSP) have reported that their attributed population may change significantly over the course of a year. Therefore, primary care physicians who participate in an MSSP ACO could find at the end of the year that – through no fault of their own – some of their patients are not actually attributable to the ACO in which they participate. Similarly, physicians who help reduce spending for an ACO population could in effect be penalized for those achievements if it causes the percentage of their payments attributable to the ACO to decrease relative to payments received for their fee-for-service patients.

"Eligible Alternative Payment Model (EAPM) Entity" Requirements. **The AHA urges CMS to find ways to capture physician participation in APMs in which other providers – including hospitals – serve as the EAPM entity and which may not require direct physician participation in the model.** The MACRA defines an EAPM entity as an entity that participates in an APM that provides for payment for covered professional services based on quality measures comparable to MIPS quality measures and requires participants to use certified EHR technology, and that bears financial risk for monetary losses under the APM that are in excess of a nominal amount (or is a medical home). In some APMs, it will be relatively easy to identify the EAPM entity, and those physicians who participate in the APM through the APM entity. For example, for accountable care models, the ACO would be the EAPM entity, and CMS could identify participating physicians through the participation agreements required by the model's rules.

For other payment models, such as bundled payments, it may not be as straightforward to tie a physician to a particular EAPM. For example, in some Bundled Payments for Care Improvement models and in the Comprehensive Care for Joint Replacement Program, hospitals bear the risk for financial and quality outcomes for qualifying episodes of care. Physicians who provide care during qualifying episodes may not be required to have a formal agreement in place that ties them to the APM; yet, those physicians certainly impact financial and quality outcomes, and should receive "credit" toward becoming a qualifying APM participant for delivering such care, provided they actively engage with the APM entity on financial and quality targets. In such cases, CMS could implement an approach by which a physician would attest to active

participation in the APM, perhaps by specifying they are engaged in a gainsharing or other contractual arrangement with the EAPM entity.

Finally, given the increasing prevalence of Medicare Advantage (MA), the AHA urges CMS to explore ways to capture risk-sharing arrangements for care provided to beneficiaries enrolled in MA plans in the APM framework.

Nominal Financial Risk. **The AHA strongly urges CMS to adopt an expansive definition of "financial risk" when determining whether an entity qualifies as an EAPM entity. Specifically, CMS's definition of "financial risk" should go beyond simply requiring an entity to take on downside risk; it should also recognize the significant up-front investment that must be made by providers who develop and implement APMs.**

Providers who participate in APMs invest significant time, energy and resources to develop the clinical and operational infrastructures necessary to better manage patient care. For example, an AHA analysis estimated start-up costs of $11.6 million for a small ACO and $26.1 million for a medium ACO. If CMS does not acknowledge this type of significant up-front investment, and instead defines "financial risk" very narrowly to require an EAPM entity to take on downside risk, the 99 percent of ACOs that participate in Track 1 of the MSSP would not qualify as EAPM entities. The AHA believes that such a result is undesirable and at odds with the MACRA's clear goal of rewarding those physicians who have been early adopters of APMs. In addition, this could inhibit physician movement toward APMs, particularly in early years, if physicians cannot engage with existing model participants – which have a head start on building infrastructure and engaging in care redesign – and instead must start from scratch. While we acknowledge CMS's interest in encouraging providers to move toward accepting increased risk, such an interest must be balanced with the reality that providers are starting at different points, and will have different learning curves. CMS should define "financial risk" in a way that provides a path for physicians who are interested in participating in risk-bearing models – particularly those who are exploring such models for the first time – rather than serving as a barrier to entry.