**MODEL COMMENT LETTER**

**ON CMS’S MACRA PHYSICIAN QUALITY PAYMENT PROGRAM**

**PROPOSED RULE**

*These are model comments to guide AHA members in crafting their own comments to the Centers for Medicare & Medicaid Services.* ***All comments must be received no later than Monday, June 27 at 5 p.m. ET.***

**[LETTERHEAD]**

**[DATE]**

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 *[name of hospital/health system],* we appreciate 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). The implementation of the MACRA will have a significant impact on [*name of organization*]. We partner with [*number of employed or contracted physicians and other eligible clinicians*] to deliver quality care to patient and families. For many of these physicians, we will help defray the cost of the implementation of and ongoing compliance with the new merit-based incentive payment system (MIPS), as well as be at risk for any MIPS payment adjustments. We also anticipate that clinicians in our community will call upon us to participate in advanced alternative payment models (APMs) to help them qualify for APM bonuses.

**We support many 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 good first step towards 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) category of the MIPS. Additionally, we support the flexible, group-based approach CMS has proposed for calculating the amount of care provided through an APM. Moreover, we agree that the agency should consider both patient counts and payment amounts when assessing APM participation.

**However, we urge CMS to make significant changes to several other proposals that will impinge on successful participation in the QPP. Our key comments and concerns follow.**

Advanced APMs. **[*Name of organization*] is disappointed that few of the models in which hospitals have invested will qualify as advanced APMs; we urge CMS to adopt a more inclusive approach. Specifically, we are concerned about CMS’s proposed financial risk standard, under which an APM generally must require participating entities to accept significant downside risk to qualify as an advanced APM.** This approach fails to recognize the significant resources providers invest in the development of infrastructure and the redesign of care processes. [*If your hospital participates in an excluded model, such as MSSP Track 1, identify the model and describe your efforts to transform care, as well as data on your investment to date if available*.] Although the clinicians participating in these 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 among providers that are not yet prepared to jump into two-sided risk models. Further, CMS has attempted to provide a glide path to APMs that fall 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.

Use of CMS Hospital Measures in MIPS. **[*Name of organization*] urges CMS to implement a hospital quality measure reporting option for hospital-based clinicians in the MIPS as soon as possible.** A provision in the MACRA allows CMS to develop MIPS participation options for hospital-based physicians to use their hospital’s CMS quality and resource use measure performance in the MIPS.We are pleased that in the proposed rule, CMS expresses an interest in implementing such an option. [*Name of organization*] believes using hospital measure performance in the MIPS would help physicians and hospitals better align quality improvement goals and processes across the care continuum.[*Provide examples here of any collaborative quality improvement efforts you are undertaking with either employed or aligned physicians, and explain how using the same measures for both hospitals and physicians would be helpful. For example, efforts to reduce readmissions and infections*].

Socioeconomic Adjustment. **[*Name of organization*] strongly urges the robust use of risk adjustment – including socioeconomic adjustment, where appropriate – to ensure caring for more complex patients does not cause providers to appear to perform poorly on measures.** Patient outcomes are influenced by factors other than the quality of the care provided. 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. 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. [*Include example of any impacts of socioeconomic status on outcomes among your hospital/health system’s patient population, using data if available*].

ACI Category. Providers are committed to utilizing certified electronic health records (EHRs) as part of a foundation for care improvements, patient engagement and new models of care. [*Name of organization*] appreciates the move to greater flexibility in the MACRA proposed rule but we have three overarching concerns with the proposal:

* The requirements for use of certified EHRs remain too complex;
* The complexity of the requirements will make a full year of reporting challenging, and
* The bar for clinician success in the ACI category remains too high.

**We are concerned, that the ACI category contains a high degree of complexity and eligible clinicians will not have sufficient time to review the rule and begin a full year of reporting on Jan. 1, 2017.** Prior experience has demonstrated that the number of measures that an eligible clinician would be required to meet, the length of the reporting period in the first reporting year, and the readiness of technology to support attainment of the measures are issues that have consistently presented challenges to successfully meeting program requirements. **[*Name of organization*] recommends that CMS offer a reporting period of 90 days for CY 2017. Additionally, [*Name of organization*] supports the proposal to permit eligible clinicians to meet the ACI base score requirements that leverage the Modified Stage 2 objectives and measures and the certified EHRs currently in use.**

**[*Name of organization*] 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 critical access hospitals under the Medicare and Medicaid EHR Incentive Program.**

Thank you for this opportunity to comment.

Sincerely,