



800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100 Phone
www.aha.org

August 18, 2017

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

RE: CMS-5522-P, Medicare Program; CY 2018 Updates to the Quality Payment Program, June 30, 2017.

Dear Ms. Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule updating the physician quality payment program (QPP). Mandated by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the QPP began on Jan. 1, 2017, and includes two tracks—the default Merit-based Incentive Payment System (MIPS), and a track for clinicians participating in certain advanced alternative payment models (APMs). The rule proposes changes for the calendar year (CY) 2018 reporting period, and would affect payment in CY 2020.

The AHA supports many of CMS's proposed policy changes that relieve regulatory burden and foster greater collaboration across the health care system, including the facility-based measurement in the MIPS and the gradual, flexible increase in reporting requirements. However, we urge CMS to better align the meaningful use requirements of electronic health records (EHRs) for hospitals with those of clinicians, enhance its approaches to risk adjustment, and provide additional opportunities for clinicians to earn incentives for collaborating with hospitals to enhance the quality and efficiency of care through advanced APMs.

A summary of our key recommendations follows.



MIPS FACILITY-BASED MEASUREMENT OPTION

The AHA applauds CMS for responding to our long-standing request to develop a facility-based measurement option for the MIPS, and we support nearly all of the proposed policy. Facility-based measurement in the MIPS will help clinicians and hospitals better align quality improvement goals and processes across the care continuum, and reduce data collection burden. However, we recommend CMS provide additional flexibility in the option's eligibility criteria for group practices, take steps to better equip hospitals to work with the clinicians that choose to use this option, and consider future expansion of the option to a broader array of facility types.

MIPS YEAR 2 FLEXIBILITY

The AHA supports CMS's proposal to raise the low-volume threshold for CY 2018 reporting, and encourages CMS to consider adopting this higher threshold for CY 2017 reporting as well. The AHA agrees that CMS's proposal to raise the threshold to \$90,000 of Part B billing charges or 200 or fewer Medicare Part B patients would provide needed relief and additional time to transition into the MIPS for small and rural providers. **However, to provide additional transitional flexibility, the AHA also urges CMS to retain a continuous 90-day reporting period for the quality category for CY 2018, while allowing groups to report up to a full year if they are ready to do so.**

MIPS ADVANCING CARE INFORMATION (ACI) CATEGORY

The AHA appreciates the proposals for additional flexibility to meet the ACI performance category of the MIPS, including a 90-day reporting period in 2018 and 2019, and the continuation of modified stage 2 meaningful use requirements through 2018. **At the same time, we urge CMS to align the requirements for eligible clinicians in the ACI performance category with the requirements for eligible hospitals and critical access hospitals in the Medicare and Medicaid EHR Incentive Programs.**

MIPS RISK ADJUSTMENT

The AHA supports CMS's proposed bonus points based on patient complexity as a first step to improving the fairness of MIPS penalties. **However, we urge CMS to continue enhancing the risk adjustment approaches used for MIPS measures, including the incorporation of sociodemographic adjustment where necessary and appropriate.** This will ensure that providers do not perform poorly in the MIPS simply because of the patient mix and communities they serve.

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Our detailed comments follow. Thank you for the opportunity to provide input on this proposed rule, and we look forward to continuing to work with CMS to ensure the QPP realizes its potential to support the ongoing transformation of health care delivery. Please contact me if you have questions or feel free to have a member of your team contact Akin Demehin, director of policy, at (202) 626-2365 or ademehin@aha.org.

Sincerely,

/s/

Ashley B. Thompson
Senior Vice President
Public Policy Analysis and Development

**American Hospital Association
Detailed Comments on the CY 2018 MACRA Physician Quality Payment
Program (QPP) Proposed Rule**

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

The AHA has urged the Centers for Medicare & Medicaid Services (CMS) to implement the MIPS in a way that measures providers accurately and fairly; minimizes unnecessary data collection and reporting burden; focuses on high-priority quality issues; and fosters collaboration across the silos of the health care delivery system. To achieve this desired state, we have previously recommended that CMS prioritize the following MIPS policy approaches:

- Adopt gradual, flexible increases in reporting requirements in the initial years of the program to allow the field sufficient time to adapt;
- Streamline and focus the MIPS quality and cost measures to reflect the measures that matter the most to improving outcomes;
- Allow facility-based clinicians the option to use their facility's quality reporting and pay-for-performance program to 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 patient mix and communities they serve; and,
- Align the requirements for eligible clinicians in the advancing care information (ACI) performance category with the requirements for eligible hospitals and critical access hospitals (CAHs) in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs.

The AHA is pleased that many proposed policies in the rule align with the above priorities, including incremental changes in reporting requirements and a facility-based measurement option. However, opportunities remain to better align the ACI category requirements with the Medicare EHR Incentive Program, to align measurement priorities, and to improve risk adjustment.

MIPS ELIGIBILITY AND EXCLUSIONS

Low-volume Threshold. **The AHA supports CMS's proposal to raise the low-volume threshold for CY 2018 reporting and encourages CMS to consider adopting this higher threshold for CY 2017 reporting as well.** The low-volume threshold for the current reporting period (i.e., CY 2017) excludes from the MIPS those clinicians and groups that have Medicare Part B billing charges of \$30,000 or less, OR provide care to 100 or fewer Medicare Part B

patients. Rural hospitals have continued to express significant concerns about their readiness to assist physicians and other clinicians in participating in the MIPS. Thus, the AHA agrees that CMS's proposal to raise the threshold to \$90,000 of Part B billing charges or 200 or fewer Medicare Part B patients for CY 2018 reporting would provide needed relief and additional time to transition into the MIPS.

While the AHA supports CMS's proposal, we are concerned by the potential for confusion resulting from a *higher* low-volume threshold in the second year of the MIPS than in the first year. According to CMS's analysis in the proposed rule, approximately 134,000 clinicians participating in the CY 2017 MIPS reporting would NOT have to participate in the MIPS in CY 2018. This inconsistency would make strategic and operational planning for MIPS reporting much more challenging. **Thus, the AHA urges the agency to consider applying the proposed CY 2018 low-volume threshold to CY 2017 reporting as well.** Given that CMS has not yet issued the required second round of reports notifying clinicians whether they are below the low-volume threshold, we believe it is feasible to implement the lower threshold before the end of the CY 2017 reporting period.

In addition, the AHA urges CMS to continue working with the field to evaluate the low-volume threshold to determine when it is appropriate to lower it. During this time of transition, the higher thresholds CMS has proposed provide much needed time to prepare for the transition to value-based payment under the MIPS. At the same time, the higher thresholds make the pool of participating clinicians much smaller than it would be otherwise. In the context of a budget-neutral program, this means the potential upside of the MIPS will be quite limited until more clinicians are included. CMS should monitor the progress of the field in adopting more value-oriented payment approaches, and consider lowering the threshold as the field gains experience with these payment models.

Group Practice Definition. CMS proposes to continue allowing eligible clinicians to participate as individual clinicians or as part of group practices, a policy the AHA has long supported. **However, we encourage CMS to explore providing additional flexibility to allow clinicians to submit group rosters to CMS to define a MIPS reporting group.** For the purposes of the MIPS, a "group practice" is two or more clinicians that bill under the same tax identification number (TIN). Many health systems include large, multi-specialty practices that for a variety of reasons have chosen to bill under a single TIN. However, CMS's definition of group practice means that the groups must select measures that may not be relevant to all of the clinicians in their group. The option of submitting a group roster would allow multispecialty groups to split into clinically relevant reporting groups. The use of group rosters also could allow the possibility of multiple TINs within a delivery system to report under a common group.

We recognize that CMS would need to balance the benefit of this approach with the administrative burden required to implement it. At the same time, the option could help MIPS reporting more accurately reflect the ways in which health care systems are organizing themselves.

MIPS FACILITY-BASED MEASUREMENT

The MACRA gives CMS the option to score facility-based clinicians on the MIPS quality and cost categories using measures and results from CMS's quality reporting and pay-for-performance programs for hospitals and other facilities. CMS proposes to implement a facility-based measurement option starting with the CY 2018 MIPS performance year. Those clinicians electing this option would have their MIPS quality and cost scores tied to their hospital's fiscal year (FY) 2019 value-based purchasing (VBP) program performance. That is, CMS would convert a hospital's total performance score (TPS) in the hospital VBP program into scores for the MIPS quality and cost categories. Clinicians and groups opting to use this option would not submit separate quality and cost data for the MIPS.

The AHA applauds CMS for responding to our long-standing request to develop a facility-based measurement option for the MIPS, and we support nearly all of the proposed policy. Facility-based measurement in the MIPS will help clinicians and hospitals better align quality improvement goals and processes across the care continuum and reduce data collection burden. At the same time, we recommend CMS provide additional flexibility in the option's eligibility criteria, take steps to better equip hospitals to work with the clinicians that choose to use this option, and consider future expansion of the option to a broader array of facility types, such as post-acute care providers.

Eligibility Criteria. CMS proposes that the facility-based measurement option would be available to facility-based clinicians (of any specialty) that have at least 75 percent of their covered professional services provided in the inpatient hospital and/or emergency department (ED) settings. For group practices, CMS would require that at least 75 percent of clinicians in the group meet the "facility-based" threshold for individual clinicians. CMS would determine whether clinicians and groups have met these threshold by reviewing claims to determine what percentage of covered professional service claims are identified by place of service (POS) codes 21 (for inpatient hospitals) and 23 (for EDs).

The AHA supports a 75 percent threshold, but urges CMS to increase the flexibility in meeting the facility-based threshold for group practices. That is, group practices should be eligible for the reporting option if 75 percent of its clinicians meet the individual clinician definition of facility-based, OR 75 percent of a group's total billing for covered professional services are provided in the inpatient and/or ED settings. CMS has employed a similar "either/or" approach in applying MIPS low-volume threshold and advanced alternative payment model (APM) eligibility, in which clinicians and groups qualify for exemption and inclusion respectively based on patient counts or total billing. Furthermore, the structures of group practices vary, and while some may have the vast majority of their activity performed in the inpatient and/or ED setting, not all of their clinicians may be as focused on those settings. We believe examining both individual clinicians and total group practice billing would capture additional practices that do spend most of their efforts on providing inpatient and ED care.

The AHA also urges CMS to examine how to include professional services billed under POS code 22 for hospital outpatient departments. We understand the agency's desire to focus the initial implementation of the facility-based measurement option on clinicians in the inpatient and ED settings, especially given the option's linkage to the hospital VBP program, which predominantly measures inpatient care. At the same time, some hospital-based clinicians may find that they spend small but significant time providing care in settings such as observation units or same-day surgical units based in hospitals. This may mean they fall short of the proposed threshold, but would still characterize their practice as primarily inpatient. To make the facility-based option available to this subset of clinicians, CMS could, for example, include those clinicians that have at least 65 percent of their services billed under POS codes 21 or 23, and would meet the 75 percent threshold if one included POS code 22.

Data for Hospitals. **The AHA urges CMS to provide a report to each hospital identifying the clinicians CMS would link to its facility under the facility-based measurement option.** We applaud CMS's plan to share reports with clinicians and groups before and during the reporting period alerting them whether they would qualify for the facility-based reporting option. However, we also believe hospitals would benefit greatly from knowing which clinicians working with them may qualify for the option. While hospitals could estimate which of its employed clinicians might qualify for the option, it would be more challenging to know which contracted clinicians might qualify. The most significant benefit to a facility-based measurement option is the opportunity for hospitals and clinicians to collaborate on improving performance. A list of clinicians would facilitate this collaboration.

Future Expansion to Other Facility Types. **The AHA also urges CMS to work with the hospital field to consider how to expand the reporting option to a broader array of facility-types in the future.** The current facility-based measurement option ties to the hospital VBP program, as well as hospital inpatient and ED sites of service. This means that clinicians practicing in other facility types – such as inpatient rehabilitation facilities, skilled nursing facilities, long-term acute care hospitals and inpatient psychiatric facilities – would be unlikely to qualify for the reporting option. Each of these facility types has a Medicare quality reporting or pay-for-performance program from which to draw measures, making it feasible to implement facility-based reporting for them as well. Furthermore, our members from these facilities have noted the significant gaps in available MIPS quality and cost measures that meaningfully reflect practice in those facilities.

We urge CMS to explore methodologies for translating the performance in the CMS quality reporting programs for those facilities into MIPS scores. For example, CMS could use an approach similar to its proposal in which clinicians are scored on a composite of the measure scores from the facility-level program. Alternatively, the agency could identify specific measures from the programs, and allow clinicians to have their MIPS performance tied to them.

MIPS VIRTUAL GROUP REPORTING OPTION

The AHA supports CMS’s proposal to create a virtual group reporting option starting with the CY 2018 MIPS performance period. The MACRA permits individual clinicians and groups of 10 or fewer clinicians to participate jointly in the MIPS. We appreciate that the agency has chosen not to place restrictions on the size and specialty composition of virtual groups before gaining experience with the option. We especially commend CMS’s efforts to provide upfront technical assistance to groups considering the option to ensure they meet the eligibility criteria.

MIPS QUALITY CATEGORY

Reporting Period. **The AHA urges CMS to retain a continuous 90-day reporting period for the quality category in CY 2018, rather than requiring a full year of data as proposed.** We acknowledge CMS’s interest in “raising the bar” on quality data reporting, and agree that in general, a longer data collection period can yield more reliable performance data. However, during this time of transition, clinicians should have the utmost flexibility. Moreover, CMS has also proposed to increase the MIPS Final Score’s “performance threshold” above which positive payment adjustments apply, and below which clinicians would be subject to negative adjustments. With some clinicians continuing to report concerns about their readiness to participate in the MIPS, we are concerned that a requirement to report a full year of data might make it more likely for clinicians to experience a penalty.

Retaining the 90-day reporting period adopted for CY 2017 would afford additional time to plan and prepare for data collection. Furthermore, this approach would not preclude those clinicians that are prepared to submit a full year of data to do so.

Number of Required Measures. **The AHA supports CMS’s proposal to maintain the current number of measures required for reporting under the MIPS. At the same time, we continue to urge CMS to align further measurement efforts across the health care system.** We applaud the efforts of CMS’s recent “Core Measure Collaborative” 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. 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.

However, we continue to urge CMS to ensure 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 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. As we noted in our comment [letter](#) on the CY 2017 QPP proposed rule,

the National Academy of Medicine's (NAM) 2015 *Vital Signs* report provides a potentially useful framework to help identify the highest priority measures for development and implementation in the MIPS and across all CMS programs.

Data Completeness Standards. The AHA supports CMS's proposal to retain its data completeness standards for CY 2018 reporting, but urges the agency not to finalize an increase for the CY 2019 reporting period at this time. CMS proposes that eligible clinicians and groups using the registry and EHR reporting options report data on at least 50 percent of the patients that meet the criteria for inclusion in a measure's denominator for CY 2018. CMS would increase this completeness threshold to 60 percent for CY 2019 reporting.

The AHA agrees with the value of data completeness standards and believes they can help ensure the reliability and accuracy of measure data. However, MIPS data collection just began on Jan. 1, 2017. CMS and the field as a whole lack sufficient data and experience to inform an increase to the thresholds. We encourage CMS to reevaluate the data completeness standard after the conclusion of the CY 2017 reporting period.

MIPS COST / RESOURCE USE CATEGORY

The AHA supports CMS's proposal to apply a weight of zero percent to the cost category for CY 2020. However, we are concerned that the cost category would rise significantly to 30 percent of the MIPS score starting with CY 2021 payment adjustments. We urge CMS to consider applying the same statutory flexibility it used for CYs 2019 and 2020 to raise the weight of the cost category more gradually, such as to 10 or 15 percent, in CY 2021. The AHA believes that value-based payment programs like the MIPS should include an assessment of cost performance. However, given the novelty of the MIPS, assigning a lower weight to cost performance and increasing it gradually would provide a more appropriate timeframe for providers to prepare and adapt.

In addition, we encourage CMS to conduct a "dry run" of weighted cost performance using CY 2017 and CY 2018 data. As we understand it, the agency intends to provide clinicians with reports showing their scores on the cost measures. While providing measure scores will be helpful, we also encourage CMS to simulate how clinicians and groups would have performed on their overall MIPS final scores if the cost category were assigned weights between 10 percent and 30 percent. This information would help providers see what performance gaps they may need to close.

Lastly, we continue to urge CMS to assess the extent to which sociodemographic factors impact cost measure performance. Sociodemographic adjustment should be incorporated as needed. The evidence showing the link between sociodemographic factors and patient outcomes continues to grow. Most recently, this connection is clearly evident in a report to Congress from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and in NAM's series of reports on accounting for social risk factors in Medicare programs. Both reports provide evidence-based confirmation of what hospitals and other providers have long known –

patients' sociodemographic and other social risk factors matter greatly when trying to assess the performance of health care providers.

The NAM reports show that performance on a variety of outcomes – readmissions, cost and patient experiences – is affected by social risk factors. The ASPE report demonstrates that clinicians, hospitals and post-acute providers alike are more likely to score worse on CMS pay-for-performance programs when they care for large numbers of poor patients. Unfortunately, failing to adjust measures for sociodemographic factors when necessary and appropriate can adversely affect patients and worsen health care disparities because the penalties divert resources away from hospitals and other providers treating large proportions of vulnerable patients. It also can mislead and confuse patients, payers and policymakers by shielding them from important community factors that contribute to worse outcomes.

MIPS IMPROVEMENT ACTIVITY CATEGORY

Given the novelty of the improvement activity category, we support CMS's proposals to continue the flexible approach to meeting this category's requirements in CY 2018. 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 has a list of over 90 medium- and high-weight improvement activities 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.

In addition, the AHA urges CMS to increase the weight of participation in Hospital Improvement and Innovation Networks (HIINs) from "medium" to "high." In the CY 2017 QPP proposed rule, CMS suggests that high-weight improvement activities are those that address the agency's quality priorities and programs and involve the performance of multiple tasks. We believe the HIIN's strong alignment with significant quality priorities, scope and engagement with clinicians merit a high weight.

HIINs stem from a proven framework for driving progress on critical quality priorities. CMS created Hospital Engagement Networks (HENs) in 2011 to address critically important quality and safety topics. HENs carried out two highly successful phases of work between 2011 and 2016, preventing 125,000 patient harms and saving an estimated \$1.2 billion in costs. The AHA/Health Research & Education Trust (HRET) convened the largest HEN, and its efforts helped 1,500 hospitals prevent 70,000 readmissions and 23,000 adverse drug events. HIINs supplanted the HENs in September 2016, and have two overarching goals to reach by 2019: a 20 percent reduction in all-cause inpatient harm, and a 2 percent reduction in readmissions. HRET is again the largest HIIN, with over 1,600 participating hospitals and 38 state partners.

The specific topics chosen for the HIIN have an impact across the health care delivery system. These include adverse drug events (include opioid-related events), healthcare-associated

infections, falls, pressure ulcers, readmissions, patient and family engagement, and health equity. Furthermore, the HIINs work actively with a number of CMS priority programs. For example, the HRET HIIN partners with six Quality Improvement Network-Quality Improvement Organizations, and with a Support and Alignment Network for CMS's Transforming Clinical Practice Initiative.

Physicians are vital to the success of the HIIN, and the program has prioritized physician engagement. Examples of this engagement include:

- Educational sessions to help physicians lead and support their hospitals' work on the HIIN. These have included virtual offerings and in-person trainings;
- Podcasts on best practices for activating rural physicians; and
- A dedicated area on the HRET HIIN's [website](#) to provide physician-relevant information.

Lastly, the HRET HIIN has partnered with the American Board of Medical Specialties (ABMS) to align HIIN participation with Maintenance of Certification (MOC), thereby reducing duplication of quality improvement efforts. Specifically, physicians can earn credit towards their MOC Part IV requirements by working with HRET HIIN hospitals on any of the HIIN-related hospital-acquired condition topics. HIIN activities involve a significant investment of time and energy from physicians. We believe their efforts should receive greater recognition in the improvement activity category.

MIPS ADVANCING CARE INFORMATION (ACI) CATEGORY

CMS proposes revisions to the ACI performance category to provide flexibility in the health information technology (health IT) and health information exchange reporting requirements for MIPS-eligible clinicians.

ACI Objectives and Measures Reported for 2018. For the 2018 reporting period, CMS proposes that MIPS-eligible clinicians may choose to report the ACI category transition objectives and measures derived from modified stage 2 of the Medicare and Medicaid EHR Incentive Programs. CMS further proposes that MIPS-eligible clinicians may use the 2014 Edition, 2015 Edition or combination of 2014 and 2015 Edition certified EHRs to report the ACI transition objectives and measures for the 2018 performance period. **The AHA strongly supports the proposal to offer relief from the mandatory start to the ACI objectives and measures derived from meaningful use stage 3 in CY 2018.** We agree with CMS's statement that additional time would benefit MIPS-eligible clinicians as they receive, implement, train and optimize the use of 2015 Edition EHRs. This proposal, if finalized, also would align with the recently finalized requirements for eligible hospitals and CAHs in the Medicare and Medicaid EHR Incentive Programs. The AHA supports the alignment of provider requirements across programs requiring the use of certified EHRs.

ACI Reporting Period in 2018 and 2019. CMS retains the 2018 reporting period of a minimum of any 90 consecutive days and proposes a 2019 ACI reporting period of a minimum of any 90 consecutive days. **The AHA appreciates the 90-day reporting period in 2018 and supports the proposal for a 90-day reporting period in 2019.**

ACI Performance Score. CMS proposes to increase the ACI public health and clinical registry reporting measures available for the ACI performance score. Specifically, CMS proposes that MIPS-eligible clinicians unable to report to an immunization registry may earn five percentage points in the performance score, up to a maximum of 10 percentage points, by reporting to other public health and clinical registries: syndromic surveillance reporting; electronic case reporting; public health registry reporting; and clinical data registry reporting. **The AHA supports the proposal to increase the available options for the public health reporting portion of the ACI performance score.** We believe that MIPS-eligible clinicians should not be placed at a disadvantage in ACI performance scoring due to the inability of immunization registries to receive electronically submit data.

ACI Bonus Points.

ACI Bonus Points for Designated Improvement Activities. CMS proposes to add 11 designated activities in the MIPS improvement activities category eligible for ACI bonus points when the designated activities include the use of a certified EHR. The AHA supports the use of health IT for designated improvement activities as MIPS-eligible clinicians and groups should be encouraged to implement and use health IT in a manner that supports their goal to coordinate care, improve health outcomes and engage patients.

With respect to specific activities proposed for addition to the improvement activities category and eligible for ACI bonus points in the 2018 performance period, the AHA recommends that CMS not include the activity titled consulting appropriate use criteria (AUC) using clinical decision support when ordering advanced diagnostic imaging. The description of the activity states that the MIPS-eligible clinician would attest that they are consulting specified applicable AUC through a qualified clinical decision support mechanism for all advanced diagnostic imaging services ordered. This activity would be available for MIPS-eligible clinicians that are early adopters of the Medicare AUC program in the CY 2018 performance year. In the CY 2018 Medicare physician fee schedule proposed rule, CMS proposes that AUC reporting requirements will begin Jan. 1, 2019 and proposes that 2019 will be considered an educational and operations testing year. **Given the proposal to delay the launch of AUC for clinical decision support in the physician fee schedule proposed rule, we recommend that CMS delay the availability of this designated activity to a date no sooner than 2019.**

The AHA supports the designated activity titled advance care planning for inclusion in the improvement activities category and eligible for the ACI bonus points but recommends the activity is available for the ACI bonus no sooner than the 2019 reporting period. We believe certified EHRs can support patient access to information about advance care plans and support conversation-readiness among health professionals about advanced illness management.

Proactive discussions by patients, their caregivers and clinicians that are supported by documented patient preferences and clinical insight should enhance care team coordination and increase patient confidence that their choices will be known and honored.

The 2015 Edition certified EHR functionality will support the inclusion of health-related data created, recorded or gathered by or from patients or caregivers to help address a health concern including an advance care plan. At this time, few 2015 Edition certified EHRs are available. This rule proposes that MIPS-eligible clinicians have the option to continue use of the 2014 Edition or a combination of the 2014 and 2015 Edition certified EHRs for the 2018 reporting period and the 2014 Edition does not support incorporation of a patient generated advance care plan into the certified EHR. Additionally, according to the Office of the National Coordinator for Health IT (ONC) 2015 Edition Certification Companion Guide to the patient health information capture certification criterion, 45 CFR 170.315(e)(3), a standard is not required to support the certification criterion. As a result, each health IT vendor may determine how their certified technology will meet the certification requirement and the lack of consistency may affect the use of the advance care plan when electronically exchanged among certified EHRs. **The AHA recommend CMS work with the ONC to monitor how well and consistently health IT developers will innovate to meet this functionality in the 2015 Edition EHR and then reconsider inclusion of this designated activity for the 2019 reporting period.**

ACI Bonus Points for Use of 2015 Edition Certified EHR. CMS also proposes to offer a one-time bonus of 10 percentage points in the ACI category for first-time MIPS-eligible clinicians reporting ACI objectives and measures solely using the 2015 Edition certified EHR. The AHA recommends that CMS continue to make ACI bonus points available for MIPS-eligible clinicians that use certified EHRs to support public health and clinical data registry reporting and the use of EHRs to meet requirements of designated improvement category activities. We caution that providing bonus points for the use of 2015 Edition certified EHRs in 2018 may disadvantage MIPS-eligible clinicians with prior experience with certified EHRs that work diligently to implement and utilize the 2015 Edition EHR by the close of the 2018 reporting period, but are unable to implement all of the requisite certified technology due to vendor issues beyond their control. Additionally, this proposal does not support the intention of MIPS to move beyond the measurement of EHR adoption.

Proposed Changes to ACI Objectives and Measures and ACI Transition Objectives and Measures. CMS proposes changes to terminology in the ACI Patient Electronic Access Objective. Beginning with the 2018 performance period, CMS proposes to define “timely” electronic access to health information and patient-specific education as within four business days of the information being available to the MIPS-eligible clinician. **The AHA supports the proposed definition of timely.** CMS also proposes to modify the ACI Transition Patient Electronic Access Objective, beginning in the 2017 performance period, by removing the word “electronic” from the description of timely access for measure one. CMS states that it was the intention to align the requirement with objectives Patient Specific Education and Patient Electronic Access in the modified stage 2 EHR Incentive Programs final rule that does not include the word “electronic.” **The AHA supports the proposed clarification.**

For the measures supporting the ACI Health Information Exchange objective, CMS proposes to add exclusions to the measures beginning with the 2017 performance period for MIPS-eligible clinicians who do not regularly refer or transition patients in the normal course of their practice.

Specifically, for measure one, patient care exchange, CMS proposes an exclusion for the MIPS-eligible clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period. For measure two, the incorporation of a summary of care document, CMS proposes an exclusion for the MIPS-eligible clinician who receives transitions of care or referrals or has patient encounters in which the MIPS-eligible clinician has never before encountered the patient fewer than 100 times during the performance period. CMS states that the implementation burden of the objective is too high as some MIPS-eligible clinicians may not meet the measures and achieve an ACI base score because they seldom refer or transition patients. **The AHA supports the proposed exclusions.**

Hardship Exceptions in the ACI Category for Select MIPS-eligible Clinicians. CMS proposes to revise the hardship exceptions available for the ACI category to assign a zero weight for MIPS-eligible clinicians who successfully demonstrate a significant hardship through an application process, who lack face-to-face patient interaction and are classified as non-patient facing MIPS-eligible clinicians, or who are in small practices defined as 15 or fewer clinicians and solo practitioners. **The AHA supports the proposal to reweight the ACI category to zero for MIPS-eligible clinicians demonstrating a significant hardship.**

CMS also proposes a new hardship exception for MIPS-eligible clinicians that cannot report the ACI category due to the decertification of their EHRs. **The AHA supports the proposal to make the hardship exception available during the performance period or the year preceding the performance period for the MIPS payment year for eligible clinicians with decertified EHRs. The AHA also recommends that CMS communicate the relief that will be available for MIPS-eligible clinicians, hospitals and CAHs that learn the certified EHRs in their organization does not conform to the ONC certification requirements.** The settlement between the Department of Justice and eClinical Works makes clear that EHR non-conformance to ONC certification criteria can be determined outside of the scope of the ONC decertification process. Additionally, the recent statement by the Department of Health & Human Services Office of Inspector General that EHR certification will be an area of enforcement indicates that MIPS-eligible clinicians, hospitals and CAHs require expedited action on this issue.

MIPS FINAL SCORE – COMPLEX PATIENT BONUS

In response to concerns raised by the AHA and others about the adequacy of the risk adjustment to measures in the MIPS program, CMS proposes to give clinicians and group practices up to three bonus points (to be added to their MIPS Final Score) based on their average CMS Hierarchical Condition Category (HCC) score. HCC scores are derived from Medicare claims

data and are a proxy for measuring the clinical risk factors of patients – the higher a clinician or group’s HCC score, the more complex its patients.

The AHA supports CMS’s proposed bonus points based on patient complexity as a first step to improving the fairness of MIPS penalties. **However, the HCC scores have significant shortcomings, and in the long run, CMS must take steps to enhance the risk adjustment approaches used for individual MIPS measures. This includes the incorporation of sociodemographic adjustment where necessary and appropriate.**

Experience from the use of HCC scores in the value-based payment modifier (VM) raises significant questions about its adequacy in accounting for patient risk. CMS used HCC scores to provide modest increases to performance scores to groups treating significant numbers of high-risk patients. Unfortunately, the results of the 2016 VM program show that group practices caring for patients with more clinical risk factors were still significantly more likely to receive negative VM adjustments. Indeed, more than 15 percent of groups in the top HCC quartile (i.e., the most complex patients) would have received a negative VM payment adjustment in 2016 if CMS had not held groups of 10 to 99 clinicians harmless from VM downward adjustments. In contrast, only 8.6 percent of groups in the lowest HCC quartile would have received negative adjustments. (See Table 1 below.) Given the significant overlap of measures between the VM and the MIPS, we believe CMS must improve the risk adjustment of the individual measures in the MIPS program.

Table 1: Distribution of 2016 Value Modifier Results by HCC Scores

	Lowest HCC Quartile	Second HCC Quartile	Third HCC Quartile	Top HCC Quartile
Positive VM Payment Adjustment	1.5%	1.9%	1.3%	1.5%
Neutral VM Payment Adjustment	90.0%	94.5%	92.8%	82.0%
Negative VM Payment Adjustment*	8.6%	3.6%	5.9%	15.4%

Source: CMS, 2016 Value-Based Payment Modifier Program Experience Report, May 2017.

**Note: For the CY 2016 VM program, CMS held harmless groups of 10 to 99 clinicians. The totals in this row include both those that experienced negative adjustment and those that would have absent a hold harmless policy*

The proposed rule also includes discussion of an alternative proposal in which CMS would award the complexity bonus based on the proportion of dual-eligible patients that clinicians treat. Dual-eligibility is a proxy for sociodemographic status, and the AHA greatly appreciates CMS’s examination of it as a potential mechanism to account for complexity. If CMS should adopt this approach, we would recommend it only as an interim step to adjusting the individual measures for sociodemographic factors. CMS also could consider adding the bonus point derived from the duals percentile to those derived from the HCC scores, again, as only an interim step.

ADVANCED ALTERNATIVE PAYMENT MODELS (APMs)

CMS proposes to continue most CY 2017 policies governing the advanced APM track into CY 2018. Disappointingly, this includes criteria for downside financial risk that exclude most of the Medicare APMs in which many hospitals, health systems and clinicians participate, including Track 1 of the Medicare Shared Savings Program. **The AHA remains concerned that this approach fails to recognize the significant resources providers invest in the development of APMs. We continue to 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.**

The successful implementation of an APM requires providers to acquire and deploy infrastructure and to 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.

We appreciate that CMS has offered the Track 1+ model in an attempt to create a glide path to assuming downside risk. Nevertheless, clinicians participating in shared savings-only models are working hard to support CMS's goals to transform care delivery; under CMS's policy, their efforts will not be sufficiently recognized.

FINANCIAL RISK STANDARD FOR COMPREHENSIVE PRIMARY CARE PLUS (CPC+) MODEL

In 2016, CMS finalized a relaxed financial risk standard to allow qualified medical home models to qualify as advanced APMs without requiring significant downside risk. However, CMS limited the relaxed standard, beginning in 2018, to APM entities owned and operated by organizations with 50 or fewer clinicians. The only existing model to qualify for the relaxed standard is the CPC+ model, which began Round 1 Jan. 1, 2017. CMS's limitation meant that CPC+ practices owned and operated by hospitals or health systems would not receive credit toward advanced APM incentives after 2017. However, CMS now proposes to exempt from the 50-clinician limitation those CPC+ practices enrolled in Round 1. Organizations that enroll in later rounds would be subject to the limitation; those organizations would be required to accept downside risk to receive advanced APM credit.

The AHA is pleased that CMS will allow clinicians who partnered with hospitals as early adopters of the CPC+ models to receive advanced APM credit for those efforts; however, we oppose application of the 50-clinician limitation to future rounds of CPC+ participants.

We dispute CMS's notion that a larger organization is better positioned to accept risk. As we have seen with our members who participate in APMs, many complex factors determine an organization's readiness for financial risk, and each organization starts in a different place. If clinicians are striving to achieve CMS's care transformation goals by participating in one of the agency's advanced APMs, those clinicians should receive credit for those efforts regardless of whether they partner with a larger organization

OTHER PAYER APM DETERMINATION PROCESS

The AHA supports the development of an other payer advanced APM determination process and urges CMS to use it to mitigate provider burden where possible. Beginning in 2018, CMS would use this process to evaluate whether payment arrangements under Medicaid, Medicare Advantage and CMS multi-payer models (such as CPC+) qualify as advanced APMs. Payers (including state Medicaid agencies) would be able to submit details of their payment arrangements to CMS in advance of the 2019 performance year and to obtain pre-approval for the All-Payer-Combination Option across all practices that participate in the financial arrangements. CMS would extend this process to private payers starting in performance year 2020.

The AHA also supports CMS's proposal to allow APM entities to use the other payer advanced APM determination process when payment arrangements have not otherwise been reported by payer. We believe this approach would significantly lessen the administrative burden on clinicians and may enhance the relationships between the APM entity and participating clinicians.