



June 26, 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 the Arizona Hospital and Healthcare Association (AzHHA), thank you for the opportunity to offer comments 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). AzHHA is a statewide association of 71 hospitals, affiliated healthcare systems, and other healthcare organizations across Arizona. Our members are committed to working collectively to improve the quality of healthcare and the health of all Arizonans.

The implementation of the MACRA will significantly impact our member hospitals and health systems, which partner with thousands of physicians and other clinicians across the state through employment and contracted arrangements. Our members report they expect to defray implementation and compliance costs associated with the new merit-based incentive payment system (MIPS), as well as be at risk for any MIPS payment adjustments, for many of these physicians. Our members also anticipate partnering with community clinicians in advanced alternative payment models (APMs) to help them qualify for APM bonuses.

AzHHA appreciates and supports many of the flexibilities CMS proposes to provide under both the MIPS and APM programs. Specifically,

- We believe the proposed reduction in the number of quality measures that MIPS-eligible clinicians and groups would be required to report will lead to greater focus in quality improvement efforts.
- We support the steps CMS has taken to introduce greater flexibility in meeting meaningful use requirements in the Advancing Care Information (ACI) category of the MIPS; and

- We appreciate 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 hinder successful participation in the QPP. Our key comments and concerns follow.

Advanced APMs

AzHHA is disappointed that few of the models in which our member hospitals have invested will qualify as advanced APMs, and we urge CMS to adopt a more inclusive approach. Specifically, we are concerned about CMS’s proposed financial risk standard that generally requires participating entities to accept significant downside risk to qualify as an advanced APM. This approach fails to recognize the significant resources providers invest in developing the infrastructure and redesign of care processes. 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 these efforts. We fear this will deter participation in new models among providers that are not yet prepared to jump into two-sided risk. And, while we appreciate the “glide path” to APMs that fall short of advanced APM status through the MIPS APM designation, we are concerned that the potential benefits offered to the MIPS APMs will not be realized. Providers who fall into MIPS APM 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, which may be too high an administrative hurdle to overcome.

Use of CMS Hospital Measures in MIPS

AzHHA urges CMS to implement a hospital quality measure reporting option for hospital-based clinicians in the MIPS as soon as practical. The MACRA permits 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 CMS expresses an interest in implementing such an option. AzHHA believes using hospital measure performance in the MIPS would help physicians and hospitals better align quality improvement goals and processes across the care continuum. Many AzHHA members have been building such alignment into existing performance-based contracts, which has resulted in improved quality and efficiencies.

Socioeconomic Adjustment

AzHHA strongly urges the robust use of risk adjustment – including socioeconomic adjustment, where appropriate. 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. Without the use of risk adjustment, providers who care for complex patients may appear to perform poorly on certain measures.

ACI Category

Providers are committed to utilizing certified electronic health records (EHRs) as part of a foundation for care improvement, patient engagement and new models of care. AzHHA 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. **AzHHA recommends that CMS offer a reporting period of 90 days for CY 2017. Additionally, we support 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.**

Further, AzHHA 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 the opportunity to comment on the proposed rule. Please do not hesitate to contact me if you have any questions.

Sincerely,



Debbie Johnston
Senior Vice President, Policy Development