November 17, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS-3321-NC
P.O. Box 8016
Baltimore, MD 21244-8016


Dear Mr. Slavitt:

The Wisconsin Hospital Association is a statewide nonprofit association with a membership of more than 140 Wisconsin hospital and health systems that includes not only critical access hospitals providing crucial services to their rural communities, but also major academic medical centers providing high quality care, research, and training. On behalf of our members, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) request for information on implementation of the Medicare Access and CHIP Reauthorization Act regarding Merit-based Incentive Payment System and Alternative Payment Models.

WHA strongly supports payment systems that reward value and believes value-based payment policies can drive better quality, lower cost of care, and can reduce overall costs for health care programs. However, such programs must be thoughtfully implemented, recognize administrative burdens and complexities and be highly accurate in order to drive improvement. Further, as the Merit Based Incentive Payment System (MIPS) is implemented, we urge CMS to provide a seamless transition from the current programs, and emphasize outcomes-focused quality measures.

Section A – The Merit-based Incentive Payment System

Section A3 – Quality Performance
Our comments on quality performance are primarily on available reporting mechanisms (Section 3a).

First, WHA recommends that all of the existing mechanisms for reporting PQRS measures should remain under MIPS. Eligible professionals (EPs) have highly variable information technology capacity and access to staff to support data collection and improvement. The breadth of current options allow EPs the ability to choose an option they can afford and is most likely to support improvement work within their practice. WHA suggests that the quality measures should reflect the population of patients served by a provider, not the quality received by an individual patient. Patients are commonly cared for by a team of providers, with the team being responsible for the outcomes of care. Therefore, we do not view it as problematic if that patient is in the measured population of multiple EPs, even for the same measure. However, an EP should not be allowed to submit data for the same measure via different submission methods.
We recommend that the reporting criteria for MIPS be modified from what is currently used for PQRS. The current set of acceptable measures is not robust enough to be satisfactory for all specialties and results in EPs reporting on measures that are not applicable to their patients. Requiring nine measures is too aggressive until more measures are developed. We suggest the criteria be changed to five measures. We also recommend that the requirement to report across three National Quality Domains is too aggressive due the lack of an equal number of measures in all of the domains. We recommend this be scaled back to two domains and at least one of the measures be outcome-based. These numbers could be increased in the future if sufficient measurement development work is done to ensure meaningful measures for all specialties in each of the areas required by the criteria.

While we understand the interest in stratifying the data, it is not appropriate to require stratification of measures by demographic variables. This would add significant data collection and processing burden on EPs. Demographic variables such as race and ethnicity are often in a different data system than the clinical information. Requiring that data from two systems be combined to allow for stratification will eliminate the ability to report measures for some EPs, especially those in smaller practices or facilities.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) reporting should be moved to become part of the clinical practice improvement activities. The current requirement that an approved CAHPS vendor be used to submit this data makes it unaffordable for some EPs, especially those in smaller practices or facilities. CMS should seek ways to make CAHPS reporting more affordable so that more physician groups can participate.

Finally, we encourage CMS to actively pursue the development of additional measures so that EPs in all specialties have meaningful measures. The biggest challenge with active engagement of physicians is the lack of meaningful measures for all specialties and limited local technical assistance and resources to collect and report the measures.

Section A4 – Resource Use Performance Category

WHA has long advocated for the inclusion of robust measures of cost, efficiency and resource use in value-based programs. We continue to advocate for value-based care as a reflection of cost and quality equally weighted. We encourage CMS to continue exploring and proposing measures of cost and resource use that align with quality measures as a better representation of value-based care for MIPS.

While we encourage robust measures for cost, efficiency and resource use, the existing cost measures are challenging, especially for low volume providers or those specialties which do not do primary care. CMS should actively pursue additional resource use of Episode Cost measures that are aligned to the disease states covered by the quality measures so that providers are encouraged to simultaneously improve value; both quality and cost. Episode of care measures are more meaningful and actionable than global measures such as the Total Per Capita Cost measure. If a provider performs high on a global Total Per Capita Cost measure it would be very difficult to know where to begin making changes that could affect the overall performance. WHA recommends that Part D drug costs be excluded from the resource use category. Drug costs are not controlled by individual physicians. Physicians can control utilization but they cannot control the costs of drugs. Including drug costs assumes that all physician see the same mix of patients, which is not accurate. A physician should not be penalized if they serve a larger mix of patients who require more expensive medications.
WHA also recommends that the resource use measures use specialty specific peer groups when assigning benchmarks. CMS should not use geographic peer groups, which would imply a different standard of care based on where a patient lives. If one part of the country can be efficient, other geographic areas can replicate that efficiency.

Finally, as we have commented in prior rulemaking, WHA remains concerned about the inaccuracy of the Geographic Practice Cost Index (GPCI), which can result in downward payment adjustments unreflective of the actual cost of physician practices. As members of the Healthcare Quality Coalition, this remains of concern as the price standardization methodology used in the value based payment modifier for resource use measures would be directly impact, and we are concerned the standardization methodology will be carried over in the efficiency/resource measures in the MIPS program.

Section A5 – Clinical Practice Improvement Activities Performance Category
WHA recommends that CMS clarify the number of clinical practice improvement subcategories a provider must participate in. We suggest that CMS require participation in two of the six categories listed, with bonus points given if more than two are reported. We support adding additional categories, however CMS must ensure there are objective ways of measuring what is suggested related to categories such as equity, social involvement, emergency preparedness and integration of primary care and behavioral health. These subcategories should be scored equally and none used as a multiplier because not all providers will have an equal opportunity to benefit from a multiplier.

Multiple data collection options should be made available including web portal, QCDR, registries and EHRs. CMS will ideally develop a method for data validation, however simple attestation measures may be a place to start. These measures are not likely to change on a regular basis so we suggest that CMS start with annual reporting. Ideally these measures would be started as a Yes/No measure, similar to the structural measures used on the HIQRP program. Having to collect the number of hours a provider participated would be extremely burdensome and could prevent most providers from participating. The number of activities used to score the maximum number of points in a subcategory should be dependent on the number of possible activities an EP may be eligible for. We encourage CMS to allow greater flexibility in the first few years of the program until these activities are well defined and an appropriate number have been developed. Further, during this time, activities and subcategories should be weighted equally.

WHA recommends that the clinical practice improvement activities be designed to include a large enough number of activities to choose from so that providers in all size groups and geographic regions can participate and get meaning from the work. If there is a large enough selection then it is up to the provider to select activities that are most meaningful to their patient population and community. If the provider is not involved in the choice there is less likelihood they will try to derive meaning from this work, but will rather do just enough to “check the box”.

We also recommend that CMS consider existing quality improvement programs and opportunities for inclusion as options for providers and health systems as part of the Clinical Practice Improvement criteria. For example, membership in a regional health improvement collaborative, successful completion of a formal initiative sponsored by a RHIC, attendance at one or more learning events sponsored by the RHIC, or
membership and participation in a hospital quality collaborative effort such as a hospital engagement network.

**Section A6 – Meaningful Use of Certified EHR Technology Performance Category**

WHA does not believe that the performance score for the meaningful use performance category under the MIPS should be based solely on full achievement of meaningful use. WHA has previously opposed an “all-or-nothing” approach of the meaningful use reporting requirements under the Medicare and Medicaid EHR Incentive Program. Subjecting providers to significant Medicare reimbursement penalties for failing to meet a single measure by even a single percentage point is punitive. Nor does it accomplish Congress’s goal to reward and incentivize the delivery of high-value health care, since the provider that meets all but one meaningful use measure would be subject to the same reimbursement penalties as the provider that does not meet any measures.

Implemented properly, a tiered methodology can increase flexibility for providers by not withholding large payments for small mistakes. Such a methodology rejects the “all-or-nothing” approach and more equitably allocates payment to the varying degrees of meaningful use achievement. This approach is particularly important because many of the meaningful use reporting requirements under Stage 3 of the Medicare and Medicaid EHR Incentive Program do not have widespread acceptance, are new for some providers, and with respect to the patient engagement measures, put the ability of providers to succeed largely outside of providers’ control by making success contingent on the actions of patients.

In considering rules for a tiered methodology, CMS should not measure meaningful use achievement relative to geographic peer groups, which would imply different meaningful use needs based on where a patient lives and would inadvertently punish states (e.g., Wisconsin) or geographic regions (e.g., the Midwest) that have higher than average meaningful use achievement levels. In addition, CMS should not introduce additional complexity to make it unnecessarily challenging for providers to assess their meaningful use achievement; providers need to know which meaningful use measure thresholds they will be assessed at before the start of the reporting period in order to predict and monitor their performance.

**Section A8 – Development of Performance Standards**

WHA strongly encourages CMS to use the same method of setting performance standards and measuring improvement as used in the Hospital Value Based Purchasing (VBP) program. However, performance standards should be specialty specific. This would allow providers to receive credit for both achievement and improvement. If a provider does not report on the same measures across two consecutive time periods then they should be scored on achievement only. The performance threshold should never exceed the 75th percentile for the first time period measured. If the measures eventually “top out” then they should be removed from the program.

Similar to the hospital VBP program, achievement and improvement should be scored at the measure level and these scores combined to create a category score. This would promote fairness for providers who have been able to achieve high performance or improvement on some, but not all measures as would be required if scoring was on a composite measure. CMS should also seek a method that is easy to understand and promotes a willingness to improve lower scoring measures. If the score method is complicated and hard to understand it will not influence providers to make positive changes.
Section A11 – Public Reporting
WHA recommends that public reporting be done at the category level, not the individual measure level. We further suggest that a minimum case volume of 30 should be used to include a measure in a category score. It is unrealistic to consider reporting measures stratified by race, ethnicity and gender for two reasons. The first reason is that reporting measures stratified in this way would create an extreme data collection burden on providers. The second reason is that reliable data at this level of reporting would require statistically large sample sizes, which again adds to the data collection and reporting burden. We encourage CMS to start simple so that all providers have the ability to participate and then add complexity as the program advances over the coming years.

Section A12 – Feedback Reports
WHA recommends that feedback reports should be available to providers through a web-based portal. Data on these reports should be limited to MACRA/MIPS requirements and should not be combined with programs from other payers. These reports should be available to designees the provider or their practice administer authorizes, including organizations that may be providing technical assistance. This authorization should be online and easy to use. Reports should be produced quarterly to allow for concurrent tracking of results. The report format should be similar to the graphics used in the QRUR report, however the reports should be expanded to include the following:

- Peer group used for the provider, applicable dates and indication if reporting requirements were met.
- Calculated performance on each measure, along with the corresponding baseline, threshold and calculated rate of improvement.
- Peer group baseline, threshold and rate of improvement for each measure reported by the provider.
- Indication (Yes or No) for each clinical improvement activity and meaningful use category
- Resulting payment adjustment

Data validation reports should be available to each provider and their data submitter. The reports should include patient level details on any cases that failed to meet the data requirements, including what caused the case to fail – these reports should be available with each data upload.

Section B – Alternative Payment Models (APMs)

Section B 1 a and b - APM Revenue Thresholds
Overall, although we understand the established APM revenue thresholds are statutorily-bounded, we are concerned the thresholds are too high for most providers and systems to develop and implement sustainable APMs. We ask CMS to take this position into consideration to the extent possible in developing rules, and explore ways to be more flexible in meeting the requirements to participate as an APM.

Section B 1 c - APM Patient Approach Thresholds
WHA appreciates that CMS is exploring options to allow for patient data in lieu of revenue-only to meet the established APM thresholds. We support this as an option and believe flexibility should be allotted for entities to meet the aggressive thresholds via patient numbers data.

In lieu of meeting the established thresholds via specified Medicare Part B and/or all-payer service revenue, the law grants CMS the authority to use a “patient approach.” The patient approach is an alternative method
to be an eligible APM, and CMS is requesting comments on using patient numbers and how this should be defined. WHA appreciates that CMS is offering patient number data as an option for meeting the aggressive revenue thresholds. Wisconsin’s reimbursement is amongst the lowest in the nation per beneficiary, so although Medicare patients may represent significant levels of patient visits, the revenue may be very small. As such we believe CMS should be flexible in allowing for various forms of patient number data to be used for purposes of qualifying as an APM.

**Section B 1 f (3) – EAPM Entity Requirements Use of Certified EHR Technology**

WHA does not support CMS requiring providers to use additional components of certified EHR technology for APM participants. For many providers, improved quality may be achieved through more efficient and innovative approaches than a single, one-size-fits-all approach to EHR functionality; additional, prescriptive certification requirements may slow the ability to innovate or require all technology to be similar in ways that might not be in the best interest of the industry and of patients.

This is especially true in Wisconsin, where providers have been leaders in making health information technology (HIT) investments to help them deliver higher-quality and more cost-effective health care, with many of these investments beginning well before the establishment of the Medicare and Medicaid EHR Incentive Programs. According to this spring’s release of the Agency for Healthcare Research & Quality’s quality measure scores, Wisconsin received the second-highest score in the country and received exceptionally high scores for the quality measures related to the adoption of EHR technology.

If, however, CMS does decide to require additional EHR functionalities, these additional functionalities should not require investments and workflow disruptions that will outweigh potential health care cost savings or improvements in patient outcomes. One way to help accomplish this is to ensure that any new standards or infrastructure are sufficiently mature before their use becomes mandated or included in reimbursement methodologies. The transition to new technology supporting Stage 2 was a challenge for providers due to lack of vendor readiness, mandates to use untested standards, compressed timelines, and enormous expenses. In submitting a comment letter to CMS on the proposed rule for Stage 3 of the Medicare and Medicaid EHR Incentive Programs, WHA expressed similar concerns about the immaturity of certain EHR certification standards to support Stage 3. If CMS is considering additional required EHR functionality to support reporting under the MIPS, WHA would encourage CMS to confirm that such functionalities are mature enough to be included in regulation and that they actually support meaningful use requirements in accordance with clinical needs.

**Section B2 - Information for Physician-Focused APMs and the Technical Advisory Committee (TAC)**

WHA encourages CMS to establish a clear path and efficient process for becoming an APM. New payment models should include forms of capitated payment arrangements, incent an organizational structure that encourages care coordination, and allow for tools for providers to control over when, where and how the beneficiaries they are aligned with health care services.

WHA believes physician-focused APM’s will be instrumental in driving delivery system reform, coupled with a new robust value-based fee-for-service payment system. At this point, it remains a bit unclear as to the process for an organization to become an APM other than meeting specified criteria. We ask CMS to clearly articulate in the proposed rule the options available for entities and the process of obtaining CMS approval.
In addition, we encourage the use of existing infrastructure to the extent feasible. To minimize administrative burden, quality reporting, for example, should build on existing initiatives and reporting infrastructure. Also, Physician-focused APMs should incent an organizational structure that encourages care coordination. Patients will be better served with a team of providers collaborating on their care, as opposed to individual providers operating in silos with limited or no connections to other providers caring for those patients. Integration among providers is a key element to cost and quality improvement.

In delivering coordinated care, new APMs should include a form of capitated payment structure. By receiving payment up front, through per-beneficiary, per-month payments, providers would have the flexibility and resources necessary to invest in care management and processes to reduce overutilization, without having to be concerned about how a particular service is reimbursed under Medicare. Providers would also know upfront their patient population and could engage with them to influence how they receive care, and such, need proper tools to improve quality and reduce cost. Providers will be willing to take on more payment risk if they are given more control over when, where, and how the beneficiaries they are aligned with seek health care services. Providers should have tools, in APMs to help facilitate provider networks, obtain prior authorization, and tiered cost-sharing to allow providers to encourage their patients to seek out high-value care at the right time from the right provider. Finally, resources available for rural providers in underserved areas also ensure tools are in place to ensure continuity for vulnerable populations. We appreciate the law’s inclusion of technical assistance to small, rural practices and those serving shortage areas.

**Conclusion**

With the opportunity to transform the healthcare system towards value-based care, WHA appreciates the opportunity to comment on this important RFI. Representing hospitals and health systems, we urge CMS to work together with hospitals and physician groups to ensure value-based payment programs are working in tandem to achieve the goals of better quality and lower cost. We look forward to continuing to provide feedback on the implementation of the new payment programs in MACRA.

If you have questions, please contact Joanne Alig, senior vice president, policy & research, at (608) 274-1820 or jalig@wha.org.

Sincerely,

/s/

Eric Borgerding
President