Washington State Hospital Association

June 27, 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 101 hospitals and health systems, including 39 critical access hospitals in Washington State, the Washington State Hospital Association appreciates 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). WSHA supports the general direction and goals of the act, but we are concerned that it be implemented in a way that provides sufficient time and flexibility for hospitals and providers to successfully transition to new service delivery and payment. This is a particular concern for critical access hospitals where operating margins are either slim or nonexistent.

WSHA supports the comments and recommendations set forth by the American Hospital Association. In addition, we would like to highlight the following specific concerns:

Advanced APMs. We are concerned that the current list of approved advanced APM models is too limited and we urge CMS to adopt a more inclusive approach. Washington State has been encouraging innovative payment models that reward quality for a while for both its Medicaid population and for state employees. Hospitals and provider groups also have entered into such approaches with private payors. These quality measure and service delivery components are usually constructed with the whole of the payment population in mind. Washington State has put effort into streamlining quality measures used for value-based payment. We are concerned that the work and progress through these arrangements will be lost if hospitals and providers need to start over.

Additionally, 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. During the time of transformation there is often little capacity for downside risk. This is a particular issue for critical access hospitals, which already receive no more, and generally less than the cost of providing care to Medicare enrollees. We fear the insistence on significant downside risk could

have a chilling effect on experimentation with new models among providers that are not yet prepared to jump into two-sided risk models. We recognize 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. WSHA 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. Many physician-based quality measures assume either a primary care or referred specialist type of relationship with the patient. We believe because of the patient mix and type of services provided by many hospital-based providers, the hospital measures are a more appropriate. We believe using hospital measure performance in the MIPS would help physicians and hospitals better align quality improvement goals and processes across the care continuum.

Incorporation of Partnership for Payments Improvements. We are concerned regarding the lack of clarity regarding how improvements in quality and safety already achieved by hospitals will be reflected in quality scoring under the program. The Washington State Hospital Association's member hospitals achieved great success in obtaining reductions in readmission and sepsis rates through the *Partnership for Patients* program, though our hospitals' rates were already lower than most other regions of the country. These improvements in quality and safety are already providing significant Medicare savings. Because of the work already done, it will be difficult for our hospitals to maintain as large a degree of reductions compared to hospitals that are starting off with higher rates. We are concerned that the proposed scoring mechanism may penalize hospitals that have already made significant care improvements. WSHA urges CMS to ensure that hospitals have already made care improvements on their own or through early participation in CMS initiatives such as *Partnership for Patients* receive the full financial benefit for these improvements.

Socioeconomic Adjustment. We strongly urge 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. Failure to adequately adjust for differences in socioeconomic status unfairly penalizes hospitals and providers that serve high proportions of vulnerable patients. If this issue is not addressed, it could result in lost access to care for patients. Patient outcomes are influenced by factors other than the quality of the care provided. Evidence continues to mount that sociodemographic factors beyond providers' control – such as the availability of primary care, physical therapy, stable housing, easy access to medications and appropriate food, and other supportive services – influence performance on outcome measures.

In Washington State, hospitals are currently subject to payment reductions due to readmission rates under both the Medicare and Medicaid programs. In both cases a disproportionate burden of payment reductions is falling on safety net hospitals that provide service large numbers of homeless and other vulnerable patients. The Washington Medicaid agency is gathering data for consideration of a future adjustment based on socioeconomic factors and we encourage CMS to do the same as quickly as possible. CMS payment policy should encourage care for vulnerable patients, not punish the providers who serve these patients.

Meaningful Use. WSHA appreciates the move to greater flexibility in the MACRA proposed rule but we are concerned that it is a significant barrier for critical access hospitals and other rural providers as they have historically received less attention from the major EHR providers and unless part of a system, have less opportunity for shared systems and data with other entities. Our 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. We support the American Hospital Association's recommendation that CMS offer a reporting period of 90 days for CY 2017 and 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.

Additionally, we urge 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.

We again thank you for the opportunity to provide comments. If you have questions, please contact Andrew Busz, WSHA Policy Director, Finance at andrewb@wsha.org or (206) 216-2533.

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