

August 21, 2017

Ms. Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW, Room 445-G
Washington, D.C. 20201

RE: CMS-5522-P, Medicare Program; CY 2018 Updates to the Quality Payment Program; Proposed Rule (*Federal Register*, Vol. 82, No. 125, June 30, 2017)

Dear Ms. Verma:

On behalf of our more than 200 member hospitals and 50 health care systems, the Illinois Health and Hospital Association (IHA) is taking this opportunity to formally comment on the proposed rule continuing the implementation of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, Quality Payment Program (QPP) into Year 2 of the Program, Calendar Year (CY) 2018. This proposed rule addresses new policies that will affect the upcoming Medicare payment systems for physician services—the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). IHA commends the Centers for Medicare & Medicaid Services (CMS) for its thorough analysis of the law, and appreciates the agency's willingness to solicit and accept industry comments.

Given the large number of various policies and issues addressed in the rule, this comment letter is divided into four sections: those proposals that IHA supports; those proposals that IHA supports, with recommendations for improvement; those for which we have concerns and others. So, on behalf of our members, IHA offers the following comments for your consideration:

QPP PROPOSALS WHICH IHA SUPPORTS:

- **Incorporating Performance Improvement in the Total Performance Composite Score:** Last year, IHA strongly recommended that CMS include points for improvement in its calculation of the MIPS composite score, similar to the methodology used in the current hospital inpatient value-based purchasing (VBP) system. At that time, CMS did not include a scoring mechanism for improvement activities, but did request comments on the use of one of three options to incorporate improvement over time into the MIPS scoring methodology. Option 1 would pattern the improvement score on the current hospital VBP system. Option 2 would pattern the improvement score

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on the current Medicare Shared Savings Program. Option 3 would pattern the score based on the Medicare Advantage 5-Star rating methodology. Federal Fiscal Year (FFY) 2017 marks the fifth year in which the hospital VBP system has been in effect and hospital providers are very familiar with its methodology and application. In the VBP system, improvement is measured by comparing a hospital's performance in the current reporting period on a particular measure to its performance on that measure during the baseline period. An improvement score in a particular measure is used in the calculation of the composite score when it exceeds the hospital's performance score in that measure.

CMS proposes to incorporate a hybrid of Option 1--an "improvement score" in both the Quality and Cost domains, effective for payment years 2020 and 2021, respectively, recognizing eligible clinicians' improvement in performance comparing the performance period to the prior period. **IHA supports this proposal.**

- **Exemptions from MIPS, with an "Opt-In" Clause.** CMS proposes to increase the low-volume thresholds for MIPS participation exemptions from the current \$30,000 in allowable charges, or up to 100 Medicare patients treated during the performance period, to \$90,000 in allowable charges, or up to 200 Medicare patients treated. Eligible clinicians who exceed one of the two thresholds can "opt in" to MIPS, starting with the 2019 performance period. **IHA supports this proposal.**
- **Reporting Requirements for the Four Domains:** For the Quality and Cost domains, CMS proposes that for the 2021 payment period, the performance period would be the 12-month period from Jan. 1, 2019 through Dec. 31, 2019 (two years prior to the payment year). For the Advancing Care Information and Clinical Care Improvement Activities domains, the performance period would be a continuous 90-day period occurring two years prior to the payment period. **IHA is satisfied that the period of time between performance and payment is adequate, and recommends no changes to CMS.**

QPP PROPOSALS WHICH IHA SUPPORTS WITH RECOMMENDATIONS:

- **Re-weighting the Cost Domain for 2020:** There is considerable uncertainty concerning the methodology for the calculation of the Cost Efficiency Domain. Individual clinicians' claims data can be voluminous and clinicians will need guidance as to how the data is interpreted and applied. **Consequently, IHA strongly supports continuing the 0 percent domain weight through the 2020 payment period.** However, CMS proposes to apply a weight of 30 percent in 2021. **IHA believes that the increase from zero to 30 percent is too stark for one year, and instead, recommends 10 and 20 percent applications in payment years 2021 and 2022, respectively.**
- **Adding Bonus Points for Caring for Complex Patients:** Last year, IHA strongly urged CMS to incorporate a risk adjustment, including a socioeconomic adjustment, to ensure

caring for more complex patients does not result in the assignment of unfair poor performance scores for providers. The need for such an adjustment in the current Medicare Readmissions Reduction Program led to legislation (Section 102 of H.R. 5273- Helping Hospitals Improve Patient Care Act of 2016) that ultimately resulted in CMS proposing a methodology for the implementation of this adjustment in its Readmissions Reduction Program in FFY 2019. That proposal can be found in CMS' final FFY 2018 Inpatient Prospective Payment System (IPPS) Medicare payment rule.

Relative to the QPP, CMS proposes to include an adjustment of up to three bonus points to the total Composite score for those clinicians who treat medically-complex patients. While IHA believes that these additional points are justified, CMS fails to include a socio-economic adjustment for those clinicians who treat dual-eligible (Medicare & Medicaid) patients, although it does request comments on the feasibility of assigning up to five bonus points to clinicians who treat higher percentages of these patients. **IHA strongly recommends that CMS incorporate the five-point, dual-eligible payment adjustment, but at the same time, increase the additional number of points for complex patients to five.**

- **Program Improvements for Rural and Small Practices:** CMS proposes several improvements to the Quality Payment Program designed in deference to rural or small practices. **IHA supports the following CMS proposals with reservations:**
 - **Offering the Virtual Groups Participation Option.** Beginning with the 2018 performance period, CMS proposes to allow individual clinicians and group practices comprised of 10 or fewer clinicians to participate and report under MIPS requirements as a group under one Tax Identification Number (TIN). However, CMS proposes that for a virtual group to be in effect for 2018, it must notify CMS prior to the start of the 2018 performance period; i.e., meaning that the virtual group must notify CMS no later than Dec. 1, 2017. **IHA supports the concept of virtual groups and believes this is a viable option for physicians practicing in rural areas to participate in the QPP. However, the deadline for notification (Dec. 1) is much too early. The final rule is not expected until sometime in October, giving clinicians little time to plan and coordinate their participation. IHA recommends that CMS extend the notification period until July 1, 2018 and modify the performance period for these groups to allow those eligible clinicians to perform a thorough evaluation of the attractiveness of participation.**
 - **Adding Bonus Points for Small Practices.** CMS defines a small practice as one consisting of 15 or fewer clinicians, and will add points to the final composite score provided the practice submits data in at least one performance category. **IHA recommends that CMS make this option available to small rural practices as well, but should reduce the number of participants to 10, making this consistent with the virtual group requirement discussed above.**

QPP PROPOSALS WITH WHICH IHA HAS CONCERNS:

- **Offering the Opportunity to Use Facility-Based, Value-Based Purchasing (VBP) Scores for Facility-Based Clinicians:** Last year, IHA was concerned that clinicians practicing in a hospital setting could be penalized in their Quality and Cost domain performance scores because of the fact that they were treating the more complex patients seen in hospitals. CMS proposes that eligible clinicians practicing in a hospital setting and meeting the 75 percent volume requirement could use the hospital's Total Composite Score as derived from the its most recent VBP program results. **While the use of the hospital's composite score would greatly reduce the reporting burden for eligible clinicians (with which IHA agrees), there are concerns with simply transferring a hospital's VBP Composite Score to its hospital-based clinicians:**

- Hospitals have been questioning the methodology for computing their specific, as well as the national Medicare Spending-Per-Beneficiary (Cost) benchmarks.
- The hospital's VBP score is based upon a prior three-year reporting period. Hospital-based clinicians who have significantly improved the quality and/or the efficiency of their practice will have the impact of those improvements lessened by applying the three-year performance period used in the hospital VBP program, as opposed to the one-year application as applied in the QPP, where the impact of those improvements would be realized sooner.

IHA supports the linkage of the hospital's VBP results with the eligible clinicians' reporting requirements under MIPS, but strongly recommends that CMS allow for adjustments in the hospital's score when warranted.

- **Exclusion of Track 1, Medicare Shared Savings Program (MSSP) APMs:** The current structure of the Medicare Shared Savings Program should be given more consideration under the APM framework; that would permit Track 1 participants to transition to Tracks 2 or 3. Currently, participation in the Medicare Shared Savings Program requires a three-year commitment, effectively precluding Track 1 programs from eligibility as an Advanced Alternative Payment Model. Although the clinicians participating in these Track 1 models are working to achieve CMS' goals to transform care delivery, under this proposed rule they would receive no recognition for those efforts. **IHA urges CMS to expand the eligibility criteria for Advanced APMs to include Track 1 ACO participants. This would alleviate our concern that as currently proposed, providers that are considering participation as APMs must accept significant downside risk to qualify as an Advanced APM.**

OTHER:

- **Effect of Sequestration on MIPS Payments:** The proposed rule makes no mention of the impact of the 2 percent sequestration reduction on payments under either the MIPS or APM systems. **IHA assumes that the reduction will be applied after any incentive or penalty adjustment to the fee schedule payment, but requests that CMS confirm this.**

- **“Seamless” Registration and Submission of Data:** CMS must ensure that eligible professionals are able to understand and complete the electronic registration process and actually submit the data to the agency. CMS states in the proposed rule that eligible providers will receive their performance data in a format that can be reviewed and analyzed. **To accomplish this, IHA recommends that CMS continue to conduct periodic educational sessions or webinars, and make its staff available for ongoing questions and consultations. IHA also cautions CMS that the sheer numbers of eligible providers could result in a cumbersome data file, making the methods of disseminating that data especially important.**

- **Publication of Reporting Data on Physician Compare:** Physician Compare is CMS’ public reporting vehicle for information on physicians enrolled in the Medicare program. It is expected that with PQRS and MIPS reporting systems, Physician Compare will expand public reporting over the next several years. MACRA requires that the following information be made publicly available:
 - The MIPS eligible physician’s composite performance score;
 - The MIPS eligible physician’s performance in each performance category: Quality, Cost, Advancing Care Information, and Clinical Practice Improvement;
 - The names of eligible clinicians participating in Advanced APMs; and
 - Ranges of composite scores for both aggregate and individual category performance.

MACRA also provides the opportunity for clinicians to review their specific information before it is made available to the public. This is consistent with the review process available to hospitals when their quality performance data is published on Hospital Compare. CMS is proposing a 30-day review period prior to this publication.

As part of our ongoing work in the transforming the delivery of Illinois healthcare, IHA strongly supports publication and transparency of health data which will improve the quality of care provided to Illinois residents. **IHA supports CMS’ proposal to include a review period prior to the publication of the data. However, we recommend that this review period be extended to 60 days.** Taken together, with other information included on this website (e.g., individual physicians’ billed Medicare charges and Part B payments), the amount of information to review is voluminous. Since Physician Compare is a comparatively new reporting system, it is likely that many physicians will be uncomfortable with, or possibly unaware of, its usage. Many may be unfamiliar with the process of submitting corrections or appealing the data. **Therefore, in addition to recommending an extended review period, IHA strongly suggests that CMS conduct multiple education sessions directed toward the purpose, uses and of Physician Compare data, and how such data can be corrected, if necessary.**

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Ms. Verma, thank you again for the opportunity to comment. If you or your staff has any questions on the comments, they should be addressed to Thomas Jendro at (630) 276-5516 or tjendro@team-iha.org.

Sincerely,

A.J. Wilhelmi
President & CEO