Tom Bell  
President and CEO  

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 127 member hospitals and their 119 rural health clinics, the Kansas Hospital Associations 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). Our member hospitals employ and contract physicians and qualified clinicians. For many of these physicians, community hospitals will help defray the cost of the implementation of and ongoing compliance with the new merit-based incentive payment system (MIPS), as well as be at risk for any MIPS payment adjustments. We also anticipate that clinicians in our community will call upon our hospitals to participate in advanced alternative payment models (APMs) to help them qualify for APM bonuses.  

We appreciate many of the flexibilities CMS proposes to provide under both the MIPS and APMs. With respect to the MIPS, we support CMS’s proposal to reduce the number of quality measures that MIPS-eligible clinicians and groups would be required to report and believe it is good first step towards achieving greater focus in quality improvement efforts. We also appreciate that CMS has taken steps to introduce greater flexibility in meeting meaningful use requirements in the Advancing Care Information (ACI) category of the MIPS. Additionally, we support 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 encourage CMS to make significant changes to several other proposals that will impinge on successful participation in the QPP. Our key comments and concerns follow.
Advanced APMs. The Kansas Hospital Association is concerned that the APM track is too limited. Very few of the models in which hospitals have invested will qualify as advanced APMs. The KHA encourages CMS to adopt a more inclusive approach to include Track 1 and the new joint replacement model, for example. A primary concern is 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. 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 those efforts. The KHA is concerned that this may discourage participation in new models among providers that are not yet prepared to jump into two-sided risk models and is counter to the move toward aligning quality initiatives. Further, 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. The KHA encourages CMS allow an option for physicians that are hospital based to report hospital quality measures as part of MIPS to facilitate quality alignment. 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. The KHA believes using hospital measure performance in the MIPS would help physicians and hospitals better align quality improvement goals and processes across the care continuum.

Socioeconomic Adjustment. The KHA encourages 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. Absence of adjustment for Social Economic Status (SES) in risk adjustment methodologies remains a concern. There are compelling reasons to include SES factor in the hospital risk adjustment models and KHA encourages CMS to consider economic status, particularly relative to readmissions. Research continues to show that factors that have nothing to do with the quality of care patients received while hospitalized increase the likelihood that patients will be readmitted. These factors include: living alone; the lack of primary care, home health and rehabilitation services in the community; a lack of transportation options, particularly in rural areas, that enable patients to go to follow up appointments; and challenges adhering to dietary restrictions or health promoting activities; among others. We remain concerned that hospitals caring for patients from poorer communities, where these kinds of sociodemographic factors are more common, will be disproportionately penalized.

ACI Category. Kansas providers are committed to utilizing certified electronic health records (EHRs) as part of a foundation for care improvements, patient engagement and new models of care. The KHA appreciates the move to greater flexibility in the MACRA proposed rule but we have other overarching concerns with the proposal. Flexibility is helpful, but requirements for the use of certified EHRs is too complex. The complexity of the requirements will make a full year of reporting hard to do and the bar for success too high. 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. New software, changes to workflows, training staff and testing are required for any new measure. These transitions take time and require substantial resources of both vendors and providers. The KHA suggests a 90-day reporting period for calendar year 2017 and supports 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.

**Information blocking and surveillance attestations.** There are three attestations proposed for hospitals, CAHs and eligible clinicians concerning information blocking:

1. Hospitals, CAHs and physicians did not “knowingly and willfully take action to limit or restrict the compatibility or interoperability” of their certified EHR.
2. The technology is implemented to conform with standards, allow patient access and support secure and trusted bi-directional exchange of structured health information with other health care providers, including unaffiliated providers, and with disparate certified EHR technology and vendors.
3. Hospitals, CAHs or physicians responded in good faith and in a timely manner to requests to retrieve or exchange electronic health information, including from patients, health care providers, and other persons, regardless of the requestor’s affiliation or technology vendor.

Statute requires only the first of the three attestations and the KHA see significant problems with the two additional. For example, the second attestation is asking for functionality that current infrastructure and technology do not support. The KHA is concerned that third attestations requirement to provide access to information and to respond to requests for information make no mention of privacy. This notion of trusted bidirectional exchange is not something that today’s certified EHRs enable. The KHA suggests that CMS consider only the first of the attestations because it is the only one that mirrors the statute. The others are embellishments that are more aspirational than practical. Vendors should be held accountable to make this technology possible and the certification process should include determining whether the technology is consistent with standards and whether it is capable of bidirectional exchange.

Finally, the KHA 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.

Kansas hospitals are committed to moving toward an e-enabled health care system to improve patient care and safety and achieve national goals for improved health. We appreciate the opportunity to share our concerns and comments.

**Sincerely,**

Tom Bell
President and CEO