Presence Health®

August 21, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-5522-P; Medicare Program; CY 2018 Updates to the Quality Payment Program; Proposed Rule; June 30, 2017

Dear Ms. Verma:

Presence Health is one of the largest health systems in Illinois with 11 hospitals, over 20 nursing and senior living facilities, more than 90 ambulatory care sites, dozens of doctors' offices, home care, hospice and one of the largest behavioral health service networks in the state - all total more than 150 sites of care. Presence Health is pleased to submit comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule ("proposed rule") entitled *Medicare Program; Medicare Program; CY 2018 Updates to the Quality Payment Program* ("QPP") (Federal Register 2017-13010, June 30, 2017), as part of the implementation of the provisions of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

SUMMARY

Presence Health recognizes that the U.S. healthcare system is evolving and taking on a whole new set of considerations, and we appreciate that MACRA's intent is to reduce health care spending and overall utilization by rewarding providers for improved quality and outcomes. We are encouraged by CMS's proposal to ease the onerous administrative tasks that bog down physicians and keep them from their clinical responsibilities. CMS's proposal to alleviate the burden of implementing new electronic health record (EHR) technology will facilitate lower costs in the application of the new quality reporting program.

Presence Health has over 2,250 physicians with Presence Medical Group (PMG) and Presence Health Partners (PHP), both employed and contracted. As a result, we will bear substantial costs from implementation of and ongoing compliance with the new MACRA reporting requirements for physician performance, as well as be at risk for any payment adjustments. In regard to the QPP proposed rule, there are several positive changes that will benefit our physicians, but also some potentially negative changes that may halt our progress or make the future insecure for our physician groups in terms of provider engagement and participation. Presence Health welcomes the positive changes, but notes with concern the changes to the rule that may affect our ongoing

progress towards value based care. In this letter, we would like to comment on several provisions relevant for our organization related to the QPP proposed rule.

POSITIVE UPDATES

Presence Health supports the provision in the proposed rule to provide expanded opportunities for bonus points under the Merit-Based Incentive Payment System (MIPS) scoring methodology for both advanced EHR technology and complex patient care. Additionally, under the proposed rule change, CMS allows for the combining of commercial and Medicare Alternative Payment Model (APM) models to qualify for an advanced APM. This is a positive change for Presence Health in that it allows for us to gain credit for many risk based contracts that we currently use and as we pursue and grow our Medicare Advantage contracts. Furthermore, we also support the decreased risk in medical home models to 2 percent from 2.5 percent. This change helps provide us with an opportunity over the next year to explore the medical home model within our employed physician groups. Additionally, we applaud CMS' efforts to recognize quality improvement even when absolute thresholds are not reached as quality improvement is a gradual process.

AREAS OF CONCERN

Design of Virtual Groups

CMS's proposed rule allows for solo physicians or physicians in groups of 10 or fewer to virtually combine for MIPS participation. To become a virtual group, a solo physician or group must combine with at least one other solo physician or group, regardless of location or specialty, and register before the 2018 performance year. Solo physicians must be eligible for MIPS on their own. Under the current proposal for the design of virtual groups, Presence Health is concerned that independent physicians may form their own virtual groups without regard for a specific healthcare system, resulting in the lack of care coordination between these groups and healthcare systems. While many providers today participate in Accountable Care Organizations (ACO), virtual groups would decrease provider incentive to be a part of an ACO. In addition, these virtual groups will lack the necessary infrastructure that providers receive from an ACO.

Significantly, we are concerned that the creation of virtual groups may segregate providers from healthcare system components, as these groups can be formed by independent physicians without the engagement of a healthcare system. Most ACO groups include provider practices, hospitals, and other healthcare systems that share in savings by working together to meet quality-of-care objectives and reduce costs. Virtual groups on working solely their own could possibly cause a lack of care coordination, which could lead to higher costs, serious complications, including medication errors, preventable hospital readmissions, and unnecessary pain and suffering for patients. By aligning with a healthcare system rather than virtual groups, healthcare systems can

align interests to benefit both groups for quality and cost improvement. With data fully accessible to participating providers and healthcare systems, ACOs have been able to more quickly identify target patients, intervene to improve health, track compliance, create alignment between physicians, and ensure meeting of performance standards.

Presence Health urges CMS to reconsider the virtual groups' aspect of the rule as it may lead to a disengagement from inpatient and outpatient care models. Should CMS chose to proceed with the provision for virtual groups, we recommend that CMS update the proposed rule to require these virtual groups to align with specific health systems. We recommend that these groups be anchored to specific systems to establish a defined delivery model. Additionally, CMS should propose a structure for reimbursement of administrative costs for virtual groups. Furthermore, CMS should provide some direction on how it would like to see virtual groups form, specifically some rules on data sharing among virtual groups. Additionally, CMS should create waiver opportunities for virtual groups to allow more options within virtual groups to manage their metrics.

Low-Volume Threshold for MIPS System

In 2017, clinicians or groups were exempt from MIPS reporting requirements if they billed $30,000 or less in Medicare Part B charges annually or had 100 or fewer Medicare Part B beneficiaries. This left just one-third of Medicare clinicians eligible for MIPS. However, to ease the burden on small and rural practices, CMS now proposes raising this threshold in 2018 to 200 Medicare Part B beneficiaries and $90,000 in Medicare Part B allowed charges per year. Since there will be less qualified providers, Presence Health is concerned this provision will limit the amount of money available in the pool; increase the chances for penalty and poor performance; and decrease potential for overall revenues gained. We are concerned that with fewer providers, the current adjustment factor will decrease significantly. We are also concerned that this may impact providers' incentive to participate and continue quality improvement initiatives when the rewards are not worth the effort. The prospect of more physicians being able to opt out of MIPS raises questions about how useful the data collected will be in achieving MACRA's goals. **Presence Health urges CMS to change this threshold and exemption to create additional pathways for people to be able to participate in MIPS, so the overall number of participants keeps growing. Perhaps, by allowing voluntary participation for providers who qualified for this year but may not qualify for the following year could be a way to continue the progress and engagement from the provider groups and recognize their investment in the process.**

Weight of MIPS Composite Score

In the proposed rule, CMS weights the composite MIPS score at Quality- 60 percent; Cost- 0 percent; Advancing Care Information- 25 percent; and Improvement Activities- 15 percent. The

agency was proposed to "gradually increase" the cost scoring beginning in 2018 to 30 percent. While the cost is still weighted at 0 percent next year, MIPS scoring ramps up the category's weight to the full legally mandated 30 percent in performance period 2019. Presence Health is concerned that this change would be a dramatic jump that would seriously change the formulation of the previous two years. With cost being 0 percent, providers have been focused on quality improvement and technology enhancement, adding the cost factor to this level would mean a significant change in their directives and behavior which can leave many providers vulnerable to face a penalty. **We recommend that CMS implement a gradual increase in the percentage of the cost category of the ACI. We recommend a gradual transition of 10 percent in CY 2019, 20 percent in CY 2020, and 30 percent in CY 2021. Alternatively, if the statute locks us into cost at 30percent in 2019, we would recommend voluntary consideration for providers or bonus opportunity to include cost as part of their MIPS calculation**

More Incentives for APMs

In 2016, CMS finalized the criteria by which clinicians will be determined to be qualified APM participants to receive the incentives. Under the proposed rule change, CMS will assess clinicians' participation in APMs in 2018 for the 2020 incentive payment. Presence Health is concerned that under the proposed rule, there are still very few advanced APMs qualifying for incentives. We are disappointed that few of the models in which hospitals have engaged will qualify as advanced APMs. Specifically, we are concerned about CMS's proposed generally-applicable financial risk standard, under which an APM generally must require participating entities to accept significant downside risk to qualify as an advanced APM.

CMS's proposed approach fails to recognize the significant resources providers invest in the development of APMs. Although clinicians participating in shared savings-only 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. We fear this could have a chilling effect on experimentation with new models of care among providers that are not yet prepared to jump into two-sided risk models. CMS has attempted to provide a glide path to APMs that falls 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. Given limited resources, providers are likely to focus on achieving the successful performance required to avoid negative payment adjustments through the MIPS, leading to the unintended consequence of reduced interest in APMs. **Presence Health urges CMS to expand its definition of financial risk to include the investment risk borne by providers who participate in APMs, and to develop a method to capture and quantify such risk. We also urge the agency to update existing models, such as the Bundled Payments for Care Initiative and the CJR, so that**

those models would qualify as advanced APMs. We also encourage CMS to provide additional transparent opportunities for clinicians to become advanced APMs.

Length of Reporting Period

The proposed rule includes a full calendar year of reporting for the ACI category. Even if the MACRA rule is finalized in the fall, providers will have very little time to understand the changes, work with their vendor and prepare to meet the revised requirements. The use of objectives and measures derived from the Modified Stage 2 also will provide time for the adoption and safe implementation of 2015 edition certified EHRs. Experience to date indicates that the transition to new editions of certified EHRs is challenging due to lack of vendor readiness, the necessity to update other systems to support the new data requirements, mandatory use of standards that may be immature, and a timeline that frequently is too compressed to support successful change management. The receipt of a new edition of a certified EHR initiates a 19-month process from software assessment, installation, implementation and training to building of performance before the required reporting period. **Presence Health recommends that CMS finalize a shorter, 90-day reporting period for the ACI category and for any provisions in the final rule where an eligible clinician would use a certified EHR to meet a program requirement.**

Aligning the Meaningful Use Program with MIPS

Presence Health supports changes to the EHR Incentive Program for physicians that begin to offer flexibility in how physicians and other eligible clinicians are expected to use certified EHRs to support clinical care. As these changes are implemented, it will be essential to ensure that program requirements are aligned across all participants, including physicians, hospitals, and CAHs. This alignment is essential to ensuring the ability of providers to share information and improve care coordination across the continuum. Presence Health recommends that CMS 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 CAHs under the Medicare and Medicaid EHR Incentive Program.

We are encouraged by CMS's proposal for a facility-based clinician reporting option, and applaud the agency's proposal to extend the use of modified stage 2 meaningful use requirements through 2018. However, we will encourage CMS to provide the same relief to hospitals. Presence Health recommends that CMS move away from an "all or none" scoring approach for the ACI category, and ensure that programmatic changes for eligible clinicians are aligned with those of the EHR Incentive Program for eligible hospitals. **We ask CMS to simplify the ACI requirements by permitting eligible clinicians to use objectives and measures derived from the EHR Incentive Program Modified Stage 2 objectives and measures to meet the ACI requirements. Presence Health also recommends that CMS recognize the considerable**

complexity of achieving the proposed ACI requirements by offering a reporting period of 90 days for the ACI category.

CONCLUSION

While Presence Health believes that there are positive aspects of the QPP proposed rule that will benefit our health care system, we are concerned about the many provisions of the rule change that may inhibit our ability to progress in the future. Given that we employ over 2,250 physicians that stand to be affected by the rule change, we urge CMS to consider our recommendations as stated above. We look forward to working with you on these and other issues. If you have any questions about the issues raised in this letter or need more information, please contact Will Snyder, System Vice President, External Affairs, Presence Health, at 312.308.3222 or william.snyder@presencehealth.org.

Sincerely,

Michael Englehart
President and CEO
Presence Health