



September 2, 2014

Ms. Marilyn Tavenner  
Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building, Room 445-G  
200 Independence Ave. SW  
Washington, DC 20201

**Ref: CMS-1612-P: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015**

Dear Ms. Tavenner,

Thank you for the opportunity to submit comments on the above-captioned proposed rule. America's Essential Hospitals appreciates and supports the Centers for Medicare & Medicaid Services' (CMS') work to encourage improved care delivery across the entire health care industry. However, proposals included under the Medicare Shared Savings Program (MSSP) may have a negative impact essential hospitals—those dedicated to serving the vulnerable, first and foremost. With that in mind, America's Essential Hospitals asks CMS to consider, as it finalizes this rule, the unique challenges inherent in caring for these patient populations.

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. As essential community providers (ECPs), our nearly 250 member hospitals fill a vital role in their communities, serving the uninsured and patients covered by public programs. Specifically, our members provide a disproportionate share of the nation's uncompensated care and devote more than half of their inpatient and outpatient care to uninsured or Medicaid patients. Our members provide this care while operating on

margins substantially lower than the rest of the hospital industry: -0.4 percent compared with 6.5 percent for hospitals nationally.<sup>1</sup>

In addition to offering specialized inpatient and emergency services, members of America's Essential Hospitals play a vital role in providing ambulatory care to their communities. The average member operates a network of 20 or more ambulatory care sites. And, in 2012, the average member saw more than four times as many non-emergency outpatient visits as other acute care hospitals in the country.

Our members offer more comprehensive ambulatory care than many other providers and create medical homes for community residents through networks of provider-based ambulatory health clinics. For example, their hospital-based clinics include onsite features not typically offered at freestanding physician offices, such as radiology, laboratory, and pharmacy services. And they deliver ambulatory care services to schools and housing developments through mobile units, many of which offer onsite behavioral health support services, interpreters, and patient advocates who can access support programs for patients with complex medical and social needs.

The high cost of providing comprehensive, complex care to low-income and uninsured patients leaves our hospitals with limited resources, which compels them to find increasingly efficient strategies for providing high-quality care to their patients. Several members are participating in the MSSP and have made the needed investments to participate as accountable care organizations (ACOs). However, our members have faced challenges as they continue to make investments necessary for ACO participation, including for technology, process redesign, personnel, care coordination, quality measurement, risk management, compliance, network development, governance, and in their legal structure.

To ensure our members can continue these activities and are not unfairly disadvantaged for serving the most vulnerable among us, the comments below focus on proposed changes to the MSSP. CMS should consider these comments when finalizing the MSSP section of the above-mentioned proposed rule to encourage participation by essential hospitals, which serve a vital role in their communities.

1. CMS should continue to refine the measure set used to establish ACO quality performance standards so it contains only reliable and valid measures that provide an accurate representation of quality of care.

**CMS should ensure that valid, sound measures that improve quality are included in the measure set used to establish the quality performance standards ACOs must**

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<sup>1</sup>Katie Reid, B. Roberson, S. Laycox, M. Linson. *Essential Hospitals Vital Data, 2012: Results of America's Essential Hospitals Annual Characteristics Survey, FY 2012*. Washington, DC: America's Essential Hospitals; 2014. <http://2c4xez132caw2w3cpr1il98fssf.wpengine.netdna-cdn.com/wp-content/uploads/2014/08/VitalData-FullReport-20140804.pdf>. Accessed August 14, 2014.

**meet to be eligible for shared savings.** America's Essential Hospitals supports programs that encourage quality improvement. However, CMS must verify that quality improvement program measures are properly constructed and do not lead to unintended consequences.

CMS proposes to remove eight measures from the measure set used to establish ACO quality performance standards because the measures no longer represent clinical best practice, are redundant, or can be replaced with similar measures that are more appropriate for ACO quality reporting. America's Essential Hospitals supports the removal of measures that no longer represent best practices or accurately capture distinctions in quality of care. Removing these measures reduces the administrative burden on ACOs and ensures that the measure set is kept up to date.

- a. CMS should account for socioeconomic and other appropriate factors by risk-adjusting the measures used to establish ACO quality performance.

**CMS should incorporate risk adjustment for socioeconomic factors in its methodology for scoring outcomes measures in the MSSP so the results are accurate and reflect the differences in ACO patients.** In the above-mentioned rule, CMS proposes the addition of 12 measures. This represents a shift to more outcomes measures in the measure set used to establish the quality performance standards ACOs must meet to qualify for shared savings.

Outcomes measures, especially readmissions measures, do not accurately reflect quality of care if they do not account for socioeconomic factors that can complicate care. Factors outside of hospitals' direct control, such as homelessness, income, education, and primary language, can influence patients' health care outcomes. Patients who do not have a reliable support structure are more likely to be readmitted to a hospital or other institutional setting.

Additionally, the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey can vary due to patient characteristics. Measures taken from the CAHPS survey also should be adjusted for sociodemographic factors to ascertain whether the variance reflects true differences in quality of care.

The need to take socioeconomic factors into account has been increasingly suggested for quality measurement programs. For example, legislation recently introduced in both chambers of Congress would require CMS to account for socioeconomic status when assessing hospitals on readmissions in the Hospital Readmissions Reduction Program (HRRP). Further, the Medicare Payment Advisory Commission also has made this recommendation for the Medicare HRRP.<sup>2</sup> Additionally, the National Quality Forum

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<sup>2</sup>See, e.g., *Report to Congress, Medicare and the Health Care Delivery System*. Washington, DC: Medicare Payment Advisory Commission; June 2013. [http://www.medpac.gov/documents/Jun13\\_EntireReport.pdf](http://www.medpac.gov/documents/Jun13_EntireReport.pdf). Accessed August 14, 2014.

(NQF) board of directors voted in July 2014 to assess on a trial basis the impact and implications of risk-adjusting certain quality measures for sociodemographic factors. This decision stems from the work of an NQF-convened expert panel, which recommended that certain quality measures be risk adjusted for these factors. The growing consensus highlights the importance of risk adjustment to ensuring accurate and useful information in quality programs. **Therefore, CMS should not include measures to establish ACO quality performance standards until those measures have been risk adjusted for socioeconomic factors.**

- b. CMS should not include measures that have not been endorsed by NQF in the measure set used to establish ACO quality performance standards.

CMS proposes to include the Skilled Nursing Facility (SNF) 30-day All-Cause Readmission measure, which is currently under review by NQF. CMS also proposes to include three additional measures: All-Cause Unplanned Admissions for Patients with Diabetes Mellitus (DM), Heart Failure (HF) and Multiple Chronic Conditions. These three measures are still under development though a CMS contract with Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation to develop quality measures specifically for ACO patients with heart failure, diabetes, and multiple chronic conditions.

NQF endorsement is imperative to ensuring measure validity and reliability. The endorsement and approval processes require that measures be fully vetted and approved through a consensus-building approach that involves the public and interested stakeholders. CMS should continuously monitor the measures in the program for NQF endorsement status and remove existing measures that remain unendorsed or have had their endorsement withdrawn. Further, measures that remain under development also have not been thoroughly vetted to ensure validity and reliability and should not be added to the program. **Because the SNF 30-day All-Cause Readmission measure and All-Cause Unplanned Admissions for Patients with DM, HF and Multiple Chronic Conditions measures have not been fully evaluated, they are not ready to be included in the measure set used to establish quality performance standards for ACOs.**

- c. CMS should eliminate the diabetes and coronary artery disease (CAD) composite measures, as the composite scoring structure does not encourage quality improvements.

**CMS should eliminate the composite measures from the measure set used to establish quality improvement for ACOs because the scoring structure does not allow providers to target care improvement initiatives.** The MSSP includes all-or-nothing score for two measures: diabetes composite and CAD composite. Including composite measures can produce confusing and opaque performance scores if the individual indicators vary widely in average performance, allowing outlier measures to have the strongest impact on the composite measure rate. Further, CMS proposes the

inclusion of the ACO #27 Diabetes Hemoglobin A1c Poor Control measure, which is a reverse-scored measure. The inclusion of a reverse-scored measure in the diabetes composite measure could lead to additional confusion. These factors could lead to the misinterpretation of composite measures and invite inappropriate policies if the dimensions of the individual indicators are ignored.

CMS should eliminate the composite measures because they are not ideal for understanding performance shortfalls or implementing remedies for improvement. Rather, CMS should score each submeasure individually to allow for precise measurement.

However, as CMS proposes to refine the measures, instead of removing the composites altogether, America's Essential Hospitals urges the agency to ensure measures reflect the best practices for diabetes and CAD care and fully reflect processes and outcomes within an ACO's control.

**To facilitate accurate performance measurement and allow ACOs to implement quality improvements, CMS should eliminate the diabetes and CAD composite measures from the measure set used to establish the quality standards ACOs must meet.**

- d. CMS should ensure that the measure set used to establish quality performance for ACOs appropriately encourages beneficiary engagement.

CMS has proposed additional measures for the patient experience/caregiver experience domain. This domain is important for ACOs to capture beneficiaries' experiences with health care providers. However, measures in this domain do not encourage beneficiary engagement. Providers can explain and encourage beneficiaries to make choices that are in the best interest of their health and help drive down the cost of care. But the final decision rests with the beneficiary. **Therefore, as CMS continues to refine the measures added to the Patient/Caregiver Experience Domain, the agency should only include measures that appropriately capture and encourage beneficiary engagement.**

- e. CMS should exclude measures that dilute the focus of the MSSP.

**CMS should eliminate the Percent of Primary Care Providers (PCPs) who Successfully Meet Meaningful Use (MU) Requirements (ACO #11) measure from the measure set used to establish ACO quality performance standards because the goals of this measure are captured by the MU program, which has its own regulations and timelines.** CMS proposes to expand the existing ACO #11 measure, which measures the percentage of providers that successfully qualified for an electronic health record (EHR) incentive, to now capture the percentage of providers that meet MU requirements. The use of EHRs is critical to good care coordination and allows providers to deliver care more efficiently. However, the MU program is a separate program that has its own

financial incentives and disincentives. Requirements for achieving MU go beyond the use of EHRs. Measuring the percentage of providers who meet MU requirements is superfluous to the MSSP and dilutes the focus of the program.

Moreover, meeting the meaningful use requirements requires a large investment in time and financial and technological resources. This presents a challenge to some providers—especially essential hospitals, which have limited resources. Including this measure in the MSSP potentially penalizes providers and may hinder their participation in the MSSP. **Therefore, CMS should remove the ACO #11 measure from the measures used to establish quality performance for ACOs.**

2. CMS should provide consistency in how the agency determines when a measure is topped out for pay-for-performance programs and should not prematurely remove measures that encourage clinical processes leading to better health outcomes.

**CMS should align the criteria among all public reporting programs for determining which measures should be removed by finalizing the same criteria for identifying topped out measures with a modification to ensure measures are not prematurely removed.** CMS proposes to deem a measure as topped out for the purposes of evaluating an ACO's performance when national fee-for-service (FFS) data results in the 90<sup>th</sup> percentile for a measure are greater than or equal to 95 percent. CMS would then use flat percentages for that measure. However, in the calendar year (CY) 2015 outpatient prospective payment system proposed rule, CMS proposes two criteria for determining which measures are topped out and should be removed from the Outpatient Quality Reporting Program:

- statistically indistinguishable performance at the 75<sup>th</sup> and 90<sup>th</sup> percentiles
- truncated coefficient of variation less than or equal to 0.10

CMS adopted these criteria for the Inpatient Quality Reporting Program in the fiscal year (FY) 2015 inpatient prospective payment system final rule, and also uses nearly identical criteria for the Value-Based Purchasing Program. America's Essential Hospitals appreciates any efforts by CMS to reduce the reporting burden on hospitals. By removing measures that no longer show improvements in quality, CMS will enable hospitals to use their limited resources for quality improvement, as opposed to reporting activities. However, as CMS finalizes its criteria for determining which measures have topped out, it should use identical criteria across the various quality reporting programs to avoid inconsistencies among the programs.

CMS should apply to the MSSP the same criteria used for other programs, with the modification that a measure could not be removed from the MSSP until it has topped out for at least three years. This will provide stability to participants during their MSSP agreement period as they work to improve quality.

3. CMS should ensure that future quality measures are relevant to the program, are reliable and valid, and take into account the socioeconomic and demographic factors that complicate care for vulnerable patients.

CMS seeks public comment on a variety of areas for future development. Any measures that are adopted for the program should (1) be relevant to the purposes of the MSSP, (2) lead to better health outcomes, improved care coordination, and improved patient safety, and (3) reflect activities within the control of the ACO. Additionally, the MSSP measure set should be limited to NQF-endorsed measures that are valid and reliable, are aligned with other existing measures, and, especially for outcomes measures, are risk adjusted for socioeconomic factors. Specific comments on areas CMS identified for future measures development follow.

- a. CMS should not require ACOs to report on measures that are specific to the post-acute care setting.

Coordinating care with providers across the care continuum is a critical element in the success of ACOs. These providers include not just primary care providers, specialists, and acute care institutions, but also post-acute care institutions, such as SNFs, home health agencies, and inpatient rehabilitation facilities. However, the types of measures that are tailored specifically to post-acute care settings, such as the SNF readmission measure proposed for the MSSP measure set, are not appropriate mechanisms for measuring ACO quality for ACOs that do not have post-acute care providers. In fact, many ACOs do not have participants from the post-acute care setting, or may have only certain types of post-acute care providers in their organization, so measuring outcomes tied specifically to these settings does not necessarily reflect quality of care provided by the ACO. ACOs already have multiple incentives to coordinate care with these different types of providers, so measuring outcomes in specific post-acute care settings that may not be under the control of the ACO is not an optimal way of improving ACO quality. In addition, requiring ACOs, particularly those that do not have post-acute care providers within their ACO, to collect and report data for post-acute care providers with which they have no formal relationship, is administratively burdensome. For these reasons, CMS should not require ACOs to report on post-acute care measures.

- b. CMS should align MSSP measures with value-based payment modifier (VM) measures.

CMS notes in the rule that beginning in CY 2017, the VM would apply to physicians participating in ACOs. The agency seeks comments on the benefits of aligning MSSP quality measures with VM quality measures. **CMS should align MSSP measures with VM measures to reduce the reporting burden on providers and to ensure consistency between measures used to assess providers.** Aligning MSSP measures with VM measures will reduce the reporting burden on providers who participate in an ACO and who also are required to report on VM measures separately. Moreover, alignment of measures will avoid conflict between measures in different programs and

will create uniformity in measures used to assess the quality of physician care within and outside of the ACO context. **For these reasons, CMS should align MSSP measures with VM measures.**

- c. CMS should not include self-reported health and functional status measures in the quality performance standard.

CMS is soliciting feedback on including a self-reported health and functional status measure in the quality performance standard. Currently, self-reported health and functional statuses are incorporated in the patient experience of care survey, but are not included in the quality performance standard as stand-alone measures. Self-reported measures require additional standardization, and vulnerable populations treated by ACOs will face difficulty with self-reporting measures due to language barriers and low health literacy. Further, as outcomes measures, these measures would need to be risk adjusted to account for differences in health status that are attributed not to the quality of care the ACO provides, but to socioeconomic factors outside the ACO's control. **For these reasons, CMS should not include self-reported health outcomes measures in the MSSP measure set.**

4. To the extent there are new measures, CMS should ensure ACOs have adequate time to learn to report on quality measures before they are subject to pay-for-performance standards.

**CMS should clarify the regulations to expressly provide that during a second or subsequent participation agreement period, an ACO would be assessed for reporting on new measures before being subject to pay-for-performance penalties.** America's Essential Hospitals appreciates CMS' efforts to clarify the regulations regarding second or subsequent participation agreement periods for ACOs. However, CMS must ensure that new measures include a pay-for-reporting period before becoming subject to pay-for-performance standards. ACOs need sufficient time before being subject to pay-for-performance standards to gain experience reporting on new measures and make care improvements. **Therefore, CMS should ensure that any new measures in the MSSP during an ACO's second or subsequent participation agreement period be assessed by pay-for-reporting standards.**

5. CMS should continue to develop incentives that reward quality improvement for MSSP participants.

**CMS should encourage quality improvement by rewarding ACOs that make significant gains in their quality of care.** CMS proposes to award bonus points to ACOs that achieve improvements within the MSSP program's existing four quality measure domains. America's Essential Hospitals encourages CMS to implement incentives, such as the one proposed, that emphasize quality improvements. Focusing the incentive on quality improvement signals to MSSP participants that the agency recognizes and values the progress made by individual ACOs in improving the quality of care provided to



patients. This focus further emboldens ACOs to implement innovative systems and processes to attain quality improvement for as many Medicare beneficiaries as possible. Additionally, an incentive program that focuses on improvement will help encourage participation in the MSSP by providers serving at-risk populations. **Therefore, CMS should encourage MSSP participants with incentives that reward quality improvements.**

6. CMS should revise the timeframe for updating benchmarks to provide a stable target for ACOs as they measure quality improvement.

**CMS should match the timeframe for updating benchmarks to the ACO participation agreement period to provide a stable target for measuring quality improvement.** CMS proposes to update benchmarks every two years to provide ACOs with a more stable target for measuring quality improvement. America's Essential Hospitals applauds CMS for this goal of stability. However, the association urges the agency to consider updating benchmarks every three years to provide even greater stability. Currently, ACOs enter participation agreement periods that span three years. By synchronizing the timeframe for updating benchmarks with the participation agreement period, CMS would allow ACOs to put the necessary systems in place to produce significant quality improvements. Providers need time to implement the processes needed to improve quality and to realize the benefits of their initiatives. **CMS should provide ACOs stability and encourage robust quality improvement by updating benchmarks every three years to match the MSSP participation agreement period.**

7. CMS should not require EHR-based quality reporting under the MSSP until ACOs and providers have sufficient time to overcome current operational difficulties with EHRs.

In the proposed rule, CMS discusses its intent to integrate the use of health information technology into MSSP quality reporting requirements. While America's Essential Hospitals believes the use of EHRs can reap true benefits in improving care delivery and coordination, providers across the care continuum continue to face challenges in adopting and implementing EHR systems. **Therefore, CMS should not require the use of EHRs for quality reporting in the MSSP until all providers are at the same stage of meaningful use.**

While CMS does not yet propose imposing electronic reporting requirements on MSSP participants, it seeks comment on potential barriers, alternatives, and the best process by which to implement EHR-based reporting. Varying levels of EHR adoption by ACOs and ACO participants presents barriers to electronic quality reporting by ACOs. Eligible hospitals and professionals continue to face challenges, particularly with more exacting stage 2 meaningful use requirements. In particular, providers face challenges with health information exchange and interoperability, partly due to the use of different platforms. Providers within an ACO may be at different stages of meaningful use and, therefore, have different capabilities. Additionally, an ACO's providers may employ varying EHR

systems, meaning the data extracted from these EHRs and submitted to the ACO is not in a standard format. Providers using different platforms need to take additional steps to ensure this data is extracted in a common format. All of these difficulties hinder the ability of ACOs, ACO participants, and individual providers to submit EHR-based information for MSSP quality reporting purposes. **Because of outstanding issues with EHR adoption and wide variation in the use and types of EHR systems across providers, CMS should carefully and gradually phase in EHR-based reporting requirements.**

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America's Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Xiaoyi Huang, director of policy, at 202-585-0127.

Sincerely,

Bruce Siegel, MD, MPH  
President and CEO