**CY 2015 Medicare Physician Fee Schedule (PFS) Proposed Rule**

***MSSP Participant Outreach***

Recently, the Centers for Medicare & Medicaid Services (CMS) released the calendar year (CY) 2015 Medicare Physician Fee Schedule (PFS) proposed rule. This rule includes proposed changes to the Medicare Shared Savings Program (MSSP). Since your hospital is participating in an ACO, we would appreciate your feedback on CMS’ proposed changes to the program. As America’s Essential Hospitals works on its comments, we want to ensure that our comments reflect any concerns you may have. Specifically, we are seeking input on the questions below.

We thank you in advance for your time.

**ACO Quality Performance Standards:**

CMS proposes a number of changes to the quality measures used in establishing quality performance standards that ACOs must meet to be eligible for shared savings.

1. **CMS proposes to add the following 12 measures to establish quality performance standards that ACOs must meet to be eligible for shared savings:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Proposed Measures for Inclusion in Quality Performance Measure Set** | **NQF endorsed?** | **Replacing Existing Measure?** | **Additional Notes about Measure** |
| CAHPS Stewardship of Patient Resources | Yes | No | Survey measure, already collected but not scored; proposed to be a scored measure in the patient experience domain |
| SNF 30-day All-Cause Readmission Measure | **No – under review (NQF #2510)** | No | Claims based measure |
| All-Cause Unplanned Admissions for Patients with Diabetes Mellitus (DM), Heart Failure (HF) and Multiple Chronic Conditions | **No - under development by Yale New Haven Health Services Corporation/CORE** | No | Proposed to be added to Care Coordination/Patient Safety domain |
| Depression Remission at Twelve Months | Yes (NQF#0710) | No | Submission through GPRO |
| Diabetes Measures for Foot Exam and Eye Exam | Yes (NQF #0055 and #0056) | No | Proposed to be added to the Diabetes Composite Measure (Clinical Care for at Risk Population-Diabetes); measures would align with PQRS and EHR Incentive Program |
| Coronary Artery Disease (CAD): Symptom Management | Yes | No | Proposed to be added to the CAD Composite Measure (Clinical Care for At Risk Population-Coronary Artery Disease (CAD) domain; measure would align with PQRS (PQRS #0242) and the EHR Incentive Program |
| Coronary Artery Disease (CAD): Beta Blocker Therapy—Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF<40%) | Yes (NQF #0070) | No | Proposed to be added to the CAD Composite Measure |
| Coronary Artery Disease (CAD): Antiplatelet Therapy | Yes (NQF #0067) | Yes - measure would replace the existing measure ACO #30, Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic, which CMS is proposing to remove because it no longer reflects current clinical guidelines | Would be added to the Clinical Care for At Risk Population-Coronary Artery Disease domain and included in the CAD Composite Measure |
| Documentation of Current Medications in the Medical Record | Yes (NQF #0419) | Yes - measure would replace ACO #12 (NQF #0097) Medication Reconciliation measure | Measure aligns with both PQRS and the EHR Incentive Program |
| Percent of PCPs who Successfully Meet Meaningful Use Requirements | Yes | Yes - modifies the name and specifications for ACO #11 Percent of PCPs who Successfully Qualify for an EHR Incentive Program Payment, so that it more accurately depicts successful use and adoption of EHR technology in the coming years | Would continue to be doubly weighted |

As you can see in the table above, some of the measures are not NQF endorsed or still under development at this point. All 37 measures would be phased in for ACOs with 2015 start dates according to a phase-in schedule - ACOs with start dates before 2015 would be responsible only for complete and accurate reporting of the new measures for the 2015 performance year, and then responsible for either reporting or performance on the measures according to the phase in schedule.

Questions regarding the proposed new measures used for establishing quality performance standards for the MSSP:

1. Some measures are being proposed to replace existing measures:
   * Coronary Artery Disease (CAD): Antiplatelet Therapy (NQF #0067) would replace ACO #30, Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
   * Documentation of Current Medications in the Medical Record (NQF #0097) would replace ACO #12 (NQF #0097) Medication Reconciliation measure

In these instances, are the proposed new measures an improvement over the current measure?

1. Is there anything about the collection and reporting of these measures that should be highlighted for CMS?
2. Are there any issues with the measures already included in the existing program? ([*See Table 50*](http://essentialhospitals.org/wp-content/uploads/2014/07/MSSP-Table-of-Measures-for-Establishing-Quality-Performance-Standards.pdf)*, which demonstrates what measures would be used to assess ACO quality under the Shared Savings Program if CMS’ proposals are finalized*)
3. For the measures taken from surveys, do you have any concern about how those measures are collected?
4. **CMS proposes to remove the following 8 measures to establish quality performance standards because they have not kept up with clinical best practice, are redundant or can be replaced with similar measures that are more appropriate for ACO quality reporting:**
   * ACO #12, Medication Reconciliation after Discharge from an Inpatient Facility
   * ACO #22, Diabetes Composite measure: hemoglobin A1c control (<8 percent)
   * ACO #24, Diabetes Composite: Blood Pressure (<140/90) (NQF #0729)
   * ACO #25, Diabetes Composite: Tobacco Non-use (NQF #0729)
   * ACO #23, Diabetes Composite: Low Density Lipoprotein (<100) (NQF #0729)
   * ACO #29, Ischemic Vascular Disease: Complete Lipid Profile and LDL Control (<100mg/dl) (NQF #0075)
   * ACO #30, Ischemic Vascular Disease: Use of Aspirin or another Antithrombotic (NQF #0068)
   * ACO #32, Coronary Artery Disease (CAD) Composite: Drug Therapy for Lowering LDL Cholesterol (NQF #74)

Questions regarding the proposed removal of measures used for establishing quality performance standards for the MSSP:

1. Are there any concerns or red flags about the removal of these measures?
2. Is CMS proposing to remove the right measures from the quality measurement set?
3. Do you agree with CMS’ proposal to remove these measures?
4. Do these measures no longer represent best practices?
5. Should CMS consider removing any other measures from the set? ([*See Table 50*](http://essentialhospitals.org/wp-content/uploads/2014/07/MSSP-Table-of-Measures-for-Establishing-Quality-Performance-Standards.pdf)*, which demonstrates what measures would be used to assess ACO quality under the Shared Savings Program if CMS’ proposals are finalized*)
6. **CMS proposes to update the Diabetes All-or-Nothing Composite Measure.**

Currently, the Diabetes All-or-Nothing Composite measure consists of the following measures:

* + ACO #22: Hemoglobin A1c Control (<8 percent)
  + ACO#23: Low Density Lipoprotein (<100)
  + ACO#24: Blood Pressure <140/90
  + ACO #25: Tobacco Non Use
  + ACO #26: Diabetes Mellitus: Daily Aspirin or Antiplatelet Medication Use for Patients with Diabetes Mellitus and Ischemic Vascular Disease

CMS proposes to update the Diabetes All-or-Nothing Composite measure to consist of the following measures:

* + ACO #26: Diabetes Mellitus: Daily Aspirin or Antiplatelet Medication Use for Patients with Diabetes Mellitus and Ischemic Vascular Disease
  + ACO #27: Diabetes: Hemoglobin A1c Poor Control
  + ACO #41: Diabetes: Foot Exam
  + ACO #42: Diabetes: Eye Exam

CMS proposes to retire the following measures from the composite:

* + ACO #22: Hemoglobin A1c Control (<8 percent)
  + ACO#23: Low Density Lipoprotein (<100)
  + ACO#24: Blood Pressure <140/90
  + ACO #25: Tobacco Non Use

Questions regarding the proposed changes to the Diabetes All-or-Nothing Composite Measure:

* + 1. Does CMS’ proposed update to the diabetes composite measure include the right measures?
    2. Is CMS retiring the right measures from the composite?
    3. Are there other measures that should be removed or included?
    4. Given the general concerns around composite measures and their use, CMS seeks comment on how to combine and incorporate component measure scoring for the composite. In particular, CMS is interested in whether stakeholders have any concerns about including ACO #27, reverse-scored measure, whether there are any methodological considerations we should consider when including a reverse-scored measures in composites. What are your thoughts on this?
    5. Are there any other issues or changes to the diabetes composite measure that CMS should consider prior to finalizing its proposal?
    6. Do the selected measures represent best practices for diabetes care?
    7. Do the measures proposed for inclusion in the diabetes composite encourage the best care for diabetes patients?
    8. Does the change in the composite measure impact how you report? Impact your score?

1. **CMS is also proposing to update the Coronary Artery Disease (CAD) Composite Measure.**

Currently, the CAD Composite Measure consists of the following measures:

* + ACO#32: Drug Therapy for Lowering LDL-Cholesterol
  + ACO#33: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy – Diabetes or Left Ventricular Systolic Dysfunction (LVEF<40%)

CMS proposes to update the CAD Composite to include the following measures:

* + ACO #33: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy – Diabetes or Left Ventricular Systolic Dysfunction (LVEF<40%)
  + ACO #43: Antiplatelet Therapy
  + ACO #44: Symptom Management
  + ACO #45: Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF<40%)

CMS proposes to retire the following measure from the composite:

* + ACO#32: Drug Therapy for Lowering LDL-Cholesterol

Questions regarding the proposed update to the CAD Composite Measure:

* + 1. Does CMS’ proposed update to the CAD composite measure include the right measures?
    2. Is CMS retiring the right measures from the composite?
    3. Are there other measures that should be removed and/or included?
    4. Does the proposed update impact - negatively or positively - the collection of the CAD composite measure?
    5. Are there any other issues or changes to the CAD composite measure that CMS should consider prior to finalizing its proposal?
    6. Do the selected measures represent best practices for CAD care?
    7. Do the measures proposed for inclusion in the CAD composite encourage the best care for patients?
    8. Does the change in the composite measure impact how you report? Impact your score?

1. **CMS is soliciting feedback on additional measures that CMS may consider in future rulemaking.**

Questions regarding additional measures for the MSSP:

* + - 1. CMS is looking into possibly including measures that address quality of care in the various provider settings that may be part of an ACO (i.e. SNF, home health) for the MSSP. Should this be a focus area for the MSSP? If yes, do you have any recommendations or good approaches for CMS to move forward?
      2. CMS is considering whether or not to add more caregiver experience of care measures. Should this be a focus area for the MSSP? If yes, do you have any recommendations or good approaches for CMS to move forward?
      3. CMS is considering further work to align the ACO quality measures set with the measures used under the VM. Should CMS focus on this for the MSSP? If yes, do you have any recommendations or good approaches for CMS to move forward?
      4. CMS is considering whether or not to include measures that address the frail elderly population. Should CMS focus on this for the MSSP? If yes, do you have any recommendations or good approaches for CMS to move forward?
      5. Should CMS include utilization information in the aggregate quarterly reports to ACOs or should the utilization measures also be used to assess ACO quality performance as an added incentive? Please explain why.
      6. Should CMS include a self-reported health and functional status measure? Are there concerns about this type of measure due to the populations members of America’s Essential Hospitals serve? Please explain why.
      7. Are there any measures CMS should consider for retirement? Measures that are either topped out or no longer represent best clinical practice. Please explain why.
      8. Should CMS include the public health measure “Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling” (NQF #2152) to the quality measure set? Are there other public health measures that CMS should consider instead? Please explain why.

**Performance Periods and Updating Benchmarks:**

1. **CMS proposes to revise the regulations to expressly provide that during a second or subsequent participation agreement period, the ACO would continue to be assessed on its performance on each measure that has been designated as pay for performance.** That is, during subsequent agreement periods, pay for performance will apply for all three performance years. New measures that are added to the quality performance standard would be phased in along the timeline indicated when the measure is added and in operational documents.

Current MSSP regulations can be read to imply that the quality performance standard for ACOs in the first performance year of a subsequent agreement period would also be set at the standard of full and accurate reporting. CMS noted that it does not believe it is appropriate for an ACO in a second or subsequent agreement to report quality measures and not have to meet performance goals if they have previously reported these measures in a prior agreement period.

Questions regarding the clarification for second or subsequent participation periods:

* 1. Do you have any concerns about the proposed change to the quality performance standard that would apply to an ACO for subsequent participation agreement periods?

1. **CMS proposes to update benchmarks every two years to provide ACOs with a more stable target for measuring quality improvement.** Currently, CMS modifies quality performance benchmarks annually. To illustrate the change, existing quality performance benchmarks, which are based on data submitted in 2013 for the 2012 reporting period would apply for a total of 2 performance years (the 2014 and 2015 performance years) after which CMS would reset the benchmarks for all ACOs based on data for the 2014 reporting period that is reported during 2015.

Questions regarding the proposal to update benchmarks every two years:

* + 1. Should CMS finalize this proposal to revise the timeframe for setting benchmarks? Should CMS utilize the approach where one benchmark would apply to two performance years? Are there any concerns with this approach or revised change?
    2. Should we urge CMS to update benchmarks every 3 years to match the agreement periods?
    3. How should CMS address the benchmark update when measures change?
    4. Are there any concerns or red flags about this proposed change?

**Health Information Technology (HIT):**

1. CMS proposes to amend the regulations of the MSSP to align with the requirements previously adopted under the Medicare Electronic Health Record (EHR) Incentive Program so that EPs participating in an ACO under the MSSP can satisfy the clinical quality measure reporting component of meaningful use for the Medicare EHR Incentive Program when the ACO reports GPRO web interface measures. This change would apply only if: (1) the eligible professional extracts data necessary for the ACO to satisfy its GPRO quality reporting requirements from CEHRT; and (2) the ACO satisfactorily reports the ACO GPRO measures through a CMS web interface.

CMS intends to take future steps to further align and integrate EHR use into quality reporting under the MSSP. CMS seeks comments and suggestions for consideration of future proposals regarding HIT. Specifically, CMS is looking for comments on whether ACO providers/suppliers could use a local registry-like version of the GPRO web interface to capture relevant clinical information and to monitor performance on all Medicare patients throughout the year and to more easily report quality data to CMS annually. CMS is also seeking comment on the issues addressed in the following questions.

Questions regarding the proposed changes to HIT/EHR:

* + 1. Which of the following is preferable?:
       - for the EPs within each ACO participant to individually submit EHR data to CMS;
       - for each ACO participant to report as a group;
       - for the ACO itself to aggregate EHR data from its ACO participants and then submit the quality measures to CMS; or
       - for the ACO to submit quality measure data via a data submission vendor that would be responsible for aggregating and submitting the data on the ACO’s behalf?
    2. Is it feasible for ACOs to be a convener and submitter of quality measures through an EHR?
    3. Can you identify any barriers to ACO EHR quality measure reporting?
    4. CMS is seeking suggestions on alternative ways that we might implement EHR-based reporting of quality measures in the MSSP, such as directly from EHRs or via data submission vendors. Is there a preferred alternative that CMS should utilize to implement EHR-based reporting of quality measures?
    5. Should CMS make EHR reporting a requirement for all participating ACOs or should they phase reporting in gradually?
    6. Should CMS continue to align the MSSP with the Medicare EHR incentive program?

**Topped Out Measures:**

1. **CMS proposes to make certain modifications to the benchmarking methodology to address the way that such “topped out” measures are treated for purposes of evaluating an ACO’s performance.** Specifically, when the national FFS data results in the 90th percentile for a measure are greater than or equal to 95 percent, CMS would use flat percentages for the measure. CMS also seeks other approaches for addressing topped out measures.

Questions regarding CMS’ proposed modifications to addressing topped out measures:

* + 1. Should the criteria be consistent across federal quality reporting programs?
    2. Is CMS’ proposed definition for topped-out measures an accurate way to define measures that are topped-out?
    3. Is your hospital doing well on measures that may be topped out soon under the proposed criteria? If yes, how would that impact your score?

**Rewarding Quality Improvement:**

1. **CMS proposes to add a quality improvement measure to award bonus points for quality improvement to each of the existing four quality measure domains.** For each quality measure domain, CMS would award an ACO up to two additional bonus points for quality performance improvement on the quality measures within the domain. These bonus points would be added to the total points that the ACO achieved within each of the four domains.

Under this proposal, the total possible points that can be achieved in a domain, including up to 2 bonus points, could not exceed the current maximum total points achievable within the domain. For example, currently the total possible points for the patient/caregiver experience domain, which has seven individual measures, is 14 total possible points. Under this proposal to provide for quality improvement bonus points, the maximum possible points within this domain would continue to be 14. If an ACO scored 12 points and was awarded two additional bonus points for quality improvement then the ACO’s total points for this domain would be 14. However, if instead this same ACO had scored 13 points, then this ACO’s total points after adding the bonus points could still not exceed 14. The additional points will factor into the calculation of an ACO’s shared savings.

The quality improvement measure scoring for a domain would be based on the ACO’s net improvement in quality for the other measures in the domain. Measures that were not scored in both the performance year and the immediately preceding performance year, for example, new measures, would not be included in the assessment of improvement.

Questions regarding rewarding quality improvement:

* + 1. Has your hospital been able to improve upon your own performance?
    2. Do you think that CMS’ proposal to award bonus points for quality improvement is a positive change?
    3. Are there other approaches to incentivize quality improvement that we should highlight to CMS?