June 6, 2011

Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Ref: CMS-1345-P. Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations

Dear Dr. Berwick:

The National Association of Public Hospitals and Health Systems (NAPH) appreciates the opportunity to submit comments on the above captioned Proposed Rule. NAPH represents the nation’s largest metropolitan area safety net hospitals and health systems, many of which have integrated care delivery systems. Our members are well positioned to adopt health reform delivery models by implementing coordinated care strategies for our vulnerable populations. Although our members treat a larger portion of Medicaid beneficiaries than Medicare beneficiaries, they also see a disproportionate share of dual-eligibles, a population with unique challenges and that accounts for 36% of Medicare expenditures and 39% of Medicaid expenditures.

While NAPH supports CMS’ efforts to foster the creation of alternative delivery system models, our long experience in treating the nation’s poorest and most vulnerable patients, including dual-eligibles, leads us to conclude that delivery system reform for these populations is going to require special attention and unique solutions. Approaches that work with a wealthier, more stable patient base will not necessarily translate into a viable model for the poor. Moreover, to the extent that these delivery system changes are successful in limiting movement between systems, they are likely to accentuate racial and/or ethnic differences in where patients receive care and further reinforce health and health care disparities.1 Therefore, to address the special needs of dual-eligibles, Medicaid beneficiaries, and the uninsured, we strongly encourage CMS to consider our proposed Safety Net Accountable Care Organization (ACO) Demonstration

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(which we have separately submitted to the Center for Medicare and Medicaid Innovation), which is designed to test effective models of care for low-income patients.

NAPH supports CMS’ efforts to integrate care coordination to improve population health, enhance the patient experience, and reduce costs. While our members are eager to participate in delivery system reform, the Medicare Shared Savings Program (MSSP) as proposed would preclude the participation of many NAPH health systems. Safety net health systems simply do not have the disposable resources to make the investments that are required by the MSSP as proposed, including investments in technology, process redesign, personnel, care coordination, quality measurement, risk management, compliance, network development, governance and legal structure. According to a study conducted by the American Hospital Association, these costs range between $11.6 to $26.1 million. Moreover, the potential for shared savings is not nearly significant enough or sufficiently attainable to warrant such investments even if the disposable funding were available. Therefore, to the extent that CMS desires the participation of these providers and their patients in the program, NAPH recommends that CMS provide funding (perhaps through the Innovation Center) to help cover these significant investment costs, and improve the potential for shared savings for safety net providers, including through mechanisms described below.

We also urge CMS to establish a Safety Net ACO learning collaborative through the Innovation Center that would support safety net ACOs participating in the MSSP or other CMS-sponsored ACO programs and demonstrations. Technical assistance and peer learning will be essential for all ACOs, but particularly for those serving safety net populations. CMS could significantly boost the ability of these providers to participate in innovative new delivery models by providing focused resources to support their efforts. NAPH, through its newly-established Transformation Center, stands ready to partner with CMS in this endeavor.

The comments below focus on the issues specific to the safety net that we urge CMS to reconsider in drafting the MSSP final rule in order to encourage participation by our members and other safety net providers. In drafting the final rule, we also encourage CMS to align program requirements with an eye towards facilitating the participation of providers in other shared savings models, including Medicaid and our proposed Safety Net ACO Demonstration—for example, through the alignment of performance measures that are applicable for multiple programs. NAPH appreciates the opportunity to submit these comments and looks forward to providing additional comments as proposals for further elements of the MSSP are rolled out.

1. Disproportionate Share Hospital and Indirect Medical Education Payments Should Be Excluded from Shared Savings Calculations

CMS proposes to calculate an ACO’s shared savings by comparing the ACO’s actual expenditures during each year of participation in the MSSP to the ACO’s expenditure benchmark. CMS proposes to include disproportionate share hospital (DSH) and indirect medical education (IME) payments in calculating an ACO’s benchmark and actual expenditures. The proposed rule does not address direct graduate medical education (DGME) payments;

presumably, this silence means DGME payments will also be included in both calculations (although we recommend that CMS clarify its intended treatment of DGME expenditures in the final rule). In the proposed rule, CMS acknowledges that it has statutory authority to exclude DSH and IME payments from its calculations of an ACO’s benchmarks, but questions its statutory authority to exclude such payments from its calculations of actual expenditures. To avoid setting an artificially low benchmark, CMS has proposed to include DSH and IME in its calculation of both the benchmark and the actual expenditures. CMS suggests that its proposed policy of including DSH and IME payments may encourage ACOs that include teaching or DSH hospitals to participate in the MSSP, because they will have a higher benchmark against which savings are measured and may earn back a portion of foregone IME and DSH payments in the form of shared savings.

NAPH appreciates CMS’ concern that ACOs that include DSH and/or teaching hospitals be permitted to share in the full savings that they achieve through better care coordination and reduced admissions, including savings associated with the reduction in DSH and IME payments. NAPH members are actively engaged in efforts to reduce unnecessary inpatient utilization because it is the right thing to do for their patients. Nonetheless, the reduced utilization does impact revenues, and a significant portion of the lost revenues for NAPH members is related to DSH and IME payments. As a result, we share CMS’ desire to ensure that our hospitals be able to share in savings derived from reduced DSH and IME adjustments.

Nonetheless, after careful reflection, we have concluded that CMS’ proposal to include these payments in the shared savings calculation will not achieve the intended goal. Instead, we believe it will result in a distorted calculation of real savings, as reductions in DSH and IME payments would not reflect how well an ACO coordinates or improves the overall efficiency of care. Moreover, including DSH and IME payments in shared savings calculations may encourage ACOs that do not include teaching and DSH hospitals to divert patients away from these institutions. The ACOs would be able to achieve “savings” without any improvements in care coordination or quality by switching patients who counted toward the benchmark and received care from a teaching or DSH hospital during the benchmark period (thus increasing the benchmark) to a non-teaching or non-DSH hospital during the program year in which the actual expenditures are calculated. NAPH is concerned that such shifting may not be in the best interests of the patients. Moreover, the loss of revenues associated with the diverted patients—all of the revenues, not just the DSH and IME portions of the payments—would undermine the fragile funding base that supports these critical institutions training the next generation of health care professionals and treating the poor. NAPH therefore recommends that CMS exclude DSH, IME, and DGME payments from both the expenditure and benchmark used to determine shared savings. At the same time, as described further below, we urge CMS to take steps to ensure continued support for the teaching and safety net missions of these hospitals through an alternative support payment.

Contrary to CMS’ assertions, NAPH believes CMS does have the clear authority to exclude DSH, IME and DGME payments from the benchmark expenditure calculation under section 1899(i) of the Social Security Act as added by the Affordable Care Act. That section authorizes CMS to adopt alternative payment models “if the Secretary determines appropriate,” including “any payment model that the Secretary determines will improve the quality and efficiency of
items and services furnished under this title” as long as the model does not result in additional program expenditures. This authority to deviate from the shared savings model described elsewhere in Section 1899 is broad, and is more than sufficient to allow CMS to exclude add-on payments from the shared savings calculation.

Indeed, CMS itself relies on this broad authority to propose modifications to the statutory shared savings methodology where appropriate. For example, it has proposed to allow most ACOs in the first or second year of the Track 1 model to share only in those savings achieved above a specified threshold, rather than allow first-dollar shared savings for all ACOs as set forth in Section 1899(d)(2). CMS acknowledges that it has deviated from the statutory methodology but explicitly cites Section 1889(i) as the source of its authority to make such adjustments. 76 Fed. Reg. 19528, 19613 (April 7, 2011). That authority can similarly be applied to reflect more accurately the real savings generated as a result of ACO operations by removing DSH, IME and DGME payments from the benchmark and expenditure calculations.

While we believe that it is essential that these adjustments be excluded from the shared savings calculation, it is similarly crucial that teaching and DSH hospitals not lose the funding that supports their teaching and safety net activities. Those activities—and the significant costs associated with them—will remain even as care is better coordinated and more efficiently delivered. Teaching and DSH hospitals should not be asked to shoulder a higher burden of those costs simply because ACOs are improving the way care is delivered. Therefore, we recommend that CMS exercise its authority to adopt alternative payment models under Section 1899(i) to establish a direct payment to ACOs that include DSH and teaching hospitals that ensure that the ACO providers can maintain these “public good” activities. These payments would ensure that total DSH, IME and DGME payments remain constant throughout the agreement period as compared to the years prior to the agreement period. In so doing, it would appropriately divorce Medicare support for graduate medical education and care for the poor from the important work of improving the delivery of care to Medicare patients, removing savings distortions and skewed incentives that could otherwise undermine Medicare payment policies in all of these areas.

2. CMS Should Exclude Bonus Payments from the Shared Savings Calculation

CMS has appropriately excluded expenditures or savings associated with value-based bonus payments or penalties for physicians under the Physician Quality Reporting System and physician incentive payments for meaningful users of electronic health records in order to ensure that ACO incentives are aligned with and promote the purposes of those important initiatives. But CMS asserts it does not have the statutory authority to exclude the analogous hospital bonus payments from the calculation, including the Hospital Value-Based Purchasing Program and the hospital meaningful use incentive payments. CMS clearly recognizes the compelling policy rationale for excluding these bonus payments. NAPH urges CMS to exercise its authority under Section 1899(i), as described above, to develop alternative payment arrangements to exclude all incentive bonus payments and penalties from the shared savings calculations.
3. **Assignment of Beneficiaries**

- **The Assignment of Beneficiaries Should Promote Effective, Proactive Care Coordination and Hold ACOs Responsible Only for Care Actually Provided**

CMS proposes to assign beneficiaries to an ACO retroactively at the end of the performance period. CMS proposes this method of retrospective assignment in an effort to ensure that ACOs are held accountable for the actual population treated during the performance year, to encourage ACOs to change the care experience of all patients, and to protect against cost-shifting. In an effort to assist providers with identifying their expected assigned population, CMS also proposes to provide ACOs with quarterly aggregate and, upon request, monthly beneficiary level data for the beneficiaries used to generate the ACO’s expenditure benchmark.

In order for ACOs to successfully manage the care of their patients, they must (1) know who the patients are whose care they are managing and (2) actually be caring for those patients. These two key criteria are in tension in the debate over whether ACO assignment should be “prospective” or “retrospective,” particularly when retaining free choice of providers for beneficiaries is a paramount goal as it appears to be in the MSSP. NAPH therefore urges CMS to set aside the “prospective” and “retrospective” labels, and instead focus on designing a system to provide ACOs with real-time data on its assigned beneficiaries and exclude beneficiaries who do not receive their care from ACO providers. Such a system is particularly crucial to the extent that CMS expects an ACO to assume risk in the MSSP.

Such a system must, at a minimum, include the following elements:

- Notification to the ACO of their preliminarily assigned beneficiaries prior to the start of the performance period. This notification would permit the ACO to target care coordination and improvements to patients who would benefit most.
- CMS notification to these beneficiaries of their assignment to the ACO with an opportunity to opt-out of the ACO and data sharing associated with the ACO. CMS would also be responsible for educating beneficiaries on the rights and responsibilities of participation in the care coordination mechanisms required by an ACO. ACOs would not be held accountable for the care of any beneficiaries who have opted out or have declined to allow their claims data to be shared. Proper beneficiary education, along with the ability to opt out, would help ensure that the ACO is responsible for only those beneficiaries who are willing participants.
- CMS would share quarterly aggregate data on the preliminarily assigned beneficiaries and monthly beneficiary-identifiable claims data as proposed, in a format that ACOs can easily analyze.
- On a monthly basis, CMS would make adjustments to the preliminarily assigned beneficiaries, excluding those who are actually receiving a plurality of services (all services, not just primary care services) outside of the ACO. This would ensure that ACOs are not held accountable for care they are not providing, even if the ACO primary care provider referred the beneficiary for treatment outside of the ACO.
- At the end of the performance period, finalize the beneficiary assignment based on actual care utilization patterns during the year.
CMS’ proposal to implement a retrospective assignment methodology derives at least in part from its understandable desire that the shared savings program change the care experience of all patients, and not just an ACO’s assigned Medicare beneficiaries. Toward that end, we point out that many of the quality measures CMS has proposed include non-Medicare patients (e.g., the seven ambulatory sensitive conditions admissions measures cover discharges of patients age 18 years and older). Since performance on these measures will be used to determine whether an ACO can share in savings, ACO providers will already have an incentive to improve quality for all patient populations.

- **CMS Should Expand the Type of Providers Used for Purposes of Beneficiary Assignment**

CMS proposes to assign beneficiaries to an ACO based on the plurality of primary care services. For purposes of the plurality determination, only primary care services provided by primary care physicians (i.e., internal medicine, family practice, general practice, geriatric medicine) are included in the calculation. NAPH urges CMS to make two modifications with respect to the practitioners used in the plurality determination.

First, NAPH recommends CMS expand the type of providers to include non-physicians, such as nurse practitioners (NPs) and physician assistants (PAs), who in their respective states are allowed to bill for their services. As our nation’s health care delivery system continues to change, beneficiaries more and more receive their primary care from providers other than physicians. In fact, according to the Kaiser Commission on Medicaid and the Uninsured, NPs and PAs accounted for 27 percent and 15 percent of primary care providers nationally in 2009, respectively. Additionally the quality of care provided by NPs and PAs is as good as the quality provided by physicians on important clinical outcome measures, such as mortality, improvement in pathological condition, reduction of symptoms, health status, and functional status. For beneficiaries receiving the majority of their primary care through non-physician clinicians, CMS’ proposal fails to accurately capture where beneficiaries receive the plurality of primary care.

As discussed below, we believe CMS has the statutory authority to include these primary care services because they are provided indirectly under the supervision of a physician. If, however, CMS concludes it does not have the legal authority to include primary care services provided by non-physicians, we urge CMS to seek an amendment from Congress to include non-physician practitioners. Further, we ask CMS to ensure that, going forward, all other ACO demonstrations include all primary care practitioners.

NAPH also urges CMS to expand the scope of providers used to calculate plurality to include specialists who provide primary care. Many beneficiaries with chronic conditions, such as dual-eligibles, often receive the majority of their primary care through their specialists. In addition, beneficiaries in areas with primary care shortages are often forced to rely on specialists for their primary care services. Exclusion of primary care services provided by specialists in the

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4 Ibid.
calculation of plurality would again fail to accurately capture where beneficiaries receive the plurality of primary care. To determine plurality, we propose CMS include primary care services provided by primary care practitioners and primary care services provided by the following seven types of specialists, which we believe are most likely to provide primary care services: pulmonologists, endocrinologists, cardiologists, nephrologists, neurologists, rheumatologists, and gastroenterologists. CMS should allow specialists to determine which ACO they belong to for purposes of beneficiary assignment, and at the same time, should ensure that specialists can continue to treat patients assigned to different ACOs.

- **CMS Should Amend the Formula Used to Calculate Plurality**

CMS proposes to assign beneficiaries to an ACO if they receive a plurality of their primary care services from primary care physicians within an ACO. In making this determination, CMS proposes to compare the primary care services a beneficiary receives from an ACO’s primary care physicians to the total amount of primary care services the beneficiary receives. Thus in this formula, primary care services provided by specialists would be included in the total primary care services for the beneficiary, but would not be included in the count of the primary care services the beneficiary receives from an ACO. To more accurately determine where beneficiaries receive the plurality of their primary care services, NAPH recommends CMS compare the primary care services beneficiaries receive from an ACO’s primary care physicians only to the total primary care services beneficiaries receive from primary care providers, thereby excluding primary care services provided by specialists from the denominator in the plurality calculation. Alternatively, NAPH recommends CMS adopt our proposal from above to include primary care services provided by an ACO’s specialists in the plurality determination, which would more accurately capture where beneficiaries receive the plurality of their primary care services.

4. **FQHC Patients Should Be Eligible for Assignment to an ACO**

Under the proposed rule, federally-qualified health centers (FQHCs) would not be permitted to independently form an ACO, but would be able to participate in the MSSP by forming an ACO with other eligible ACO participants, such as ACO professionals in a group practice arrangement or a hospital employing ACO professionals. While the rule permits FQHCs to be ACO participants, it prohibits the assignment of FQHCs’ Medicare patients to ACOs for shared savings purposes. Many NAPH members have FQHCs within their health systems or have entered into affiliations with FQHCs; in many communities FQHCs are a major source of primary care for the poor. By excluding FQHC patients from the MSSP, CMS is unnecessarily skewing the program away from the safety net and away from the most vulnerable Medicare beneficiaries, including dual-eligibles, who could most benefit from the intensive care coordination and improvements the program seeks to foster. The policy may also preclude NAPH members from reaching the 5,000 Medicare beneficiary threshold necessary for participation and could discourage other ACOs from including NAPH members as ACO participants. NAPH is also concerned that the narrow way CMS defines primary care in the proposed rule will be problematic if carried over into other shared savings models, including NAPH’s Safety Net ACO Demonstration proposal.
The exclusion of FQHC patients from assignment to ACOs results from an unnecessarily narrow interpretation of CMS’ authority to determine an assignment methodology. CMS assumes that the statute requires that a primary care physician directly provide a primary care service for the service to qualify as primary care for purposes of MSSP assignment. But indirect provision of primary care services by a physician, through practitioners supervised by a physician, is also a possibility for including primary care services furnished by FQHC providers. NAPH urges CMS to reevaluate the scope of its authority to determine an assignment methodology with an eye towards a more inclusive approach that will capture more of a true cross section of Medicare beneficiaries.

5. **ACOs Serving Large Dual-Eligible Populations Should Be Eligible for Additional Shared Savings**

In order to encourage ACOs to include FQHCs and rural health centers (RHCs), CMS proposes to allow ACOs with a strong FQHC or RHC presence to share in an increased percentage of savings (an additional 2.5 percent for the one-sided model and 5 percent for the two-sided model). In addition, CMS proposes to allow certain ACOs that include an FQHC or RHC to share in first-dollar savings, regardless of whether they are at risk for losses. CMS then invites comment on whether payment preferences should be provided to ACOs serving large dual eligible populations.

NAPH strongly urges CMS to adopt such preferential payment policies. The Medicare populations served by NAPH member systems are disproportionately comprised of low-income, dual-eligible patients, and the challenges of serving and effectively coordinating the care of this population are substantially higher than for the average Medicare patient. Moreover, the safety net providers who are caring for this population are typically under-resourced and shoulder large burdens of caring for uninsured patients as well. The substantial investments required for participation in the MSSP will discourage participation of these safety net providers in the program. Until an adequate risk-adjustment methodology can be developed, enhanced shared savings place participating ACOs on equal footing as they redesign their care delivery models to achieve the MSSP’s goals of improving quality while reducing costs. By improving the prospects for significant shared savings, CMS could make the program more attractive to these key providers, and thereby bring in their largely dual-eligible Medicare patient population—those who account for a disproportionate share of program expenditures. The additional cost to Medicare of sharing a greater percentage of the savings with dual-eligible providers would certainly be more than offset by the greater potential for savings with this high-cost population. The alternative would be to implement a shared savings program without the participation of major safety net providers and the safety net populations, including dual-eligible patients, that these providers serve. This could put major safety net providers at a competitive disadvantage within their markets and further reinforce existing health and health care inequities.

NAPH therefore recommends that CMS set a threshold percentage of assigned beneficiaries who are dual-eligible and designate ACOs who meet or exceed that threshold percentage as eligible for (1) first-dollar savings and (2) a higher shared savings rate. This approach is similar to what CMS has proposed for ACOs with significant FQHC and RHC participation, but we would recommend that the enhanced shared savings rate be significantly higher than the 2.5% and 5%
increase proposed for those entities. We would instead recommend an enhanced rate of up to 20 percent for one-sided, dual-eligible ACOs (for a total of 70 percent shared savings) and 25 percent for two-sided, dual-eligible ACOs (for a total of 85 percent shared savings).

6. Alternative Risk Models Should be Offered to Facilitate Participation

CMS proposes two tracks of risk-sharing models for ACOs—Track 1 includes two years of one-sided risk sharing and one year of two-sided risk sharing, and Track 2 includes three years of two-sided risk sharing. To help facilitate widespread adoption of the accountable care model, especially by providers who care for a disproportionate share of vulnerable populations, CMS should consider offering a track with one-sided risk sharing (i.e., shared savings only) for all three years of the first ACO agreement. This would give ACOs additional flexibility to manage the risk inherent in operating an ACO and, at the same time, allow them time to make the necessary improvements in care that would benefit their patients. Additionally, CMS should give ACOs an opportunity—like the Agency did for the Physician Group Practice (PGP) Demonstration participants—to share in a portion of the savings, above the minimum savings rate, based on the ACOs’ ability to meet cost savings goals only and for meeting quality goals.

7. Quality Measures Should Be Phased in Gradually and Tailored to the ACO Participants

CMS’ proposal for quality and reporting requirements includes 65 quality measures in five domains. In the first year of the three year agreement, ACOs would be required to accurately and completely report on all 65 measures in order to be eligible for shared savings. For subsequent years, in addition to reporting these measures, ACOs would have to meet quality performance standards in order to be eligible for shared savings. Under the proposed rule, ACOs would need to achieve a minimum attainment level (as proposed, the 30th percentile of fee-for-service/Medicare Advantage rates or 30 percent, depending on the measure) for each measure in a domain for that domain to be eligible for shared savings. The performance score for each domain, equally weighed, would then be translated into a total performance score that determines the percentage of shared savings that the ACO is eligible to receive. Failure to achieve the minimum threshold for any measure would result in a score of zero. CMS has proposed a sliding scale methodology, under which ACOs that achieve a higher total performance score will share in a higher percentage of shared savings (and a lower percentage of losses under the two-sided model) subject to a cap. Under the proposed methodology, an ACO could fail to achieve the minimum attainment level for one or more domains and still earn shared savings if scores in other domains are sufficiently high. CMS has, however, proposed to give a warning to ACOs that fail to achieve the minimum attainment level for one or more domains. Continued underperformance in the subsequent year would result in termination of the ACO’s MSSP agreement.

While NAPH acknowledges that most of the 65 measures proposed by CMS address clinically-appropriate conditions, we are concerned that the requirement to report on all 65 measures during the first year of the MSSP may not be feasible. We anticipate that even those of our member organizations with an advanced quality reporting infrastructure already in place will have difficulty reporting on all 65 measures in the first year. Using the PGP Demonstration as a guide, which only required participants to report on 10 diabetes measures for the first year and a
total of 32 measures by the end of the third year, NAPH recommends that for the first year of the MSSP, CMS allow ACOs to report on only a selected subset of the proposed measures, with some flexibility for the ACO to choose among the measures, as in the electronic health record (EHR) incentive program. We recommend that the number of measures be kept relatively low, in keeping with both the PGP Demonstration and the approach adopted by the National Committee for Quality Assurance in developing draft ACO accreditation standards (which propose only 11 measures and certain survey data). As measures are phased in, ACOs would be allowed to earn shared savings based on reporting for one year, before being held to a standard. For subsequent years of the MSSP, additional performance measures could be added to the initial subset of measures. This transitional approach could help ACOs manage some of the high operational costs associated with forming and running an ACO.

NAPH also recommends that CMS allow ACOs to meet performance goals based on improvement as well as attainment. This approach parallels policies adopted in the Hospital Value-Based Purchasing program, and will help facilitate participation by providers serving at-risk populations. It will also better achieve the program goal of improving quality for as many Medicare beneficiaries as possible, particularly the most complex and high-cost patients.

To help prioritize among the measures, NAPH proposes that CMS limit the list to those measures that have been endorsed by the National Quality Forum. Specifically, CMS should eliminate the following measures: #8-9, #19-23, #39, #46, #56, and #61. Additionally, NAPH urges CMS to adopt measures that also meet the Joint Commission’s criteria for accountability measures. Furthermore, NAPH recommends that CMS eliminate and reconsider certain measures because they do not meet the goals of the MSSP.

- **Composite Measures**

In the proposed rule, CMS proposes an all-or-nothing score for two measures: diabetes composite and coronary artery disease composite. This method can produce poor performance rates if the individual indicators vary widely in average performance, allowing outlier measures to have the strongest impact on the composite measure rate. This, in turn, could lead to the misinterpretation of composite measures and invite simplistic policy conclusions or inappropriate policies if the dimensions of the individual indicators are ignored. NAPH recommends that CMS eliminate these measures (#35 and #52) because composite measures are for the reasons noted above not ideal for understanding performance shortfalls or implementing remedies for improvement. Furthermore, since CMS proposes to score each sub-measure individually, removing the two composite measures will eliminate redundancy while still allowing precise measurement.

- **Health Care Acquired Conditions Measure**

In the proposed rule, CMS also proposes to include a Health Care Acquired Conditions (HAC) Composite measure. Many of the sub-measures within this composite are low-incidence complications that have not been tested for rate-based comparisons (e.g., air embolism), so assigning percentiles will be fraught with difficulties due to small numerators. The HAC Composite measure also includes sub-measures that are already part of other programs under
Medicare. For example, Medicare’s HAC policy prohibits payment for these conditions, the Hospital Value-Based Purchasing Program includes HACs as a performance measure, and in 2015, Medicare will implement an additional payment penalty to further prevent HACs from occurring. NAPH supports CMS’ efforts to improve patient safety but does not believe it is necessary to tackle this particular aspect of patient safety in virtually every single Medicare initiative. Therefore, NAPH recommends that CMS eliminate the Health Care Acquired Conditions Composite measure (#24).

- **Meaningful Use Measures**

CMS proposes to include five measures that would link an ACO’s performance on these measures to the ACO participants’ ability to meet meaningful use requirements under the EHR incentive program. For example, one measure requires that at least 50 percent of an ACO’s primary care physicians be meaningful EHR users by the start of the second performance year in order to continue participating in the Shared Savings Program. CMS has already proposed a timeline for compliance with the meaningful use requirement in the EHR incentive program payment penalty policy. Given the different timelines of the EHR incentive program and the MSSP, CMS should not impose a requirement for the MSSP that would accelerate the timeline for compliance with the EHR incentive program. Meeting the meaningful use requirements requires a large investment in time and financial and technological resources. Requiring providers, especially safety net providers, to speed up their implementation of EHR systems may hinder such providers and their associated organizations from participating in the MSSP. NAPH strongly urges CMS to eliminate the five meaningful use measures (#19-23).

- **CAHPS Measures**

CMS proposes to include seven patient experience of care measures for the first year of the MSSP. Given that these measures and the surveys used to collect the data for these measures are still in the early stages of use, with multiple versions available and inconsistencies among the versions,\(^5\) NAPH recommends postponing these measures (#1-7) until they have been field-tested and standardized. CMS could wait until a patient-centered medical home (PCMH) experience of care survey, which may be more appropriate for capturing the performance of an ACO, completes field-testing and analysis before including patient experience of care measures in the MSSP.\(^6\) CMS or the Agency for Healthcare Research and Quality could analyze the data from the PCMH survey to understand the variation in responses and develop appropriate adjustments so that the measures would be more appropriate for use in the MSSP context.

- **CMS Should Phase In Measures that Require the Use of the GPRO Tool**

CMS proposes reporting 47 quality measures through a new data collection tool—the Group Practice Reporting Option (GPRO), which CMS developed for the PGP Demonstration. NAPH urges CMS to consider the substantial learning curve associated with a new reporting

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\(^6\) Ibid.
mechanism, on top of requiring ACOs to report on measures they do not currently collect. The experience of the PGP Demonstration participants suggests that it would take ACOs much longer than one year to learn how to efficiently use the GPRO reporting tool. Of the remaining 45 measures that NAPH believes would be appropriate for use in the MSSP, 33 would require the use of the GPRO tool. NAPH recommends that CMS phase these measures (#26-34, #36-38, #40-45, #47-51, #53-55, #57-60, #62-64) in over time to allow for ACOs to develop the necessary technical expertise without sacrificing patient care. Alternatively, CMS can give ACOs at least another year to meet quality performance requirements through reporting only.

8. **Beneficiary Representation on the Board Should Not Be Required for Certain ACOs**

As noted above, many NAPH members are already comprehensive, integrated systems that could participate in the MSSP on their own, without incorporating additional providers into the ACO. As such, under the proposed rule, the ACO would not be required to create a new and separate legal structure. Yet the proposed rule also requires that an ACO’s governing board include a member that is a Medicare beneficiary served by the ACO. State and local laws often dictate the composition of public hospital/health system boards and restrict the authority those boards may be able to delegate (given their authority over taxpayer funds), thus some NAPH members may not legally be able to satisfy this requirement. Recognizing this governance requirement may conflict with state laws, NAPH strongly urges CMS to eliminate this requirement, at least where local laws preclude compliance or where the formation of a new legal structure is not otherwise required. NAPH believes this governance requirement is unnecessary to ensure that ACOs are providing patient-centered care—for example, the quality measures and performance goals included in the proposed rule encourage the provision of coordinated and seamless care, without the need for additional input from beneficiary or community groups. If this requirement is not eliminated, NAPH members in states such as Florida and New York may be prohibited from complying with this requirement and thus participating in the MSSP. We believe a governance requirement that precludes the participation of many public hospitals in the MSSP would frustrate CMS’ goals of improving population health and patient experience.

9. **Participation in Multiple Shared Savings Programs**

Section 1899(b)(4) prohibits the participation of MSSP ACOs in other Medicare shared savings programs, such as the Independence at Home Medical Practice Demonstration, the Medicare Health Care Quality Demonstration, and the PGP Demonstration. This prohibition is reiterated in the preamble to the proposed rule. The text of the regulation itself, however, does not clearly limit the prohibition to other Medicare shared savings programs. Proposed 42 C.F.R § 425.24 prohibits MSSP participation if any ACO participants participate in “a model tested or expanded under section 1115A of the Act that involves shared savings ….” Since the Innovation Center created under section 1115A is also intended to promote the development of new models under Medicaid as well as Medicare and to involve other payers, NAPH recommends that CMS clarify the regulatory text to apply only to an Innovation Center model “that involves shared savings in the Medicare program.”

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NAPH appreciates the opportunity to submit these comments. We strongly support reform of the health care delivery system through greater collaboration as envisioned in the ACO model. Toward this end, we again strongly urge CMS to consider our proposed Safety Net ACO Demonstration to help improve care delivery for the special vulnerable populations served by our nation’s safety net. If you have any questions, please contact Xiaoyi Huang at (202) 585-0127.

Sincerely,

Bruce Siegel, MD, MPH
Chief Executive Officer