



## AMERICA'S ESSENTIAL HOSPITALS

September 6, 2016

Mr. Andrew Slavitt  
Acting 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-1654-P: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage and Part D Medical Low Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model**

Dear Mr. Slavitt:

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) and proposals related to alignment with the forthcoming Quality Payment Program (QPP) final rule under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), may have a negative impact on essential hospitals—those that serve vulnerable patients, 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. Filling a vital role in their communities, our nearly 275 member hospitals provide a disproportionate share of the nation's uncompensated care and devote approximately half of their inpatient and outpatient care to Medicaid or uninsured patients. Through their integrated health systems, members of America's Essential Hospitals offer primary through quaternary care, including trauma care, outpatient care in ambulatory clinics, public health services, mental health and substance abuse services, and wraparound services vital to vulnerable patients.

In addition to offering specialized inpatient and emergency services, members of America's Essential Hospitals offer more comprehensive ambulatory care than many other providers and create medical homes for community residents through networks of provider-based ambulatory health clinics. And they deliver ambulatory 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 essential hospitals with limited resources, which compels them to find increasingly efficient strategies for providing high-quality care to their patients. Several essential hospitals are participating in the MSSP and have made the needed investments to participate as accountable care organizations (ACOs). However, our members face challenges as they continue to make investments necessary for ACO participation, including capital investments in technology, process redesign, personnel, care coordination, quality measurement, risk management, compliance, network development, governance, and in their legal structure.

To ensure essential hospitals 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 as well as alignment with policies proposed in the QPP proposed rule. We ask CMS to 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 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 and administrative burden to hospitals such as essential hospitals already operating with limited resources.

- a. CMS should seek to align and simplify quality reporting across programs and settings.

We urge the agency to seek greater alignment in quality measurement across Medicare programs and to focus measurement on areas of highest priority—i.e., areas that represent the current best opportunities to drive better health and better care, based on available literature. As highlighted by the Institute of Medicine's (IOM's) Committee on Core Metrics for Better Health at Lower Cost, there is a need to reduce the burden of unnecessary and unproductive reporting by reducing the

number, sharpening the focus, and improving the comparability of measures.<sup>1</sup> We, along with other hospital organizations support the IOM committee's core measure set of "vital signs" for tracking progress toward improved health and health care in the United States. This starting measure set emphasizes the importance of streamlining measures to promote greater alignment and harmonization and to reduce redundancies and inefficiencies in health system measurement.

CMS proposes to retire two Agency for Healthcare Research and Quality (AHRQ) ambulatory sensitive conditions admissions measures—ACO-9 and ACO-10—as these measures are redundant with two existing measures for heart failure and multiple chronic conditions—ACO-37 and ACO-38, respectively. Additionally, CMS proposes to retire three measures—ACO-21, ACO-31, and ACO-33—in an effort to reduce provider burden and align with the Core Quality Measures Collaborative<sup>2</sup>—a multi-stakeholder process to promote harmonization of measure use and collection across payers in both public and private sectors—as well as proposals found in the forthcoming QPP final rule. 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 administrative burden on ACOs and ensures that the measure set is kept up to date. We encourage CMS to continue to examine and refine the measure set used to assess ACO quality performance.

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

America's Essential Hospitals supports the creation and implementation of measures that lead to quality improvement. CMS proposes the addition of three measures – ACO-12 (medication reconciliation post-discharge), ACO-44 (image studies low back pain), and ACO-43 (ambulatory sensitive condition acute composite). However, before including measures in the MSSP, CMS must verify they are properly constructed and would not lead to unintended consequences as has been the case with the HRRP measures. For example, ambulatory sensitive conditions, such as ACO-43, have significantly higher rates among children who are black, had Medicaid insurance and lived in poorer areas compared with their counterparts.<sup>3</sup> As more CMS quality reporting programs move to outcomes-based measures and fewer process measures, it is important that the measures chosen for these programs accurately reflect quality of care and take into consideration factors beyond the control of a hospital. CMS should ensure the measure set includes metrics that are valid and reliable, aligned with other existing measures, and risk adjusted for sociodemographic factors. **CMS should not include measures to**

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<sup>1</sup> Institute of Medicine Committee on Core Metrics for Better Health at Lower Cost. Blumenthal, D, Malphrus, E, McGinnis, J.M. Vital Signs: Core Metrics for Health and Health Care Progress. Washington, DC: The National Academies Press; 2015.

<sup>2</sup> Core Quality Measures Collaborative. News Release.

<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-02-16.html>. Accessed August 2016.

<sup>3</sup> Jennifer D Parker , Variation in Hospital Discharges for Ambulatory Care Sensitive Conditions Among Children. Pediatrics October 200 vol 106.

**establish ACO quality performance standards until those measures have been appropriately risk adjusted for socioeconomic and sociodemographic factors.**

We have previously urged CMS, in comments on hospital inpatient quality reporting programs, to consider a patient's sociodemographic status—language and existing level of post-discharge support, for example—in its risk-adjustment methodology. We have made these comments out of a preponderance of evidence that patients' sociodemographic status impacts outcomes of care.<sup>4</sup> Outcomes measures, especially readmissions measures, do not accurately reflect quality of care if they do not account for socioeconomic factors that can complicate. For example, patients who do not have a reliable support structure are more likely to be readmitted to a hospital or other institutional setting. Reducing preventable readmissions is of paramount concern to America's Essential Hospitals and its members. We believe that any program directed at reducing readmissions and improving beneficiaries' health through the episode of care must target readmissions that are preventable and include appropriate risk-adjustment methodology. America's Essential Hospitals has previously expressed concern that the Hospital Readmissions Reduction Program (HRRP) unduly penalizes hospitals that serve the nation's most vulnerable populations because it fails to account for external factors that explain higher readmission rates.

The need to take socioeconomic factors into account has been increasingly suggested for quality measurement programs. For example, the House of Representatives recently approved H.R. 5273, the Helping Hospitals Improve Patient Care Act. In part, this bill would amend the HRRP to level the playing field for hospitals that are disproportionately penalized by the program: those that care for large numbers of low-income and other disadvantaged patients. This provision—modeled on H.R. 1343, the Establishing Beneficiary Equity in the Hospital Readmission Program Act—recognizes the socioeconomic complexities of vulnerable populations when calculating quality measures to ensure that hospitals are assessed on the work they do, rather than on the patients they serve.

In 2014, the NQF convened an expert panel to examine whether the lack of sociodemographic adjustment in performance scores might lead to incorrect conclusions about quality (i.e., the conclusion that hospitals with a disproportionate share of disadvantaged patients provide lower quality care simply as a function of their case mix). The panel, which ultimately recommended risk adjusting certain quality measures for sociodemographic factors, found that excluding such factors could lead to greater disparities in care. For example, disadvantaged populations could lose access to care if providers who work primarily with them are asked to achieve the same results as those who work with wealthier populations.<sup>5</sup>

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<sup>4</sup> See, e.g., America's Essential Hospitals. Sociodemographic Factors Affect Health Outcomes. October 21, 2015. <http://essentialhospitals.org/institute/sociodemographic-factors-and-socioeconomic-status-affect-health-outcomes/>. Accessed June 2016.

<sup>5</sup> See, e.g., NQF Technical Report. Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors. August 2014. [http://www.qualityforum.org/Publications/2014/08/Risk\\_Adjustment\\_for\\_Socioeconomic\\_Status\\_or\\_Other\\_Sociodemographic\\_Factors.aspx](http://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociodemographic_Factors.aspx). Accessed June 2015.

Furthermore, in July 2014, the NQF board of directors approved the Sociodemographic Status (SDS) Trial Period which allows inclusion of SDS factors in risk adjustment of performance measure scores when there are conceptual reasons and empirical evidence that inclusion is appropriate. The work being done by NQF, along with the Office of the Assistant Secretary for Planning and Evaluation's (ASPE) separate study of risk adjustment for SDS factors in quality measures, is forthcoming. We urge CMS to examine closely the findings of both the NQF Trial Period and ASPE, and to align its quality programs across settings, to capture accurate hospital quality performance and not unfairly penalize hospitals that serve complex and vulnerable patients, as a growing body of literature points to the need for such adjustment, which greatly affects the populations served by essential hospitals.<sup>6</sup>

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

CMS proposes to add three measures to the MSSP quality measure set. CMS also proposes modifications to the specifications of the existing EHR measure such that the measure would be considered a newly introduced measure and set at the level of pay-for-reporting for the first two reporting periods—2017 and 2018. We urge CMS to maintain its policy of a pay-for-reporting period of at least two years for any new measure or measure that has undergone significant modification, such as the proposed EHR measure, before being assessed by 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.

- 3. CMS should apply the proposed modifications to the EHR measure only for tracks in the MSSP that could meet the requirements for designation as advanced APMs.**

Under the proposed QPP, three existing physician quality programs will sunset—the physician quality reporting system (PQRS), Medicare EHR Incentive Program for eligible professionals, and the value-based payment modifier—and consolidate into the MIPS. CMS proposes a methodology for assessing the total performance of each MIPS-eligible clinician. The agency proposes four performance categories that would be used to determine a composite performance score including an advancing care information category.

The QPP would also offer additional incentives to physicians to participate in advanced APMs. Advanced APMs must meet three requirements—that participants use certified EHR technology (CEHRT); payment for covered services be based on quality measures comparable to those used in the quality performance category of MIPS; and the APM bear more than a nominal amount of risk for monetary losses. The existing ACO-11 measure—Percent of Primary Care Physicians (PCPs) Who

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<sup>6</sup> See, e.g., America's Essential Hospitals. Sociodemographic Factors Affect Health Outcomes. October 21, 2015. <http://essentialhospitals.org/institute/sociodemographic-factors-and-socioeconomic-status-ses-affect-health-outcomes/>. Accessed June 2016.

Successfully Meet Meaningful Use Requirement—assesses the level of CEHRT used by PCPs who participate in an ACO. CMS proposes to broaden the specifications of this EHR measure to assess the degree of CERHT use of not just PCPs but all providers and suppliers, designated as eligible clinicians under the proposed QPP rule, who participate in the ACO.

CMS believes the modification to the specifications for ACO-11 would better align with the QPP proposals and potentially allow more ACOs to qualify to be Advanced APM entities because they would meet the advanced APM criteria of participant use of CEHRT. However, under the QPP, the result of the proposed financial risk component of advanced APM qualification is that only Tracks 2 and 3 of the MSSP would have the potential to meet all criteria to qualify as advanced APMs. In other words, the savings-only ACOs—i.e., Track 1 participants—would not qualify because they do not meet the criteria for financial risk bearing of more than a nominal amount for monetary losses. Since Track 1 participants would not meet this financial risk criteria, it would be unreasonable to expect those participants to fulfill an expanded EHR measure requiring collection of data from all providers, not just PCPs. For this reason, CMS is considering the application of the modified EHR measure only for tracks that would otherwise meet the requirements for designation as Advanced APMs under the forthcoming QPP final rule—i.e., Tracks 2 and 3. CMS notes that the modification in specifications will be extensive and require eligible clinicians to gain familiarity with the reporting requirements under the QPP proposed rule. **Provided the QPP is finalized as proposed in terms of criteria for advanced APM selection, America’s Essential Hospitals supports CMS’ proposal to only apply the new EHR measure to Tracks 2 and 3, to avoid unnecessary confusion and administrative burden to Track 1 participants.** In doing so, CMS will ensure that the scope of application of this new measure is limited to those ACO participants that could ultimately benefit as an advanced APM under the QPP proposed rule.

**4. CMS should delay incorporation of a voluntary alignment process in the MSSP until an automated process is developed for all Tracks and ACOs that is not cumbersome to ACOs and has a positive impact on beneficiary assignment.**

Patient activation—a patient’s knowledge, skills, ability, and willingness to manage their own health and care—has been shown to result in better health outcomes.<sup>7</sup> America’s Essential Hospitals supports CMS’ effort to focus on patient centered care and improve beneficiary engagement. CMS proposes to incorporate beneficiary attestation into the assignment methodology for the MSSP, effective for assignment for the 2018 performance year.

Specifically, CMS would develop a process by which beneficiaries could designate their “main doctor” or the other healthcare provider they believe is responsible for their overall care. CMS proposes an automated approach to capture such

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<sup>7</sup> Hibbard JH, Greene J. What The Evidence Shows About Patient Activation: Better Health Outcomes And Care Experiences; Fewer Data On Costs. *Health Affairs*. <http://content.healthaffairs.org/content/32/2/207.abstract>. Accessed August 2016.

information for Tracks 1 and 2. However, the agency is considering use of a manual process for Track 3 participants until an automated process can be developed. The manual process is currently performed in the Pioneer ACO model and thus far as proven, by CMS' own admission, to be resource intensive for both ACOs and the agency itself. CMS should ensure the impact of any future automated process appropriately captures and encourages beneficiary engagement while avoiding intense resource use by ACOs. Additionally, future program guidance and outreach activities should use terminology that is tailored to beneficiaries and the populations served by the ACOs. **We urge CMS to perform further analysis on the current beneficiary attestation process used in the Pioneer ACO model, and engage stakeholders in the development of any future automated alignment process.**

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