



# AMERICA'S ESSENTIAL HOSPITALS

December 19, 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-5517-FC: Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models**

Dear Mr. Slavitt:

Thank you for the opportunity to submit comments on the above-captioned final rule. America's Essential Hospitals appreciates and supports the Centers for Medicare & Medicaid Services' (CMS') work to identify measures and activities that appropriately assess performance, promote quality of care, and improve outcomes through the implementation of the merit-based incentive payment system (MIPS) and promotion of alternative payment models (APMs) under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). We are pleased that the final rule with comment period includes a transition year and staged approach for adoption of this new payment system. However, essential hospitals—those that serve the nation's most vulnerable—face unique challenges inherent in caring for these patient populations. We urge CMS to rigorously monitor, evaluate, and modify the new Quality Payment Program (QPP) to ensure success across providers and settings, both now and in future years.

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.

Members of America’s Essential Hospitals work daily to improve care quality through a broad variety of initiatives—from reducing readmissions to preventing falls, blood stream infections, and other patient harm events. They have created programs to break down language barriers and engage patients and families to improve the care experience.

The QPP will sunset three existing physician quality programs—the physician quality reporting system (PQRS), the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, and the value-based payment modifier—and consolidate them into the MIPS. CMS has finalized 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: quality, resource use, clinical practice improvement activities, and advancing care information.

The QPP also gives physicians incentives to participate in Advanced APMs. Advanced APMs must require participants to use certified EHR technology and base payment on quality measures comparable to those found in the MIPS. Additionally, Advanced APMs must require that participating entities bear more than nominal financial risk for monetary losses. Beginning in 2019, an eligible clinician that participates in an Advanced APM can become a Qualifying APM Participant (QP). QPs are defined as those eligible clinicians who meet the specified threshold(s). We have concerns with the calculation of threshold scores for QP determination, specifically as it relates to Advanced APMs that have high ratios of specialists, resulting in substantial amounts of care delivered to non-attributed beneficiaries. We urge CMS to reexamine the QP determination process, to ensure parity under the QPP and encourage participation in APMs by all providers.

To ensure alignment across programs and allow all providers the flexibility needed to be efficient and successful under the QPP, CMS should consider the following comments when implementing the above-mentioned final rule.

1. CMS should continue to develop a hospital-based physician reporting option for the MIPS, risk adjust the quality measures for sociodemographic factors—including socioeconomic status—and offer flexibility in the options for group reporting under the MIPS.

CMS has finalized the measures, activities, and data submission standards for each of the four MIPS performance categories listed above. As CMS moves forward with implementing and monitoring MIPS, we ask the agency to consider the following comments related to the finalized MIPS provisions.

- a. CMS should continue to seek stakeholder input in the development of a hospital-based physician reporting option for the MIPS.

MACRA includes a provision allowing CMS to develop MIPS participation options that apply hospitals’ quality and resource use performance measures to their employed physicians. We support the inclusion of such options in future rulemaking and believe they would help physicians and hospitals improve care coordination and align quality improvement goals. The agency has stated this

option is feasible, but not until future years of the MIPS.<sup>1</sup> We encourage CMS to seek input from hospitals, physicians, and other stakeholders to establish a process for hospitals and physicians to designate themselves for hospital-based physician reporting and to expedite the implementation of this option. The MIPS is an opportunity for CMS to improve the value of quality measurement by simplifying the current measure set rather than merely incorporating all the current programs into MIPS.

- b. CMS should finalize measures in the MIPS that align with existing quality reporting programs, minimize unnecessary data collection and reporting burden, and streamline measurement efforts to focus on highest-priority measures.

The quality performance category under the MIPS includes a list of quality measures from which eligible clinicians will choose for purposes of assessment during each one-year performance period. We applaud CMS' reduction in the reporting burden under the quality category from the PQRS' nine measures to six measures, and the added flexibility provided by the agency in the final rule requirement allowing clinicians to report only one measure during the transition year to demonstrate participation. However, we urge the agency to seek greater alignment to avoid reporting multiple versions of measures that assess the same aspect of care simply to satisfy differing reporting requirements. Measures should focus on areas of highest priority—i.e., areas that represent the best opportunities to drive better health and better care, based on available literature.

We support the tailoring of the MIPS measure set over time and encourage CMS to only include measures that are valid, reliable, and endorsed by organizations with measurement expertise, such as the National Quality Forum (NQF) and its Measure Applications Partnership. Through these processes, measures are fully vetted and approved through a consensus-building approach that involves the public and interested stakeholders.

- c. CMS should incorporate risk adjustment for sociodemographic factors—including socioeconomic status—in the quality measures chosen for the MIPS and APMs.

America's Essential Hospitals supports the creation and implementation of measures that lead to quality improvement. However, measures finalized for inclusion in the MIPS should first be verified to ensure they are properly constructed and will not lead to unintended consequences. CMS should ensure the measure set includes metrics that are valid and reliable, aligned with other existing measures, and risk adjusted for sociodemographic factors to accurately represent the quality of care hospitals provide.

While we support CMS' move to stratify and analyze MIPS quality measure data by demographic characteristics to identify trends and areas in need of improvement, we strongly urge the agency to incorporate risk adjustment into the quality measure set. The impact of inadequate risk adjustment has been raised as a

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<sup>1</sup> Inside Health Policy. CMS To Let Hospital-Employed Docs Use Hospital Measures for MIPS. May 20, 2016. <https://insidehealthpolicy.com/daily-news/cms-let-hospital-employed-docs-use-hospital-measures-mips>. Accessed June 2016.

significant concern in the context of the hospital readmissions reduction program (HRRP). We previously have urged CMS, in comments on the 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. Without proper risk adjustment, clinicians would be held responsible for outcomes resulting from factors beyond their control. We believe that risk adjusting the measure set used in the MIPS will benefit the public by accurately reflecting the care offered by eligible clinicians. This is consistent with existing efforts within CMS on quality measures across settings and programs, such as the Medicare Advantage Star Rating system, in which CMS recently proposed to implement risk adjustment for a subset of star ratings measures to adjust for plans serving a vulnerable population.

Furthermore, in July 2014, the NQF board of directors approved the Sociodemographic Status Trial Period, which allows inclusion of sociodemographic factors in risk adjustment of performance measure scores when there are conceptual reasons and empirical evidence that inclusion is appropriate. The work underway by NQF, along with the Office of the Assistant Secretary for Planning and Evaluation’s (ASPE’s) separate study of risk adjustment for sociodemographic factors in quality measures, is forthcoming. We urge CMS to adjust for these factors in the interim, as a growing body of literature points to the need for such adjustment, which greatly affects the populations served by essential hospitals.<sup>2</sup>

As noted in the recent National Academies of Sciences, Engineering, and Medicine report examining methods of incorporating social risk factors in Medicare payment, “achieving good outcomes (or improving outcomes over time) may be more difficult for providers caring for patients with social risk factors precisely because the influence of some social risk factors on health care outcomes is beyond provider control.” Essential hospitals often face the compounded task of treating the most vulnerable patients, as well as identifying availability of post-discharge community-based services, including non–health care services such as transportation, meal services, housing for homeless patients, and language assistance. Thus, the measures included in the MIPS should be properly risk adjusted to account for these factors.

Most recently, legislation to risk adjust quality reporting for socioeconomic status was included in the bipartisan 21st Century Cures legislation, passed by both the U.S. House of Representatives and the Senate, and signed into law in December. This legislation requires the Secretary of the Department of Health and Human Services to implement a transitional risk adjustment methodology to serve as a proxy of socioeconomic status for the HRRP.<sup>3</sup> This legislation serves as a transitional adjustment that recognizes the Secretary’s authority to use a more refined methodology following the analysis of the forthcoming ASPE report, but also understanding that the current methodology is flawed and we must act now to correct these flaws and ensure fairness in the program.

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<sup>2</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>3</sup> 21st Century Cures Act of 2016, H.R. 34, 114th Cong. §15002 (2016) (enacted).

- d. CMS should create an option for a MIPS identifier that would allow large multispecialty groups to have subgroups under the same tax identification number (TIN) to assess quality performance in a meaningful way.

We support CMS' plan to allow clinicians to report as an individual or as part of a group. However, we believe there is a need for further flexibility under the final rule in the options for reporting to allow a large, multispecialty group under one TIN to "split" into clinically-relevant reporting groups. Under the final rule, MIPS-eligible clinicians have the option to have their performance assessed as part of a group consisting of a single TIN with two or more eligible clinicians—as identified by their individual National Provider Identifier—who have reassigned their billing rights to the TIN. As noted by CMS, groups will have varying compositions. By expanding the definition of a group to include subsets in a TIN, groups of specialists or subspecialists within a TIN could be allowed to aggregate in a way that fosters a more meaningful comparison under the QPP. Conversely, there might be related TINs that wish to report as a group, such as a practice that has multiple TINs for business or legal reasons but for all other purposes the clinicians are part of the same group and would want to be identified for reporting purposes under the same identifier. We encourage the agency to establish a group MIPS identifier that would allow for more options to assess eligibility, participation, and performance.

We recognize and support CMS' intent to reduce the participation burden that could be experienced by large groups, by use of a group's billing TIN to identify the group. However, we believe in this era of evolving delivery and practice models, practices and health systems should be given the opportunity to assess the advantages and disadvantages of various reporting options under the MIPS and select whichever option works best.

2. CMS should reexamine the QP determination process for eligible clinicians participating in Advanced APMs to ensure accuracy and fairness.

America's Essential Hospitals supports CMS' efforts to develop the use of APMs and delivery models that strive to achieve the Triple Aim of better care, lower costs, and improved health. Shifting providers to APMs is one of the goals of MACRA, as reflected in the final rule, which offers bonus payments to eligible clinicians who participate in an Advanced APM and meet certain thresholds. As both hospitals and clinicians are encouraged to move into Advanced APMs, CMS must ensure that attribution and threshold calculations used for QP determination accurately account for a beneficiary receiving services through one Advanced APM, but ultimately being attributed to a different Advanced APM.

While specialists, in most cases, might participate in only one accountable care organization (ACO), they often see a broad variety of patients across many networks, most of whom are not attributed to the specialist's particular ACO. Essential hospitals are committed to care coordination and improved outcomes for all patients. One demonstration of this commitment is their significant investment in Advanced APMs, such as the Next Generation ACO, that provide access to needed services. These particular ACOs often have high ratios of specialists resulting in substantial amounts of care being delivered to non-attributed beneficiaries.

Under the final rule, the QP determination depends on the level of payments or patients furnished services through an Advanced APM. We believe the QP determination process might have the unintended consequence of discouraging participation in Advanced APMs due to the uncertainty of the results of the threshold score and its underlying calculation. Specifically, an Advanced APM could provide evaluation and management services to a beneficiary, thereby labeling the beneficiary as “attribution-eligible,” but this does not necessarily mean the beneficiary will be an “attributed beneficiary.” Beneficiaries seen by a specialist at one ACO might have strong, active primary care relationships with clinicians who are aligned with other ACOs or no ACO at all—resulting in dilution of the threshold calculation and, at a minimum, representing a threat to certain clinicians being able to meet the thresholds. Entities and the clinicians providing access to specialty care through Advanced APMs should have an equitable path to QP determination. If clinicians participating in Advanced APMs cannot meet the QP thresholds due to CMS’ finalized methodology, the agency is essentially discouraging participation and penalizing these entities for fulfilling their missions of treating a wide variety of beneficiaries and for using their expertise as broadly as possible.

We urge CMS to consider alternative ways to evaluate non–primary care practitioner participants for the purposes of QP threshold calculations, such as removing beneficiaries attributed to other Advanced APM entities from their denominator, or reducing the thresholds to ensure participation is appropriately incentivized.

3. CMS should engage stakeholders in the development of the ACO Track 1+ Model to appropriately incentivize participation by essential hospitals.

In its final rule, CMS identified a limited number of APMs that would qualify as Advanced APMs in calendar year 2017. These include the Medicare Shared Savings Program tracks 2 and 3, the Next Generation ACO Model, the Comprehensive End-Stage Renal Disease Model, Comprehensive Primary Care Plus, and the two-sided risk variant of the Oncology Care Model.

Improving care coordination and quality while maintaining a mission to serve the most vulnerable is a delicate balance. Challenges finding resources necessary for upgrading technology, process redesign, and network development often preclude essential hospitals from participation as ACOs. Essential hospitals are not alone—many in the field are struggling to learn how to effectively transition to APMs.

We applaud CMS’ recognition that providers differ in their readiness to adopt new delivery and payment models, such as MIPS and APMs, and the extent to which the agency has provided options and flexibility under the final rule for implementation through the transition year. Additionally, we are pleased that CMS looks to expand the number of eligible Advanced APMs in future years, including the development of a new ACO—the ACO Track 1+ Model. We urge CMS to implement flexible requirements around this new ACO model to incentivize participation, which would be of particular importance to providers serving the most vulnerable patients. Additionally, we continue to encourage the agency to consider all

organizations with any downside risk, required savings or discounts, or significant up-front investment to be considered an eligible Advanced APM.

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America's Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Director of Policy Erin O'Malley at 202-585-0127 or [eomalley@essentialhospitals.org](mailto:eomalley@essentialhospitals.org).