



## AMERICA'S ESSENTIAL HOSPITALS

June 27, 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-P: 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 proposed 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). However, essential hospitals—those that serve the vulnerable, first and foremost—face unique challenges inherent in caring for these patient populations. We urge CMS to strive for alignment across programs and allow all providers flexibility in demonstrating performance under the new Quality Payment Program (QPP).

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), Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, and the value-based payment modifier—and consolidate them 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: quality, resource use, clinical practice improvement activities (CPIAs), 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 entities participating in the APM to bear more than nominal financial risk for monetary losses.

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

1. **CMS should develop a hospital-based physician reporting option for the MIPS, align measures across quality programs, risk adjust for socioeconomic and sociodemographic factors, give flexibility to clinicians in their reporting of quality improvement activities to accurately reflect their efforts, and provide clarification around data reporting options.**

CMS proposes the measures, activities, and data submission standards for each of the four MIPS categories, along with each category's respective proposed weight. CMS proposes to determine a composite performance score based on these weighted elements. As CMS moves forward with the planning and implementation of the MIPS, we ask the agency to consider the following comments related to the proposed categories in its implementation of the MIPS.

- a. CMS should 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 goal of such options 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 the second year of the MIPS implementation.<sup>1</sup> Given the fact that the MIPS is 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.

completely new system, and to avoid additional confusion, 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 measures by simplifying the current measure set rather than merely incorporating all the current programs into MIPS.

- b. CMS should adopt 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 must choose for purposes of assessment during each one-year performance period. We appreciate CMS' proposal to reduce the reporting burden under the quality category from the PQRS' nine measures to six measures. 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 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>2</sup> We support the 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. As CMS finalizes the MIPS quality measure set, we urge the agency to seek measures that are outcomes-focused, meaningful at a patient level, and representative of the broader concerns facing the U.S. health system, as referenced by the IOM, such as: care access, community engagement, and preventative services.

CMS does propose to increase the number of outcomes measures in future rulemaking to emphasize the importance of these measures over clinical process measures. We support the tailoring of the MIPS measure set over time, and encourage CMS to implement a process, similar to that found in the hospital inpatient quality reporting programs, to routinely identify and remove those measures that are either topped-out or no longer adhere to clinical guidelines. **Additionally, we urge 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

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<sup>2</sup>Institute of Medicine Committee on Core Metrics for Better Health at Lower Cost. Blumenthal D, Malphrus E, McGinnis JM. *Vital Signs: Core Metrics for Health and Health Care Progress*. Washington, DC: The National Academies Press; 2015.

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 socioeconomic and sociodemographic factors 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, before including measures in the MIPS, CMS must verify they are properly constructed and would not lead to unintended consequences. CMS should ensure the measure set—to be amended annually with the addition or removal of measures—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' use of stratification of MIPS quality measure data by demographic characteristics as an opportunity for the agency to analyze available data, identify trends and areas in need of quality improvement, we strongly urge the agency to incorporate risk-adjustment into the quality measure set.

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. **CMS should ensure the measure set, is risk adjusted for sociodemographic factors to accurately represent the quality of care hospitals provide.** 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 at essential hospitals. This is consistent with existing efforts within CMS on quality measures across settings and programs. After receiving stakeholder concerns that the Medicare Advantage Star Rating system creates a disincentive for plans to serve dually eligible or low-income beneficiaries, CMS recently proposed to implement risk adjustment for a subset of star ratings measures that is meant to adjust for plans serving this vulnerable population.

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>3</sup>

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<sup>3</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 separate study of risk adjustment for SDS 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>4</sup>

- d. CMS should ensure flexibility in the reporting of activities under the CPIA performance category to capture activities being performed by clinicians at essential hospitals.

Under MACRA, clinical practice improvement is defined as an activity that improves care delivery and, when effectively executed, results in improved outcomes. CMS proposes to include subcategories in the CPIA performance category in the MIPS. We are pleased to see that achieving health equity and emergency preparedness are among the proposed subcategories. These are areas in which essential hospitals are already demonstrating performance. When a crisis, natural disaster, or emergency event occurs, functioning health care systems are critical to their communities. Essential hospitals and their staff are trained in responding quickly and appropriately to these events by implementing emergency protocol and well-established preparedness and response strategies. In recent years, the United States and particularly the Midwest and Northeast have seen a handful of record-breaking winter storms. Extreme winter weather has impacted major cities with disaster-like conditions. Many essential hospitals have "command centers" in place that are fully staffed for dealing with such weather-related issues. These centers enable a hospital to strategically and methodically tackle problems while maintaining standard operating procedures to ensure patients continue to receive necessary care. We encourage CMS to include such activities in the inventory of CPIA activities listed as being sufficient in demonstrating performance under the emergency preparedness subcategory.

Additionally, under the achieving health equity subcategory, we would point CMS to the work being done currently by essential hospitals to improve the patient experience by breaking down language barriers and engaging patients and families. One essential hospital in Missouri advanced a two-pronged strategy that targeted both inpatient and outpatient clinical settings to reduce 30-day diabetes readmissions among its diverse patient population. Inpatient strategies included designating a physician champion and developing a process using an EHR to readily identify high-risk patients in need of ancillary services. These activities promote care coordination, beneficiary engagement, patient safety, and, ultimately, better outcomes.

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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-ses-affect-health-outcomes/>. Accessed June 2016.

In future rulemaking, CMS looks to add subcategories, including: promoting health equity and continuity and social and community involvement. America's Essential Hospitals supports the addition of these subcategories; however, we urge CMS to adopt of broad definition of demonstration for the CPIA category, such that services currently being provided by essential hospitals, which would fall under future subcategories, may be included in the proposed rule's subcategories and likewise the initial inventory of CPIAs. Homelessness, for example, is a complex social factor that can significantly affect health and health care. For medical professionals, linking homeless patients to primary care services is a method for treating their medical needs and ensuring they receive comprehensive care. Recognizing this important connection, an essential hospital in California developed a homeless health care program that offers not only a main, physical clinic site, but also a smaller-scale medical respite program at a local homeless shelter. Homeless patients who receive care at medical respites show a reduction in admissions and total hospital days, 90-day readmissions, and admission length of stay.<sup>5</sup> This is one model demonstrating what likely would be considered an activity under the social and community involvement subcategory, which has not been proposed for adoption in the first year of the MIPS. This is just one example that demonstrates the importance of flexibility in the measures included in the proposed subcategories, enabling providers to demonstrate performance through these types of innovative partnerships with entities beyond the hospital walls.

**CMS should allow for flexibility for the specific requirements demonstrating performance under the CPIA category—e.g., threshold and quantity of activities—so as not to unduly burden providers. America's Essential Hospitals supports the broad parameters of CMS' proposed subcategories; however, we urge CMS to provide flexibility when finalizing the inventory of CPIAs, so that providers have the ability to develop plans and build partnerships in a way that is tailored to the needs of the communities they serve and consistent with their resources.**

- e. CMS should provide further clarification regarding data submission, to avoid unnecessary confusion during the transition to the MIPS, and provide performance updates to eligible clinicians throughout the performance period.

CMS proposes that MIPS eligible clinicians be required to submit data on measures and activities for three of the performance groups—quality, CPIA, and advancing care information. No data submission requirements are proposed for the resource use category.

Clinicians and groups have multiple options for data submission, including qualified registries, Medicare claims-based reporting and EHR reporting. We are pleased to see CMS has proposed that data submission not be limited to one mechanism for each MIPS performance category. However, **we encourage CMS to provide**

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<sup>5</sup>Doran KM, Ragins KT, Gross CP, Zerger S. Medical Respite Programs for Homeless Patients: A Systematic Review. *Journal of Health Care for the Poor and Underserved*. 2013;24(2):499-524.

**further clarification in the finalized rule as to the data submission process and how clinicians will transition from the existing reporting platforms.**

Additionally, robust guidance—including frequent updates of performance to eligible clinicians throughout the performance period to better track performance under the MIPS—and resources from the agency will be needed during this period of transition.

**2. CMS should offer eligible clinicians flexibility in the advancing care information performance category and avoid duplicative reporting requirements.**

**As CMS considers how best to offer flexibility for clinicians in the MIPS, we urge CMS to reduce burden and duplicative requirements between the advancing care information category and the EHR Incentive Program.** MACRA removes the Medicare EHR Incentive Program as a standalone program and instead requires eligible clinicians to use certified EHR technology (CEHRT) as part of the advancing care information performance category in the MIPS. However, the Medicaid EHR Incentive Program for eligible professionals, as well as the Medicare and Medicaid EHR Incentive Programs for eligible hospitals, will continue in their current form.

Beginning in calendar year (CY) 2017, eligible clinicians will be required to use CEHRT to report on measures in the advancing care information performance category, which CMS proposes will count for 25 percent of the composite performance score of the MIPS. In large part, the requirements of the advancing care information category mirror the final Stage 3 EHR Incentive Program requirements. CMS proposes to include the same objectives and associated measures but offers a different scoring methodology, which would give eligible clinicians more flexibility and depart from the current all-or-nothing approach of the program. America's Essential Hospitals appreciates that CMS has recognized the difficulty providers continue to face in meeting requirements for the meaningful use of CEHRT. However, CMS should also incorporate the following recommendations, which will ensure further alignment across different provider types and programs requiring the use of CEHRT.

- a. CMS should shorten the CY 2017 reporting period for the advancing care information performance category to one calendar quarter.

**To assist the transition for clinicians to more advanced objectives requiring the use of CEHRT, CMS should offer eligible clinicians flexibility by shortening the 2017 MIPS reporting period to one calendar quarter instead of the proposed full calendar year reporting period.** In the proposed rule, CMS establishes a reporting period for all performance categories of a full calendar year. America's Essential Hospitals urges the agency to allow for a shortened reporting period for the advancing care information category in 2017 to accommodate clinicians during the short transition period and provide for adequate lead time. The flexibility offered by a shorter reporting period will be critical, as eligible clinicians are required to move to the advanced objectives in MIPS regardless of their current performance in the Medicare EHR Incentive Program. Many of the objectives in the advancing care

information category are new objectives with added requirements with which clinicians have limited experience, so they will benefit from the additional preparation time afforded by a shorter reporting period. A shorter reporting period will give clinicians in their first year of the MIPS the additional time needed to make necessary technological and workflow changes as they prepare to report on the required objectives. This flexibility is particularly important given what will be a short timeframe between the publication of the final rule and the beginning of the 2017 reporting period.

- b. CMS should revise its scoring methodology for the advancing care information performance category to allow eligible clinicians to choose which measures are most relevant for their practice.

The scoring methodology for the advancing care information category consists of a base score of 50 points and a performance score of up to 80 points, with the total possible points for the category capped at 100. Clinicians will receive all 50 points for the base score if they simply report a numerator and denominator, or a yes/no statement where applicable, on all 11 measures under six objectives. The actual score or threshold achieved on these measures does not affect the base score.

The remainder of the score for the advancing care information category is determined by a clinician's performance rate on each of eight measures under the patient electronic access, coordination of care through patient engagement, and health information exchange objectives. Unlike the current EHR Incentive Program, there are no minimum thresholds that a clinician is required to meet to successfully receive points for the performance score. This new scoring methodology is a positive step away from CMS' rigid all-or-nothing approach in the EHR Incentive Program, in which a provider will fail the entire program for missing the percentage threshold on even one measure. However, although there is no minimum threshold for measures to receive a performance score, a clinician is essentially required to report on all the measures to receive 50 points for the base score. **CMS should give clinicians the option to report on a subset of measures to satisfy the base score.** By allowing a clinician to choose a subset of the proposed measures, the clinician can satisfy the base score by reporting a subset of measures relevant to the clinician's practice, instead of receiving no points for the base score for not reporting on one measure. By providing this option, if a clinician finds that a particular measure is irrelevant or unfeasible for their practice due to the clinician's specialty or type of patients, the clinician will not have to report on the given measure but can still receive 50 points for the base score. CMS notes that certain types of providers will be exempted from reporting on measures in the advancing care information category, such as hospital-based physicians, and we commend CMS for this clarification.

- c. CMS should exempt eligible professionals in the Medicaid EHR Incentive Program from reporting measures in the advancing care information category.

Eligible professionals who currently participate in the Medicaid EHR Incentive Program can avoid penalties in the Medicare EHR Incentive Program by virtue of



their participation in the Medicaid version of the program. Going forward, however, a Medicaid eligible professional will also have to separately report on measures in the MIPS to receive a score in the advancing care information category. Doing so would be redundant and also add to the reporting burden by requiring providers to report measures to their state Medicaid agency and also to CMS through the MIPS. **To minimize the reporting burden on providers, CMS should exempt professionals who participate in the Medicaid EHR Incentive Program from having to report again in the MIPS.**

- d. CMS should eliminate the all-or-nothing structure of the EHR Incentive Program for eligible hospitals to align the program with requirements for eligible clinicians in the MIPS.

**To encourage eligible hospitals to adopt and meaningfully use EHRs, CMS should change the all-or-nothing structure of the program.** CMS has responded to the need for flexibility on the eligible clinician side and we believe this flexibility is equally imperative for eligible hospitals. Hospitals already struggle with difficult measures in the program, such as the measure requiring electronic exchange of a summary of care document or the measure requiring a certain percentage of patients to electronically access their health information. Under the program's current structure, if a hospital meets all objectives and measures except for a single measure under a single objective, the hospital is not deemed a meaningful user and will be penalized. Penalizing a hospital that is willing and able to meet the thresholds for all of the objectives and measures, but cannot meet the thresholds for one or two measures, is a disincentive to program participation. The rigid requirements of the program can actually become an obstacle to fulfilling the true promise of EHRs.

To alleviate this concern, CMS could use separate rulemaking to extend flexibility to the EHR Incentive Program for eligible hospitals similar to the flexibility it has provided to eligible clinicians in the MIPS. Allowing hospitals flexibility in choosing meaningful use objectives will be consistent with the direction the program is taking for eligible clinicians as required by MACRA. Giving hospitals similar discretion and moving the program away from the all-or-nothing approach would align the two programs. The agency has emphasized its goal of moving providers into APMs, with the goal of 50 percent of Medicare fee-for-service payments being paid through APMs by 2018.<sup>6</sup> Shifting providers to APMs is also one of the goals of MACRA, with CMS offering bonus payments to physicians who are part of an advanced APM. As both hospitals and physicians are encouraged to move into APMs, such as accountable care organizations (ACOs), CMS should maintain parity between the structure of physician and hospital measures.

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<sup>6</sup>U.S. Department of Health and Human Services. Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value. January 26, 2015. <http://www.hhs.gov/about/news/2015/01/26/better-smarter-healthier-in-historic-announcement-hhs-sets-clear-goals-and-timeline-for-shifting-medicare-reimbursements-from-volume-to-value.html>. Accessed June 3, 2016.

The meaningful use statute provides the agency with broad authority to determine the requirements of information exchange and meaningful use of CEHRT.<sup>7</sup> Therefore, using this discretion, the agency should allow hospitals to choose a subset of measures and be able to report on measures without failing the entire program for falling short on percentage thresholds.

**3. CMS should facilitate stakeholder efforts to increase health information exchange and monitor nationwide progress toward interoperability before requiring detailed attestations from providers.**

MACRA requires providers in the EHR Incentive Programs to demonstrate that they did not knowingly and willfully engage in information blocking by interfering with the interoperability of their CEHRT. The effective date of this requirement was April 16. Accordingly, CMS is requiring that for EHR Incentive Program attestations submitted on or after April 16, hospitals and professionals participating in the EHR Incentive Programs, as well as MIPS-eligible clinicians, will be required to provide detailed attestations that the provider

- did not knowingly and willfully take action (such as to disable functionality) to limit or restrict the compatibility or interoperability of certified EHR technology;
- responded in good faith and in a timely manner to requests to retrieve or exchange electronic health information, including from patients, health care providers (as defined by 42 U.S.C. 300jj(3)), and other persons, regardless of the requestor's affiliation or technology vendor; and
- implemented technologies, standards, policies, practices, and agreements reasonably calculated to ensure, to the greatest extent practicable and permitted by law, that the certified EHR technology was, at all relevant times
  - (i) connected in accordance with applicable law;
  - (ii) compliant with all standards applicable to the exchange of information, including the standards, implementation specifications, and certification criteria adopted at 45 CFR part 170;
  - (iii) implemented in a manner that allowed for timely access by patients to their electronic health information;
  - (iv) implemented in a manner that allowed for the timely, secure, and trusted bidirectional exchange of structured electronic health information with other health care providers (as defined by 42 U.S.C. 300jj(3)), including unaffiliated providers, and with disparate certified EHR technology and vendors.

The first of the above requirements mirrors the language in MACRA—the other detailed, technical requirements, however, are additional requirements imposed by CMS in the proposed rule. America's Essential Hospitals is committed to and has

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<sup>7</sup>Social Security Act § 1886(n)(3)(A)(i)-(iii)(2010).

previously voiced support for an interoperable learning health system, as outlined by the Office of the National Coordinator for Health Information Technology in its Shared Nationwide Interoperability Roadmap. Essential hospitals realize the need for patients' health information to be readily accessible by providers across the care continuum. However, there are many obstacles, most of which are outside of the control of hospitals, that prevent a hospital from being able to seamlessly exchange information. The Government Accountability Office recently pointed to the many remaining challenges to attaining a truly interoperable nationwide health information technology infrastructure.<sup>8</sup> There are multiple private- and public-sector initiatives to improve the interoperability landscape, but there is still much work to be done to allow providers to easily exchange information. We are concerned that the second and third attestations in particular hold providers to an exacting standard for health information exchange that is not in line with the reality of nationwide progress toward health information exchange. **To this end, CMS should ease the attestation requirements on providers until substantial progress is made that will enable providers to seamlessly exchange health information.**

**4. CMS should take an expansive approach when implementing the APM provisions of MACRA to encourage adoption of this approach and reward physicians who demonstrate movement toward APMs.**

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. Essential hospitals understand the importance of providing coordination throughout the care continuum. However, 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.

Recently, CMS issued a final rule for the Medicare Shared Savings Program (MSSP). In part, the rule establishes an option for ACOs in the one-sided model (Track 1) to extend their initial participation for an additional year before transitioning to the two-sided risk model (Tracks 2 and 3). CMS emphasized that changes found in the final rule demonstrate the agency's commitment "to facilitating entry and continued participation in the [MSSP] by ACOs with varying levels of experience and differing degrees of readiness to take on performance-based risk."<sup>9</sup> We applaud CMS' recognition that providers differ in their readiness to adopt new delivery and payment models and we encourage the agency to apply the same level of flexibility when implementing the MIPS and APMs under the proposed rule.

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<sup>8</sup>U.S. Government Accountability Office. Nonfederal Efforts to Help Achieve Health Information Interoperability. GAO-15-817. September 2015. <http://www.gao.gov/assets/680/672585.pdf>. Accessed June 3, 2016.

<sup>9</sup>Centers for Medicare & Medicaid Services. Final Medicare Shared Savings Program Rule (CMS-1644-F). June 6, 2016. <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-06.html>. Accessed June 2016.

Among the policy principles set forth by CMS for the APM incentive payments, the agency “[does] not want to constrain the robust development of new Advanced APMs by framing standards only in terms of today’s APMs.” However, CMS’ proposed definition of financial risk is overly narrow and does not include many APM models. The agency identifies a limited number of APMs that would qualify as advanced APMs in CY 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 model of the Oncology Care Model. **We urge CMS to implement flexible requirements around classification of APM participants and 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 APM.**

Additionally, CMS proposes that advanced APMs would base payment on quality measures “comparable” to those found in the MIPS. In its proposed rule, CMS defines comparable to mean any actual MIPS measures or other measures that are evidenced-based, reliable, and valid. We urge CMS to allow for maximum flexibility in how quality is measured for APMs by broadly defining eligible APM measures that are comparable to MIPS’ measures, while maintaining a rigorous level of measure assessment by seeking guidance from NQF.

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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).