



AMERICA'S ESSENTIAL HOSPITALS

August 21, 2017

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue SW
Washington, DC 20201

Ref: CMS-5522-P: Medicare Program; CY 2018 Updates to the Quality Payment Program

Dear Ms. Verma:

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 Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Essential hospitals—those that serve the nation's most complex patients—face unique challenges inherent in caring for this population. We are pleased that the proposed rule includes potential bonus points for the care of complex patients, continued flexibility in reporting, and an option for facility-based measurement scoring. We urge CMS to rigorously monitor, evaluate, and modify the Quality Payment Program (QPP) to ensure success across providers and settings as the program continues.

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to providing high-quality care to all people. Filling a vital role in their communities, our more than 300 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 disadvantaged 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.

With the implementation of the QPP in calendar year (CY) 2017, 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—were consolidated into the MIPS. CMS previously finalized a methodology for assessing the total performance of each MIPS-eligible clinician through a composite score based on four categories: quality, resource use (i.e., cost), clinical practice improvement activities, and advancing care information.

The QPP also gives eligible clinicians incentives to participate in Advanced APMs, which require participants to use certified EHR technology (CEHRT) and base payment on quality measures comparable to those found in the MIPS. Additionally, Advanced APMs require that participating entities bear more than nominal financial risk for monetary losses. An eligible clinician that participates in an Advanced APM can become a Qualifying APM Participant (QP) by meeting specified thresholds.

Providers differ in their readiness to adopt new delivery and payment models, such as the MIPS and APMs, and we urge CMS to continue to provide options and flexibility in the proposed updates for the QPP. To ensure alignment across Medicare programs and allow all providers the flexibility needed to be efficient and successful under the QPP, CMS should consider the following comments before finalizing CY 2018 updates to the program.

- 1. CMS should adopt a facility-based measures scoring option for the MIPS, define and set appropriate thresholds for clinicians to be eligible for this option, and ensure communication to clinicians and hospitals regarding eligibility and participation.**

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 CMS' efforts to develop a hospital-based measures scoring option for the MIPS that appropriately identifies those clinicians providing services at the hospital, while ensuring flexibility for clinicians to meet the required eligibility threshold and take advantage of this option. We urge CMS to reexamine the definition of eligibility, to ensure parity under the QPP and encourage participation by providers.

- a. CMS should adopt a threshold for individual MIPS-eligible clinicians to elect the facility-based measurement option. This would ensure clinicians can use the option without undue burden.

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 the MIPS. For this reason, we support the inclusion of a facility-based measures scoring option and believe such an option will help clinicians and hospitals improve care coordination and align quality improvement goals. The agency previously stated this option is feasible, but not until future years of the MIPS.¹

For the 2020 MIPS payment year, CMS proposes to allow a facility's performance to be attributed to a MIPS-eligible clinician. This voluntary option would distinguish a MIPS-eligible clinician who furnishes a defined amount of services at certain sites as being "facility-based," and enable them to apply their facility's value-based purchasing (VBP) program performance score to their quality and cost categories of the total MIPS score. CMS proposed to define a facility-based clinician as one who furnishes 75 percent or more of their covered professional services in an inpatient hospital or emergency department (ED). We support reducing the reporting burden on facility-based MIPS-eligible clinicians by leveraging existing quality data sources and VBP experiences.

Further, CMS proposes that a MIPS-eligible clinician would qualify for facility-based measurement if they are determined to be facility-based as an individual. We recognize and support CMS' proposal to provide an option for facility-based clinicians that is intended to reduce their participation burden. However, if the threshold set for an individual MIPS-eligible clinician is too high, this option will not achieve its intended goal. **We urge CMS to adopt a threshold of inpatient or ED services that ensures flexibility for individual clinicians to meet the requirements for facility-based measurement.**

- b. For facility-based measurement group participation, CMS should adopt the definition for eligibility that results in the greater number of MIPS-eligible clinicians meeting the threshold for facility-based measurement.

In addition to the proposed option for individual MIPS-eligible clinicians to use facility performance scores, CMS also sets forth two proposals for facility-based measurement group participation. The first proposal would require 75 percent or more of the MIPS-eligible clinician national provider identifiers (NPIs) billing under the a practice group's tax identification number (TIN) to be eligible for facility-based measurement as individuals, as defined above. This threshold could limit eligibility of clinicians.

¹ 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.

CMS' alternative proposal would set a threshold in which the practice group, under a single TIN, furnishes 75 percent or more of its covered professional services in the inpatient setting or ED. This option might allow for increased eligibility. **We urge CMS to perform both calculations when determining facility-based measurement group participation and use whichever calculation allows a group to meet the established threshold for MIPS scoring purposes.**

- c. CMS should provide clear communication to MIPS-eligible clinicians about their facility-based status for purposes of the MIPS. The agency also should provide hospitals a report of all clinicians at their facility that have attested to the facility-based measurement option.

We recognize and support CMS' proposal to provide an option for facility-based clinicians that might reduce their participation burden. However, in this era of evolving delivery and practice models, it is important to give clinicians, practices, and health systems the opportunity to assess the advantages and disadvantages of various reporting options under the MIPS. **CMS should provide timely communication to clinicians of their eligibility status under this new facility-based measurement option.** Further, CMS should notify facilities of the number of clinicians at their facility participating in the voluntary facility-based measurement option.

We encourage CMS to seek input from hospitals, clinicians, and other stakeholders as they develop a process by which clinicians can designate themselves for facility-based measurement. The agency should monitor the implementation of this option for any unintended consequences.

2. **CMS should risk adjust measures in the MIPS where warranted, streamline efforts to focus on highest-priority measures; continue to weigh the cost category at zero; ensure measures are properly vetted before inclusion in the MIPS; and allow flexibility in reporting under the advancing care information category.**

CMS has proposed measures, activities, and data submission standards for each of the four MIPS performance categories—quality, cost, performance improvement activities, and advancing care information. As CMS moves forward with implementing and monitoring the second year of the QPP, we ask the agency to account for social risk factors in the MIPS measure set and bonus point scoring methodology.

- a. CMS should incorporate risk adjustment for social risk factors—including socioeconomic status—in the quality measures chosen for the MIPS.

Socioeconomically disadvantaged populations experience a disproportionate share of many diseases and adverse health conditions. Essential hospitals are called to fulfill the complex clinical and social needs of all patients that come through their doors. As such, our members treat a high proportion of patients with social risk factors that are outside the control of the hospital—including lack of transportation

for follow-up care or limited access to nutritious food—that can affect health outcomes. When calculating quality measures, Medicare programs should account for the socioeconomic and sociodemographic complexities of vulnerable populations to ensure clinicians are assessed on their work, rather than on factors outside their control. In addition, differences in patients’ backgrounds might affect complication rates and other outcome measures. By ignoring these factors, CMS will skew quality scores against hospitals and clinicians that provide care to the most complex patients, including those with sociodemographic challenges and the uninsured.

As required by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act, the Department of Health and Human Services’ (HHS’) Office of the Assistant Secretary for Planning and Evaluation (ASPE) in December 2016 released a report in which the connection between social risk factors and health care outcomes was clearly demonstrated.² The report provides evidence-based confirmation of what essential hospitals and other providers have long known: Patients’ social risk factors matter greatly when assessing the quality of health care providers.

The ASPE report illustrates that hospitals and other providers caring for large numbers of low-income patients are more likely to receive penalties under the Hospital Readmissions Reduction Program (HRRP) and several other pay-for-performance programs. Unfortunately, failing to adjust measures for social risk factors when necessary and appropriate can adversely affect patients and worsen health care disparities, because penalties divert resources away from hospitals and other providers treating disadvantaged populations. Doing so also can mislead and confuse patients, payers, and policymakers by shielding them from important community factors that contribute to worse outcomes. 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.

Policies aiming to improve quality of care should be expanded to include a specific focus on improving population health for the most complex and underserved. We urge CMS to further examine the recommendations found in the ASPE report for future incorporation in the QPP. Further, CMS should continuously engage stakeholders to ensure transparency and reduce administrative burden.

As noted by the National Academy of Medicine (NAM) in its series of reports on accounting for social risk factors in Medicare programs, “Achieving good outcomes (or improving outcomes over time) might 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.”³ Like the growing body of research on socioeconomic risk adjustment, NAM found that community-level

²Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation. Report to Congress: Social Risk Factors and Performance Under Medicare’s Value-Based Purchasing Programs. Washington, D.C.; December 2016.
<https://aspe.hhs.gov/system/files/pdf/253971/ASPESESRTCfull.pdf>. Accessed June 13, 2017.

³National Academies of Sciences, Engineering, and Medicine. Accounting for Social Risk Factors in Medicare Payment. Washington, DC: The National Academies Press; January 2017.
<http://nationalacademies.org/hmd/Reports/2017/accounting-for-social-risk-factors-in-medicare-payment-5.aspx>. Accessed June 13, 2017.

factors that providers are not able to change can indicate risk unrelated to quality of care.⁴

We urge CMS to examine NAM's report for examples of available data that could be included in measure risk adjustment. The agency also should develop analytic methods for integrating patient data with information about contextual factors that influence health outcomes at the community or population level. Identifying which social risk factors might influence outcomes, as well as how to best measure and incorporate those factors into payment systems, is a complex task, but doing so is necessary to ensure better outcomes, healthier populations, and lower costs. We look forward to working with CMS in accounting for social risk factors and reducing health disparities across Medicare programs, including the QPP.

CMS recently included provisions of the 21st Century Cures Act related to risk adjustment in the HRRP rulemaking process. The law requires the HHS secretary to implement a transitional risk adjustment methodology to serve as a proxy of socioeconomic status for the HRRP.⁵ We were pleased with this first step, but more must be done to appropriately risk adjust for hospitals treating patients with social and economic challenges across all Medicare programs, including the QPP.

Additionally, we support CMS' move to stratify and analyze MIPS quality and cost measures using social risk factors to identify trends and areas in need of improvement. However, we strongly urge the agency to use confidential reporting of stratified rates in the initial years of the QPP, in lieu of publicly reporting such data on Physician Compare. In doing so, clinicians, hospitals, and the agency will have the necessary time to examine, understand, and address social risk factors in quality improvement efforts.

- b. CMS should continue to refine the measures in the MIPS to align with existing quality reporting programs; minimize unnecessary data collection and reporting burden; and streamline 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 assessment during each one-year performance period. We applaud CMS' previously finalized reduction in 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, including those that represent the best opportunities to drive better health and better care, based on available literature.

⁴America's Essential Hospitals. Sociodemographic Factors Affect Health Outcomes. April 18, 2016. <http://essentialhospitals.org/institute/sociodemographic-factors-and-socioeconomic-status-ses-affect-health-outcomes/>. Accessed June 13, 2017.

⁵ 21st Century Cures Act of 2016, H.R. 34, 114th Cong. §15002 (2016) (enacted).

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 NQF processes, measures are fully vetted and approved through a consensus-building approach that involves the public and interested stakeholders.

America's Essential Hospitals supports the creation and implementation of measures that lead to quality improvement. However, measures finalized for inclusion in the MIPS first should 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.

- c. CMS should continue to weigh the cost category at zero percent and ensure any measures under development are fully vetted before inclusion in this MIPS performance category.

America's Essential Hospitals and its members understand that the assessment of cost is vital to ensuring that clinicians are providing high-value care to Medicare beneficiaries. For example, one essential hospital in Colorado uses care managers and social workers to address the social determinants of health that often drive cost.

For the first year of the QPP, the cost performance category was weighted at zero percent of the final MIPS score to allow clinicians an opportunity to transition into the QPP. **We urge the agency to finalize its proposed continued weighting of zero percent for the cost category for the 2020 MIPS payment year.** In doing so, clinicians and CMS will have the opportunity to become more familiar with measures in this category and data generated, without affecting a clinician's total MIPS score.

As the MIPS evolves, CMS should ensure the measures by which clinicians are evaluated are proven to actually improve patient outcomes and increase quality for all patients. For the 2018 MIPS performance period, CMS proposes to adopt the Medicare spending per beneficiary (MSPB) measure and to not use 10 episode-based cost measures focused on clinical conditions or procedures that were previously adopted for the 2017 MIPS performance period.

We support CMS' decision to delay incorporating episode-based measures into the cost category of MIPS, as it would be premature to adopt these measures before understanding whether there might be unintended consequences or a need to adjust for social risk factors. Further, both clinicians and CMS need time to understand and become familiar with the measures.

We urge CMS to use the initial years of the QPP to provide feedback on the MSPB measure and the new episode-based measures for informational purposes only. CMS also must ensure the validity of the episode-based measures, seek NQF endorsement, and address any concerns about incorporating social risk

factors into the measures to improve quality of care while not unduly penalizing essential hospitals.

- d. CMS should finalize its proposed flexibility on what CEHRT edition a MIPS-eligible clinician must use in the 2018 performance period.

The CEHRT upgrade process involves many different parties—both inside and outside the hospital—and requires a substantial investment of time and staff resources, along with capital improvements. Once providers begin upgrading their EHRs, there inevitably will be issues that need to be resolved by working with the provider’s information technology staff and vendor. Fully implementing a new EHR platform and ensuring it is ready to use involves training staff, updating workflows, and testing the technology.

As such, CMS should finalize its proposed flexibility regarding the edition of CEHRT a MIPS-eligible clinician must use in 2018. Specifically, **we support CMS’ proposal to give eligible clinicians the option of continuing to use 2014 edition CEHRT for the CY 2018 performance period**, with a bonus for those opting to use the 2015 edition CEHRT during that period.

3. **We urge CMS to incorporate bonus points for MIPS-eligible clinicians who care for complex patients, to set a higher cap for bonus points, and to consider social risk factors in addition to the Hierarchical Condition Category (HCC) when determining patient complexity.**

CMS proposes special consideration for MIPS-eligible clinicians who care for complex patients. Specifically, a complex patient bonus of up to three points would be added to the final score for the 2020 MIPS payment year. It is CMS’ intent that this bonus structure be implemented as a “short-term strategy for the [QPP] to address the impact patient complexity may have on final scores.”

As the ASPE report to Congress indicated, essential hospitals have other unmeasured differences in patient characteristics that might contribute to differences in outcome quality outside the control of the hospital. Facilities and clinicians that care for patients with social risk factors—such as essential hospitals—face greater challenges than other hospitals, potentially placing MIPS-eligible clinicians who care for complex patients at a disadvantage under the program.

We urge CMS to extend the bonus strategy beyond the 2018 performance year. We feel it is necessary to continue to provide such a bonus in future years of the QPP and potentially to increase the cap to more than three bonus points.

For purposes of defining patient complexity, CMS examined two well-established indicators in the Medicare program: medical complexity as measured through HCC risk scores and social risk as measured through the proportion of patients dually eligible for Medicaid and Medicare. Although CMS acknowledges that these indicators are interrelated, the agency has proposed to use only one of the indicators—the average HCC risk scores—for the 2020 MIPS payment year, with potential use of dual-eligible status in future years of the program. In the HRRP,

CMS proposed using dual-eligible status as a proxy for social risk factors. This is a first step and **CMS should consider and test additional variables when accounting for social risk factors for purposes of structuring a bonus for treating complex patients.** We urge the agency to closely examine NAM's four recommended domains for risk indicators in federal programs:

- income, education, and dual eligibility;
- race, ethnicity, language, and nativity;
- marital/partnership status and living alone; and
- neighborhood deprivation, urbanicity, and housing.

Regardless of the methodology for bonus point calculation implemented by CMS, it is important that the methodology is transparent so hospitals and stakeholders can replicate the agency's calculations. We urge CMS to continue to engage stakeholders as it further develops the structure of a complex patient bonus in the MIPS.

4. CMS should continue to engage stakeholders in development of Other Payer Advanced APMs, such as Medicaid APMs.

Beginning in the 2019 performance period, if eligible clinicians participating in Advanced APMs do not become QPs under the Medicare option, CMS proposes to perform QP determinations for those eligible clinicians under the All-Payer Combination Option, which incorporates participation in other payer Advanced APMs, including Medicaid APMs. These scores are compared with the relevant QP thresholds, applying the most advantageous result to eligible clinicians.

Essential hospitals understand the importance of creating partnerships to manage the clinical and social needs of the most at-risk members of their community. For example, an essential hospital in Minnesota formed a safety-net accountable care organization (ACO) to transform delivery and payment of care to Medicaid beneficiaries. In 2012, this hospital launched its Medicaid ACO, which uses a care team approach to identify and engage high-risk patients and provide care across clinics, a public hospital, and the community.⁶ As a result, health has improved due to better access to primary care and reduced use of acute care. **CMS should continue to engage stakeholders in development of other payer Advanced APMs, such as Medicaid APMs, to encourage broader participation in risk arrangements by clinicians participating in the QPP.**

CMS proposes that beginning in 2018—on a specific date yet to be determined by the agency—a state, APM entity, or eligible clinician can request that CMS determine whether a payer arrangement authorized under Title XIX is either a Medicaid APM or a Medicaid Medical Home Model that meets the Other Payer Advanced APM criteria. **We urge CMS to develop a simple attestation process**

⁶ Hostetter M, Klein S, McCarthy D. Hennepin Health: A Care Delivery Paradigm for New Medicaid Beneficiaries. The Commonwealth Fund. October 2016. http://www.commonwealthfund.org/publications/case-studies/2016/oct/~media/files/publications/case-study/2016/oct/1905_Hostetter_hennepin_hlt_case_study_v2.pdf. Accessed July 2017.

with only the information necessary for calculations to minimize burden on both clinicians and the agency. Overly burdensome requirements, including potentially compelling plans to verify the information, could create an insurmountable hurdle to clinicians accurately estimating their beneficiary counts.

5. CMS should engage stakeholders in the development of future models to appropriately encourage participation by essential hospitals in Advanced 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. Shifting providers to APMs is one of the goals of MACRA, as reflected in the QPP, which offers bonus payments to eligible clinicians who participate in an Advanced APM and meet certain thresholds.

CMS identified a limited number of APMs that would qualify as Advanced APMs in the first year of the QPP. These included 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 vulnerable is a delicate balance. Essential hospitals often face challenges finding the resources necessary to upgrade technology, redesign processes, and develop a network; these challenges can preclude them from participation as ACOs. Our members are not alone—many in the field struggle to effectively transition to APMs.

We are pleased that CMS seeks to expand the number of eligible Advanced APMs in future years of the QPP. We urge CMS to implement flexible requirements for new models to promote participation among providers serving the most complex 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 as potentially eligible Advanced APMs.

* * * * *

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.

Sincerely,

Bruce Siegel, MD, MPH
President & CEO