December 22, 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 Ave. SW
Washington, DC 20201

Ref: CMS-5522-FC and IFC: Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year

Dear Administrator Verma:

Thank you for the opportunity to comment on the above-captioned final rule and interim 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 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 vulnerable and complex patients—face unique challenges inherent in caring for this population. We are pleased the final rule includes an increase in potential bonus points for the care of complex patients and a future option for facility-based measurement scoring and Other Payer Advanced APMs. We also commend the agency for responding to the challenges clinicians and facilities face in extreme and uncontrollable circumstance, such as hurricanes. 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 325 member hospitals provide a disproportionate share of the nation’s uncompensated care and devote about half their inpatient and outpatient care to Medicaid or uninsured patients. Through their integrated health systems, members of America’s Essential Hospitals offer
primary care 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.

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. An eligible clinician that participates in an Advanced APM can become a Qualifying APM Participant (QP) by meeting specified thresholds.

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.

1. **CMS should implement a facility-based measurement option for the MIPS 2020 payment year and adopt a flexible eligibility definition that results in all applicable MIPS-eligible clinicians being able to meet the threshold for this option.**

America’s Essential Hospitals supports CMS’ efforts to develop MIPS participation options that apply hospitals' quality and resource use performance measures to their employed physicians. The hospital-based measurement option for the MIPS should appropriately identify those clinicians providing services at the hospital, while ensuring flexibility for clinicians to meet the required eligibility threshold and take advantage of this option.

America’s Essential Hospitals supports including a facility-based measures scoring option and believes such an option will help clinicians and hospitals improve care coordination; align quality improvement goals; and improve the value of quality measurement by simplifying the current measure set rather than merely incorporating all the current programs into the MIPS. The hospital-based measurement option will 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 for the 2020 MIPS payment year to allow a facility's performance to be attributed to a MIPS-eligible clinician. However, as finalized, this option would not be available until a year later. We support reducing the reporting burden on facility-based, MIPS-eligible clinicians by leveraging existing quality data sources and VBP.
experiences and urge CMS to implement this option as originally proposed for the 2020 MIPS payment year (i.e., the 2019 performance period).

Further, we urge CMS to re-examine the definition of eligibility, to ensure parity under the QPP and encourage participation by providers. CMS has finalized its definition of a facility-based clinician as one who furnishes 75 percent or more of covered professional services in an inpatient hospital or emergency department (ED). We recognize and support CMS’ provision of an option for facility-based clinicians that seeks to reduce their participation burden. However, we share in CMS’ concern that some clinicians practicing primarily in hospitals will not be eligible for facility-based measurement due to the complicating factor of observation services. Specifically, the final rule does not include place of service (POS) code 22, which is used for on-campus outpatient hospitals, when determining applicability of facility-based measurement. This POS code is used for providing observation services, which often are provided in the same physical space as inpatient services and, as such, are indistinguishable from inpatient services. If the threshold set for an individual MIPS-eligible clinician is too high and/or does not fully capture services provided, this option will not achieve its intended goal. We urge CMS to study the impact of observation services and to ensure flexibility for individual clinicians to meet the requirements for facility-based measurement.

2. CMS should risk adjust measures in the MIPS when warranted and streamline efforts to focus on the highest-priority measures.

CMS has finalized measures, activities, and data submission standards for each of the four MIPS performance categories: quality, cost, performance improvement activities, and advancing care information. America’s Essential Hospitals supports creating and using measures that lead to quality improvement. However, measures finalized for inclusion in the MIPS 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.

Socioeconomically disadvantaged populations experience a disproportionate share of many diseases and adverse health conditions. Essential hospitals are called on to meet 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 fall outside the hospital’s control and that can affect health outcomes, including lack of transportation for follow-up care and limited access to nutritious food. As CMS implements and monitors the second year of the QPP, we continue to urge the agency to incorporate risk adjustment for social risk factors—including socioeconomic status—in the quality measures chosen for the MIPS.
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. For example, patients who do not have a reliable support structure at discharge are more likely to be readmitted to a hospital or other institutional setting. 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.

The Department of Health and Human Services’ Office of the Assistant Secretary for Planning and Evaluation (ASPE) in December 2016 released a report that clearly demonstrated the connection between social risk factors and health care outcomes.¹ 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 concealing important community factors that contribute to worse outcomes. We urge CMS to further examine the recommendations found in the ASPE report for future incorporation in the QPP.

Further, we urge CMS to examine the National Academy of Medicine’s (NAM’s) series of reports on accounting for social risk factors in Medicare programs. The NAM reports provide examples of available data that could be included in measure risk adjustment. Like the growing body of research on socioeconomic risk adjustment, NAM found that community-level factors that providers are not able to change can indicate risk unrelated to quality of care.² 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 to account for social risk factors and reduce health disparities across Medicare programs, including the QPP.

CMS also should continue to refine the measures in the MIPS and seek greater alignment to avoid reporting multiple versions of measures that assess the same aspect of care. 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.

3. **CMS should continue to weigh the cost category at zero percent and ensure developing measures are fully vetted before including them in this MIPS performance category.**

America’s Essential Hospitals and its members understand that the assessment of cost is vital to ensure clinicians provide high-value care to Medicare beneficiaries. For the first year of the QPP, the cost performance category was weighted at zero percent of the final MIPS score to give clinicians an opportunity to transition into the QPP. CMS proposed to continue the zero percent weighting for the 2020 MIPS payment year; however, the agency finalized a 10 percent weight for the cost category. **We urge the agency to continue the 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.

For the 2018 MIPS performance period, CMS has adopted the Medicare spending per beneficiary (MSPB) measure and will 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. Similarly, it would be inappropriate to weight this category at 10 percent. **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, with a continued zero percent weighting for this category.**

4. **We support CMS’ incorporation of bonus points for MIPS-eligible clinicians who care for complex patients, and we urge the agency to set a higher cap for such points and to consider social risk factors in addition to the Hierarchical Condition Category (HCC) and dual-eligible status when determining patient complexity.**

In the final rule, CMS provides consideration for MIPS-eligible clinicians who care for complex patients. Specifically, a complex patient bonus of up to five points (an increase from the three as proposed) will be added to the final score for the 2020 MIPS payment year. It is CMS’ intent that this bonus structure serves as a “short-term strategy for the [QPP] to address the impact patient complexity may have on final scores.” **We support CMS’ increase in the bonus points available to these MIPS clinicians. However, the need for such a bonus is continuous and the impact of the bonus on the final score, even when increased to five points, likely will be modest.**
There is more still that should be addressed within the MIPS scoring methodology to incorporate social risk factors.

As the ASPE report to Congress indicated, safety-net providers have 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 disadvantaging MIPS-eligible clinicians who care for complex patients under the program.

We urge CMS to extend its bonus strategy beyond the 2018 performance year. We believe 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 five 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. In the final rule, CMS acknowledged that these indicators are interrelated and, as such, decided to pair the average HCC risk scores with the proportion of dual-eligible patients—for the 2020 MIPS payment year. While we appreciate CMS seeking to creating a more complete complex patient indicator, this is but a first step. **CMS should consider and test additional variables when accounting for social risk factors for purposes of structuring a bonus for treating complex patients.** We continue to 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 CMS uses to calculate bonus points, 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 develops the structure of a complex patient bonus in the MIPS.

5. **CMS should continue to engage stakeholders in development of Other Payer Advanced APMs, such as Medicaid APMs, and develop a simple attestation process related to this QPP pathway.**

Beginning in the 2019 performance period, if eligible clinicians participating in Advanced APMs do not become QPs under the Medicare option, CMS will 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 will be 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. **CMS should continue to engage stakeholders in developing other payer Advanced APMs, such as Medicaid APMs, to encourage broader participation in risk arrangements by clinicians participating in the QPP.**

Beginning in 2018, CMS will allow a state, APM entity, or eligible clinician to submit certain information and request that the agency 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. In this final rule, CMS seeks further comment on the submission process—specifically, whether CMS should establish a process to extend Other Payer determinations for a period longer than a single year, if the design and structure of the arrangement have not changed since previous determination. **We support establishing a process that allows determinations for multiple years. We urge CMS to develop a simple attestation process, with only information necessary to verify no changes since prior determination, to minimize burden on both clinicians and the agency.**

6. **CMS should finalize its extreme and uncontrollable circumstances policies for the 2017 and 2018 MIPS performance years, and apply such policies uniformly across the QPP.**

CMS finalized policies beginning in the 2018 performance period for reweighting the quality, cost, and improvement activities performance categories based on extreme and uncontrollable circumstances. Under the policy, MIPS eligible clinicians who are affected by extreme and uncontrollable circumstances may submit a request for reweighting of the quality, cost, and/or improvement activities performance categories for the second year of MIPS by the deadline of December 31, 2018. The policy does not apply to APM Entities. Essential hospitals affected by these events already are significantly burdened and should not be subject to MIPS reporting requirements. As such, **we support this policy.**

Recognizing that MIPS-eligible clinicians have been affected by recent hurricanes Harvey, Irma, and Maria occurring during the 2017 MIPS performance period, CMS also issued an interim final rule outlining an automatic extreme and uncontrollable circumstance policy. This policy does not require that clinicians submit an application to CMS. Under this policy, the quality, improvement activities, and advancing care information performance categories for the 2017 MIPS performance period will be automatically assigned a weight of zero and a final score equal to the performance threshold. Groups are not included in the automatic extreme and uncontrollable circumstance policy. **We support this policy and its goal to reduce clinician burden during times of extreme circumstances, such as**
hurricanes and other natural disasters. We urge CMS to apply the policy uniformly, at both the individual and group level.

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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.

Sincerely,

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