

August 29, 2014

Ms. Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
U. S. Department of Health and Human Services
Attention: CMS-1612-P
Hubert H. Humphrey Building
200 Independence Avenue, SW
Room 445-G
Washington, DC 20201

RE: CMS-1612-P, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015; Proposed Rule

Dear Ms. Tavenner:

On behalf of the Premier healthcare alliance serving approximately 3,000 leading hospitals and health systems and 110,000 other providers, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) calendar year (CY) 2015 physician fee schedule proposed rule. Premier healthcare alliance, a 2006 Malcolm Baldrige National Quality Award recipient, maintains the nation's most comprehensive repository of hospital clinical, financial and operational information and operates one of the leading healthcare purchasing networks. Our comments primarily reflect the concerns of our owner hospitals and health systems that not only employ physicians, but also operate accountable care organizations. Premier runs the largest population health collaborative in the country, the Partnership for Care Transformation (PACT). In addition, Premier is also currently serving as a qualified clinical data registry (QCDR) under the Medicare Physician Quality Reporting System (PQRS).

PROVIDER-BASED DEPARTMENTS

CMS seeks to better understand hospital acquisition of physician offices and subsequent treatment of those locations as off-campus provider-based outpatient departments through the collection of information to analyze frequency, type and payment for services furnished in those

Ms. Marilyn Tavenner

August 29, 2014

Page 2 of 46

provider-based departments. CMS notes that there are impacts of these acquisitions on beneficiaries, who may have increased copayments, and on the program, which incurs an additional hospital facility payment. In addition, CMS notes it may use such data for changes to the practice expense calculation under the Physician Fee Schedule.

In the 2014 OPPS rulemaking cycle, CMS sought public comment on the best means to collect this information. CMS believes the most efficient and equitable way to collect this information is to create a HCPCS modifier to be reported on both the CMS-1500 claim form and the UB-04 form (CMS Form 1450) with every code for physicians' services and outpatient hospital services furnished in an off-campus, provider-based department of a hospital. It is not clear to us whether the line item detail is really necessary or if a single place of service code could be placed on the claim to reduce burden. While we recognize that some claims could contain some on-campus and some off-campus services on the same day of service, it is unlikely to be so frequent that it would dramatically skew any results. **CMS should consider a single code per claim rather than line item detail.**

The Premier healthcare alliance requests CMS to be transparent on exactly how the data collected at the procedure level will be used to inform payment policy. It is not clear to us how only collecting payment information will inform and be used to adjust outpatient payment or the physician practice expense. While we are hesitant to suggest more administrative tasks for our members given the lack of clarity around CMS' purpose, we believe parsing cost data associated with on-campus versus off-campus services will be necessary to put the spending data into context. Although a line level HCPCS modifier will provide utilization information, it will not capture the differences in costs associated with off-campus hospital services versus freestanding physician clinic services. For example, discharge planning, stand-by capacity, social work resources, and other costs incurred by hospital-based off-campus facilities should be considered when comparing the differential spending across these sites. The agency must fully understand the role off-campus provider-based departments play in ensuring access to quality care for beneficiaries before making any changes to the payment systems to avoid unintended consequences on beneficiaries. **The Premier healthcare alliance recommends CMS explore Medicare cost reports where hospitals are already separating off-campus service cost centers from on-campus service cost centers to inform future data collection. In addition, CMS should create a technical expert panel to determine appropriate data collection for on- and off-campus provider-based outpatient department and physician services.**

CHRONIC CARE MANAGEMENT SERVICES

In the proposed rule regarding Chronic Care Management (CCM), CMS outlines *non-face-to-face* care management services for Medicare beneficiaries with two or more chronic conditions. Included in the CCM scope of services, CMS appropriately encourages communications between beneficiaries and providers outside the traditional face-to-face office visit. The proposed scope of services for CCM covers the sharing of information via telephone, secure messaging, internet, or “other asynchronous *non-face-to-face* consultation methods.” However, the rule does not expressly provide for the reimbursement of electronic ordering, capture, and review of Patient Generated Health Data, which is defined as “clinically relevant data captured outside traditional care settings.”¹

Premier believes CMS should clarify the scope of services for CCM in the final rule, which will encourage continuous care management for beneficiaries in between office visits through the use and review of automated data feedback from mobile applications and other software. The inclusion of such data would enhance providers’ capabilities to monitor effectiveness of/adherence to a beneficiary’s care plan and consequently, improve the quality of care provided to beneficiaries. The Premier healthcare alliance **believes that CMS should clarify that the electronic ordering, capture, and review of Patient Generated Health Data by a clinician is permitted as a *non-face-to-face* care management service for these beneficiaries.**

ACCESS TO IDENTIFIABLE DATA

CMS notes that it will be conducting qualitative and quantitative analyses of the impact of models conducted by the Center for Medicare & Medicaid Innovation (the Innovation Center) on quality of care, program expenditures and other factors. To do this, CMS says it must be able to determine specifically which individuals are receiving services from or are subject of the intervention being tested by the entity participating in the model test and, therefore, must have access to patient records not generally available to the agency.

CMS proposes to exercise its authority in section 1115A(b)(4)(B) to establish requirements for states and other entities participating in the testing of past, present, and future models by the Innovation Center to collect and report information that CMS has determined is necessary to monitor and evaluate such models. This means that model participants, and providers and

¹ Shapiro M, Johnston D, Wald J and Mon D. Patient-Generated Health Data: White Paper Prepared for the Office of the National Coordinator for Health Information Technology by RTI International. April 2012. Available at: <http://www.rti.org/pubs/patientgeneratedhealthdata.pdf>.

Ms. Marilyn Tavenner

August 29, 2014

Page 4 of 46

suppliers working under the models, would be required to produce individually identifiable health information and other information as the Secretary identifies as being necessary. CMS further proposes to require the submission of identifiable health and utilization information for patients of private payers treated by providers/suppliers participating in the testing of such models when an explicit purpose of the model test is to engage private sector payers. CMS adds that if finalized, this regulation will provide clear legal authority for HIPAA covered entities to disclose any required protected health information, which is intended to be the minimum data necessary to carry out statutorily mandated research work relating to model impact.

Premier strongly supports the Innovation Center's mission to test and evaluate new innovative care models and is in fact a facilitator convener under the Bundled Payment for Care Improvement (BPCI) initiative. We recognize that evaluation of patient data is an important mechanism to assess the impact of the models on quality of care and healthcare expenditures, but it is not clear what the timing of the requests will be, how the information will be transmitted to CMS or its contractors and the magnitude of such requests. Premier is concerned that such an open-ended mandate will be problematic.

With no notice and comment period required as part of the demonstrations, there will be no opportunity for stakeholders to weigh in with their perspective of what constitutes the minimum necessary information to achieve the evaluation goals. With such a broad proposal of what CMS might request, it is difficult to say what will truly meet the HIPAA standards unless each program is considered individually.

Moreover, many of the demonstrations like BPCI are not funded, as suggested by CMS, leaving the participants to absorb the costs of the additional administrative burden. The delay in the use of the B-CARE tool in the BPCI should sound a cautionary note for CMS. We are concerned that CMS's proposal will invite the same issues experienced under that initiative. This is especially true given that CMS outlines in its proposal some of the same elements that were included in or related to the B-CARE tool. For CMS to acknowledge the problems of data collection through one tool and then turn around and require the data through another mechanism under the guise of evaluation is disingenuous. As CMS moves forward it should be conscious of the administrative burden of such requests and make an effort to use information that is already collected as part of the natural workflow and captured as part of EHRs.

To avoid similar problems, the Innovation Center should first determine the specific data elements that are required for evaluation purposes for the existing programs. This information should be shared transparently with participants who should, at minimum, be given an

opportunity to provide comment on the required inputs for which they will be responsible as part of the evaluation. Moving forward, the Innovation Center should develop such requirements in advance of the program start for participants to allow them an opportunity to provide feedback and weigh the information as part of their decision to participate in the program. **We strongly recommend that CMS consider the necessary data elements on a program by program basis rather than establishing a blanket approval, or at minimum limit the scope of the approved data requirements and uses.**

OPEN PAYMENTS

Current law relating to the Open Payments (Physician Payment Sunshine Act) program requires applicable drug and device manufacturers and group purchasing organizations (GPOs) to disclose any ownership or investment interests in such entities held by physicians or their immediate family members, as well as information on certain payments or transfers of value made to physicians and teaching hospitals. It also excludes the reporting of payments associated with certain continuing medical education (CME) events (those meeting the accreditation or certification requirements and standards of certain listed organizations). **Premier has consistently supported policies aimed at making financial relationships between pharmaceutical and medical device companies and physicians more transparent.**

CMS, in the new proposed regulations, seeks to eliminate the current exclusion for certain CME events because it believes this may have the unintended consequence of appearing to endorse or support the continuing education events of some accrediting organizations but not others. CMS, however, also provides for reporting exclusion in cases where a sponsoring manufacturer is unaware of the identity of the speakers for 18 months, which together could be impracticable since most of the CME program agendas and speakers are publicly noticed prior to and during the events. CMS also proposes two alternatives to current requirements, to expand the current list of accreditation organizations or to establish exclusion qualifying accreditation or certification standards, which CMS itself notes may not address the concerns of endorsement or how and who would enforce the accreditation/certification standards.

We believe clarity and consistency of the rules as applied with added enforcement value should be the barometer in any revision of the current CME rules. Anything short of robust accreditation standards required by prominent organizations such as Accreditation Council for Continuing Medical Education (ACCME), for instance, may jeopardize the law's goals. Furthermore, if CMS seeks to provide exclusions for certain types of CMEs based on the timing of notice by manufacturers, it will be essential to provide clear and realistic notice thresholds, such as if the covered industry sponsor is unaware of the speakers and other participants before

Ms. Marilyn Tavenner

August 29, 2014

Page 6 of 46

committing to fund the CME activity. If the intent of the proposed rule is to set guidelines and standards to safeguard against undue influence by manufacturers, it will be critical for CMS to build upon current rules by focusing on current accreditation or certification standards and provide clear and realistic timeframe in determining notice and knowledge by covered industry sponsors. **Thus, we urge CMS to build upon current accreditation standards and provide clear and realistic timeframe regarding sponsor notice as it considers proposals to eliminate the current CME exclusion.**

PHYSICIAN COMPARE WEBSITE

The proposed rule includes a table summarizing CMS' proposed plans for public reporting of various performance data on the Physician Compare website. In commenting on the Physician Compare portions of the proposed rule, Premier is able to take advantage of its experience with Hospital Compare. In that vein, we wish to emphasize the importance of having downloadable Excel files available through Physician Compare as well as consistent formatting across files. We would also note that the information available through Hospital Compare makes cross-sectional comparisons feasible but does not readily permit comparisons across time. We would encourage CMS to take steps to make the information available via both Hospital Compare and Physician Compare as user-friendly as possible and, in particular, to make sure that the available information is maximally useful to the provider and research community. **CMS should make available downloadable Excel files of Physician Compare data for use by providers and other stakeholders.**

Composite Measures

CMS specifically requests comment on creating composites using 2015 data and publishing composite scores in 2016 by grouping measures based on the PQRS Group Practice Reporting Option (GPRO) measure groups, if technically feasible. When the measure set is relatively small and heterogeneous, standalone measures are preferable to composites, because they identify specific deficiencies that can be addressed to improve quality for beneficiaries. But as the measure set grows beyond a dozen or so, some aggregation is required to make sense of quality comparisons among providers. The proliferation of these individual elements of quality (some very narrow and noisy) strengthens the value of composites. Nevertheless, as we discuss below in the context of the Medicare Shared Savings Program (MSSP), a useful composite score requires more than some arbitrary combination of individual components, no matter how sound they may be on their own. In addition, the weighting on the components is critical to providing information that does not distort the purpose of the general measure. CMS should go through

scientific testing on all of the composites it proposes as part of any quality program and focus group testing for those it intends to publicly display. In our estimation, this cannot be sufficiently accomplished for public reporting in 2015. **We urge CMS to go through NQF endorsement of individual components and composites if it plans to use individual components as a part of the Value-based Payment Modifier (VM) or the MSSP scoring system, but display composites on Physician Compare.**

Qualified Clinical Data Registry

With respect to public disclosure of QCDR data, CMS says that a QCDR would be required to declare during its self-nomination if it plans to post data on its own website and allow Physician Compare to link to it or if it will provide data to CMS for public reporting on Physician Compare. We believe it would be better for Physician Compare to link to the QCDR sites, rather than attempt to incorporate QCDR data directly into the Physician Compare site. In part, this is because QCDRs tend to use custom measures and the display of associated data might need to differ in important ways from the information otherwise available on the Physician Compare website. In addition, the inclusion of QCDR data on the Physician Compare website might end up confusing consumers and encouraging inappropriate comparisons of measures with similar names but materially different constructs. **We support CMS' proposal to allow QCDRs to display information on their public websites rather than the results being placed on Physician Compare.**

PHYSICIAN QUALITY REPORTING SYSTEM

The proposed rule addresses a wide range of policies under the PQRS. With respect to the claims and qualified registry reporting options, CMS proposes that the submitted measures would need to include at least two of 18 specified "cross-cutting" measures if an EP or group practice sees at least one Medicare patient in a face-to-face encounter during the reporting period. We believe that the threshold of one case is too low for required reporting. These clinicians who rarely treat Medicare patients should not have to go through the process of reporting. They are more likely to take the penalty on their handful of cases, but this leaves the group vulnerable on the requirement that 50 percent of the group successfully reports for the value-based payment modifier (VM) if they chose to report individually. **CMS should conduct testing to determine a more appropriate minimum threshold that does not require reporting for clinicians who rarely treat Medicare beneficiaries and remove them from the 50 percent test for the VM.**

Required Outcomes Measures

With respect to the QDCR reporting option, CMS proposes to require a QCDR to have at least three outcome measures or, in lieu of three outcome measures, at least two outcome measures and at least one of the following other types of measures – resource use, patient experience of care, or efficiency/appropriate use. Premier also agrees that a growing emphasis should be placed on outcomes measures. However, we are concerned that the definitions in the proposed rule for outcome, resource use, patient experience of care and efficiency/appropriateness measure types appear to overlap and we fear this will produce considerable confusion and uncertainty for QCDRs and their participating EPs. For example, the proposed rule defines an outcome measure as “a measure that assesses the results of healthcare that are experienced by patients (that is, patients’ clinical events; patients’ recovery and health status; patients’ experiences in the health system; and efficiency/cost” [emphasis added]. But CMS proposes to define a patient experience of care measure as “a measure of person- or family-reported experiences (outcomes) of being engaged as active members of the healthcare team and in collaborative partnerships with providers and provider organizations” [emphasis added]. There also appears to be some overlap between “efficiency/cost” outcome measures and two other measure types, resource use and efficiency/appropriate use. Thus, while CMS appears to want to distinguish outcome measures from “other” types of measures, the proposed definitions do not cleanly do so. In addition, the proposed rule provides only a single example of an outcome measure, unplanned hospital readmission after a procedure. We strongly recommend that the final rule provide a number of examples of each measure type so that QCDRs and other stakeholders will have a better idea of CMS’ expectations. Lastly, it is not clear whether the requirement to submit additional outcome measures (or certain other types of measures) will be difficult for specialists to satisfy given QCDRs are so new. **The Premier healthcare alliance supports the proposal to increase the number of outcome measures, but urges to CMS to first clarify its definition of “outcome.”**

Maximum Number of Custom Measures

CMS also proposes to increase the maximum number of non-PQRS measures that can be reported on behalf of an eligible professional (EP) from the current 20 to 30. We believe this will enhance the ability of QCDRs to meet EP needs. In particular, this may assist with providing custom measures to mid-level practitioners who may now be integrated into the VM. While they have been part of PQRS, having payment tied to their performance may increase the demand for more relevant measures. In addition, this will allow QCDRs to use customized versions of

measures used in other payment systems that may not be part of PQRS. **Premier strongly supports the proposal to increase the maximum number of non-PQRS measures that are reportable to CMS from 20 to 30.**

Measure Program Alignment

CMS currently allows EP's to submit PQRS measures via a CEHRT to satisfy the clinical quality measure reporting requirement for meaningful use (MU). However, there is no explicit language that allows a QCDR, which has a CEHRT and approval from CMS to submit clinical quality measures (CQMs), to provide the same submission for the EP for both PQRS and the EHR Incentive program requirements. This would allow a QCDR to work with EP's in selecting meaningful measures that would depict consistent physician performance measurements for consumers. While a QCDR can submit measures on behalf of an EP for PQRS, it is not totally clear that a QCDR can be approved to submit measures to satisfy the CQM reporting requirements to satisfy MU. This will likely result in EPs exclusively using their EHRs or data submission vendors to satisfy reporting requirements, because those EPs who choose to use a QCDR will still need to contract with multiple vendors to satisfy all of the quality measure reporting requirements to ensure requirements are fulfilled for both measurement programs. **CMS should clarify that QCDRs approved for the submission of CQMs, can meet the MU and PQRS requirements at the same time for the EPs for whom they are submitting.**

Public Posting

Beginning in 2015, CMS proposes that a QCDR make available to the public the quality measures data for which its EPs report. More specifically, CMS proposes that the QCDR must have the quality measures data by April 31 of the year following the applicable reporting period (that is, 30 days following the March 31 deadline for transmitting QCDR data to CMS). CMS also proposes to defer to the QCDR in terms of the method it will use to publicly report the quality measures data and whether to report such data at the individual EP level or aggregate the results for certain sets of EPs who are in the same practice together.

General Requirement

With respect to the public disclosure of QCDR data, Premier strongly believes that it would be premature to require the disclosure of 2015 data. The program is brand new and many questions remain about their operations. At minimum, CMS should go through one cycle of QCDRs reporting the data to make sure all goes smoothly before committing to reporting the information

Ms. Marilyn Tavenner

August 29, 2014

Page 10 of 46

publicly. Moreover, QCDRs need more experience in working with their participating EPs and more time to develop all the necessary processes and policies related to public disclosure of performance data. Plus, the infrastructure must be built for public facing display of information that has heretofore resided on private sites. Such public disclosure must not be rushed, or risk unintended consequences for both providers and beneficiaries. In addition, with only one year of data the benchmarks may not be as robust as they might be with multiple, and there will be no trend information. Furthermore, it will be the first year of ICD-10 based reporting for which we cannot predict the affect on quality measure results. **CMS should not require public disclosure of quality data by QCDRs in 2015, but should revisit the issue during 2016 rulemaking.**

Timing

We are concerned about the March 31 deadline for QCDR data submission to CMS. Especially during the early years of the QCDR program, we do not believe this deadline gives providers and QCDRs sufficient time to complete necessary tasks. To ensure providers have enough time to review all measure rates for the entire data collection period (calendar year) the timeline should be extended to May 31 of the reporting year starting with 2017 data submission (2016 data collection). This would allow sufficient time for the QCDR to receive accurate clinical information and finalized coding for the November and December months. However, for 2016 data submission (2015 data collection), the deadline should be June 30, 2016 due to the complication of reporting data using the International Classification of Diseases, 10th Revision (ICD-10-CM and ICD-10-PCS) codes for the first time. We expect there to be a delay in a provider's ability to send information to a QCDR as there will likely be frequent updates to clinical charts, electronic health records, and billing codes during the ICD transition period. This will hamper a QCDR's inability to rapidly provide feedback reports to the provider to allow for a timely review prior to the submission deadline. We furthermore suggest that CMS reconsider the March 31 deadline for submission in 2015 (2014 data collection) as it will be difficult for providers to adequately review their data in such a short time frame in the first year of the program, when there is more likely to be errors or databugs. **Thus, for submission in 2016 (2015 data collection) CMS should establish a deadline of June 30, 2016, and for subsequent years revise the deadline to May 31 of each year.**

CMS also asks whether quarterly reporting would be appropriate. We agree that this would allow providers additional time to know if there are transmission or other problems. This would also minimize the amount of data providers and vendors are trying to review and process quickly before the final reporting deadline. It will also provide early data for CMS to track how the ICD-10 implementation is progressing, or detect systematic problems in the submission system. This

should, however, be voluntary as not all providers will want to take this option. **We support CMS' proposal to allow quarterly reporting under PQRS, and for QCDR reporters in particular.**

Premier is similarly concerned that the proposed timeline for the public disclosure of data in any given year would give QCDRs too little time to prepare. The proposed April 30 deadline is far too ambitious, even if it were first to apply in 2017 (for data collected in 2016), rather than in 2016 (for data collected in 2015).² QCDRs would then need to take the next step to load the data and generate reports that are user friendly and meaningful. **We would, instead, recommend an October 31 date for public reporting deadline each year, but beginning no earlier than for data collected in 2016.**

Group Reporting

In addition, CMS asks about the prospect of reporting results as a group on the QCDR websites. One aspect of this that would need to be worked out is the fact that part of a medical group may report through a QCDR, while the rest reports through another mechanism. Thus, some indication would need to be given of the portion of the group reporting, or the individuals who constitute the group in this situation. However, the concept of allowing group level reporting has advantages given the small number of cases associated with individual clinicians. Premier also believes that QCDRs should have the option of publicly disclosing performance data by physician specialty within a group (for example, aggregating data for all hospitalists under a single tax identification number (TIN)), in addition to being able to disclose the information at the individual EP level or aggregate the results for EPs who are in the same practice. Of course, this option would only be exercised once public disclosure of QCDR-collected data is required. **CMS should continue developing a policy to allow group reporting by QCDRs with stakeholder input.**

Consumer Assessment of Healthcare Providers and Systems

With respect to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, CMS proposes that beginning with the 12-month reporting period for the 2018 PQRS payment adjustment, group practices of 25 or more EPs that are participating in the GPRO would be required to report and pay for the collection of the CAHPS for PQRS survey measures using a CMS-certified survey vendor. CMS should leave this as a voluntary option until it is clearer how

² The proposed rule says the deadline would be April 31 but this is clearly an error, since the month of April only has 30 days.

much this will cost physician groups. While CMS notes that a list of certified vendors should be available on the web, the list is not yet posted making it difficult for EPs to even estimate costs. The estimates we have heard vary dramatically as some are priced per physician while some appear to be priced per survey. Premier is concerned that this proposed CAHPS requirement might be too burdensome, especially for smaller groups. **At the very least, we believe that CMS should cover the costs of the CAHPS survey administration and reporting for the first two years of any such requirement, as it did for groups of 100 or more EPs and the first two years of MSSP. If not, CMS should retain this as a voluntary participation component.**

MEDICARE SHARED SAVINGS PROGRAM

We appreciate that CMS continues to use the National Quality Strategy as its framework across measurement programs, and continues to emphasize outcomes measures for high impact conditions. Furthermore, we support CMS' efforts to align the Medicare Shared Savings Program (MSSP) with the Physician Quality Reporting System (PQRS); however, we are concerned that CMS is not making similar efforts with the Inpatient or Outpatient Quality Reporting Programs. Hospitals are integral components of ACOs, even if they are not the conveners, and represent a large portion of both the care provided and spending incurred. **We urge CMS to align the hospital quality reporting programs with the MSSP as well.**

Quality Measures Additions

CMS proposes to increase the measures applicable to ACOs from 33 to 37 effective with the 2015 reporting period (submitted in 2016). This would involve the addition of 12 new measures and the retirement of eight current measures and corresponding adjustments to the Diabetes and Coronary Artery Disease composite measures. CMS notes that the increased number of measures is accounted for by measures that would be calculated by CMS using administrative claims data or from a patient survey, and that the total number of measures that ACOs would need to directly report through the CMS website interface would decrease by one. We appreciate that CMS is being attentive to the relative burden associated with the measures it is considering for the MSSP. Our member participants have struggled with the Web interface process and a lack of clarity around the measure specifications for the chart-abstracted measures. We are pleased to see that CMS made assurances in the rule that the agency is working with measure stewards to ensure the most up to date specifications are released prior to the performance period. **It is**

crucial that CMS lock down the measure specifications before the performance period to ensure no rework is required for an already labor intensive process, and consistency in reporting across participants.

Patient and Caregiver Experience Domain

Tables 1-11 below shows the measures CMS proposes to add to the ACO measure set in performance year 2015. It also includes the NQF endorsement status, the measure steward, and the method of data submission as well as the transition plan for each measure. For the Patient and Caregiver experience domain, CMS proposes to add one measure as shown in Table 1.

Table 1.

Domain	ACO Measure #	Measure Title	NQF #	Steward	Method of Data Submission	Pay for Performance R = Reporting P = Performance		
						Yr1	Yr2	Yr3
Patient/Caregiver Experience	ACO-34	CAHPS: Stewardship of Patient Resources	NA	CMS/A HRQ	Survey	R	P	P

CAHPS Stewardship of Patient Resources- This measure is NQF endorsed as part of the Clinical Group-CAHPS and asks the patient whether the care team talked with the patient about prescription medicine costs. According to CMS, this measure has been included as an unscored component of the ACO CAHPS survey instrument with the results provided to ACOs for informational purposes only. Through the first two administrations of the ACO CAHPS survey, CMS notes that the measure has exhibited high reliability, and beneficiaries that participated said that prescription drug costs were important to them. What is not clear in the rule is whether CMS conducted testing on the instrument as a whole with the addition of this measure, and its effect on the overall composite. CMS should share the results of such testing on its website or with the final rule.

We appreciate the foundation for the question given that prescription drug costs are far more variable for Medicare beneficiaries than other services and that high costs may prevent some beneficiaries from appropriately taking their medication. However, we are concerned about forcing this conversation with all patients at all visits to achieve high performance on this measure. Moreover, by asking them whether costs are a concern, there is an expectation that the physicians know what the costs are. When in fact the physicians do not and cannot know the copays for each drug under each insurance plan and product. A patient who is subsequently

asked about whether the care team talked to the patient about costs, but for whom the copays were not known, will likely answer no because sufficient information was not available.

We believe it would be better for CMS to focus on either generic utilization and/or medication adherence measures. Generic utilization would be a good proxy for whether the care team is considering the financial implications of drugs for patients and engaging members by discussing changes to their medication regimen. An adherence measure would be more clinically meaningful and presumably would catch patients having difficulty affording their medication. Both measures would allow physicians to focus on a smaller set of patients with whom to have this conversation, which would better allocate precious time during these visits. **We recommend CMS defer implementing the Stewardship of Patient Resources measure in favor of implementing generic utilization and/or medication adherence measures in the future.**
Care coordination/ Safety Domain

CMS proposes to add four measures to the Care coordination and Safety domain as shown in Table 2.

Table 2.

Domain	ACO Measure #	Measure Title	NQF #	Steward	Method of Data Submission	Pay for Performance R = Reporting P = Performance		
						Yr1	Yr2	Yr3
Care Coordination/ Safety	ACO-35	Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)	2510	CMS	Claims	R	R	P
Care Coordination/ Safety	ACO-36	All-Cause Unplanned Admissions for Patients with Diabetes	TBD	CMS	Claims	R	R	P
Care Coordination/ Safety	ACO-37	All-Cause Unplanned Admissions for Patients with Heart Failure	TBD	CMS	Claims	R	R	P

Domain	ACO Measure #	Measure Title	NQF #	Steward	Method of Data Submission	Pay for Performance R = Reporting P = Performance		
						Yr1	Yr2	Yr3
Care Coordination/ Safety	ACO-38	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	TBD	CMS	Claims	R	R	P
Care Coordination/ Safety	ACO-39	Documentation of Current Medications in the Medical Record	419	CMS	CMS Web Interface	R	P	P

Skilled Nursing Facility 30-Day All-Cause Readmission-this claims-based measure would not increase the collection burden on providers, however, it is not yet NQF endorsed or MAP approved. It follows the same basic methodology as the other readmission measures already in use in the program, and as such raises some of our continuing concerns as outlined in our discussion of the unplanned admissions measures below. In particular, the c-statistic is only 0.66. Thus, it is troublesome to use such measures within pay for performance programs as the scoring system will make a distinction between providers for payment purposes that may not exist. Meaning the scoring system will assume one provider performed higher than another because the one score was slightly higher than the other, when statistically they are indistinguishable.

We agree that the measure provides better line of sight to opportunities in post-acute care, but it is wholly duplicative of the cases already captured in the existing readmission measures used within the program. We are concerned about including this measure in the pay for performance program as it will effectively double weight readmissions. If CMS wishes to emphasize the magnitude of readmissions as part of the scoring system, it should directly propose this as a change to the weighting system. Moreover, as we note below, we are concerned about the potential proliferation of utilization measures within the program and the use of measures that do not include socio-economic status adjusters. However, these results could be helpful in ACOs' quarterly reports so that the information can be used to work with post-acute providers on improved care and perhaps as part of gainsharing arrangements. **CMS should not include the SNF readmissions measure as part of the pay for performance program, but should add it in ACOs' quarterly reports.**

Ms. Marilyn Tavenner

August 29, 2014

Page 16 of 46

All-Cause Unplanned Admissions for Patients with Diabetes Mellitus, Heart Failure, and Multiple Chronic Conditions- These measures are under development through a CMS contract with Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation, but are not yet NQF endorsed. We support the development of population health level measures, and appreciated that these are claims based measures with no collection burden. However, we have fundamental concerns about the construction of these measures and inclusion in the MSSP program. Moreover, we caution CMS not to rush to include measures that are not yet fully through the consensus building process. This process is intended to ensure the measures are not only scientifically rigorous, but meaningful to patients and clinicians. It also establishes credibility for the measures and facilitates the rapid adoption by providers. While we do anticipate these measures will be eventually approved, we expect some of our concerns with these measures will persist.

Generally, we have concerns about including utilization measures, as we note below. In this case, the incentive to drive towards fewer admissions is very strong based on the spending targets. Where CMS should include utilization metrics as a *quality* measure are areas in which it is concerned there will be *underutilization*. Focusing in this way will help CMS arrive at a parsimonious measure set that is truly meaningful to clinicians and beneficiaries, and can monitor for unintended consequences of the program.

We understand CMS' interest in introducing an all-cause admission measure set is driven in part, by the fact that AHRQ's PQI admission measures only estimate disease-specific admissions not all-cause admissions, for any given condition. However, we believe that more measures are not necessarily better. And, it is not yet clear if these measures are or will be better than the AHRQ PQI measures. **CMS should not retain the AHRQ's PQI measures if it adopts these measures as part of pay for performance under MSSP due to significant clinical overlap.**

Specifically, we are concerned that these measures, among other MSSP measures, do not incorporate social determinants of health, in particular socioeconomic status (SES) into the risk adjustment methodology. We understand CMS expects that factors such as patient lifestyle should be modified by ACOs that optimally apply population health management tactics. However, the approach of comparing ACO performance between markets of widely varying SES, without taking the SES of the populations served into account is flawed. Social determinates play a major role in influencing health and wellness. There is a substantial body of evidence that sociodemographic factors—such as patients' income, housing, education and race—influence a variety of patient outcomes and some processes that are out of a provider's control. As noted by Christine Cassel, “not adjusting for patients' sociodemographic factors might actually harm patients, exacerbate disparities in care, and produce misleading performance

Ms. Marilyn Tavenner

August 29, 2014

Page 17 of 46

scores for a variety of providers, which means that no one has accurate information to use for comparison.”³ Moreover, including SES in risk adjustment is congruent with a recommendation from a recent report released by the National Quality Forum. The report calls for adjusting for sociodemographic factors performance measures used to determine providers’ payment. A robust risk-adjustment approach will strengthen the reporting process and help to minimize the potential for unintended consequences.

Furthermore, these new measures apply concepts with respect to the denominator (person years at risk) and numerator (all cause admissions) that are not well tested. CMS should protect against unintended harm of reputation and revenue consequences to their ACOs by thoroughly testing these measures and achieving NQF endorsement.

Finally, we cannot locate any information on the testing of these measures. As noted above, the c-statistic of many of the other similarly constructed measures are quite low. This is not as concerning for measures that are used by providers for comparing their own performance across time, but becomes troublesome when the results are used to differentiate performance across providers for payment differentials. CMS should release additional information about the testing of these measures to better inform stakeholders in their consideration of these measures. **CMS should not add the All-Cause Unplanned Admissions measures to the ACO measure set at this time.**

Documentation of Current Medications in the Medical Record-this measure is intended to replace ACO # 12, Medication Reconciliation after Discharge from an Inpatient Facility. While this is a labor-intensive, chart-abstracted measure it is NQF endorsed and MAP approved for PQRS. However, it is different from the MU objective and clinical quality measure. CMS notes in the rule that the medical community believes it is better clinical practice to perform medication reconciliation at every office visit rather than immediately following a hospital discharge. We concur that ongoing medication reconciliation is most appropriate for the chronically ill beneficiaries who are part of ACOs, rather than solely at hospital discharge. Furthermore, we continue to believe that it is important to measure medication reconciliation as both a safety consideration and to improve overall outcomes. However, the measure is quite burdensome as it requires reconciliation for all medications, including over the counter and

³ Cassel, Christine. “Should Provider Performance Measures Be Risk-Adjusted For Sociodemographic Factors?” Health Affairs. 2014, March 27. Accessed online at <http://healthaffairs.org/blog/2014/03/27/should-provider-performance-measures-be-risk-adjusted-for-sociodemographic-factors/>

herbal supplements, at *each* visit. **We support CMS’ replacement of ACO #12 with Documentation of Current Medications in the Medical Record, but should quickly move the less burdensome MU measure as soon as possible.**

Clinical Care for At Risk Population - Depression

Table 3.

Domain	ACO Measure #	Measure Title	NQF #	Steward	Method of Data Submission	Pay for Performance R = Reporting P = Performance		
						Yr1	Yr2	Yr3
Clinical Care for At Risk Population - Depression	ACO-40	Depression Remission at Twelve Months	710	MN Comm. Measure	CMS Web Interface	R	P	P

Depression Remission at Twelve Months-This measure is NQF endorsed and MAP approved for PQRS. As we discuss below, we do agree with CMS that this is a gap area and this measure more directly targets the outcome of care. However, we have some concerns with the measure. First, it appears somewhat duplicative of ACO #18 that requires an assessment and some follow and care plans. Second, depression can be a life-long struggle marked by multiple remissions and reoccurrences, and achievement of remission can take more than a year for those who are severely depressed. We suggest that the measure be re-cast as improvement rather than “remission.” It is just as valuable, if not more so, to move a patient from a score of 27 (the top) to 17 as it is to move a patient from 15 to five.

In addition, ACO #18 allows the providers to choose which assessment instrument to use rather than requiring the PHQ9 as ACO #40 would. We do not believe there is conclusive evidence that this is the best tool and would prefer to let participants to at least choose from a menu of options. This, however, would require some sort of calibration across instruments to ensure that the measure could be collected comparably despite different tools. Or, in fact, electronically specified and built into EHRs as part of the workflow rather than a separate instrument. To improve the measure in these ways would require more time than is available before 2015. **Thus, we suggest CMS work with the measure steward to make material changes to the measure or develop its own and propose it in future rulemaking.**

We also note that we appreciate CMS retaining ACO #18 even if it adopts ACO #40. This will provide credit to the ACOs for administering the assessments even if they weren't able to achieve high results in depression remission.

Clinical Care for At-Risk Population – Diabetes Composite

As shown in Table 4, CMS proposes to add two measures to the Clinical Care for At-Risk Population domain's Diabetes composite. We provide specific comments on the proposed additions here, but note that we also make comments on the related removals and composite construction later in the letter.

Table 4.

Domain	ACO Measure #	Measure Title	NQF #	Steward	Method of Data Submission	Pay for Performance R = Reporting P = Performance		
						Yr1	Yr2	Yr3
Clinical Care for At-Risk Population - Diabetes Composite (All or Nothing Scoring) ACO-26, 27, 41, 44	ACO-41	Diabetes: Foot Exam	56	NCQA	CMS Web Interface	R	P	P
Clinical Care for At-Risk Population - Diabetes Composite (All or Nothing Scoring) ACO-26, 27, 41, 45	ACO-42	Diabetes: Eye Exam	55	NCQA	CMS Web Interface	R	P	P

Diabetes Eye Exam- This measure is NQF endorsed, but not MAP approved, and has been in use for many years as a HEDIS measure. However, there is debate over the right clinical practice for this measure, specifically whether the exams should be done annually or biennially. In addition, the proposed construction of the composite measure is not currently endorsed. As we discuss below, just because individual measures are sound, does not mean that a composite of those measures will also be sound. **We suggest that CMS wait until it can implement NQF-endorsed electronic specifications for the Diabetes Eye exam measure that seamlessly draw from the clinical workflow. If CMS finalizes these elements, it should test the composite as a whole prior to implementation.**

Diabetes Foot Exam- This measure is also NQF endorsed, but not MAP approved, and has been in use for many years as a HEDIS measure. Despite the fact that this care is well engrained in

practice across the country, we are not aware of any studies that link them to the prevention of the outcome of concern (amputation). In addition, we are concerned that the measure may catch differential documentation and reporting, rather than true differences in care. At present, there may be an uneven playing field depending on how well you are able to capture the documentation in the providers' EHR. In addition, the proposed construction of the composite measure is not currently endorsed. As we discuss below, just because individual measures are sound, does not mean that a composite of those measures will also be sound. **We suggest that CMS wait until it can implement NQF-endorsed electronic specifications for the Diabetes Foot Exam measure that seamlessly draw from the clinical workflow. If CMS finalizes these elements, it should test the composite as a whole prior to implementation.**

We note that the proposed construction of the composite measure is not currently endorsed. As we discuss below, just because individual measures are sound, does not mean that a composite of those measures will also be sound. **We suggest that CMS subject the new composite measure to testing and put it forth for NQF endorsement prior to including it in the MSSP measure set.**

Clinical Care for At-Risk Population – Coronary Artery Disease Composite

As shown in Table 5, CMS proposes to add three measures to the Clinical Care for At-Risk Population domain's Diabetes composite.

Table 5.

Domain	ACO Measure #	Measure Title	NQF #	Steward	Method of Data Submission	Pay for Performance R = Reporting P = Performance		
						Yr1	Yr2	Yr3
Clinical Care for At-Risk Population – CAD Composite (All or Nothing Scoring)	ACO-43	Antiplatelet Therapy	67	ACC	CMS Web Interface	R	R	P
Clinical Care for At-Risk Population – CAD Composite (All or Nothing Scoring)	ACO-44	Symptom Management	NA	AMA-PCPI	CMS Web Interface	R	R	P

Domain	ACO Measure #	Measure Title	NQF #	Steward	Method of Data Submission	Pay for Performance R = Reporting P = Performance		
						Yr1	Yr2	Yr3
Clinical Care for At-Risk Population – CAD Composite (All or Nothing Scoring)	ACO-45	Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF<40%)	70	ACC	CMS Web Interface	R	R	P

Antiplatelet Therapy-This measure is NQF endorsed, but is not approved by MAP for PQRS value-based payment modifier or the Physician Compare website. The use of antiplatelet therapy has been shown to reduce the incidence of vascular events including MI and death. In 2011, the Writing Group of the ACCF/ AHA / AMA-PCPI revised its definition of this measure to include only patients receiving Aspirin or Clopidogrel as these are the only two agents for which good evidence of effectiveness is available. This measure is consistent with current best practice. However, we are concerned that this measure is not MAP supported. It may be that the measure was not endorsed in an effort to reduce the proliferation of measures under the physician measure programs, but may be appropriate for MSSP. We urge CMS to work with MAP to determine the root of the concerns. **We believe that ACO #43 may be appropriate for future inclusion to the CAD composite; however, CMS should test the composite as a whole before implementing it.**

Symptom Management –This measure is neither NQF endorsed, nor approved by MAP for PQRS value-based payment modifier or the Physician Compare website. Certainly effective management of the condition must begin with an assessment of the patient’s symptoms and their progression over time. Providing appropriate, evidence based care would be expected to improve outcomes of patients over time. However, we have a number of concerns about the measure interpretation and practicability.

This measure is one of a pair of measures that the National Quality Measures Clearinghouse recommends be used together. It is not recommended that either of the measures be used independently. The related measure is one that documents the assessment of symptoms and effectively forms the denominator of this symptom management measure. The reason this information is important is that reporting only the symptom management measure has the potential to result in a perverse incentive. That is, only providers who actually document the

assessment of the patient's symptoms will be subjected to this measure. Providers who make no such attempt will have few patients in the denominator and could, wrongly perhaps, be judged to be providing excellent care, even though the majority of their patient population does not have documentation of symptom assessment.

Collection of the denominator for this measure could be straight forward enough if the medical record has been set up to document the Canadian Cardiovascular Society Angina Class, however there is no reason to believe that providers have designed their electronic records in this way. The absence of this Class information would require the use of a patient reported questionnaire. Unfortunately, the current state-of-the-art of the EHR is such that integration with patient reported outcomes is difficult at best and many times beyond the capability of most systems.

The problem is compounded in the collection of the numerator data which would require documentation of two anti-anginal drugs, or documentation of a referral for invasive intervention or for further evaluation. This data is likely to be scattered throughout the EHR, and unless providers have specifically designed their systems in this way – an assumption that is doubtful – this information may prove challenging to retrieve. **We do not support the addition of ACO #44 to the CAD composite.**

Beta Blocker Therapy- This measure is NQF endorsed, but is not approved by MAP for PQRS value-based payment modifier or the Physician Compare website. The use of beta-blocker therapy for patients with prior MI or LVEF < 40% is currently best practice. In 2011, the Writing Group of the ACCF/ AHA / AMA-PCPI revised its description and denominator definition for this measure and the proposed measure appears to be consistent with that revision. We are again concerned that this measure is not MAP supported, and urge CMS to work with MAP to determine whether the measure is appropriate for MSSP. **ACO #45 is may be appropriate for future inclusion to the CAD composite; however, CMS should test the composite as a whole before implementing it.**

We note that the proposed construction of the composite measure is not currently endorsed. As we discuss below, just because individual measures are sound, does not mean that a composite of those measures will also be sound. **We suggest that CMS subject the new composite measure to testing and put it forth for NQF endorsement prior to including it in the MSSP measure set.**

Quality Measure Removal

Care Coordination/ Safety Domain

As shown in Table 6, CMS proposes to remove one measure from the Care Coordination/Safety Domain.

Table 6.

Domain	ACO Measure #	Measure Title	Current Measure Status	NQF #	Measure Steward	Method of Data Submission	Pay for Performance R = Reporting P = Performance		
							Yr 1	Yr 2	Yr 3
Care Coordination / Safety	ACO-12	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility	Replace with ACO-39	97	AMA-PCPI/NCQA	GPRO Web Interface	R	P	P

Medication Reconciliation after Discharge from an Inpatient Facility- As discussed earlier, CMS proposes to replace ACO #12 with ACO # 39, Documentation of Current Medications in the Medical Record. **We support the replacement of ACO#12 with the broader ACO#39 measure.**

Clinical Care for At-Risk Population – Diabetes Composite

As shown in Table 7, CMS proposes to remove four measures from the Clinical Care for At-Risk Population domain’s Diabetes composite. As discussed above, CMS proposes to replace these measures with two additional measures.

Table 7.

Domain	ACO Measure #	Measure Title	Current Measure Status	NQF #	Measure Steward	Method of Data Submission	Pay for Performance R = Reporting P = Performance		
							Yr 1	Yr 2	Yr 3
At-Risk Population - Diabetes	ACO-22	Diabetes Composite (All or Nothing Scoring): Hemoglobin A1c Control (<8 percent)	Retire	729	MN Community Measurement	GPRO Web Interface	R	P	P
At-Risk Population - Diabetes	ACO-23	Diabetes Composite (All or Nothing Scoring): Low Density Lipoprotein (<100)	Retire	729	MN Community Measurement	GPRO Web Interface	R	P	P
At-Risk Population - Diabetes	ACO-24	Diabetes Composite (All or Nothing Scoring): Blood Pressure <140/90	Retire - Redundant Measure	729	MN Community Measurement	GPRO Web Interface	R	P	P
At-Risk Population - Diabetes	ACO-25	Diabetes Composite (All or Nothing Scoring): Tobacco Non Use	Retire - Redundant Measure	729	MN Community Measurement	GPRO Web Interface	R	P	P

Diabetes Composite Measure: Hemoglobin A1c control-CMS notes that it has concerns that the HbA1c level monitored in this measure (<8 percent), is considered too low to comprehensively evaluate HbA1c control for the frail elderly population. We agree that this measure too tightly manages HbA1C measures in the frail elderly and could have unintended consequences. **We support the removal of ACO # 22.**

Diabetes Composite: Low Density Lipoprotein-CMS notes it is proposing removal of this measure due to the release of a new clinical guideline by the American College of Cardiology and American Heart Association. Minnesota Community Measurement is the steward, but this is

built upon a HEDIS measure. We note that NCQA retired this DM indicator from their new HEDIS 2015 product (for measurement year 2014). **We agree that clinical practice has moved away from this measure and support the removal of ACO #23.**

Diabetes Composite: Blood Pressure-CMS believes there is clinical overlap with ACO #28, Hypertension: Blood Pressure Control. **We agree that there is clinical overlap in measures and support the removal of ACO #24, unless CMS suspends scoring on ACO #28 per our recommendation below.**

Diabetes Composite: Tobacco Non-Use- CMS believes this measure is somewhat duplicative of ACO #17, Tobacco Use Assessment and Tobacco Cessation Intervention. **We agree that there is overlap in measures and support the removal of ACO #25.**

Clinical Care for At-Risk Population – Ischemic Vascular Disease

As shown in Table 8, CMS proposes to remove two measures from the Clinical Care for At-Risk Population domain related to ischemic vascular disease.

Table 8.

Domain	ACO Measure #	Measure Title	Current Measure Status	NQF #	Measure Steward	Method of Data Submission	Pay for Performance R = Reporting P = Performance		
							Yr 1	Yr 2	Yr 3
At-Risk Population – Ischemic Vascular Disease	ACO-29	Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL Control <100 mg/dl	Retire	75	NCQA	GPRO Web Interface	R	P	P
At-Risk Population – Ischemic Vascular Disease	ACO-30	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	Replace with ACO-43	68	NCQA	GPRO Web Interface	R	P	P

Ischemic Vascular Disease: Complete Lipid Profile and LDL Control- CMS notes it is proposing removal of this measure due to the release of a new clinical guideline by the American College

of Cardiology and American Heart Association. **We agree that clinical practice has moved away from this measure and support the removal of ACO #29.**

Ischemic Vascular Disease: Use of Aspirin or another Antithrombotic-This measure is being replaced by the new measure for antiplatelet therapy. **We agree with the removal of ACO #30 in favor of ACO #43.**

Clinical Care for At-Risk Population – Coronary Artery Disease Composite

As shown in Table 9, CMS proposes to remove one measure from the Clinical Care for At-Risk Population domain Coronary Artery Disease (CAD) Composite.

Table 9.

Domain	ACO Measure #	Measure Title	Current Measure Status	NQF #	Measure Steward	Method of Data Submission	Pay for Performance R = Reporting P = Performance		
							Yr 1	Yr 2	Yr 3
Clinical Care for At-Risk Population – CAD	ACO-32	CAD Composite: All or Nothing Scoring: Drug Therapy for Lowering LDL Cholesterol	Retire	74	CMS Composite AMA-PCPI – individual	GPRO Web Interface	R	R	P

Coronary Artery Disease Composite: Drug Therapy for Lowering LDL Cholesterol- CMS notes it is proposing removal of this measure due to the release of a new clinical guideline by the American College of Cardiology and American Heart Association. **We agree that CMS should remove ACO #32.**

Quality Measure Revision

Care Coordination/Safety Domain

As shown in Table 10, CMS proposes to make one modification to an existing measure in the Care Coordination/Safety Domain.

Table 10.

Domain	ACO Measure #	Measure Title	NQF #	Steward	Method of Data Submission	Pay for Performance R = Reporting P = Performance		
						Yr1	Yr2	Yr3
Care Coordination/ Safety	ACO-11	Percent of PCPs who Successfully Meet Meaningful Use Requirements		CMS	EHR Incentive Program	R	P	P

CMS also proposes to modify the name and specifications for existing ACO measure #11, which would now read Percent of PCPs who Successfully Meet MU Requirements rather than Percent of PCPs who Successfully Qualify for an EHR Incentive Program Payment. This measure would continue to be doubly weighted. **The name change does not appear to be material, and thus we do not have concerns with the change.**

Clinical Care for At-Risk Population – Hypertension

As shown in Table 11, CMS does not propose any changes to ACO #28.

Table 11.

Domain	ACO Measure #	Measure Title	NQF #	Steward	Method of Data Submission	Pay for Performance R = Reporting P = Performance		
						Yr1	Yr2	Yr3
Clinical Care for At-Risk Population - Hypertension	ACO-28	Hypertension (HTN): Controlling High Blood Pressure	18	NCQA	CMS Web Interface	R	P	P

However, CMS recently issued an MLN Matters directing physicians to follow revised clinical guidelines on controlling blood pressure. NCQA is in the midst of materially updating their measure specifications. We are concerned that the maintenance of this measure sends mixed signals to clinicians about what the true standard of care is at this time. We believe CMS needs to update the measure to reflect the JNC8 standards and the appropriate standard of care immediately. **CMS should issue subregulatory guidance altering the measure specifications for ACO # 28 and converting the measure to pay for reporting for 2015. Once sufficient**

data has been collected to set a reasonable benchmark that is announced in advance of the reporting year, CMS can return it to pay for performance status.

Composite Measure Scoring

CMS requests input on the creation of composites, publishing composite performance scores by grouping measures, and scoring. As noted earlier, when the measure set is relatively small and heterogeneous, standalone measures are preferable to composites, because they identify specific deficiencies that can be addressed to improve quality for beneficiaries. But as the measure set grows beyond a dozen or so, some aggregation is required to make sense of quality comparisons among providers. Indeed, CMS is proposing to increase the measure set from 33 to 37 with the expectation that more components may well be needed to round out a more comprehensive evaluation of the quality of care. The proliferation of these individual elements of quality (some very narrow and noisy) strengthens the value of composites. Nevertheless, as we discuss below, a useful composite score requires more than some arbitrary combination of individual components, no matter how sound they may be on their own. The weighting on the components is critical to providing information that does not distort the purpose of the general measure. CMS should go through scientific testing on all of the composites it proposes as part of any quality program and focus group testing for those it intends to publicly display. **We urge CMS to go through NQF endorsement of individual components and composites if it plans to use individual components as a part of the MSSP scoring system, but display composites on Physician Compare.**

On the specific Diabetes and CAD composites proposed, we again urge CMS to seek NQF endorsement of the specific combination of endorsed elements that minimize statistical noise and distortion. For example, the Diabetes composite was approved by NQF as a specific combination of elements developed by Minnesota Community Measurement. The proposed composite is materially different (but at least each of the proposed elements is individually NQF endorsed). Also, reverse scoring (of ACO-27, hemoglobin A1c, for example) is really not a concern. In other measurement settings we have converted mortality to deaths averted so that the components of the composite all move in the same direction.

Although “equal” weighting of composite elements in creating a composite score may be the consensus, the attainment of equal weighting can be elusive, since individual components of the composite score are typically distributed differently throughout the provider population. To illustrate, if diabetes ACO-26 (antiplatelet meds) has a much wider variation across providers than the other three components of the composite, ACO-26 achievement will dominate the

composite score. This will result in effectively non-egalitarian weighting, even if the diabetes composite score is computed as the simple average of the four components (theoretically equal weight). Hence, the weighting scheme used to compute each composite should be considered separately by composite, based on how its components are distributed. **CMS should delay changes to the composites until further testing of the final combination of elements and NQF endorsement.**

Second Agreement Period

CMS notes that an ACO that transitions to a new agreement period would continue to be assessed on the quality performance standard that would otherwise apply to an ACO in the third performance year of its first agreement period (that is, the ACO would be responsible for performance on a measure, and not revert to a complete and accurate reporting standard). **The Premier healthcare alliance supports the application of year 3 rules to ACOs in later performance years of the program.**

New Measure Transition

In each of the Tables above detailing the proposed new ACO measures, we also included the proposed phase in of the measures. CMS proposes to start all measures with a pay for reporting year regardless of the ACO contract year. And, in some cases, extends that to a second year, for those ACOs in the second year of their first contract. For third year ACOs and beyond, all participants will enter into the pay-for-performance stage in the second year of performance. **We support the phase in of measures including pay for reporting for all participants in the first year. However, we recommend CMS institute pay for reporting for two years for new measures so that the data can be used to establish reasonable benchmarks that are announced in advance of the pay-for-performance year.**

Sample Size

CMS proposes to reduce the sample for each ACO measure reported through the CMS Web interface, from 411 to 248, as it is proposing to do under the PQRS GPRO. This change would reduce the burden on providers associated with reporting through the GPRO Web interface process. At the same time, CMS analyses suggest that the reduced sample size would still achieve reliable results. **Thus, the Premier healthcare alliance supports the reduction of the sample size from 411 to 248 for ACO measures.**

Future Quality Measures

In the rule CMS tees up a series of areas in which it believes there are measurement gaps and solicits comments. We support the addition of new measures that are well defined, risk adjusted, tested and fill gaps without adding undue burden on providers. CMS should continue to work within the NQS framework and focus on outcomes measures of high impact conditions for which there is evidence that improvement opportunities exist. In addition, it should be clear that there is relevance to clinicians and consumers. **We appreciate that CMS specifically notes that it plans to seek NQF endorsement of such future measures and that it will officially propose the measures through rulemaking before adoption in the program.**

Behavioral Health

We agree that there is a gap in measurement in the behavioral health area. However, this is a difficult area for ACOs to focus on currently due to the limited data provided by CMS on mental health and substance use services. While we may get a portion of the picture based on related physical health claims, the rest of the information is critical to appropriate follow-up and intervention with patients. This area is also particularly difficult as patients may not be truthful with their caregivers or in surveys. **Thus, we believe CMS must improve data access and invest significant effort in developing appropriate measures before behavioral health measures can be included in the pay-for-performance system.**

Caregiver experience of care

We agree that patients' perception of their care experience reflects important aspects of the quality of the care they receive. We believe that this also extends to caregivers, particularly for patients who are unaware of their surroundings based on their conditions, but it is difficult to comment on the merit of such possible measures without more detail. **We urge CMS to continue investigating caregiver experience of care measures at the same time it is assessing the success of the existing ACO CAHPS, and then raise the issue again in future rulemaking with additional information provided to stakeholders.**

Alignment with VM measures

CMS proposes to apply the VM to all physicians, including those in ACOs who had previously been exempt, no later than January 1, 2017. In relation to this proposal, CMS asks whether there would be synergies that can be created by aligning the ACO quality measures set with the

Ms. Marilyn Tavenner

August 29, 2014

Page 31 of 46

measures used under the VM, such as the Composite of Acute Prevention Quality Indicators (PQI) and the Composite of Chronic PQIs. These measures could replace the two ACO claims-based ambulatory sensitive conditions admissions measures that are already part of the MSSP measure set. We appreciate any alignment CMS can create across Medicare programs. We recognize that the intent to provide improved quality and reduce cost with the VM program is very much aligned with the goals of the MSSP. Furthermore, this will create a larger pool of providers with comparable measures to develop strong benchmarks and display publicly for beneficiaries' use. However, we believe that each measure should be brought up in rulemaking as we cannot make a blanket statement that all measures should be harmonized. Ultimately, these are two very different programs. For instance, EPs under PQRS can choose which measures to report, whereas ACOs are required to report all of the MSSP measures. **CMS should seek to align with the VM to the extent practicable, but should go through formal rulemaking before adding such measures to the MSSP.**

Frail Elderly Population

We agree that there are extra challenges in caring for the health needs of the frail elderly. And, we further agree there are challenges associated with defining this population and measuring their quality of care. CMS should consider the use of ICD-10 codes along with SNOMED to define the population as we move forward with EHRs as a consistent and straightforward definition will be integral to developing measures in this area. CMS should focus on developing measures using electronic specifications where the elements can be pulled from EHRs and built into the standard workflow. Otherwise such measures would likely be very burdensome on providers. **In the short term, CMS should assess measures for relevance to the frail elderly as a criterion for prioritizing measures for inclusion within MSSP, and in the long-term CMS should investigate EHR based measures that could be used to ensure high-quality care for this vulnerable population.**

Utilization

CMS asks if it is sufficient to provide periodic feedback to ACOs regarding utilization or whether utilization measures should be used to assess ACO performance as an added incentive to provide more efficient care. As noted in the steward's first Technical Expert Panel meeting, CMS needs to have a clear understanding about what this type of measure incentivizes for different providers. There are already extensive incentives as part of MSSP to reduce utilization in order to achieve success on the overall spending reduction component of the calculations. No further incentive is necessary. However, an important reason for establishing quality metrics and tying them to payment in the ACO setting is to ensure that the quality of care is not diminished

by an effort to reduce cost. The proposed measures, like the unplanned admission measures, create additional incentives to reduce utilization, without providing any balancing metrics to ensure that *necessary* admissions are not being avoided. CMS should instead develop underutilization metrics that track changing care patterns as part of the model that may be detrimental to beneficiaries. In this case, the utilization metrics are indeed *quality* metrics rather than markers of efficiency. **We do not support the addition of utilization measures to the MSSP pay-for-performance program unless they are assessing potential underutilization.** Providing over-utilization data can be helpful to ACOs to assist them in identifying areas of opportunity to reduce payer spending, which will ultimately improve the overall success of the ACOs and the MSSP as a whole. Providing under-utilization metrics can assist ACOs in altering care patterns to avoid unintended consequences that may lead to poor outcomes and increased spending. **We fully support CMS including utilization (over and under) measures in the CMS quarterly reports to ACOs, and hopefully in the future with additional accompanying tables and data for drill downs.**

Health Outcomes

CMS requests comments on the area of health outcomes including inclusion of a self-reported health and functional status measure, the appropriateness of using a tool such as the Health Outcomes Survey for health plans, which assesses changes in the physical and mental health of individual beneficiaries over time, and suggestions for alternatives to self-reported measures.

Research has demonstrated that patients who are more engaged in their health can better manage their own disease(s) and well-being. This results in more appropriate utilization, improved health outcomes and more satisfied patients. Incorporating the patient perspective through self-reporting health and functional status measures as a part of overall health outcomes can create a dynamic where the provider is incentivized to engage the beneficiary in their health. **With that said, CMS should consider a long-term pragmatic approach to the inclusion of patient reported measures.**

While the industry has been measuring patient satisfaction for decades, patient reported outcome (PRO) measures are still in their infancy. In order to be meaningful indicators, it will be critical that these types of measures are well designed, risk-adjusted and tested. The process of how best to collect the PRO responses is an important consideration. One of the greatest challenges providers face is how to collect the data, and integrate this information with clinical processes without unduly increasing administrative burden. Perhaps CMS should look towards the learnings gleaned from the Dartmouth PRO measures in electronic health records project, as well as PCORI's Workshop to Advance the Use of PRO measures in EHRs. Another key

consideration for PRO measures is the level and frequency of measurement required. CMS will need to contemplate whether to use quality of life or disease-specific measures. While disease-specific PRO measures may be more actionable, they will greatly increase collection complexity, and will have little ability to compare across various diseases. Moreover, more intensive requirement will impact the cost and complexity of data collection and storage.

Benchmarking these measures is another critical component to consider. While there have been multiple developments recently in terms of PRO survey instruments, there is no widespread use by healthcare providers, and thus limited data available to benchmark performance. Furthermore, there is limited tangible experience with embedding patient data into the care delivery process. These issues should be taken into consideration by CMS.

In addition, we urge CMS to work with the Office of the National Coordinator for Health Information Technology to create synergies with the MU program. Specifically, the patient reported measures related to heart failure, and the potential patient reported measures selected for provider performance evaluation, as required for MU Stage 2 and Stage 3 respectively.

Public Health

CMS says it is considering adding “Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling” (NQF #2152) as a public health measure. We agree that as ACOs evolve CMS should begin adding measures that address social determinants of health. However, such measures are not only difficult to collect and report, but extremely difficult to affect the outcomes. Aspects of substance/alcohol use, domestic violence and other public health measures cannot be adequately obtained from clinical or claims data. **Thus, we support this as a long-term goal within the program.**

Accelerating Health Information Technology

CMS proposes that EPs participating in an ACO under the MSSP who extract from Certified Electronic Health Record Technology (CEHRT) the data necessary for the ACO to satisfy the quality reporting requirements under MSSP would satisfy the clinical quality measure (CQM) reporting component of MU use as a group for the Medicare EHR Incentive Program. Of course, in addition to submitting CQMs as part of an ACO, EPs would have to individually satisfy the other objectives and associated measures for their respective stage of MU. What is not particularly clear is whether CMS means *all* information from CEHRT. Customarily, ACOs pull the information from the EHR, but go back to the documentation in the medical record to verify

Ms. Marilyn Tavenner

August 29, 2014

Page 34 of 46

the information. Thus, some information may change based on free text or other aspects of the records. **We appreciate and support CMS' proposal to allow MSSP reporting to satisfy the CQMs if the individual providers extracted the information from CEHRT.**

Additionally, we welcome further explanation as to how these shifts in data collection methodologies, while perhaps more efficient and less burdensome to ACOs, will impact CMS' benchmarking of performance especially if augmentation through consultation of the full medical record is not expected as that will inevitably result in the reporting of lower performance in those measures heavily dependent upon manual abstraction. **CMS should convert measures to pay for performance after two years of reporting once electronic specifications are implemented.**

CMS acknowledges that there are operational constraints that must be considered when developing policies related to electronic reporting of quality measures under the MSSP, including the fact that ACO participants and ACO providers/suppliers may be at different levels of EHR adoption, and may have chosen different platforms that are not yet seamlessly interoperable. CMS also welcomes suggestions on alternative ways that it might implement EHR-based reporting of quality measures in the MSSP and comments on whether such reporting should be a requirement for all MSSP ACOs or phased in gradually. CMS notes that it is not proposing new requirements regarding EHR-based reporting under the MSSP. We agree that there are some hurdles that must be overcome before CMS can fully align the EHR Incentive program with MSSP let alone add to these requirements. The ACOs in MSSP are often created from disparate organizations, often hospitals and physician groups coming together, that have differing platforms. It will take significant resources and time to ensure that interoperability is achieved.

We appreciate CMS working toward streamlined reporting through EHRs for those exclusions and numerator events that can *only* be satisfied through medical record data. However, to minimize the data collection burden on ACOs, CMS should first consider using their adjudicated medical and pharmacy claims to satisfy all possible exclusion and numerator requirements prior to sending sampled beneficiaries to ACOs. Further, CMS should not require any "positive" numerator hits and exclusions, as identified through their claims data, to be validated by ACOs through additional medical record data. **Whatever solution CMS pursues, we agree that ACOs are at various stages of maturity, and thus strongly urge a phase in of any EHR requirements.**

In addition, it will be important for CMS to understand the landscape of solutions in which ACOs have already invested to avoid dismantling this progress and inadvertently adding

additional burden to already strained infrastructures. **Premier suggests establishing an advisory group of experienced and new ACOs to help inform CMS of this strategy.**

CMS also seeks comment on whether ACO providers/suppliers could use a local registry-like version of the GPRO web interface to capture relevant clinical information and to monitor performance on all Medicare patients throughout the year and to more easily report quality data to CMS annually. Premier has served essentially this function for hospitals under the IQR program and now physicians under the PQRS as a QCDR. We believe registries can play an important role in assisting providers in identifying areas of opportunity and harnessing shared learnings across providers. A particular advantage of a registry in this area would be the ability to bring various EPs and providers together to see their own impact on common measures in a timely fashion that could actually be used for care improvement. However, one challenge with this approach is that tentatively attributed beneficiaries are constantly shifting quarter to quarter so knowing what the eligible patient set is at any given time may be a moving target. A second challenge is that CMS would need to consider the patient “opt-out” provisions as there may be some downstream limitations as to what ACOs could submit to a registry. One step CMS could take to ease this process, for registries and in general, would be to make available ready-made SQL or SAS code (like AHRQ does for their PQI measures) for internal monitoring using CMS’ methodologies (including sampling methodology to minimize the burden of manual abstraction). **Premier supports CMS developing a registry option for the submission of the MSSP required measures and urges CMS to reach out to stakeholders such as Premier as part of this process.**

Quality Measure Retirement

CMS requests comments regarding measure retirement including “topped out” measures. First, if a measure is to be retired, very often because of its poor ability to discriminate one provider from another, it should not be retained for pay-for-reporting only. The burden of maintaining and submitting such measures generally outweighs their discriminatory value. In a similar vein it does not make sense to add or retain topped out measures in composites, since they will have very little effect on the relative composite score, as we discussed in the section above. **CMS should not retain topped out measures as pay for reporting only or continue to include them in composite measures.**

We believe, as stated in previous comment letters across programs, that the quality measures should evolve by adding and subtracting measures to encourage performance improvement across time and across conditions. CMS has established policy around the retirement of topped

Ms. Marilyn Tavenner

August 29, 2014

Page 36 of 46

out measures in the IQR, OQR and Hospital Value-Based Purchasing (HVBP) program. In these cases if there is no statistically significant difference in the performance rates of those providers in the 75th percentile as compared to those in the 90th percentile, and if the coefficient of variation is less than or equal to 0.1, then the measures are retired. In the past we have suggested the addition of a third criterion to ensure that the minimal variation in performance score be high performance, as well, which would aid the determination of whether the measure is meaningfully topped out. This methodology has been shown to work in the other programs, and would provide some consistency and predictability for providers if it was applied more broadly across all CMS quality programs, especially as their measure sets continue to align better.

Further, we suggest a refinement to the retirement criteria. Because on the common quality measures scoring has been somewhat lower for MSSP than for other GPRO organizations, we suggest CMS specifically check to ensure that the scoring for the MSSP participants alone meets these criteria. That way, if performance within MSSP is far better or worse than the rest of the providers, the retirement determination is reflective of MSSP performance. If there continues to be room for improvement by MSSP participants, then CMS should retain the measures and continue to focus on improvement in those areas even if the rest of the GPRO cohort no longer has the opportunity to improve. Still, if PQRS/VM retires a measure, then CMS will need to convert the benchmarks to MSSP only. **Thus, the Premier healthcare alliance suggests that CMS apply the topped out criteria used in the HVBP program, but *separately* on the performance of the MSSP participants.**

Quality Performance Benchmarks

CMS proposes revisions for benchmarking measures that are “topped out” because it believes smaller practices or practices serving smaller patient populations may be able to achieve higher levels of performance more easily than larger practices and organizations serving larger populations. Thus, when the national fee-for-service (FFS) data results in the 90th percentile for a measure being greater than or equal to 95 percent, CMS proposes to use flat percentages for the measure, similar to the current policy under which it uses flat percentages when the 60th percentile is greater than 80 percent.

We appreciate that CMS is making an effort to address a concern we have raised in the past; specifically, that six measures require essentially perfect performance to receive a full two-point score. This addition would increase the number of measures where the benchmark would be based on a flat percentage. Under this methodology where overall performance is very high, but not necessarily topped out, all providers with high performance can be rewarded with high

Ms. Marilyn Tavenner

August 29, 2014

Page 37 of 46

scores. This prevents providers who are at perhaps 99.09 percent from spending undue resources chasing 100 percent performance to retain a 2 point score. In addition, this prevents CMS from arbitrarily distinguishing between providers with clustered scores in general, even if performance is not high overall. It insures that CMS does not arbitrarily provide differential payment despite scores that are statistically indistinguishable. **We support the addition of this criterion for determining which metrics should use flat percentage benchmarks.**

While there is obviously high performance on these six measures, it is not yet clear that they meet the definition of topped out that we propose CMS use under Quality Measure Retirement. It may be that the average performance score of the MSSP participants is lower than that of other GPRO participants. CMS may want to consider this in determining topped out status and how to score these measures. There are likely measures that are not yet topped out, but have clustered performance that would benefit from the use of flat percentages. In addition, we want to point out that this additional criterion does not fully address the underlying problem that many of the benchmarks were not set at reasonably attainable levels for ACOs, at least not at this point in their maturity.

Benchmark Timing

CMS further proposes to update benchmarks every 2 years, but adds that it may revisit this policy as more ACOs enter the program, more FFS data is collected which could help the agency better understand to what extent benchmarks should vary from year to year, or if it makes any future proposals regarding the use of Medicare Advantage data for setting benchmarks. More specifically, CMS says that it would reset the benchmarks for all ACOs based on data for the 2014 reporting period (reported during 2015) and the updated benchmarks would apply for the 2016 and 2017 performance years. In the early years of the program it makes sense to set benchmarks in advance for multiple years. The organizations are getting used to reporting as a group and often on new measures through a different reporting mechanism. As to whether more than one year of data should be used in establishing benchmarks, that determination should be made on a measure by measure basis depending on what is necessary for reliable measurement. We do think that CMS should revisit this in future rulemaking as the measure landscape is ever changing and more data become available. **The Premier healthcare alliance supports setting the quality benchmarks for two years at a time for the near-term.**

Rewarding Quality Improvement

CMS proposes an additional explicit reward, of up to two points per domain, for those ACOs that improve their performance from one year to the next, an approach that is rooted in the Medicare Advantage five-star rating program. This new MSSP-related program would compute an improvement score if performance on a measure is statistically higher than the prior year. It would then measure the net quality improvement by calculating the total number of significantly improved quality measures and subtracting the total number of significantly declined quality measures. The portion of the two points the ACO receives depends on the proportion of the total measures improved.

Premier is pleased that CMS is addressing Premier's longstanding suggestion to add an improvement concept to the MSSP scoring. We learned from the Premier CMS Hospital Quality Incentive Demonstration that an improvement score is important to ensure that all providers have a line of sight to an incentive payment. This encourages providers who may have poor initial performance to continue working toward achievement rather than taking a defeatist or minimalist attitude. While not entirely clear, we hope that CMS' proposal will allow improvement points to generate a score in domains where an ACO would not have generated achievement points. **The Premier healthcare alliance strongly supports the addition of an improvement score to the MSSP quality scoring system.**

For purposes of determining quality improvement and awarding bonus points, CMS proposes to include all of the individual measures within a domain, including both pay-for-reporting measures and pay-for-performance measures. If a measure is not suitable for pay-for-performance, it should not be used for improvement scoring, since it will affect payment, even if only marginally. Pay-for-reporting measures are generally either new to the system or difficult measures to collect resulting in questionable accuracy of the results. In addition, for measures that are new to the system, CMS would be mixing and matching in that some ACOs will have two pay-for-reporting years for certain measures and some ACOs will jump to pay-for-performance on those measures in the second year they are reported. Again, this may result in data that is not comparable across sites. **Pay-for-reporting measures should not be included in the improvement scoring.**

There are many ways to measure improvement. One is to add bonus points to the achievement score to determine an adjusted score. In some ways that approach amounts to double counting. Another is to compute two scores, one for achievement and the other for improvement, applying the greater of the two to each organization, as suggested by the CMS Report to Congress of

Ms. Marilyn Tavenner

August 29, 2014

Page 39 of 46

November 21, 2007: “Plan to Implement a Medicare Hospital Value-Based Purchasing Program.” In that setting the baseline threshold for improvement must be lower than the threshold for achievement, so that the improvement score can have a wider range and potentially dominate the achievement score for low achievement organizations. The advantage of the HVBP approach is that the ACOs would get the benefit of the higher score on a measure by measure basis. **With no ability to test either of these models, and no public results from CMS, we cannot definitively make a recommendation on this proposal. CMS should conduct testing to determine how each of these models performs with respect to the goal of appropriately recognizing significant improvement in quality, even if not at superior achievement level, to encourage and reinforce this behavior in ACOs and transparently report this to stakeholders.**

Both options require an arbitrary setting of the potential number of bonus points (CMS has proposed two points). However, under the HVBP methodology it is a relative range of achievement (up to 10) or improvement points (up to 9). In this case, the improvement score is relative to the magnitude of the improvement of other participants rather than just the numbers of measures on which the ACO improved as CMS proposed here. The HVBP model has the advantage of better capturing the degree of improvement compared to like providers. Under either scenario, how these total points are set depends on how much CMS wants to reward achievement relative to improvement. We agree that achievement should always provide a greater incentive than improvement, but we question whether two points is enough. The proposal can only increase a score by at most 14 percent. **If CMS maintains the suggested methodology, we urge CMS to make four points available for improvement rather than two points.**

Another option to maintain the balance of further encouraging high performance, rather than relying on improvement scores is by the addition of actual bonus points. For example, closer to the Medicare Advantage star rating bonus system, CMS could provide the top decile of performers with a higher sharing rate, if shared savings are achieved. A combination of both an improvement score and a superior performance score will help more ACOs earn a larger portion of their shared savings. Ultimately, it is so difficult for ACOs to generate enough savings to actually share in the proceeds, CMS should be using the quality scoring system to ensure there is no diminution in quality and that an acceptable performance level has been reached, not as a way to further save the government money. **CMS should consider an actual bonus for truly superior quality performance, rather than points to achieve their full savings as is currently the case.**

VALUE-BASED PAYMENT MODIFIER

CMS proposes to include *all* eligible professionals (EPs) in the value-based payment modifier (VM) and increase the associated penalties starting in payment year 2017. While we understand CMS' interest in moving forward with applying value-based purchasing principles to a broader group of clinicians (both physicians and non-physicians, in and out of MSSP), we are worried that CMS is moving too fast and could cause unintended negative consequences on providers and beneficiaries.

VM Penalty

CMS proposes to increase the amount of payment at risk under the VM from 2.0 to 4.0 percent in CY 2017, and apply a *negative* 4 percent penalty to physician and non-physician practitioners that do not meet the applicable QRS reporting requirements. Premier strongly objects to the proposed "add-on" penalty of 4 percent under the VM for failure to meet QRS reporting requirements that brings the total penalty for failure to report to 6 percent. This penalty is excessive, especially for groups of 2-9 EPs and solo practitioners, who otherwise would not be subject to a negative adjustment under the VM as a result of quality tiering. We note that under the Value-Based Purchasing Program (VBP) for hospitals, hospitals failing to report under the Inpatient Quality Reporting (IQR) program are excluded from the VBP program, exempt from the base operating diagnosis-related group (DRG) payment reduction, and not eligible for value-based payment incentives. Instead, they were only subject to the 2 percent payment adjustment under the IQR program in FYs 2013 and 2014, and are now subject to a 0.725 percentage point penalty. We believe the risk analysis of the VM policy changes provided in the rule is insufficient especially considering its application to small businesses and the magnitude of the penalties. **CMS should not increase the payments at risk or the penalty for failed reporting to 4 percent under the VM, and should conduct additional impact analyses.**

Cost Composite

CMS proposes to continue to use the Medicare Spending Per Beneficiary (MSPB) measure (includes Part A and Part B costs during the 3 days before through 30 days after discharge following an inpatient hospitalization) in calculating the cost composite for the CY 2017 VM for all EPs. Premier has long expressed concerns about this measure with respect to the VBP program but also believes that if this measure continues to apply to hospitals it should also apply under other similar programs, including the VM. Thus we support CMS' intention to continue to

include this measure as part of the cost composite under the VM, but we urge CMS to make major refinements to the measure and provide better transparency about the measures performance.

We are concerned that the risk adjustment is insufficient and may result in more clinicians treating higher risk patients getting higher penalties. We are hopeful that the add-on payment for clinicians treating patients with high risk scores will mitigate this to some extent, but we cannot conduct robust analyses given that only a 5 percent sample of physicians is available in the Standard Analytic File limited data set. In particular, we continue to believe that the MSPB measure needs to be adjusted for sociodemographic factors. **Thus, we strongly support the recommendations contained in a technical report issued by the National Quality Forum (NQF), which calls for adjusting for sociodemographic factors the performance measures used to determine provider payment.**⁴

Furthermore, we do not support CMS moving forward with condition-specific episodes of care measures given that they will be totally duplicative of care already captured in the MSPB. In addition, CMS should not pursue these measures, even for reporting to providers for performance improvement, until the fundamental reliability concerns underpinning the efficiency measures are addressed. **CMS should not implement condition-specific episodes of care measures.**

Attribution Methodology

For purposes of the VM cost measures, apply a beneficiary attribution methodology that would differ from the one used under the MSSP (however, the existing attribution methods would be used for physicians in the MSSP, Pioneer ACOs and the CPC Initiative). While we generally appreciate consistency between programs, we agree that the attribution methodology under the VM would benefit from some changes that are not currently permitted by statute under the MSSP. In particular, we agree that it is appropriate to consider the role played by non-physician primary care practitioners in step 1 of the methodology. **Premier supports the proposed changes in the basic VM attribution methodology.**

⁴ National Quality Forum, *Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors, Technical Report*, July 2, 2014.

Hospitalists

In the proposed rule, CMS says it is considering including or allowing groups that include hospital-based physicians or solo practitioner who are hospital-based to elect the inclusion of the Hospital Value-Based Purchasing (VBP) Program performance in their VM calculation. However, it is very unclear how this could be operationalized. CMS will already find it challenging to bring claims, registry, EHR, Web interface and QCDR data together to coherently create comparable measurement for the VM. This would even further complicate the calculations.

There are sufficient quality measures and reporting options for hospital-based physicians to participate in PQRS and quality tiering within VM. This is especially true given that hospital-based EPs can individually report through QCDR based on measures comparable to VBP measures. However, we are concerned about including hospital-based physicians (not just hospitalists, but emergency physicians, anesthesiologists etc.) in the cost composite and tiering. If a patient receives sufficient services in the hospital for a hospital-based physician to be attributed to the patient under the VM methodology, chances are the Medicare spending will be very high given the type of services. A primary care physician who has a patient attributed to them because they were the only evaluation and management services that year will look very different than a hospitalist whose patients are likely receiving extensive post hospital care. Using the VBP version of the MSPB measure would likely be even worse as that is based on only patients who are hospitalized at some point in the year. **CMS should consider deeming hospital-based EPs of “average cost” in the VM tiering until more testing can be done with the VM.**

Eligible Professionals

CMS proposes to apply the VM to not only all physicians, but also nonphysician EPs in groups with 2 or more EPs and to solo practitioners starting in CY 2017. There is no statutory requirement to do so for CY 2017 and we strongly believe that CMS should focus its VM implementation efforts on physicians. Further, we see no evidence that CMS proposes to release to non-physician EPs anything resembling the QRURs that will be made available to physicians. Thus, it is not clear to us that non-physician EPs will be given information that strikes us as essential to preparing for the VM. In sum, we urge CMS to use the final rule to place non-physician EPs on notice that the agency intends to apply the VM to them in the future, but not for CY 2017, and to indicate how CMS intends to provide them with information akin to that

furnished through QRURs and its timetable for doing so. **Premier strongly recommends that CMS not proceed with its plans to apply the VM to non-physician EPs, especially to those in groups of 2-9 EPs and solo practitioners.**

Quality and Resource Use Report

QRURs based on CY 2012 data were made available to groups with 25 or more EPs on September 16, 2013. The proposed rule also notes that CMS plans to disseminate QRURs based on CY 2013 data to all physicians in late summer. We note that a 9-month lag is not particularly helpful for performance improvement purposes. Moreover, it is difficult for EPs to comment on the appropriateness of the VM proposals when only a subset of physicians have received these reports.

We are concerned that CMS may not intend to provide such reports or their equivalent to all the EPs potentially subject to the VM. As noted earlier, it is not clear that such reports or their equivalent will be made available to non-physician EPs. It is not even clear that CMS intends to provide such reports or their equivalent to all physicians subject to the VM, including doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry and chiropractors. Suffice it to say that failure to make QRUR or equivalent information available to all EPs that would be subject to the VM would place some EPs at a distinct disadvantage. As we noted earlier, we believe this provides at least one reason for deferring the application of the VM to non-physician EPs for CY 2017, which CMS clearly has the authority to do. With respect to the QRURs themselves, Premier believes that the early availability of mock reports would be extremely useful to all stakeholders. **CMS should make QRURs available to all EPs who are subject to the VM and in a timely fashion.**

Medicare Shared Savings Program

CMS proposes to apply the VM to physician and nonphysician EPs participating in the MSSP, the Pioneer ACO Model, the Comprehensive Primary Care (CPC) Initiative, or other similar CMS initiatives in CY 2017. While CMS proposes to continue to use the MSPB in calculating the cost composite for all EPs starting with the CY 2017 VM, it creates an exception for MSSP EPs where they would be deemed of “average cost.”

Premier does not support the application of the VM to physicians or other EPs participating in the MSSP, Pioneer ACOs, and other like initiatives for CY 2017. We believe that the general waiver authority granted by Congress under the MSSP and the provision authorizing the Center

Ms. Marilyn Tavenner

August 29, 2014

Page 44 of 46

for Medicare and Medicaid Innovation would allow CMS to continue to exempt EPs participating in these programs from the VM.

In addition, §1848(p)(5) of the Social Security Act states, “the Secretary shall, as appropriate, apply the payment modifier established under this subsection in a manner that promotes systems-based care.” We believe that the MSSP incentives parallel the VM and meet this standard of applying a payment modifier in a manner that promotes system-based care. Arguably, it does so better than the proposed VM. As it is, CMS is proposing policies that would have the effect of treating EPs in such programs quite differently from other EPs because CMS acknowledges that these programs differ in significant ways from the traditional Medicare fee-for-service (FFS) program.

As CMS notes, the quality metrics for the Pioneers and CPC Initiative participants are not comparable, and the spending calculations across Pioneer, CPC Initiative and MSSP are not comparable. Thus, CMS proposes to deem EPs participating in Pioneer and CPC Initiative as “average quality” and those programs plus MSSP as “average cost” under various scenarios, meaning that such EPs would never be eligible for the maximum rewards (or penalties) provided under the VM methodology. Putting these providers in the game, but dulling its effects seems counter productive and duplicative to the incentives inherent to the existing programs. As if CMS is trying to shave the corners off a square to fit it in a round hole. We question whether this will further the goal of system-based care, or unduly complicate and already difficult transition to population health.

Inclusion of these EPs will be difficult for providers to follow and verify, and very difficult for CMS to administer. Moreover, with no information provided publicly on the testing of the proposed policy changes and impact on EPs (which may also mean on beneficiaries) we do not believe these changes are ready for implementation. In the early years of this program, especially when the cost composite measure needs significant refinement, CMS should err on the side of greater simplicity to minimize unintended consequences. CMS should not unnecessarily complicate the program, or rely on band aid solutions, to force this different subset of providers into the VM so early in the program. **CMS should not include EPs participating in MSSP, Pioneer and other like initiatives in the VM at this time recognizing that these programs already include the VM concept. However, if CMS maintains their participation, it should alter its proposal to allow positive adjustments only, where calculable, as it did for the first year of participation for all other participants.**

ACO Dissolves

We believe CMS needs to consider in its scenario planning the situation when an ACO dissolves mid-year (no legal entity remains) and is thus unable to satisfactorily report as an ACO through the GPRO web interface. These providers should not automatically get a PQRS and VM penalty. Many of the providers would have reported two ways to protect themselves from such a possibility, but CMS will not allow this. Thus, if the legal entity is no longer in existence and cannot submit the quality measures, CMS should allow them to elect another option within the given timeline requirements for the year for them to report. **CMS should allow the group to report individually through claims or QCDRs, or elect group options if prior to the appropriate deadlines.**

Measures included in the VM

Similar to our comments above on the pay-for-performance system within the MSSP, we believe measures should be part of the PQRS system first as pay-for-reporting for two years before they are used within the pay-for-performance under the VM. Clinicians need time to get used to collecting and reporting the data, and CMS needs time to ensure comparable measurement across disparate clinicians reporting through numerous mechanism. It is still not clear how CMS will combine the data from all of these different reporting options into a cohesive scoring system. Thus, there is no need to rush measures into the VM. **CMS should only include measures in the VM once they have been a part of the PQRS for at least a year, preferably two.**

Measures included in the VM

It is not yet clear how CMS will combine the measures from the disparate reporting methods as part of the VM. It will be challenging to create a composite that creates comparable scores across EPs when such different measures are used. This is especially true of the QCDR measures that are primarily customized. **CMS should provide additional information on how the VM composite will be calculated to stakeholders throughout the year via webinars and other means.**

Ms. Marilyn Tavenner
August 29, 2014
Page 46 of 46

CONCLUSION

In closing, the Premier healthcare alliance appreciates the opportunity to submit these comments on the CY 2015 Physician Fee Schedule proposed rule including MSSP provisions. Please do not hesitate to contact Danielle Lloyd, vice president for policy development and analysis, at 202.879. 8002 or danielle_lloyd@premierinc.com if you would like to discuss further.

Sincerely,



Blair Childs
Senior vice president, Public Affairs
Premier, Inc.