American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

January 24, 2014

George Isham, M.D., and Elizabeth McGlynn, Ph.D.
Co-Chairs, Measure Applications Partnership
c/o National Quality Forum
1030 15th St NW, Suite 800
Washington, DC 20005

RE: Measure Applications Partnership Pre-Rulemaking Draft Report, January 2014

Dear Drs. Isham and McGlynn:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Measure Applications Partnership's (MAP) January 2014 pre-rulemaking report. The AHA continues to strongly support the premise of the MAP's work – that is, improvement in our nation's health care system can be catalyzed by selecting quality measures for federal reporting and payment programs that are focused on aspects of care that a broad array of stakeholders believes to be critically important.

We also continue to believe that the MAP must play an aggressive role in fostering alignment among quality reporting and payment programs across care settings and programs. Broadly defined, alignment means that measurement priority areas are the same across payment programs, and that the decision to use particular measures in a particular program is driven by a consistent set of principles. It could mean, if appropriate, using the same measure in different programs. However, it also may mean using measures that assess different providers' responsibilities in achieving an overall desired goal. At a time when health care resources are under intense scrutiny, an aligned, focused approach to quality measurement and pay-for-performance programs can ensure that such programs are targeted at a precious few priority areas that will truly drive the most meaningful improvements across the health care delivery system.

The AHA is concerned that the MAP's approach to alignment has become too focused on ensuring the exact same measures are recommended for more than one program, rather than an assessment of whether measures truly address overarching health care system-wide improvement priorities. We agree that using the same measure in more than one program can promote alignment, but only to the extent that those measures generate reliable, accurate

performance results in more than one care setting. Moreover, providers along the care continuum often play complementary, but differing roles in advancing care, which may necessitate differences in measures.

Thus, the AHA urges the MAP to broaden its assessment of alignment to consider whether measures in programs address a consistent set of measurement and improvement priorities across the health care system. To provide a reference point for making such an assessment, we urge the MAP to identify, in collaboration with federal partners and other stakeholders, a small number of specific national priority areas for measurement each year, and recommend those measures that best address them.

While ensuring alignment is an essential goal of the MAP process, we also believe federal programs must use only measures that have sufficient reliability and validity to generate performance information that is accurate. As the Centers for Medicare & Medicaid Services (CMS) constructs its annual list of Measures Under Consideration (MUC) for the MAP's review, we believe the agency should include only those measures that generate accurate, meaningful data, are feasible to collect, and that do not carry negative unintended consequences.

For these reasons, the AHA is deeply concerned that many of the measures on this year's MUC list do not appear to be truly ready for public reporting or pay-for-performance applications. Indeed, of the 234 measures on this year's MUC list, only 20 percent (47 measures) are endorsed by the National Quality Forum (NQF). The MAP is not constituted in such a way nor given enough time to review measures and assess their technical properties. The MAP relies on NQF endorsement for this assessment, and when CMS presents measures that have not undergone such a review, it is asking the MAP to ignore the importance of knowing whether the measures being presented assess what they purport to assess.

Moreover, several measures – most notably, the readmission and mortality measures proposed for hospital programs – have significant flaws that must be addressed before they are considered appropriate for public reporting or pay-for-performance applications. Finally, CMS has proposed for inclusion in multiple programs several electronic clinical quality measures (eCQMs), but it has yet to demonstrate that hospital electronic health records (EHRs) can generate accurate data appropriate for both quality improvement and accountability. In fact, the available evidence at this point suggests the e-specified measures need a lot more work before they will be sufficiently reliable for public reporting or pay for performance.

The AHA offers the following recommendations to the MAP as it reviews its recommendations before submitting them to CMS, and to CMS as it considers which of the MAP's recommendations to adopt through formal rulemaking and as it selects measures for future MUC lists:

- CMS should include on the MUC list measures that are NQF-endorsed or that will at least have undergone a Steering Committee review to assess their reliability, validity and importance prior to the MAP meeting;

- The MAP should recommend that CMS suspend or remove the stroke mortality and readmissions measures from the inpatient quality reporting (IQR) program until the measures adequately account for stroke severity;

- The MAP should urge CMS not to proceed with the addition of the hospital-wide all-cause, all-condition readmission measure into the Hospital Readmission Reduction Program (HRRP) until it has fully addressed the question of whether the *Patient Protection and Affordable Care Act* (ACA) allows for the inclusion of a measure that is not condition-specific, it has analyzed the potential impact and fully understood the implications of including such a measure, and until there is an adequate adjustment for socioeconomic factors; and

- CMS should present eCQMs to the MAP with stronger data demonstrating their readiness to implement in programs.

ENHANCING THE MAP'S APPROACH TO ALIGNMENT

The AHA strongly believes that all federal quality measurement and reporting programs should be aligned around a common set of national priorities for quality improvement. The MAP's statutory mandate to review all quality measures being considered for federal programs affords it a unique opportunity to look across programs and measures, identifying the health care delivery system's best opportunities for aligned measurement. In this year's pre-rulemaking report, the MAP bases much of its assessment of progress on achieving alignment on the number of measures currently finalized in CMS programs and on the MUC list that appears in multiple programs. We agree that this type of analysis can signal whether federal programs are focusing on the ***same*** quality topics and issues.

However, the analysis provides limited indication of whether the measures are actually focused on the ***highest priority*** areas that must be improved across the health care system. Moreover, this type of analysis fails to consider whether measures selected for each setting are aligned to achieve an overall improvement goal. Indeed, each provider along the care continuum often contributes to an overall improvement goal in a different way. For example, while a hospital's role in improving heart attack outcomes is to provide acute interventions (e.g., surgery), an inpatient rehabilitation facility's work will be oriented toward restoring daily activities and functions (e.g., ability to walk). For that reason, while overall quality improvement goals may be the same, the measures used in each care setting may need to vary to account for the different goals of care in each setting, as well as differences in data collection processes.

Thus, the AHA urges the MAP to broaden its assessment of alignment to consider whether measures in programs address a consistent set of measurement and improvement priorities across the health care system. The key to making such an assessment possible is the prioritization of several tightly scoped, actionable areas for improvement in which strong, measures appropriate to the care setting are available to drive improvement across care settings and programs.

We also recommend that the MAP work with the National Priority Partnership, CMS and others to identify the top three to five priority areas for measurement each year. These priorities would provide more focus and direction for the MAP's measure selection efforts, and help it identify whether existing measures and measures under consideration are addressing the most important issues. High-level quality measurement and improvement priorities have been outlined in the National Quality Strategy (NQS). However, we recommend that the MAP select a limited number of elements within a priority area to address aggressively each year with available measures.

NQF ENDORSEMENT IS A FUNDAMENTAL STEP

The AHA has repeatedly and consistently urged CMS to use only NQF-endorsed measures in federal quality reporting programs, and is deeply concerned that only 47 of the 234 measures (or 20 percent) on this year's MUC list are NQF-endorsed. In our comments on the January 2013 MAP pre-rulemaking report, the AHA recommended that the MAP use a gradual, step-wise process to add measures into public reporting and pay-for-performance programs, the first step of which is NQF endorsement. We believe the very first step in bringing a measure into a national reporting or pay-for-performance program – even before putting the measure on the MUC list – should be to obtain NQF endorsement. NQF endorsement provides a baseline assurance that the measure has been tested, can reliably and accurately collect data, is feasible to implement, and is usable.

In advocating for the use of only NQF-endorsed measures, we appreciate that there are important measurement gaps in all federal programs that do not yet have NQF-endorsed measures to fill them. CMS appears to have addressed the issue of measure gaps by placing many partially developed, non-NQF endorsed measures on this year's MUC list. During the work group discussions, CMS indicated that obtaining the MAP's input on measures still under development is of value because it can help identify issues that can be addressed before the development process is complete, and presumably, before measures become part of federal programs.

The AHA is concerned that using the MAP process to vet partially developed, unendorsed measures does not produce the well-considered and thoughtful recommendations that CMS is seeking. When a measure on the MUC list lack NQF endorsement, the MAP's workgroups must guess at whether it is be reliable and valid, whether its risk adjustment and other properties are be appropriate, and therefore, whether it is appropriate for inclusion in a program. The MAP simply cannot make informed recommendations when it lacks this vital information. The time spent by MAP workgroups considering a measure's fundamental soundness also takes time away from the evaluation of whether a measure aligns with national priorities and works in complementary fashion with measures in other programs to best encourage improvement.

We do not believe the MAP's deliberations are a substitute for the full consideration of measures in the NQF endorsement process, nor do we believe it is appropriate to ask the MAP to recommend or not recommend a measure when all they know about it is its title. Endorsement committees include multiple stakeholders, but also typically include individuals with considerable clinical and quality measurement expertise in a given topic area. The

endorsement process also uses NQF's rigorous criteria to evaluate whether a measure can meet quality improvement or accountability purposes**.**

Lastly, we are concerned that placing partially developed, unendorsed measures on the MUC list may force the MAP to make premature judgments of the suitability of measures for federal programs. Indeed, under its existing process, the MAP may support a measure conditional on it receiving NQF endorsement, but it does not have an opportunity to reevaluate the measure based on the results of the endorsement process. The endorsement process may uncover limitations of measures when used on certain patient populations or by type of provider. For example, a measure under consideration for long-term acute care hospitals (LTCHs) could be endorsed for "hospital-level" reporting. But, the endorsement process may demonstrate that the measure is less reliable when applied to the patient population served by LTCHs. This type of information would be indispensable in judging the appropriateness of a measure for a public reporting program, but would be unavailable at the time the measure is presented to the MAP.

For these reasons, we strongly urge CMS to place partially developed, unendorsed measures onto the MUC list on an exceptional basis, for instance, to meet a time-sensitive statutory deadline. Moreover, CMS should ask the MAP to re-review any measures it supported conditional on NQF endorsement so that it can consider any important findings from the NQF endorsement process. By sharply curtailing the number of partially developed measures on the MUC list, and by giving the MAP the opportunity to reconsider measures based on NQF deliberations, we believe the agency will make the highest and best use of the MAP's very limited time to process the MUC list.

CMS MUST IMPROVE STROKE OUTCOME MEASURES

The MAP was asked to provide input on whether two stroke outcome measures – readmissions and mortality within 30 days of hospital discharge – should be removed from the Hospital IQR program. **The AHA remains strongly opposed to the inclusion of either measure in any federal program until adequate adjustment for stroke severity can be made.** In opposing these two measures, we do not diminish the importance of including measures in national programs that accurately reflect stroke outcomes. Rather, we do not believe these particular measures are up to the task of providing accurate information that patients can use to evaluate hospital performance, and that hospitals can use in improvement efforts.

These two measures were submitted to NQF as part of the 2012 Neurology Endorsement project. However, both measures were subsequently withdrawn from the project by the measure developers after significant criticism was offered by members of the steering committee, and therefore failed to receive NQF endorsement. During the endorsement project, the steering committee noted significant concerns about both measures. Most notably, neither measure includes an adjustment for the severity of a stroke, which is the most important determinant of clinical outcomes. Stroke severity can be measured using the National Institutes of Health Stroke Scale (NIHSS). However, the measure does not incorporate an adjustment based on the NIHSS or any other indicator that differentiates stroke severity.

A recently published Journal of the American Medical Association article underscores the necessity of incorporating an adjustment for stroke severity. Indeed, the study re-modeled the stroke mortality measure by incorporating the NIHSS into the measure risk adjustment model.[1] Nearly 58 percent of the hospitals identified as having "better than" or "worse than" expected risk-standardized mortality using the measure with stroke severity adjustment would be reclassified to "as expected mortality" using CMS's non-severity adjusted measure. **This troubling result underscores the inability of the proposed measure to differentiate meaningfully hospital performance, and demonstrates that it is not appropriate for a national quality reporting or payment program.**

In response to these concerns, CMS provided the MAP with supplemental analysis discussed during the MAP Hospital Workgroup and Coordinating Committee meetings. CMS contends that it would be infeasible to use the NIHSS in conjunction with its current measures because obtaining NIHSS data require manual chart abstraction; the current stroke measures are reported using only Medicare claims data. Moreover, the agency argues that a severity adjustment is unnecessary for two reasons. First, CMS indicates that it has found that the results generated from the existing claims-based measures are "highly correlated" with results obtained from manual chart abstraction. Second, the agency presented the MAP with an analysis suggesting that hospitals certified as Stoke Centers by The Joint Commission (TJC) have a distribution of performance that is very similar to other facilities. CMS believes these results suggest that stroke centers – which may be reasonably expected to care for a higher severity of stroke patients – are not unfairly disadvantaged by the measures.

We believe CMS's analysis of the performance of stroke centers on the measures actually supports the need for a severity adjustment. CMS did not provide the MAP with an empirical analysis to support its claim that measure results from its existing claims-based measures are highly correlated to the results from chart abstraction. We also would not expect that TJC stroke centers would have a performance distribution so similar to all other facilities. Indeed, TJC-certified stroke centers are required to implement many policies and care processes demonstrated to improve stroke outcomes.[2] CMS also notes that stroke patient volumes drive particularly high and particularly low (i.e., outlier) performance for both stroke centers and other hospitals. However, we would expect that volume would drive outlier performance on these measures because they use a risk adjustment methodology, known as hierarchical linear modeling, in which facilities with higher volumes have a stronger effect on their own performance. In short, the fact that the distribution of measure performance is no different between stroke centers and non-TJC certified facilities suggests the measure risk adjustment approach is inadequate.

[1] Fonarow et al. *Comparison of 30-Day Mortality Models for Profiling Hospital Performance in Acute Ischemic Stroke With versus Without Adjustment for Stroke Severity*. JAMA. 2012;308(3):257-264. Available at: http://jama.jamanetwork.com/article.aspx?articleid=1217240.

[2] The requirements for Joint Commission certified Primary Stroke Centers can be accessed at http://www.jointcommission.org/certification/primary_stroke_centers.aspx

ALL-CAUSE, ALL-CONDITION READMISSION MEASURE MAY UNFAIRLY INCREASE HOSPITAL PENALTIES

The MAP was asked to provide input on the suitability of CMS's all-cause, all-condition readmissions measure for the HRRP. The existing measures in the HRRP are condition-specific – that is, they measure readmissions rates for patients with heart failure, acute attacks, pneumonia, total hip and total knee arthroplasties, and chronic obstructive pulmonary disease (COPD). By contrast, the hospital-wide all-cause readmission measure generates a summary readmission rate for hospitals across nearly all clinical conditions.

The AHA does not believe it is appropriate to include the hospital-wide readmission measure in the HRRP at this time for several reasons. First, the public reporting of this measure commenced on Dec. 12, 2013, the second day of the Hospital Workgroup meeting. The field has had limited opportunity to understand the drivers behind the distribution of performance, the usability of the measure in improving performance and any potential unintended consequences of public reporting.

Second, we are concerned that the use of an all-cause, all condition readmission measure is inconsistent with the statutory intent of the ACA. The statutory language of the ACA appears to call for the use of condition-specific measures in the HRRP. Indeed, section 1886(q)(5)(B) states that the HRRP may be expanded to include "other *conditions and procedures* as determined appropriate by the Secretary" of Health and Human Services.[3] Thus, a hospital-wide readmission measure is likely outside the legislative authority of CMS to implement, and if it were implemented, would almost certainly have to be used in conjunction with the condition-specific measures already in the program in order to comply with the statute.

At a minimum, using the hospital-wide measure and condition-specific measures would create confusion among hospitals and the public as to which measures most meaningfully reflect hospital performance. **Moreover, a single readmission could be counted twice towards a hospital's performance, thereby increasing the likelihood of hospitals incurring a penalty.** Unfortunately, CMS has not articulated a plan for how the all-cause measure could be used in the HRRP without unfairly penalizing hospitals.

Lastly, the AHA remains very concerned that the all-cause, all condition readmissions measure, along with all of CMS's other readmission measures, does not adequately adjust for socioeconomic factors beyond the control of hospitals. In reiterating this concern, we appreciate that both CMS and NQF have engaged stakeholders in discussions about whether, when and how performance measures should be adjusted for socioeconomic factors. The AHA is pleased that NQF, with support from CMS, recently convened a multi-stakeholder expert panel to provide recommendations on this critically important issue. **We urge CMS to adopt the recommendations of the NQF expert panel in implementing its readmission measures and any other measures for which socioeconomic adjustment is appropriate.**

[3] Emphasis added.

All hospitals, regardless of the circumstances they face, aim to provide the highest quality of care to the patients and families that rely on them. However, there are numerous studies demonstrating that higher readmissions rates are linked to various markers of lower socioeconomic status (SES). For example, a 2012 systematic review of more than 70 articles examining various factors associated with readmissions concluded that "low socioeconomic status (Medicaid insurance, low income), living situation (home stability rural address), lack of social support, being unmarried and risk behaviors (smoking, cocaine use and medical/visit non-adherence)" all were associated with higher heart failure readmission rates.[4] Similarly, researchers from the Harvard School of Public Health studied the degree to which variation in readmission rates for congestive heart failure was explained by different community factors, and found that "supply-side variables (physician and bed supply in a community) were most important (explaining 17% of the variation) followed by socioeconomic characteristics of the community (poverty rate and racial makeup) at 9%. Differences in hospital quality explained 5% of the variation in readmission rates and differences in case mix explained 4%."[5] The study concluded that "community-level socioeconomic variables and supply-side variables play a much greater role in explaining variation in readmissions than quality of hospital care or underlying sickness of people." [6]

While we absolutely agree that hospitals should do all within their power to care for and assist the patients in challenging circumstances, we do not believe they should suffer financial penalties due to community factors beyond their control. The experience of many of our members indicates that collaborations with services in communities are critically important to reducing readmissions. Yet, forming these collaborations is much more challenging for hospitals if their communities lack primary care providers, pharmacies, mental health services, physical therapy and other rehabilitative services with whom they can work. Communities also may lack of public transportation (which can affect access to medical care), or have inconsistent access to appropriate foods for patients requiring restrictive diets.

Early experience from the implementation of the HRRP demonstrates that hospitals caring for the most economically disadvantaged patients were most likely to receive readmissions penalties. A 2012 Commonwealth Fund analysis found that hospitals in the top 25 percent of the disproportionate share hospital (DSH) payments have 30-day hospital readmission rates that are approximately 30 percent above the national average for heart attack, heart failure and pneumonia.[7] As a result of this finding, Kaiser Health News found that 12 percent of hospitals that fall into the top quartile of the DSH patient percentage were scheduled to receive the maximum readmissions penalty from CMS starting in FY 2013. In contrast, only 7 percent of hospitals in the bottom quartile of the DSH patient percentage were projected to receive the

[4] Calvillo-King L, et al Impact of social factors on risk of readmissions or mortality in pneumonia and heart failure: systematic review. JGIM (2012): 1 - 14
[5] Joynt K, Orav EJ, Jha AK Impact of community factors on readmission rates. *Circ Cardiovasc Qual Outcomes. 2012;5:A12* (Abstract presented at the Quality of Care and Outcomes Research in Cardiovascular Disease and Stroke 2012 Scientific Sessions)
[6] Joynt K, Orav EJ, Jha AK Impact of community factors on readmission rates. *Circ Cardiovasc Qual Outcomes. 2012;5:A12* (Abstract presented at the Quality of Care and Outcomes Research in Cardiovascular Disease and Stroke 2012 Scientific Sessions)
[7] Berenson, Julia and Anthony Shih. *Higher Readmissions at Safety-Net Hospitals and Potential Policy Solutions.* The Commonwealth Fund. December 2012.

maximum penalty. [8] Recent data from the fiscal year (FY) 2014 inpatient prospective payment system (IPPS) final rule (shown below) confirms that this trend has continued. Indeed, hospitals in higher DSH deciles are much more likely to incur a penalty. **Adding another measure to the HRRP that fails to adjust for socioeconomic factors will only accelerate these troubling trends.**

DSH Decile	Number of Hospitals	Penalty Up to 1%	Penalty between 1% and 2%	2% Penalty	Total Penalized Hospitals	Number of Hospitals without Penalties
1st -10th	336	116	2	2	120	216
11th – 20th	336	204	11	0	215	121
21st – 30th	336	202	16	1	219	117
31st – 40th	336	205	19	1	225	111
41st – 50th	336	203	17	0	220	116
51st – 60th	336	219	14	3	236	100
61st – 70th	336	218	12	3	233	103
71st – 80th	336	213	25	3	241	95
81st – 90th	336	240	16	3	259	77
91st – 100th	335	234	21	2	257	78
Total	**3,359**	**2,054**	**153**	**18**	**2,225**	**1,134**

Source: CMS, FY 2014 IPPS Final Rule

The agency presented the MAP Hospital Workgroup and Coordinating Committee with several analyses that, it contends, confirm that any adjustment for socioeconomic status (SES) is unnecessary. However, the AHA believes that some of these analyses actually confirm the need for such adjustments. CMS provided the MAP with an analysis that compares the readmission rates of hospitals caring for high proportions of Medicaid patients with those caring for lower proportions. CMS surmises that the proportion of Medicaid patients is a useful proxy for low SES because the Medicaid program is intended to provide insurance to poorer patients. In assessing the all-cause, all-condition readmission measure, the analysis concludes that while hospitals with high proportions of Medicaid patients "achieved a similar range" of readmissions rates compared with hospitals with low proportions "*the range was shifted toward poorer performance for hospitals with high proportions of Medicaid…patients."* (emphasis added).

We have repeatedly recommended that CMS consider using dual-eligible status as an adjustment factor in the short term. Dual-eligible status is a powerful predictor of readmission risk and is a factor that is readily available to CMS. A hospital's proportion of dual-eligible patients reflects that hospital's share of impoverished *Medicare* patients, and since the readmission measures include only Medicare beneficiaries, an adjustment based on hospitals' proportion of dual-eligible beneficiaries is appropriate and will enable fairer comparisons of performance among hospitals.

[8] Rau, Jordan. *Hospitals Treating the Poor Hardest Hit by Readmissions Penalties.* Kaiser Health News. August 13, 2012 (Updated October 13, 2012).

SELECTING THE RIGHT ELECTRONIC CLINICAL QUALITY MEASURES

The AHA is pleased that CMS asked the MAP to assess eCQMs it is considering for several program. However, the MAP's discussion highlighted the implementation challenges hospitals face in extracting data from EHRs to support measurement needs. Several members of the hospital workgroup expressed concern that they had less information about the readiness of eCQMs for public accountability applications than the chart and claims-based measures on the MUC list for other programs.

Such information is critical given the significant promise and peril of eCQMs. A major positive benefit of the movement toward adoption of EHRs should be greater ease in calculating and reporting quality of care measures for hospitals to use in their performance improvement efforts, to report to federal and other payment programs, and share to the insight with consumers. Unfortunately, for Stage 1 of meaningful use, a rushed policy process and immature technology has led to time-consuming efforts by hospitals to generate quality data.[9] Capturing the measure data has added significantly to clinicians' workload with no perceived benefit to patient care. The specifications for Stage 2 were revised months after their initial publication due to errors.

To ensure a safe and credible transition from chart-abstracted measures to eCQMs, we urge CMS to provide the MAP with additional data that allow the MAP to assess the scientific validity of eCQMs, their comparability to chart-abstracted measures and their readiness for inclusion in quality reporting and payment. We continue to believe that NQF endorsement is as necessary for eCQMs as it is for any other type of measure. As with other types of measures, CMS should ask the MAP to re-review any eCQMs that have received "conditional support" once they have undergone NQF endorsement review. Indeed, the move to electronic data collection and electronic reporting of measures does not require a diminution of the criteria used to verify the validity, feasibility and reliability of the measures.

The AHA also strongly urges CMS to utilize fully the MAP's input for anticipated Stage 3 meaningful use rulemaking. CMS indicated that the six hospital meaningful use measures reviewed by the MAP this cycle are under consideration for potential inclusion in Stage 3 of the program with a start date in 2017. Given the regulatory rulemaking cycle of the EHR Incentive Program, any eCQMs that may be considered for inclusion in a future Stage 3 also could be considered during the 2015 MAP review of measures and remain timely for inclusion in Stage 3 prior to the publication of a final rule in mid-2015. The additional time will enable the measure developers to complete the specifications and undertake some testing which would inform a consideration of the specification and technology readiness to support the efficient generation of accurate eCQMs.

[9] Many of these challenges are explained in greater detail in an AHA-commissioned study of hospital experiences with Stage 1 of Meaningful Use. A summary, along with the full study, are available at http://www.aha.org/research/policy/ecqm.shtml.

Thank you for the opportunity to comment. If you have questions, please contact me or Akin Demehin, senior associate director for policy, at (202) 626-2365 or ademehin@aha.org.

Sincerely,

/s/

Linda E. Fishman
Senior Vice President, Public Policy Analysis and Development

cc: Patrick Conway, MD, Centers for Medicare & Medicaid Services
Kate Goodrich, MD, Centers for Medicare & Medicaid Services