



**American Hospital
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March 1, 2016

Kate Goodrich, M.D.
Director, Center for Clinical Standards and Quality
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

RE: Draft CMS Quality Measure Development Plan: Supporting the Transition to the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs)

Dear Dr. Goodrich:

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 Centers for Medicare & Medicaid Services' (CMS) draft Measure Development Plan (MDP) for the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). The draft MDP was developed both to meet the requirements of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 and to describe the agency's framework for measure development to support the implementation of the new MIPS and APMs that will affect Medicare physician fee schedule (PFS) payments beginning in 2019.

The AHA agrees with several of the goals, strategies and priorities identified in the draft MDP, and we applaud the plan's comprehensiveness. As CMS continues its measure development efforts to support the MIPS and APMs, we urge the agency to be particularly attentive to the following issues:

- CMS should ensure measure development areas are aligned with concrete national priority areas across the health care system.
- CMS should make more information about its measure development pipeline publicly available so that all stakeholders have greater insight into CMS's efforts to fill gap areas.
- CMS should support the development of a MIPS reporting option for hospital-based physicians.
- CMS should examine the impact of sociodemographic factors on both existing measures and measures under development, incorporating adjustments when necessary and appropriate.



Below we provide additional feedback on each of these areas.

Alignment with National Priorities. **The AHA urges CMS to use the implementation of the MIPS and APMs as an opportunity to streamline and focus physician quality measurement efforts so they align with concrete national priority areas for improvement across the entire health care system. This effort should include both quality measure development and measure selection for programs.** There are more than 250 individual measures in the current-law Physician Quality Reporting System (PQRS) and Value-based Payment Modifier (VM) programs that affect payment for calendar year (CY) 2017. While the volume of measures stems partially from the need to have measures relevant to the variety of specialties participating in these programs, we are concerned that measures have proliferated without a well-articulated link to specific national priorities or goals. Regardless of the specialty, the significant improvement in outcomes and health that patients expect and deserve is best achieved when *all* parties in the health care system are working toward the achievement of the same objectives. To achieve this desired state, we have repeatedly urged CMS to identify concrete, actionable national goals for quality improvement, and to use those goals to select a small number of reliable, accurate and care-setting appropriate measures to ensure each relevant part of the health care system contributes to the overall goals.

The AHA commends CMS for considering how to use the National Academy of Medicine’s (NAM) *Vital Signs* report in the implementation of the MIPS and APMs. We urge the agency to use the report’s recommendations to identify the highest priority measures for development. The *Vital Signs* report notes that progress in improving the quality of health care has been stymied by discordant, uncoordinated measurement requirements from CMS and others. To ensure that all parts of the health care system – hospitals, physicians, the federal government, private payers and others – are working in concert to address priority issues, the *Vital Signs* report recommends 15 “Core Measure” areas, with 39 associated priority measures. These areas represent the current best opportunities to drive better health and better care, based on a comprehensive review of available literature. Each stakeholder would be measured on the areas most relevant to their role in achieving common goals and objectives.

CMS should examine which of the NAM core measure areas are most relevant to physician quality measurement efforts, identify available measures that already may address these areas, and develop measures for gap areas. The NAM core measure areas that appear most relevant to physicians are patient safety, preventive services, evidence-based care and care matched with patient goals.

The AHA also encourages CMS to incorporate the NAM *Vital Signs* report’s recommendations into the work of the recently launched Core Measures Collaborative (CMC). The CMC achieved an important step forward by reaching consensus on several sets of physician quality measures that could be used both in CMS programs and private insurance contracts. The use of common measures should lead to a reduction in duplicative data collection and reporting efforts. However, reaching agreement on common physician measures is just the beginning. As called for in the *Vital Signs* report, the alignment of overarching quality goals and priorities across the health care system is critical to driving collective action and progress on

improving our nation's health. We encourage the CMC to evaluate how the common measures it identifies align with the priority area identified in the *Vital Signs* report. As partners with all physicians practicing in their facilities, hospitals and health systems stand ready to work with the CMC and CMS on this effort.

Measure Development Pipeline. The AHA encourages CMS to make publicly available more information on its measure development pipeline. The draft MDP includes a table with the counts of measures by specialty area and domain of the National Quality Strategy. While this data on the current state is useful, the draft MDP lacks information on measure development efforts that are either under way or planned for the near future. Additional information on measures farther down the pipeline would help all stakeholders understand whether the agency has imminent plans to fill any areas it considers as gaps, and how much time it may take to fill those gaps.

Hospital-based Physician Reporting Option. The AHA applauds CMS's interest in assessing options to allow for facility-based physicians to use their facility's quality measure performance in the MIPS quality and resource use domains. The AHA has long supported PQRS and VM participation options for hospital-based physicians where their reporting and performance is based on measure data from CMS hospital quality reporting and pay-for-performance programs. For hospitals and physicians alike, greater integration represents the potential to better align goals and processes across the care continuum.

The AHA recommends that CMS allow physicians and groups to self-designate whether they qualify as hospital-based. CMS could allow physicians to self-designate hospital-based status through a process similar to how physician group practices currently self-designate for the group practice reporting option (GPRO) in PQRS. If needed, the agency could set parameters that ensure a strong relationship between a physician and hospital. For example, CMS could require active membership on the medical staff or an employment contract. The agency could potentially validate the relationship using claims data elements, such as inpatient and hospital outpatient department place of service codes.

Sociodemographic Adjustment. The AHA strongly urges CMS to examine the impact of sociodemographic factors on performance measures used in the MIPS and APMs, and incorporate sociodemographic adjustment when necessary and appropriate. The evidence continues to mount that sociodemographic factors beyond providers' control – such as the availability of primary care, physical therapy, easy access to medications and appropriate food, and other supportive services – influences performance on outcome measures. For example, in January 2016, NAM released the first in a planned series of reports that identifies “social risk factors” affecting the health outcomes of Medicare beneficiaries, and methods to account for these factors in Medicare payment programs. Through a comprehensive review of available literature, the NAM's expert panel found evidence that a wide variety of social risk factors may influence performance on certain health care outcome measures such as readmissions, costs and patient experience of care. These community issues are reflected in readily available proxy data on socioeconomic status, such as U.S. Census-derived data on income and education level, and

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claims-derived data on the proportion of patients dually eligible for Medicare and Medicaid. Yet, to date, CMS has resisted calls to incorporate sociodemographic adjustment.

Unfortunately, failing to adjust measures for sociodemographic factors when necessary and appropriate can harm patients and worsen health care disparities by diverting resources away from physicians, hospitals and other providers treating large proportions of disadvantaged patients. It also can mislead patients, payers and policymakers by blinding them to important community factors that contribute to poor outcomes. Physicians, hospitals and other providers clearly have an important role in improving patient outcomes and are working hard to identify and implement effective improvement strategies. However, there are other factors that contribute to poor outcomes. If quality measures are implemented without identifying sociodemographic factors and helping all interested stakeholders understand their role in poor outcomes, then the nation's ability to improve care and eliminate disparities will be diminished.

Thank you for the opportunity to comment. We look forward to continuing to work with you to ensure CMS measure development efforts help MIPS and APMs realize their potential to transform health care delivery. 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/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development