Consumer-Purchaser
ALLIANCE
Better information. Better decisions. Better health care.

September 6, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: CMS-1654-P: Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017

Dear Administrator Slavitt:

The Consumer-Purchaser Alliance is a collaboration of leading consumer, labor, and employer organizations committed to improving the quality and affordability of health care through the use of performance information to guide consumer choice, payment, and quality improvement.[1] We appreciate the opportunity to provide input on the proposed changes to the Physician Fee Schedule and other Part B payment policies and focus our comments on the proposed changes to the Medicare Shared Savings Program (MSSP).

The Accountable Care Organization (ACO) is a relatively new model of delivering and paying for care that is gaining significant traction in the marketplace: as of January 2016, there are 838 active ACOs across the country.[2] A well-designed and well-implemented ACO should improve both quality and cost of care through better coordination and collaboration driven by shared financial accountability for a defined patient population.

CMS plays an integral role in the design and proliferation of ACOs. We applaud the agency's leadership in this area and ask for continued leadership to drive quality improvement, care coordination, and cost savings. Below, we provide comments and recommendations on the proposed changes for areas of particular importance to consumers and purchasers.

[1] For brevity, we refer in various places in our comments to "patient" and "care," given that many Medicare Part B programs are rooted in the medical model. People with disabilities frequently refer to themselves as "consumers" or merely "persons." Choice of terminology is particularly important for purposes of care planning and care coordination, when the worlds of independent living and health care provider often intersect.

[2] Muhlestein M, McClellan M. Accountable Care Organizations In 2016: Private And Public-Sector Growth And Dispersion. *Health Affairs blog*, April 21, 2016. Available at http://healthaffairs.org/blog/2016/04/21/accountable-care-organizations-in-2016-private-and-public-sector-growth-and-dispersion/.

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Proposed Modifications to Performance Measures and Reporting Requirements

Performance Measures
Performance measurement is integral to improving care delivery and evaluating success. A high-impact measure set should drive quality improvement and be meaningful to consumers, purchasers, and other stakeholders. We remain concerned about the proportion of process measures included in the quality measure set. We strongly believe the measure set should focus on outcome measures, both clinical and patient-reported, and we urge CMS to advance its efforts to replace process with outcomes measures for the MSSP reporting requirements. Future sets of measures should also adopt a continually greater focus on measures of patient and caregiver experience, care coordination, and patient-reported outcomes (PROs).

We acknowledge and appreciate the work CMS has done to improve the MSSP measure set over time, particularly the continued movement toward higher value measures. Specifically:

- We support the addition of ACO-44, Use of Imaging Studies for Low Back Pain, as it addresses an important area of appropriateness and aligns with recommendations from the multi-stakeholder Core Quality Measures Collaborative.
- We support replacing ACO-39, Documentation of Current Medications in the Medical Record, with ACO-12, Medication Reconciliation Post-Discharge. The latter measure addresses a key piece of care coordination with post-acute care providers. In addition, the Core Quality Measures Collaborative recommends this measure for cross-program alignment.
- We support the inclusion of ACO-37 and ACO-38, two outcome measures that report on inpatient hospital admissions of patient with clinical conditions that could potentially be prevented with high-quality outpatient care.

Additional changes could further strengthen the measure set:
- We recommend expanding ACO-27, the Diabetes Composite, to go beyond HbA1C poor control and eye exam measures. Specifically, we recommend that CMS include NQF #0729, Optimal Diabetes Care, in the quality measure set as this composite includes controlling high blood pressure. Controlling high blood pressure is a critical element to achieving good care. While there is overlap with HTN: Blood Pressure Control, not including this element in the composite lowers the standard for diabetes care. Three Aligning Forces for Quality Communities – Cleveland, Humboldt and Minnesota – and the Integrated Healthcare Association use an optimal diabetes composite that includes blood pressure control.
- We remain very supportive of ACO-40, Depression Remission at 12 Months. CMS should consider adding the Depression Remission at 6 Months measure to the set as well.
- We encourage CMS to consider adding NQF #2483, Gains in Patient Activation Measure Scores at 12 Months, as a pay-for-reporting measure.

We strongly support CMS's proposed changes to the specifications of ACO-11, Use of Certified EHR Technology (CEHRT); we have long advocated for strengthening this measure beyond attestation to meaningfully assess the degree of CEHRT use. We applaud CMS for expanding the

relevant population under this measure to include all providers and suppliers, rather than just primary care providers.

However, we have concerns about the proposed implementation plan for the updated ACO-11. CMS proposes to expand ACO-11 beyond primary care physicians to include all eligible clinicians and to designate the measure as pay for reporting for all – PCPs and newly included clinicians alike – for the next two years. We suggest that CMS consider whether there are ways to proceed so that the measure remains a pay-for-performance measure for the primary care physicians who are already familiar with the measure and do not require additional time, and only newly included clinicians merely report for two years. Given that these newly eligible clinicians need only report, we have significant concerns with the further proposal that only one eligible clinician need meet the reporting requirements under the Advancing Clinical Information (ACI) category to achieve credit. For 2017, we strongly urge CMS to require at least 50 percent of the eligible clinicians billing through the TIN of an ACO participant to successfully report on ACO-11 to align with the Quality Payment Program's CEHRT criterion for Advanced APMs. Similarly, in the second year, CMS should update the reporting requirements to align with the CEHRT criteria for Advanced APMs.

Individual reporting by Eligible Professionals
Current MSSP regulations do not allow eligible professionals (EPs) billing through the Taxpayer Identification Number (TIN) of an ACO to independently report performance data outside of their ACO for PQRS. Under the current program design, individual clinicians and group practices are subject to financial penalties if the ACO they participate in fails to satisfy the PQRS reporting requirements. We support the proposed change to allow EPs that bill under the TIN of an ACO to report separately for the PQRS and Value Modifier payment adjustments if the ACO fails to report on behalf of its EPs. EPs should be given the opportunity to avoid financial penalties by individually submitting quality data.

Alignment of Reporting Requirements
Starting in 2019, the Quality Payment Program (QPP) will take the place of the current PQRS and EHR Incentive programs. CMS proposes that going forward, ACOs will be required to report all MSSP quality measures through the CMS Web Interface to satisfy reporting requirements for the quality performance category under the Merit-Based Incentive Payment System (MIPS), and any changes made to the CMS Web Interface measure set will be made through QPP rulemaking. We support requiring ACOs to report quality measures through the CMS Web Interface. As not all ACOs will qualify as Advanced APMs, the CMS Web Interface is a good mechanism for aligning the MSSP program reporting requirements with that of MIPS.

Voluntary Beneficiary Alignment

Under the current assignment process in MSSP, a beneficiary is eligible for assignment to an ACO if the claims data indicates that the beneficiary had a plurality of primary care services with an ACO participant. CMS is proposing to allow voluntary beneficiary attestation, in which beneficiaries provide input regarding which provider they believe is responsible for coordinating their overall care.

We support voluntary, active patient attestation over a claims-based approach, and applaud CMS for implementing this new approach for all three tracks of MSSP. We strongly support allowing beneficiaries to actively choose assignment and remain attributed despite billing patterns. However, before beneficiaries can be expected to elect into their chosen primary care provider's ACO, they must have access to materials that help them understand what the ACO model is, how the model of payment and care functions, what attestation means to them, and what their rights are with respect to accessing care from other providers. Communication should be linguistically and culturally appropriate, and tailored to the health literacy of patients and families. Such an outreach and education effort will require CMS, the ACO entity, and participating providers to take a more rigorous and focused approach to educating beneficiaries and meaningfully communicating with them, while also ensuring that communication is free of coercion.

SNF Waiver

We appreciate CMS's continued attention to and oversight of beneficiary protections when the Skilled Nursing Facility (SNF) 3-day rule is waived. We support the proposed protections to ensure that beneficiaries are not charged for a SNF stay if the ACO or SNF uses the waiver inappropriately. We believe strongly that beneficiaries should be held harmless as CMS, ACOs, and SNFs work out the details of the waiver and continue to improve on providing seamless care for beneficiaries transitioning to a SNF.

Thank you again for the opportunity to comment on the changes to this important program. As the health care system and its many stakeholders prepare for MACRA, the design and refinement of alternative payment models such as the MSSP are even more critical to the success of value-driven care. If you have any questions about our comments, please contact Stephanie Glier, Senior Manager for the Consumer-Purchaser Alliance, at sglier@pbgh.org.

Sincerely,

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