PREMIER TRANSFORMING HEALTHCARE TOGETHER®

April 16, 2021

Cheri Rice
Acting Deputy Administrator and Director of the Center for Medicare
Centers for Medicare & Medicaid Services

Dr. Lee Fleisher
Chief Medical Officer and Director of the Center for Clinical Standards and Quality
Centers for Medicare & Medicaid Services

Re: Medicare Shared Savings Program (MSSP) ACO Quality Reporting

Dear Acting Deputy Administrator Rice and Dr. Fleisher:

On behalf of the Premier healthcare alliance serving approximately 4,100 hospitals and health systems, hundreds of thousands of clinicians and approximately 200,000 other providers and organizations, we write to provide feedback on the recent quality reporting changes to the Medicare Shared Savings Program (MSSP).

Premier 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 hospitals and health systems, their employed physicians and independent physicians aligned with them. Premier runs the largest population health collaborative in the country, the Population Health Management Collaborative, which has worked with well over 200 Accountable Care Organizations (ACOs) and is currently comprised of more than 70 ACOs.

CMS finalized several fundamental changes to the MSSP quality performance standard which take effect in 2022. Premier supports the overall approach as we have long advocated for allowing ACOs to report measures through reporting mechanisms other than the CMS Web Interface and reducing the number of required measures. However, we believe the **adoption of these changes will require substantial time and resources to implement and will place significant burden on providers**, during a time in which they are still actively responding to the ongoing COVID-19 pandemic.

It is critically important to understand that ACOs vary widely in their electronic data extraction and aggregation capabilities. Some ACOs have a single electronic health record (EHR) that covers the entire organization, but more commonly ACOs have multiple different EHR instances across the organization – in some cases, numbering well over 100 different EHR instances. This reflects varying approaches to including participant practices in the ACO, which ranges from employment to alignment. For ACOs with multiple EHRs, producing electronic clinical quality measures (eCQMs) from those disparate systems requires time, money, effort in changing workflows and acquiring new technology services. Moreover, certified EHR technology (CEHRT) standards do not require support for combining data from multiple EHRs to produce a single result. CEHRT only requires the capability to report eCQMs form a single EHR.

In our capacity as CEHRT, qualified registry, and qualified clinical data registry (QCDR), Premier has been working closely with ACOs to prepare for the new requirements. We have identified several areas of the policy that create significant impediments for ACOs. Without additional relief we are concerned these changes will have the unintended consequence of ACOs altering their provider networks or leaving the program altogether. Additionally, one of the main selling points for

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independent practices to join ACOs is that the ACO will take on quality reporting for the practice. These policy changes would remove this significant incentive and place new burden on these independent practices. Overall, these changes will likely result in many providers choosing to leave the MSSP and value-based care all together.

Accordingly, **we recommend CMS implement the following changes to create a smoother transition to the new reporting requirements:**

- **Limit ACO reporting to aligned populations and start with lower data completeness**
- **Clarify and establish quality performance benchmarks in advance**
- **Seek additional input on MSSP quality measure set**
- **Retain pay-for-reporting option for new entities or when measures are newly introduced or modified**

We appreciate the one-year delay that CMS finalized for 2021, as this provided ACOs with an additional performance year to continue with the Web Interface while still testing new options. However, CMS should delay requirements or provide an exemption in 2022 for ACOs that may need additional time to transition to these new requirements.

Limit ACO Reporting to Aligned Populations and Lower Data Completeness Threshold

The MSSP quality performance standard should only assess the care provided to beneficiaries aligned to the ACO. However, under the new reporting framework, ACOs will now be required to report on all patients who meet the measure specifications regardless of payer.

We understand CMS' intent is to assess the quality of care across all patients and all payers, similar to the approach CMS uses in other quality reporting programs. However, the MSSP program is fundamentally different than setting- and provider-specific quality reporting programs. ACOs are a network of aligned providers rather than a specific provider type. This new policy has resulted in several challenges for ACO participants:

> **ACOs have limited opportunity to influence care outside of the ACO.** ACOs are uniquely positioned to create efficiencies of care across aligned or employed participants; however, it is inappropriate to assess ACOs on the care provided to patients outside the ACO. The ACO entity does not have the ability or flexibilities to design care interventions for other patients. For example, an ACO cannot utilize its fraud and abuse waivers to offer patient engagement tools or supports to patients outside of the ACO. By including all patients, the quality measures will no longer reflect the care furnished under the ACO and, therefore, is no longer a true metric of the ACO's performance.
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> **ACOs have contractual limitations on all-payer data.** ACO contracts with participant providers are often limited to the specific model or payment arrangement. ACOs may not have the necessary contracts in place with clinicians and other providers to allow for the collection of data beyond their ACO populations. Updating contracts to support data exchange will take time and resources. Additionally, guidance is needed to understand how ACOs should handle performance gaps when a patient has opted out of data sharing. Moreover, even with ACOs

engaged in risk-based contracts with other payers, the contractual terms will vary from payer-to-payer.

ACOs are considering shifting participants as a result of this policy change. ACO participant enrollment occurs at the Tax Identification Number (TIN)/practice level while ACO beneficiary alignment is based on primary care services. With the change in reporting requirements any patient seen by an ACO participant, including specialists, is included in the denominator. For example, most orthopedists or ophthalmologists do not screen patients for depression. However, their patient population could now be included in the denominator of this measure if the denominator specifications are met. This would require ACOs to coordinate care for beneficiaries who are not aligned to the ACO. This change will significantly impact ACO performance, thus ACOs are considering restructuring TINs to remove specialist from the ACO. This is counter to the goal of ACOs, coordinating care across the continuum.

We recommend that CMS only require ACOs to report quality data for beneficiaries that are aligned to their ACO. This approach provides a more accurate measure of quality of care provided by the ACO. Additionally, it would reduce the amount of time and resources necessary to adapt systems to meet new reporting requirements.

Additionally, we **recommend that CMS start with a lower data completeness threshold that would gradually increase over time.** Under the new measurement framework, clinicians must report on 70 percent of all patients. This requirement is a significant increase over the current sampling methodology required under the Web Interface. Starting with a lower threshold would allow ACOs additional time to adapt their various data systems to extract data from affiliated clinicians. This approach also aligns with how CMS implemented reporting for clinician and group reporting, which began with a data completeness of 40 percent and increased gradually to 70 percent.

At a minimum, we recommend that CMS allow individual TINs or each unique EHR instance to submit their data on an interim basis to CMS and that CMS combine the results. This would significantly reduce burden and costs for providers as they transition to these new requirements.

Clarify and establish quality performance benchmarks in advance

Under the new quality performance standard, ACOs must achieve at least the 30th percentile across all MIPS Quality performance category scores in order to be eligible for shared savings. The standard increases to the 40th percentile in PY2023 and subsequent years.

We believe that the stated strategic goal of aligning the MSSP quality standard with the MIPS quality performance category is misguided. Premier generally supports alignment across CMS programs with the aim of ensuring care outcomes for patients and reducing provider burden. However, alternative payment models (APMs) should not have to align with MIPS. Rather MIPS reporting requirements should be structured to encourage clinicians to adopt APMs. MIPS assesses the point-in-time encounters delivered by individual clinicians and groups. Moreover, MIPS reporting groups reflect clinicians related by a common financial structure. Conversely, APMs reflect total cost of care arrangements where providers are responsible for coordinating care across the continuum. Ultimately, aligning APM quality measure sets to MIPS is antithetical to the goal of moving clinicians from volume to value, that is from MIPS to APMs. **We recommend that CMS set benchmarks specific to MSSP rather than MIPS, which is a fundamentally different program.**

Additionally, we believe ACOs will be at a significant disadvantage when compared against the MIPS quality performance scores. Since MIPS participants can select which measures they report, participants are incentivized to choose measures on which they have historically performed well. As a result, the MIPS overall quality score tends to skew high, even if individual measures do not. Based on our analysis of past performance by non-Web Interface reporters, ACOs will need to achieve the 6th decile or higher on each individual measure in order to achieve the 30th percentile of overall quality score.

Finally, ACOs need clarity on what level of performance they must achieve to reach the 30th percentile. Currently, CMS publishes the quality measure benchmarks that ACOs must achieve in advance of the upcoming performance year. This information is valuable in informing ACOs' quality improvement activities and helps identify the performance standard they are aiming for. **We strongly recommend that CMS release additional information on how it will set benchmarks across reporting mechanisms and publish in advance the quality measure benchmarks.**

Retain Pay-for-Reporting for New Entities or When Measures are Newly Introduced or Modified

CMS finalized eliminating the pay-for-reporting year for ACOs that are beginning an initial MSSP contract or in instances where a measure is introduced or undergoes significant changes. Providing a year of pay-for-reporting in these instances grants ACOs valuable time to evaluate current workflows, data capture, and other operational strategies necessary to monitor and report a measure. This flexibility is particularly important for new ACOs and those with practicing providers on multiple EHR systems, where changes to measure specifications will require significant system updates. **As a result, we recommend that CMS retain a pay-for-reporting option for new entities, new measures, and measures that undergo significant changes.**

Seek Additional Stakeholder Input on MSSP Quality Measure Set

Under the revised reporting requirements, MSSP ACOs will be required to report three measures (HbA1c Poor Control, Depression Screening and Follow-Up Plan, Controlling High Blood Pressure) and field the CAHPS for MIPS survey, in addition to CMS scoring two measures from administrative claims (Readmissions, Admissions for Multiple Chronic Conditions).

While we appreciate the significant reduction in measures, **we urge CMS to take additional time to seek stakeholder input.** In particular, we are concerned that the readmissions measure has very little variation between high and low performers, which could result in providers being penalized for differences in care that are not meaningful. Additionally, providers have found the new multiple chronic condition measure to be challenging, as it is difficult to design and implement interventions targeted toward multiple chronic conditions. We would recommend granting providers additional time to gain experience with this measure. Finally, we are concerned that the measures are limited in scope and are not a true representation of the care furnished under the ACO.

CMS should use the Measure Applications Partnership (MAP) to provide input on the ideal measure set for MSSP, as the statutory intent of the MAP is to evaluate quality measures to ensure

the measures appropriately fit a program. It is critical to ensure that the MSSP measure set reflects the program and includes measures that assess how care is provided across the continuum.

Conclusion

In closing, the Premier healthcare alliance appreciates the opportunity to share our recommendations for improving the MSSP quality performance standard. If you have any questions regarding our comments or need more information, please contact Aisha Pittman, Vice President, Policy, at aisha_pittman@premierinc.com or 202.879.8013.

Sincerely,

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Senior Vice President, Public Affairs
Premier healthcare alliance