

Consumer-Purchaser ALLIANCE

Better information. Better decisions. Better health care.

June 27, 2016

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

RE: CMS-5517-P: Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models

Dear Acting Administrator Slavitt:

The Consumer-Purchaser Alliance (C-P Alliance) appreciates the opportunity to provide input on the design and implementation of the physician payment programs created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) in response to your Notice of Proposed Rulemaking (CMS-5517-P). C-P Alliance is a collaboration of leading consumer, labor, and purchaser 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.

A high-value health care system requires value-driven payment arrangements and we are encouraged by the opportunities MACRA has created to spread these arrangements to more providers. Such value-based payments should result in better health outcomes, improved care coordination and patient experience of care, and decreased costs.¹ Together with the undersigned 26 organizations, we applaud CMS's leadership in moving to value-based payments and ask for continued strong leadership in the face of opposition. We directionally support CMS's proposed implementation of MACRA and offer suggestions to strengthen the Quality Payment Program.

¹ For brevity, we refer in various places in our comments to "patient" and "care," given that the Quality Payment Program is 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.

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As the new default payment system for clinicians participating in Medicare Part B, it is critical that the Merit-based Incentive Payment System (MIPS) program be designed to reward high performance and improvement rather than support the status quo. MIPS provides the opportunity to address the limitations in existing clinician evaluation programs such as the Physician Quality Reporting System (PQRS) and to implement more rigorous clinician-level performance metrics. The proposed rule does, indeed, take steps toward a robust value-driven system. These include the increased focus on using high-value quality measures to assess performance, e.g., offering bonus points for choosing additional high priority measures and removing low-value measures from the PQRS measure set. However, rather than allowing the selection of any six measures, we recommend movement toward use of specialty- and subspecialty-specific core measure sets that would provide reliable comparative information about clinician performance. In addition, we believe that advancing the current state of performance measurement should be a top priority in MACRA implementation, and toward that end, we strongly support using the Clinical Practice Improvement Activities (CPIA) category to reward development of high-value measures, and in particular patient-reported outcomes.

Although a strong MIPS program is an important lever contributing to lower health system costs overall, it will not be sufficient to achieve the Triple Aim. The resource use component of the MIPS score offers some incentive for efficiency and prudence by clinicians, but today's measures of resource use cannot drive this change as far as is needed.

The Advanced Alternative Payment Model (APM) path goes further to encourage clinicians to ensure the care they deliver is efficient: to be a qualifying Advanced APM participant, MACRA requires a clinician to assume "more than nominal" risk. This financial risk is at the heart of the transformation of a payment arrangement from fee-for-service into a value-driven model. In tandem with this risk must be the opportunity for clinicians to practice medicine and deliver care in innovative ways as they work to improve patient experience, quality, and efficiency. We support CMS's definition that Advanced APMs must include downside financial risk and agree that model designs should take precedence for specific quality metrics and other requirements.

In addition, we support the use of the Intermediate APM (or "MIPS APM") option for clinicians participating in care and payment models that do not meet the financial risk or other Advanced APM requirements. We agree it is important to recognize providers on the path to Advanced APMs and to offer reduced reporting requirements for their participation in the MIPS program.

Value-driven models of care must not only increase efficiency but also improve the delivery of care, such as through greater care coordination, more shared care planning and partnership with patients at multiple levels of care, and better patient

care experience. These outcomes reflect the needs of consumers and other health system stakeholders. We are concerned that the process for designing and updating APMs does not consistently include feedback from consumers and purchasers. We believe this is an essential piece that should always be included.

The passage and implementation of MACRA is one of the most significant changes to Medicare clinician payment in the past few decades. We acknowledge the effort it took to develop regulations for these new programs and commend CMS on its proposal. Admittedly, the full impact on small practices/solo practitioners, specialty providers, and primary care remains to be seen as the market responds to this new program. At the same time, the focus on a few Advanced APM models may unintentionally increase provider consolidation. We strongly encourage CMS to monitor such changes in the market in the short-term and quickly make improvements to the programs to support effective participation of these providers while maintaining robust value-based purchasing programs.

In the appendices, we provide more specific comments and feedback on the proposed rule. If you have any questions or would like to discuss our recommendations further, please contact Bill Kramer (wkramer@pbgh.org) or Debra Ness (dln@nationalpartnership.org), co-Chairs of the Consumer-Purchaser Alliance.

Sincerely,

The Alliance

American Association on Health and Disability

American Cancer Society Cancer Action Network

American Federation of Labor and Congress of Industrial Organizations (AFL-CIO)

American Federation of State, County & Municipal Employees

Caregiver Action Network

Catalyst for Payment Reform

Center for Patient Partnerships

Consumers' CHECKBOOK/Center for the Study of Services

Dallas-Fort Worth Business Group on Health

The Empowered Patient Coalition

Health Policy Corporation of Iowa

Iowa Health Buyer's Alliance

Lakeshore Foundation

The Leapfrog Group

Lehigh Valley Business Coalition on Healthcare

Maine Health Management Coalition

Medicare Rights Center

Mid-Atlantic Business Group on Health

National Coalition for Cancer Survivorship

National Partnership for Women & Families

Northeast Business Group on Health
PULSE of Colorado
Pacific Business Group on Health
St. Louis Business Group on Health
Texas Business Group on Health

APPENDIX A: SUMMARY OF KEY RECOMMENDATIONS

Merit-Based Incentive Payment System (MIPS)

- Instead of a menu approach to quality measures, CMS should move toward establishing core sets of high-value measures by specialty or subspecialty. This would enable consumers and purchasers to make direct comparisons of similar providers with assurance that they are all being assessed against a consistent and standardized set of important quality indicators. *Read more under [Quality Performance Category](#), page 9*
- Information about individual clinicians is critical in addition to information about teams, practices, and groups. Quality measures, particularly patient experience, should use individual clinician-level information whenever possible. CMS should assess resource use at both the individual and group levels. *Read more under [Using Information at the Individual Clinician Level](#), page 7, and under [Resource Use](#), page 11*
- A standardized patient experience tool, such as CAHPS for MIPS, should be required for all clinicians in groups of two or more. *Read more under [Quality Performance Category](#), page 9*
- CMS should place greater weight on the collection of patient-reported outcomes as part of the Clinical Practice Improvement Activities category. These activities should encourage clinicians to collect and report data using validated tools in order to support the development, testing, and validation of new performance measures in targeted areas. *Read more under [Clinical Practice Improvement Activities](#), page 12*
- The Advancing Clinical Information category should build on the progress made in the Meaningful Use program, and its base score measure thresholds should go beyond one patient. *Read more under [Advancing Clinical Information](#), page 13*

Advanced Alternative Payment Models (APMs)

- CMS should garner multistakeholder feedback on APM program design components, particularly on the selection of quality measures used for payment. Measurement innovation should be a key feature of program requirements for most Advanced APMs. *Read more under [Comparable Quality Measures](#), page 15*
- All Advanced APMs should have two-sided risk or capitation-like arrangements to encourage real transformation that increases value to consumers, purchasers, and other stakeholders. *Read more under [Financial Risk](#), page 15*
- In addition to meeting the financial requirements, Advanced APMs must be able to show that their payment models are driving the right kind of care delivery to

achieve better health outcomes and better care experience. *Read more under [Care Delivery Requirements](#), page 16*

Intermediate APMs (or MIPS APMs)

- The non-ACO intermediate APM models' quality provisions should be used to calculate a quality performance score, ensuring better comparability with both MIPS providers and Advanced APMs. *Read more under [Intermediate APMs](#), page 17*

APPENDIX B: COMMENTS AND RECOMMENDATIONS

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Using Information at the Individual Clinician Level

Information about individual clinicians' performance is important for quality improvement, value-driven payment and insurance design, and informed consumer decision-making. For example, CAHPS results on the key dimensions of communication and health promotion, which are strongly related to outcomes, largely reflect the experience of an individual person with an individual clinician. This suggests that the most important unit of measurement in many cases is the clinician and not his or her group, although in team-based care environments both individual and group measurement are important. We urge CMS to request information about all of the MIPS performance categories at the most granular level possible, enabling both assessment of clinician performance at the individual level as well as aggregation of performance data at the group, practice, or other level as appropriate. To facilitate individual clinician-level information, we recommend that CMS use the NPI identifier throughout the MIPS program. The NPI is also used by the private sector, promoting greater alignment than would a newly created MIPS provider identifier.

Quality Performance Category

Consumers and purchasers have largely viewed PQRS as a missed opportunity for CMS to incentivize more substantial advances in the quality of care. We have previously expressed concern that PQRS asked too little of individual eligible clinicians (ECs), by only requiring them to report on a small number of self-selected measures. This was problematic for multiple reasons: the existing measure set included many low-value documentation and process measures that offer little value to consumers or purchasers; the small number of measures was unlikely to reflect the spectrum of patients and conditions treated by the EC; and by self-selecting the measures, ECs could potentially give an inaccurate picture of his/her practice.

MIPS should improve upon both the PQRS and Value Modifier criteria and evolve into a more meaningful program, with robust requirements and measures. We encourage CMS to emphasize the importance of patient-centeredness by prioritizing measures of patient-reported outcomes, shared decision-making and care planning, and the use of participant-directed services. Our comments below discuss the performance measures available for reporting, the menu approach to measure selection, and patient experience measures.

Performance measures, measure categories, and measure reporting

- Patient-reported outcome measures (PROMs) should be given greater weight.
- Continue soliciting multistakeholder input on the available and required measures through the Measure Applications Partnership (MAP).
- Update patient sampling requirements over time to eventually eliminate sampling.

We applaud CMS for identifying and emphasizing the types of measures that offer the most value to consumers and purchasers: measures of outcomes, appropriate use, patient safety, efficiency, patient experience, and care coordination. **However, we believe it is necessary to specifically call out and prioritize patient-reported outcomes (PROs) and PRO-based measures (PROMs).** While outcomes are proposed as priority measures, this category typically refers to clinical outcomes rather than PROMs. PROMs and other measures using patient-generated data assess issues that are important to patients and are a key element of patient-centered care, enabling shared decision-making and care planning.

We support the shift away from the National Quality Strategy domain requirements used in PQRS because breadth of measurement is ensured through the proposal to make resource use, outcome, and cross-cutting measures mandatory. We support the proposed three population-based measures that will be calculated using claims. In addition, we are encouraged by the proposal to maintain the PQRS requirement that clinicians who see patients in face-to-face encounters must report a cross-cutting measure.

To maintain the emphasis on high priority measures, we recommend that CMS continue to use the MAP pre-rulemaking process in determining the final list of quality measures each year. The MAP plays a critical role in ensuring that the voices of consumers, purchasers, and other stakeholders are heard.

Regarding the Data Completeness provision for this category, **we recommend the use of larger patient samples over time and the eventual elimination of sampling from reporting requirements.** This approach will better support groups in internal benchmarking for quality improvement while also enabling measurement at all levels. We support the proposal to use all-payer data for quality measures, recognizing that this data will create a more comprehensive picture of an EC's performance.² We also support all-payer data for patient experience surveys. Similarly, we support stratification by demographic characteristics to the degree that such stratification is feasible and appropriate. Stratifying measures by variables including race, ethnicity, gender, disability, and other demographic characteristics is an important tool for uncovering disparities and quality gaps as well as for

² Specifically, we support all-payer data for Qualified Clinical Data Registries, qualified registries, and EHR submission mechanisms.

identifying intervention points and strategies. We encourage CMS to make stratified quality data publicly available at both individual and practice levels.

Menu approach

- *Use core measure sets by specialty or subspecialty to enable “apples to apples” comparisons.*

To truly support high-value care and value-based purchasing, performance measurement must be meaningful to all stakeholders, useful not only for quality improvement but also to distinguish between providers who deliver excellent, average, or poor care. Although we support the direction of the proposed rule relative to the existing quality programs, we remain very concerned about the limitations of a menu approach. A menu approach may lead providers to report only those measures for which they are high performers, hiding results of poor care. A menu approach also prevents an “apples to apples” comparison, leading consumers and purchasers to make choices without critical information about provider performance. We acknowledge that the proposed rule aims to give providers flexibility to report on those measures most relevant to their practice, but that flexibility must not come at the cost of meaningful and actionable information for consumers, purchasers, and other stakeholders.

We urge CMS to redesign the MIPS Quality Performance category by establishing core sets of measures by specialty or subspecialty. A core set approach using high-value measures would enable direct comparison between similar clinicians, and would provide assurance that the comparison is based on a consistent and sufficiently comprehensive set of quality indicators. This, in turn, supports informed choice and the ability to design value-based networks. We also support providing additional incentives to encourage reporting on other priority and innovative measures.

The measure sets in the proposed rule and existing efforts to define core measure sets are a good starting point. Over time, core measure sets should be updated as better measures become available.

Patient experience measures

- *All clinicians in groups of two or more should report a standard patient experience measure.*
- *Short-form surveys, electronic administration, and alternative instruments can reduce the burden of surveying while improving utility to patients and clinicians.*

As we note above, we applaud CMS for emphasizing the importance of patient experience measures by including this category in the list of priority measures. Patient experience of care is a key tenet of a person-centered health care system and

patient experience measures are critical for quality improvement, consumer choice, and value-based purchasing. C-P Alliance has long advocated for widespread use of CAHPS tools for value-based purchasing programs including PQRS. **We strongly encourage CMS to require a CAHPS measure for all MIPS eligible clinicians in groups of two or more.**

Reporting CAHPS at the individual clinician-level is expensive under the current model, but costs could be markedly reduced if electronic administration or a short-form survey were allowed.³ We acknowledge the shortcomings of the CAHPS instruments and we support their evolution into tools that provide meaningful information to consumers, are efficient to administer, and offer providers real-time feedback for practice improvement.

C-P Alliance has previously recommended the use of specialty-specific CAHPS tools where available, such as Surgical Care CAHPS. By maintaining the core CAHPS components and focusing on elements more specific to a specialty practice, these tools provide meaningful information to consumers and purchasers as well as relevant feedback for providers. We recommend that CMS allow multiple standardized CAHPS tools to fulfill the patient experience reporting requirement.

Finally, despite the need for improvements in existing patient experience measures, **consumers urgently need this information and CMS should not delay requiring the collection and reporting of patient experience data using currently available tools.**

Scoring the Quality Performance Category

- *Over time, move away from bonus points for voluntary reporting and toward required reporting of high-value measures.*

To be effective, the MIPS scoring system must ensure comparability among clinicians, offer incentives for high performance especially on high value measures, and reward improvement over time, while remaining sufficiently simple that the incentives are understandable and effective. We support the direction of the proposal to reward achievement, using performance relative to specified benchmarks, as well as year-over-year improvement on specific measures or on net quality performance.

³ The recent short form patient experience survey project conducted by Massachusetts Health Quality Partners and the California Healthcare Performance Information System offers evidence that both a short form version of the CAHPS survey and email-based administration provide comparable results to a long form version. More information about this project and its results can be found here: <http://www.mhqp.org/EmailLinks/Short%20Form%20PES-Research%20Findings.pdf>.

The following recommendations would improve the scoring system:

- For the measures in the Web Interface reporting option, we support using the Medicare Shared Savings Program benchmark methodology because it includes more data in calculating the benchmark.
- Regarding the options to reward improvement, we find Options 1 and 2 (Hospital Value-based Purchasing and Medicare Shared Saving Program methods) to be reasonable, and would not recommend Option 3 (Medicare Advantage method).
- We support the proposal to cap the total impact of bonus points at 5% of the quality score denominator as this limits the ability of bonus points to mask poor performance. Though we strongly agree with the measures identified as priorities and for which bonus points may be awarded, **we encourage CMS to lay out a clear and prompt timeline for moving away from a bonus point system; instead, the Quality Performance category should require high-priority measures and remove low-value measures like those that are “topped out”.**

Resource Use Performance Category

- *Assess resource use at the individual level as well as the group level, even for clinicians who are assessed as part of a group for other MIPS categories.*
- *Weight total cost measures more heavily than episode-based measures.*

Resource use measures are an integral part of understanding and evaluating the efficiency and value of care delivery. We strongly support the continued use of the two total cost measures: Total Per Capita Cost and Medicare Spending Per Beneficiary (MSPB). These measures encourage clinicians to consider the resource use implications of their hospital and specialist referral patterns. We also support replacing the four condition measures with a set of measures that are more specific to services or procedures for a particular condition or diagnosis. To identify and prevent unintended consequences of these measures, we recommend that appropriate use measures accompany them whenever possible.

All clinicians should be assessed at the individual level in addition to the group level, as individual clinicians have significant control over resource use.

As such, we support the alternate attribution approach to use TIN/NPI for all clinicians, including those who choose to have their performance assessed as a group across the other MIPS performance categories. Measurement at the individual level will provide needed information on within-practice variations to individual clinicians, physician groups, CMS, and other stakeholders. Beyond this issue, we support both the proposed two-step attribution methodology and the proposed approach to ensuring reliability of the resource use measures.

We recommend that the two total cost measures be given a cumulative weight of at least 50%, and the remaining percentage be allocated equally among the

discrete episode-based measures. Total cost of care measures have a greater potential to increase value overall compared to discrete episode-based measures, and correspondingly we suggest an alternate weighting scheme.

In addition to measuring the proposed aspects of resource use, we strongly encourage CMS to move rapidly towards including Part D costs as these costs represent a substantial portion of total cost of care.

Clinical Practice Improvement Activities (CPIA) Performance Category

- *Support the development of new PROMs through widespread collection and reporting of data from specific validated patient-reported outcome tools that lack performance measures.*
- *Develop quality measures or other mechanisms to assess and demonstrate the impact of improvement activities.*

Clinical practice improvement activities should drive and support sustained, comprehensive clinical practice transformation. Patients and families should be viewed as partners in this process and be incorporated into design, quality improvement, and governance activities. The improvement of clinical practice should be responsive to patient and family caregiver needs and oriented to improving the care experience while also improving health outcomes and optimizing resources.

CMS should encourage clinicians to collaborate with patients and families in this component of the Quality Payment Program. The activities should encourage clinician recognition that patients and families have unique experiences and perspectives that can facilitate practice improvement, increase patient and family engagement, and improve care experience and outcomes. We therefore urge CMS to include activities that leverage partnerships with patients and families such as ongoing feedback systems and patient and family advisors.

CPIAs should function as a vehicle for improving infrastructure that supports efficient, high-value performance measurement as well. We were thrilled to see the inclusion of patient-reported outcome (PRO) tools in the list of activities. Such data collection could significantly improve the use of PROs in clinical practice and future development of PRO measures, which is frequently hindered by too few providers using a given PRO tool or by limited data for measure development and testing. CMS should provide guidance on preferred PROs and require data reporting back to CMS to augment measure development efforts. **In particular, we encourage CMS to target the collection of global health PROs in the public domain (e.g., PROMIS-Global or VR-12) and the use of PROs for clinical conditions that have validated PRO tools available but no PRO measures developed or in**

widespread use.⁴ Given these changes, we believe the CPIA weight for these activities should be elevated from medium to high.

Finally, we recommend that CMS monitor this category and identify specific quality measures or evolve other mechanisms to assess and demonstrate the impact of each of the improvement activities (not just those related to measurement). For many of the improvement activities, these assessment tools should measure the impact of the activity on outcomes and patient experience.

Advancing Clinical Information (ACI) Category

- *Raise the threshold for measures in the base score from just one patient to 5% beginning in 2019.*
- *Maintain a high threshold to determine Meaningful Users.*

Robust health information exchange is fundamental to improving performance in the other three categories of MIPS. The ACI category – particularly through the prioritized measures in the performance score – is clearly structured to promote activities that drive interoperability, care coordination, and patient engagement. Additionally, there are clear interrelationships between MIPS program categories regarding health IT use, especially between the ACI and CPIA categories. However, the proposed requirements for health IT adoption and use for both MIPS and APMs are not sufficient to move towards substantial, person-centered uses of health IT that support health system transformation. **Future changes to the scoring methodology and measures of health IT use will be important to truly transform care and enhance the overall health of patients.** We support the Consumer Partnership for eHealth recommendations for improving the scoring methodology and measures:

- Replace the one patient threshold for each measure in the base score with a 5% threshold beginning in 2019;
- Reduce the weighting of the base score relative to the performance score in future years;
- Award bonus points for improvement on the performance score; and
- Adopt the main proposal for using an ACI performance score of at least 75 points to determine Meaningful Users of health IT.

Keeping the “one patient” threshold – and broadening its application to all measures (not just View/Download/Transmit and Secure Messaging) – undermines CMS’s commitment to make patients and family caregivers true and equal partners in improving health through shared information and shared decision-making. **We strongly urge CMS to increase the threshold for the base score measures to five percent starting in reporting year 2019.** A minimum standard of 5% is well below or equal to all Meaningful Use thresholds for 2017, and signals a genuine

⁴ Examples of validated PRO tools for clinical conditions without corresponding PROMs are the Seattle Angina Questionnaire, MD Anderson Symptom Inventory, and Oswestry Disability Index.

expectation by CMS that organizations make the process changes necessary to support electronically enabled care. Additionally, CMS should consider increasing the weight of the performance score relative to the base score to further emphasize performance on high-value and person-centered uses of health IT.

The definition of Meaningful User may similarly have an important effect on health IT adoption and robust use. **We prefer CMS's primary proposal to use a 75-point threshold (as opposed to the alternate proposal of 50 points) to determine Meaningful Users, and urge CMS to consider a higher threshold in future years.** We oppose the alternate proposal to lower the threshold to 50 points because it would mean that clinicians who fulfill the base score (in which clinicians have to complete measures for only one patient/encounter) would be considered a meaningful EHR user. This is hardly a sufficient proxy for determining whether clinicians are robustly using health IT to improve patient care.

We support the requirement for a full calendar year reporting for the ACI category because it supports CMS's goals of alignment across performance categories. Requiring reporting for a full year is more likely to drive sustained progress and prompt changes in practice policies and provider workflows that are essential to realizing the full potential of health IT, and subsequently to transforming health care delivery.

Public Reporting of Performance Information

Publicly available performance information is central to understanding value-based performance and drives quality improvement, accountability, and consumer choice. Consumers and purchasers would like the Physician Compare website to be user-friendly and easy to navigate, and to comprise a strong set of measures that fairly characterize performance and distinguish among ECs on multiple dimensions of quality. We believe that CMS has made progress toward improving the content and usability of Physician Compare and we are pleased with CMS's commitment to transparency through the public reporting of more measures and performance information. Publicly available performance information is central to understanding value-based performance, and we applaud CMS for increasing the availability of this information. **We strongly support continued efforts to improve Physician Compare, including the reporting of individual-level provider information and data sets for others to use in their transparency efforts.**

ADVANCED ALTERNATIVE PAYMENT MODELS (APMs)

We strongly support payment models that reward value rather than volume and are extremely pleased to see CMS accelerate the movement towards APMs. Models using two-sided financial risk in a fee-for-service environment can help us move toward the triple aim. If designed and implemented effectively, APMs have the

potential to provide comprehensive, coordinated, patient- and family-centered care while driving down costs. However, we need ongoing assessment of APMs to ensure that the models achieve the goals of better outcomes, experience of care, and equity, at lower costs. Our recommendations below identify ways CMS can strengthen the APM track requirements to support this assessment over time.

Certified electronic health record technology (CEHRT)

Advanced APMs must excel in the use of health information technology to improve the quality and efficiency of care in the clinical setting, as well as to engage patients in their own health and care. We support CMS's proposal that in the first year, an Advanced APM must require at least 50% of ECs to use CEHRT to document and communicate clinical care with patients and other health care professionals. This threshold should increase over time.

Comparable Quality Measures

MACRA requires Advanced APMs to base payment on quality measures comparable to those used in MIPS. Additionally, CMS proposes a minimum of one outcome measure must be included in an Advanced APM measure set. Ultimately, however, the Advanced APMs quality measures will only be as strong as the underlying models' requirements. There is no consistency in how these models obtain feedback from consumers and purchasers on the quality measure sets or other program features. **We strongly recommend that multistakeholder input on APM quality measures and other design elements be a standard part of the process.** One way to operationalize this is to obtain the feedback through the Measure Applications Partnership. In addition, we encourage CMS to better incentivize measurement innovation in Advanced APMs by stipulating such innovation as a key feature or option in the underlying models' requirements. The measures developed should address key features that new models are trying to address (e.g., better coordination, patient-centeredness, efficient use of resources).

As we noted in our comments on the MIPS program, regardless of the type of APM, individual clinician-level quality measures should be used in addition to metrics at the APM level.

Financial Risk

Financial risk is a cornerstone of the transformation of payment arrangements from volume-based into value-driven models. C-P Alliance remains steadfast in our position that Advanced APMs should have two-sided risk or capitation-like arrangements so that clinicians are incentivized to increase value to consumers, purchasers, and other stakeholders. Models that merely tweak fee-for-service payment structures should not qualify as Advanced APMs. In addition, we encourage CMS to consider improvements to the Relative Value Unit system that underlies

most APMs, particularly those changes that would enable a more equitable distribution of resources to primary care. We support the definitions of financial risk for monetary loss, and the way CMS defines more than nominal risk for Advanced APMs. However, as CMS continues to develop new models of care and payment, and providers take on increased risk, reward, and responsibility, it is important that CMS ensure that the evolution and application of consumer safeguards keep pace. We therefore urge CMS to clarify how consumer safeguards will be enhanced as more providers move into Advanced APMs.

Care Delivery Requirements

We are concerned that there are no requirements for the clinical care models used by the Advanced APMs (other than those considered medical home models). Cost savings and the transition of health care spend to value-based payment models cannot be the lone goals of health care transformation. Meaningful transformation requires that the transition to APMs also results in improved delivery of care (e.g., greater care coordination; use of shared care planning and partnership with patients at all levels of care; demonstration of improved patient care experience). We strongly recommend that as entities take on financial accountability for quality performance and value, assume financial risk, and move towards capitation-like payment models, these entities must likewise be able to demonstrate that they promote and support sustainable, effective, evidence-based, accessible, patient- and family-centered care models.

Medical Home Model

The special consideration given to medical home models as Advanced APMs acknowledges the critically important role of primary care in improving the quality of health care overall, reining in high medical costs, and improving patient experience of care. We strongly support the separate financial standards for medical home models and appreciate CMS's attention to placing a high value on the provision of primary care. However, with regards to the requirements around medical home models, we urge CMS to go further and require medical home models seeking to qualify as Advanced APM to meet all seven of the domains listed in the proposed rule's definition of a medical home model. No one of these domains can be acceptably missing from a high-quality medical home.

In addition to requiring all seven criteria, we suggest that CMS reframe the shared decision-making domain to focus on shared care planning, of which shared decision-making is an integral part. While shared decision-making may be tied to a singular episode of care, shared care planning captures and occurs across a patient's lifespan.

We encourage CMS to move toward measuring whether meaningful shared decision-making has occurred, specifically through PROMs.

INTERMEDIATE APMs (or MIPS APMs)

C-P Alliance supports CMS's proposed Intermediate APM option to serve as a glide path from MIPS to Advanced APMs. Moreover, we support streamlining requirements for MIPS APMs to create consistency with goals of Advanced APMs and reduce barriers to becoming an Advanced APM. Ultimately, we would like to see MIPS APMs seek to become Advanced APMs rather than long-term MIPS participants. However, we are concerned that non-ACO MIPS APMS will not be subject to a quality score in the first year. **These models require payment based on quality, and those quality measures should be included in the composite score beginning in the first year.** We are also concerned that 75% of the non-ACO MIPS APMs composite performance score is based on the ACI score. The recommended addition of the quality score will help better balance the composite score components.

To support the glide path toward Advanced APMs, it is critical that CMS maintain a high bar for models to qualify as Advanced APMs, rather than weakening the qualification criteria to increase participation.