

Consumer-Purchaser ALLIANCE

Better information. Better decisions. Better health care.

September 8, 2015

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

RE: CMS-1631-P; CY 2016 Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Medicare Part B

Dear Administrator Slavitt:

The 17 undersigned organizations are part of the Consumer-Purchaser Alliance, 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. We appreciate the opportunity to comment on the proposed changes to the Physician Fee Schedule, the other revisions to Medicare Part B, and the modifications and requests for information for other programs.

Payment and reporting programs such as the Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (VM), Physician Compare, the Medicare and Medicaid Electronic Health Record “Meaningful Use” Incentive Program, and the Medicare Shared Savings Program (MSSP) are inextricably tied to ongoing efforts to transform the health care delivery system to meet the National Quality Strategy goals of better outcomes, improved patient¹ experience of care, and reduced costs. These programs will provide the foundation for the future of clinician measurement and accountability through the Merit-Based Incentive Payment System (MIPS) and its corollary, the Alternative Payment Model (APM) track for clinician payment. Overall, we note that this proposed rule includes very few major changes to existing programs. As CMS considers the design and implementation of MIPS and APMs for

¹ For brevity, we refer in various places in our comments to “patient” and “care,” given that many federal programs and initiatives are rooted in the medical model. To some, these terms could imply a focus on episodes of illness and exclusive dependency on professionals. Any effort to improve patient and family engagement must include the use of terminology that also resonates with the numerous consumer perspectives not adequately reflected by medical model terminology. For example, people with disabilities frequently refer to themselves as “consumers” or merely “persons” (rather than patients). Similarly, the health care community uses the terminology “caregivers” and “care plans,” while the independent living movement may refer to “peer support” and “integrated person-centered planning.”

www.consumerpurchaser.org

Pacific Business Group on Health
575 Market Street, Suite 600, San Francisco, CA 94105
415.281.8660 | tel

National Partnership for Women & Families
1875 Connecticut Avenue, NW Suite 650, Washington, DC 20009
202.986.2600 | tel

2019, we urge the rapid incorporation of consumer and purchaser priorities into the existing foundational programs. Specifically, we urge CMS to pursue development, collection, and reporting of high-value measures of clinical and patient-reported outcomes; to require reporting clinician performance at the individual level; and to reward clinicians who deliver high quality and appropriate care efficiently.

In the appendix, we provide specific suggestions to improve the programs included in the proposed rule and comment on CMS's proposals. Among our key comments are the following:

- We support CMS's proposals to improve payment for critical primary care services including care management, collaboration, and advance care planning. However, we encourage CMS to establish standards to ensure these services result in better health and better experiences of care.
- We support the removal of low-value measures and a greater reliance on EHR- and registry-based measures that may help improve the health information infrastructure overall. While the proposed reporting requirements for the Physician Quality Reporting System (PQRS) include many consumer and purchaser priorities, such as cross-cutting measures, CMS could strengthen these requirements even further by using more comprehensive measures whenever possible, incentivizing measures that use patient-generated data such as patient-reported outcome measures (PROMs), and expanding the use of patient experience measures.
- We applaud CMS for its commitment to improving transparency through reporting more measures and benchmarks on Physician Compare, and encourage CMS to make this information more useful to consumers by adding individual clinician-level performance and appropriate contextual background for performance measures.
- We support the potential expansion of the Comprehensive Primary Care initiative and recommend that CMS include consumers, purchasers, and other stakeholders in the design and implementation of an expansion to ensure the initiative reflects the needs of patients and the community.
- We encourage CMS to build on the Meaningful Use program by improving public information about providers' performance on functions that matter most to consumers, by expanding the health IT measures included in the Medicare Shared Savings Program measure set, and by relying on certified health IT to facilitate other program requirements such as stratifying measures or successfully reporting more high-value measures.
- We support the minor changes proposed for the Value-Based Payment Modifier program, and encourage CMS to make more significant changes such as using higher-value measures and performance scores that reflect the variation we know is present in care delivery.
- We encourage CMS to incorporate consumer and purchaser priorities in their definition of clinical practice improvement activity categories, and to expand these categories to reward the collection, use, and reporting of patient-reported outcomes.

If you have any questions, please contact either of the Consumer-Purchaser Alliance co-chairs, William Kramer, Executive Director for National Health Policy at the Pacific Business Group on Health, or Debra Ness, President of the National Partnership for Women & Families.

Sincerely,

Organizations listed in alphabetical order

AARP

The Alliance

American Association on Health and Disability

American Cancer Society Cancer Action Network

Caregiver Action Network

Consumers' CHECKBOOK/Center for the Study of Services

The Empowered Patient Coalition

Health Policy Corporation of Iowa

Iowa Health Buyer's Alliance

MidAtlantic Business Group on Health

Mothers Against Medical Error

National Business Coalition on Health

National Coalition for Cancer Survivorship

National Partnership for Women & Families

Pacific Business Group on Health

St. Louis Area Business Health Coalition

Wyoming Business Coalition on Health

APPENDIX

IMPROVING PAYMENT FOR PRIMARY CARE SERVICES

High-value primary care is linked with better access to health care services, better health outcomes, lower rates of hospitalization, decreased use of emergency department visits, and improved health equity.² Unfortunately, primary care services are undervalued in the fee-for-service environment, contributing to poorer access to services, worse care experience, and increased strain on the health care system.

CMS proposes new billing codes for a variety of services related to high-value primary care: care management services such as extended counseling; patient and caregiver education; collaboration and medication reconciliation; interprofessional consultation; and advance care planning. We believe these services are an integral part of high quality patient care and, if done effectively, can have an impact on improving outcomes and reducing costs. We have previously expressed concern that primary care services are relatively undervalued and that such undervaluation may contribute to underutilization (or, rather, underdelivery) of critical primary care services to the detriment of a person's health.

We support CMS's intent to give greater weight to these primary care services, and in particular we applaud CMS for acknowledging the importance of shared decision-making and shared care planning through the proposal to make active the advance care planning CPT codes. We believe that comprehensive advance care planning should occur in the greater context of shared care planning and shared decision-making, in partnership with the patient and his or her designated family and caregivers. Proactively and explicitly engaging an individual's family and caregivers in the development of a care plan helps to ensure that the individual's abilities, culture, values, and faith are respected, and care instructions and action steps are more likely to be understood and followed.³ The patient-provider conversations required to develop and maintain a meaningful advance care plan reflect patient-centered care.

Many care coordination and collaborative services occur behind the scenes, without the beneficiary's knowledge, or as a part of another visit. Thus, beneficiaries may be surprised when charged additional cost-sharing for services they don't recall receiving. Given this, we support consideration of testing a waiver of beneficiary cost-sharing for care management services and for interprofessional consultations and collaboration. Specifically, we support trial waiver of cost-sharing for care coordination services, including cognitive work; as waiver of beneficiary cost-

² L Shi, "The Impact of Primary Care: A Focused Review," *Scientifica*, 2012, available from <http://www.hindawi.com/journals/scientifica/2012/432892/>.

³ For more information, please see the National Partnership's *Care Plan 2.0: Consumer Principles for Health and Care Planning in an Electronic Environment*, available at <http://www.nationalpartnership.org/research-library/health-care/HIT/consumer-principles-for-1.pdf>

sharing for these services could serve both to decrease administrative burden on providers and financial burden on beneficiaries. In addition, we support CMS consideration of a Center for Medicare and Medicaid Innovation (CMMI) model to test the effectiveness of a waiver of beneficiary cost-sharing for such interprofessional consultations. However, we believe that beneficiaries should be fully aware of the involvement of specialists in their care, as well as the associated benefits of the collaboration between the beneficiary's primary care provider and a specialist.

We support the direction of CMS's proposals to improve payment for care management, collaborative care, and advance care planning services. However, we have concerns about the implications of CMS's proposed approach. In general, the Consumer-Purchaser Alliance supports payment for better outcomes. Although we agree that these services are needed to achieve better health outcomes and better patient experience of care, we prefer to see payment tied directly to such outcomes themselves, rather than services. CMS must move rapidly to develop ways to assess whether these services yield the improved outcomes and care experience we need. We encourage CMS to strengthen measures of patient outcomes and patient engagement related to these services, and to create operational definitions for the activities it lists in the scope of services. For example, we would like to see a pair of measures that show (1) patient verification of an advance care plan in the patient's health record; and (2) how closely the care a patient receives aligns with the advance care plan. We would also like to see patient reports of meaningful discussion leading to the development of a high-quality advance care plan, as well as appropriate updates to an advance care plan over time. Similarly, the proposal does not set a baseline level of acceptable service for a provider to bill for advance care planning. We urge CMS to propose standards, such as adoption of certified health IT or evidence-based policies and procedures or training, to ensure that providers have the capability to furnish the services at a high quality. In addition, we are concerned about the precedent set by these proposals to adopt piecemeal payment changes to support what should be an integrated and holistic approach to care.

Consumers and purchasers support these efforts to improve the fee-for-service system because these payment amounts and approaches lay the foundation for many alternative payment models, and because the primary care services identified in this proposed rule are crucial elements of high-value care that are important to consumers and purchasers. Ultimately, however, we believe it is more effective to pay clinicians based on their actual delivery of high value care, and encourage CMS to continue to focus its efforts on designing and encouraging participation in alternative payment models such as medical homes and accountable care organizations (ACOs) that improve upon or move away from fee-for-service payment.

APPROPRIATE USE CRITERIA FOR ADVANCED DIAGNOSTIC IMAGING SERVICES

Appropriate use of services is an important topic to consumer and purchaser communities. While the law requires CMS to use appropriate use criteria (AUC) developed by provider-led entities, we urge CMS to consider the impact of these recommendations on those stakeholders that receive and pay for care.

In the proposed rule, CMS lays out the intention to establish criteria for development of AUC by qualified entities. The goal statement indicates that AUC should be built on evidence-based medicine and should be applied in a quality improvement context. It further states that AUC must be integrated into the clinical workflow of ordering professionals in the context of full treatment guidelines for a patient's condition through clinical decision support (CDS). We strongly agree with this aspirational goal and encourage CMS to facilitate its attainment in the shortest possible time. HHS is working on multiple fronts to incentivize the health care delivery system to adopt advanced IT functionality, including EHRs that have built-in CDS capabilities, and are truly interoperable (i.e., can bidirectionally or multi-directionally share information with other EHRs and with other electronic sources of patient-specific clinical information, and can enable patient-provider information exchange). As we have stated in the past, progress towards this critical goal has been too slow, and people's experience of care and health outcomes are suffering as a result. We urge CMS to take maximum advantage of the opportunity provided by the requirements under this section to accelerate the adoption and spread of advanced health IT that supports meaningful deployment of AUC among other critical functions.

CMS further proposes a process to qualify provider-led entities that develop AUCs. The requirements for qualification include: (1) fully transparent process, (2) use of systematic evidence review, (3) AUC graded by strength of the evidence base, (4) development by a multi-disciplinary team, with disclosure of potential conflicts of interest by all team members, and (5) a process for continual review. We generally agree with these criteria, and we encourage CMS to develop robust conflict of interest definitions, criteria to ensure that multi-disciplinary teams developing AUC are objective, and inclusion of other stakeholders, such as consumers and purchasers, in the process.

Finally, it is unclear what CMS intends by its reference to fitting AUC to "local circumstances and populations" (Section 5.B). Allowing exceptions to evidence-based AUC seems antithetical to the purposes of this set of proposed requirements and should be approached with caution. We urge CMS either to eliminate this provision or, at a minimum, to clarify its intentions by specifying exactly what is intended by this proviso and ensuring that it remains consistent with evidence-based practice.

PHYSICIAN COMPARE WEBSITE

Consumers and purchasers would like the Physician Compare website to be consumer-friendly and easy to navigate, and to comprise a strong set of measures that fairly characterize performance and distinguish among EPs 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 information available to drive quality improvement, accountability, and consumer choice. We strongly support publicly reporting all available measures as soon as possible along with a benchmark, including the CAHPS summary measures for group practices. With regard to CMS's proposal for public reporting of Qualified Clinical Data Registry (QCDR) measures, we are concerned about consumer access to data and information published on individual QCDR websites. A critical feature of Physician Compare is the ability to compare the performance of two providers; posting performance information – even if the measures are identical – on two separate websites creates an unnecessary barrier for consumers. We encourage CMS to consider cross-posting performance information reported via QCDR on Physician Compare even if that information is also made public on a QCDR website directly.

We support CMS's proposal to use the ABC methodology to establish benchmarks of attainable performance, and to use these benchmarks to feed into a 5-star summary rating.

CMS offers various proposals for including new information on the Physician Compare website and/or through a downloadable database. The Physician Compare website has indicated whether an EP or group successfully participates in a number of high-value programs, including the Million Hearts initiative and the EHR Incentive Program. Such indicators of participation in high-value programs are directionally useful, but require substantial context to be meaningful to consumers. We support the direction of CMS's current proposal to indicate individuals and groups who received an upward payment adjustment through the value-based payment modifier program (VM) with a green check mark as well as CMS's proposal to include more robust VM cost and quality performance information in the downloadable database. However, we encourage CMS to add more VM performance information than just upward payment adjustments (i.e., add downward or neutral adjustments) to the Physician Compare website quickly. Similarly, in addition to continuing to report on provider involvement and successful attestation in the Meaningful Use Electronic Health Record (EHR) Incentive Program, we encourage CMS to include a measure of whether a provider offers patients online access to their health information (the View/Download/Transmit requirement of Meaningful Use). Consumers are especially interested in and likely to understand online access

to their clinical information, in addition to whether their providers fulfill Meaningful Use requirements generally. The National Partnership for Women & Families' survey found that one-third of patients would consider switching to a provider who offers online access.⁴ Therefore, displaying the measure of online access as well as the overall measure of participation in Meaningful Use would provide consumers a particularly valuable metric to utilize when comparing providers.

Meeting the Need for Individual Clinician Performance Information

As CMS notes, the primary goal of Physician Compare is to help consumers make informed health care decisions. CMS also notes that consumers are looking for measures regarding individual doctors and other health care professionals. Despite this, reporting performance exclusively at the group level remains an option in PQRS, and therefore in Physician Compare. Given the acknowledged value to consumers of having information to help them choose an individual physician who best meets their needs, we urge CMS to propose a specific timetable for mandatory collection and reporting at the individual level for all EPs, regardless of group size or participation in an alternative payment model such as an ACO. Such reporting will not only provide information that is useful for consumers but will also drive improvement, since revealing the identity of under-performing EPs is likely to give them and their group an incentive to improve. It also would more fully meet the intent of Section 10331 of the Affordable Care Act by making information more relevant to consumers who need to choose a clinician. We would suggest that the initial focus of such reporting be on patient experience with primary care physicians and selected specialists, and on clinical quality performance by specialists.

To achieve this, CMS would need to update the PQRS reporting requirements to clarify that measures submitted through any reporting option would need to include information about each participating EP's performance on each submitted measure. Should CMS decide to take this approach, it should consider the impact on sampling. Currently, the group reporting option allows for sampling of the group's patient populations sufficient to produce measures that are reliable at the group level. To enable individual physician-level reporting of all such measures, this requirement would need to be replaced by more complete sampling of the pertinent denominator population for each measure that is reported. We would suggest that moving to full sampling be viewed as another opportunity to ensure that electronic data collection, particularly via EHR, is complete and usable for performance measurement. These comments are particularly pertinent for reporting of patient experience.

While finding enough of a sample for some process and outcome measures may be difficult since these measures might not be applicable to all patients, the core communication CG-CAHPS measures apply to almost all of a physician's patients. As

⁴ National Partnership for Women & Families. (2014, December). *Engaging Patients and Families: How Consumers Value and Use Health IT*, from <http://www.nationalpartnership.org/research-library/health-care/HIT/engaging-patients-and-families.pdf>, p. 34

such, reporting these measures at the individual EP level should be achievable in the very short term, particularly for primary care providers. 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.⁵ This suggests that the most important unit of measurement for such key dimensions is the clinician and not his or her group. Moreover, this kind of information is highly valuable to consumers in selecting their clinicians. Yet, currently, CMS requires CAHPS reporting only for groups of 25 or more and data collection and reporting is at the group level. Suggestions to require individual clinician-level CAHPS reporting have been resisted on the grounds that it is too expensive. Yet, one organization has conducted field tests in which the cost for surveying using the standard CAHPS methodology and with reliable sample size was determined to be less than \$150 per physician. Of course, such costs could be markedly reduced were the CAHPS survey to be conducted electronically. If CMS were to adopt CAHPS reporting at the individual clinician level, it would not need to repeat the survey every year. Rather, it could give EPs the option of retaining their scores for multiple years before a re-survey would be required. In the short term, the EP could pay for more frequent surveying, or use shorter complementary surveys, in order to receive more frequent feedback. Also, it is possible to design surveys to collect reliable results at the individual clinician level and also aggregate the data for reporting at the group level.

We acknowledge that the CAHPS instruments have shortcomings, and we support the evolution into or separate development of a tool that is more meaningful to consumers, more efficient to administer and collect, and offers providers real-time feedback for practice improvement. However, consumers need information about patient experience now, and we urge CMS to make substantial progress in collecting and reporting individual clinician-level information as soon as possible. We must not wait for the availability of a perfect instrument.

Future Proposals

CMS seeks stakeholder input on the types of quality measures that will help fill measure gaps and meet the needs of consumers and other stakeholders. The Consumer-Purchaser Alliance strongly recommends that CMS emphasize outcomes, including clinical outcomes and patient-reported outcomes, patient and family experience of care, patient safety, and care coordination. For example, we recommend that CMS consider adding the Minnesota Community Measurement measures of functional status and quality of life outcomes following spinal surgery to PQRS and the other physician programs. In addition to prioritizing these types of measures, we encourage CMS to continue to utilize existing multi-stakeholder processes to help ensure that the measures used in high stakes programs are

⁵ Safran DG, M Karp, K Coltin, H Chang, A Li, J Ogren, WH Rogers. "Measuring Patients' Experiences with Individual Primary Care Physicians: Results of a Statewide Demonstration Project," *Journal of General Internal Medicine*, January 2006.

evidence-based, valid, and reliable and that they have the support of multiple stakeholders across the health care system.

We support including Open Payments data in individual EP profile pages along with the appropriate context to ensure consumers understand the information.

CMS notes that Physician Compare contains no or very limited quality information regarding an individual EP or group practice whose patient population includes few Medicare Part B FFS beneficiaries and many Medicare Advantage enrollees. While it would be valuable to have more information about the performance of EPs who primarily care for Medicare Advantage enrollees, the proposal to include a link from those providers' profile pages to the related Plan Finder performance information does not appear to be a valuable approach. Network adequacy and plan-level performance information is not a useful proxy for physician- or group-level performance. We encourage CMS to pursue a common set of provider-level performance measures that would apply across all its payment programs; a common set of measures used by CMS for clinicians participating in Part B and used by Medicare Advantage plans for clinicians providing care for their enrollees is within reach.

PHYSICIAN QUALITY REPORTING SYSTEM

Since 2007, the Physician Quality Reporting System (PQRS) has been a voluntary reporting program that provides a financial incentive to EPs who satisfactorily report performance on quality measures to CMS, first as an additional payment and, starting in 2015, as penalties for EPs who do not satisfactorily report. We strongly support the continued progress CMS has proposed for ensuring PQRS applies to a wide range of EPs and garners meaningful and useful performance information. In particular, we applaud CMS for continuing the trend of removing low-value measures including many low-value measures from the program, aligning measures across programs, and emphasizing measures that are high priorities for consumers and purchasers, including outcome measures and patient experience.

We support the expansion and improvement of the Qualified Clinical Data Registry (QCDR) program. Registries, particularly those that capitalize on health IT, are an important tool for care management and quality measurement. For registries to take advantage of health information exchange, however, they need to meet certain criteria. For example, registries should electronically interface with other data sources, including both EHRs and other sources of data that may be outside the EHR (e.g., imaging, product bar code, other settings). For example, a surgeon's private practice EHR may not be integrated with the EHR at the hospital where she practices, but both the surgeon's and hospital's EHRs should be able to supply data to the registry. Registries do not substitute for interoperability, but they can help in the interim. They should also be able to transmit data electronically to third parties including vendors, purchasers, and CMS. Additionally, registries should use

standards for common data elements, such as LOINC codes for laboratory data and NCPDP standards for pharmacy data. We encourage HHS to finalize data and interoperability standards to facilitate health information exchange so that QCDRs and other health IT vehicles can reach their full potential. We support the proposal to expand the QCDR reporting option to group practices as well as individual EPs; however, we reiterate our interest in seeing individual clinician-level measures reported through PQRS and reference our related comments on Physician Compare above.

We support CMS's intention to stratify and report quality measures within PQRS by disparities variables, including race, ethnicity, sex, gender identity, primary language and disability status. This type of stratification is essential to the identification and ultimately the reduction of disparities in care. For those providers participating in both PQRS and Meaningful Use, we note that Certified Health IT products may serve as a facilitator for measure stratification, as the proposed 2015 Edition certification criteria would include the technological capacity to filter and stratify electronic clinical quality measures by multiple variables that can identify disparities in care, such as sex, race and ethnicity, and patient problem list.

Satisfactory Reporting Requirements

In updating the requirements for satisfactory reporting in CY 2016, CMS proposes to further standardize the expectation that EPs will report on at least 9 measures that cover at least 3 National Quality Strategy (NQS) domains, and that EPs who see patients in face-to-face visits will report at least 1 cross-cutting measure. We support the direction and intent of these proposed changes, particularly as CMS works to improve the value and utility of the measures included in PQRS.

We strongly support the requirement to report 2 outcome measures within the individual and group QCDR reporting options and encourage CMS to incentivize measures that use patient-generated data such as patient-reported outcome measures (PROMs).

We are disappointed in CMS's proposal to exclude group practices reporting via qualified registry, EHR, or QCDR from the requirement to report CAHPS for PQRS, and we urge CMS to consider requiring all group practices to report patient experience through an appropriate instrument. As we describe in our comments above, we encourage CMS to consider taking this even further to require all EPs participating in PQRS to report patient experience regardless of the reporting option. CMS notes that some groups reporting via qualified registry, EHR, or QCDR may not find CAHPS for PQRS relevant to their practice. We have previously suggested that CMS consider using the Surgical CAHPS survey to expand the applicability of CAHPS measures to additional group practices and reiterate that suggestion now.

We are disappointed that the option for group practices to participate in the GPRO via EHR does not require reporting at least one cross-cutting measure if the practice had at least one face-to-face visit. We are also dismayed that the measures available to report via EHR may be constrained by the vendor's decision not to offer a measure. We strongly encourage CMS and ONC to establish certification requirements that compel vendors to include all PQRS measures and measure groups that may be applicable for their customers.

Quality Measures

Our support for the measures included in PQRS is based on the recommendations of the Measure Applications Partnership (MAP) as reflected in the 2015 MAP reports to CMS.⁶ We strongly support the handful of truly high-value measures included in the program, such as:

- Clinical Outcome Post-Endovascular Stroke Treatment
- Depression Remission at Six Months
- In-Hospital Mortality Following Elective Open Repair of AAAs

Overall, we urge CMS to use more comprehensive measures where possible, such as composite measures rather than individual component measures. This approach raises the bar for PQRS and garners more performance information that can be used to drive quality improvement, value-based purchasing, and consumer choice. Similarly, we encourage CMS to reconsider the inclusion of documentation measures in PQRS. We strongly prefer measures that report a score or an outcome over mere documentation of a process or that an outcome was obtained.

In a number of cases, CMS has chosen to split a single NQF-endorsed measure into separate measures for the purpose of reporting in PQRS. We are disappointed that CMS continues this approach and urge CMS to consider using these NQF-endorsed measures comprehensively as intended, rather than watering down the measures solely to increase the number of measures EPs can report. For example, CMS splits NQF #0101: Falls Screening, Risk Assessment, and Plan of Care to Prevent Future Falls into three separate measures, PQRS #154, #155, and #318. We strongly encourage CMS to consider using NQF #101 as a single, comprehensive, cross-cutting measure.

We support the proposed NQS domain changes as well as the majority of measures proposed for removal because these measures are duplicated, topped out, or low-value. We are disappointed that PQRS #335: Maternity Care: Early Elective Delivery/Induction and #336: Maternity Care: Post-Partum Follow-Up will no longer be maintained by the measure steward and encourage CMS to consider

⁶ MAP 2015 Considerations for Implementing Measures in Federal Programs: Clinicians, Final Report; March 2015. Available from https://www.qualityforum.org/Publications/2015/03/MAP_2015_Considerations_for_Implementing_Measures_in_Federal_Programs_-_Clinicians.aspx.

opportunities to maintain these measures. We are also disappointed that the Optimal Vascular Care Composite is proposed for removal due to duplication of some components with the Million Hearts measures for blood pressure, tobacco use, and aspirin use. We encourage CMS to consider retaining the Optimal Vascular Care Composite measure in PQRS and, if feasible, adjusting the Million Hearts program to acknowledge reporting of these clinical areas via the composite rather than the related Million Hearts measures. Composite measures are a more meaningful and parsimonious way to capture measures of optimal care for specific patient populations.

We generally support the new and adapted measure groups. Although some of the measures proposed for inclusion in the groups are low-value on their own, when reported as part of the complete measure group they may add insight into provider performance. We recommend that CMS add patient-centered measures of patient experience and care coordination to the CABG measure group.

ALIGNED REPORTING FOR MEDICARE MEANINGFUL USE AND COMPREHENSIVE PRIMARY CARE INITIATIVE (CPCi)

We support the proposal to expand the CPCi reporting requirement to align with PQRS reporting for other EPs; that is, to report at least 9 measures from at least 3 NQS domains. More generally, we support efforts to align quality measurement and requirements across CMS programs, including the proposal to align Meaningful Use and CPCi quality reporting. Across HHS initiatives, we urge CMS to promote the consistent prioritization of high value measures, including patient experience and outcomes, to facilitate rapid improvements in care and judicious use of public funds.

Currently, most electronic quality measures are retooled clinical process measures, not measures of patient outcomes over time. The kinds of measures necessary to support new payment and delivery models are possible in an electronic environment, but systems and infrastructure must be designed accordingly. Electronic quality measurement should look across longer periods of time, utilize more data sources and consider care in other settings beyond hospitals and ambulatory care such as long-term post-acute care, behavioral health and palliative care. With these electronic connections across different parts of the care continuum, we can truly begin to measure health outcomes comprehensively.

In any effort to align measure reporting across programs, including in the consideration of Meaningful Use-CPCi alignment, we encourage CMS to consider that alignment and accompanying flexibility have the potential to compromise the progress made in quality reporting under the Meaningful Use program. We need even further advancement in quality reporting, and thus any alignment should maintain or raise the bar in quality reporting under the Meaningful Use program instead of diluting or reversing progress.

POTENTIAL EXPANSION OF THE COMPREHENSIVE PRIMARY CARE INITIATIVE

The Consumer-Purchaser Alliance strongly supports the work CMS has done to date to transform primary care to be more high-value, and we encourage CMS to expand the Comprehensive Primary Care initiative (CPCi). We support expanding CPCi to new geographic regions, provided adequate infrastructure and resources are in place to support practices in achieving true transformation. For specific recommendations on ways to strengthen the initiative and support participating providers and practice, we refer you to comments on this proposed rule from the National Partnership for Women & Families.

As CMS considers the best methods for payers to engage with one another, participating practices, and CMS under a potential expansion, we urge the inclusion of consumers, purchasers, and other stakeholders. Integrating these perspectives early is not only important to create a true multi-stakeholder process, but is critical to ensuring the initiative reflects of the needs of the patients and the community.

To ensure that an expansion of CPCi is attractive to new payers and self-insured purchasers, we encourage CMS to offer information that purchasers want to see to know the model works, such as:

- evidence that the model leads to improved health outcomes, good patient experience, and cost reduction;
- quality measures that are comparable to other programs to assess progress across model types; and
- resource use.

MEDICARE SHARED SAVINGS PROGRAM

Quality Measures

CMS proposes to add one new quality measure and adopt a policy to address quality measures that are no longer appropriate. Regarding the quality measure set, we continue to have concerns over the domination of process measures that represent a single factor among many that interact to determine outcomes. Outcomes are what matter to patients and purchasers, and we urge CMS to advance its efforts to replace process with outcome measures for the Medicare Shared Savings Program (MSSP) and other programs. Please refer to our comments regarding the specific evolution of MSSP from February 2015, available here:

http://www.consumerpurchaser.org/files/CPA_MSSP_Comments_Feb_2015.pdf

CMS has proposed to add Measure 42, Statin Therapy for the Prevention and Treatment of Cardiovascular Disease. We support the inclusion of this measure because it addresses a costly and highly prevalent condition. We recommend that

CMS consider using this as a single measure with weighted denominators rather than as three separate measures. To determine the benchmark, CMS should examine the variability across the three denominators. If there is a significant difference in performance across the denominators, that would provide evidence for separate benchmarks. Given that this measure is in use in other Medicare and private sector programs, we recommend that CMS include it as a pay-for-reporting measure for one year, and then pay for performance in years two and three. CMS asks whether this measure should be scored for more than the usual two points. We recommend that the measure be scored at two points and not weighted more heavily than other measures. The complexity of the measure should not determine the point system, but rather the importance of the measure. This measure's importance is on par with other condition-specific measures.

We are especially pleased with the inclusion of patient-reported outcome measures (PROMs), such as Health Status/Functional Status (Measure 7) and Depression Remission at Twelve Months (Measure 40). CMS can help to move the market towards adoption of PROMs in routine care and performance reporting by including such measures in its provider incentive programs.

Regarding the proposed handling of pay-for-performance measures that are deemed no longer to be valid, we support CMS's proposal to immediately move them to pay-for-reporting status until they can be removed.

Measuring Use of Health Information Technology within MSSP

We encourage CMS to strengthen its current measure of HIT use (ACO-11), which simply requires providers to report on whether or not they have successfully attested to Meaningful Use criteria. At a minimum, this measure should be expanded to include specialists and should require a majority of participants to demonstrate that they have successfully met Meaningful Use requirements, rather than simply reporting on their attestation.

Measuring and rewarding activities that are enabled by information exchange, such as care coordination, will drive the adoption and use of health IT. Health IT and health information exchange also elevate the capacity of measures to assess the quality of care in general (i.e., not just for activities enabled by information exchange) by making data collection and aggregation more agile. For example, using health IT to collect data across time (longitudinal measurement) and space (the spectrum of providers) creates a more complete picture of patient outcomes than the pinhole picture derived from a singular event. There are specific functionalities that can only be leveraged in an electronic environment that support health IT-enabled measures. CMS should add these functionalities to program requirements to improve the availability of high-value measures. These include:

- Capturing patient information such as patient identifiers, contact information, caregiver information, primary language, and social and behavioral determinants of health.

- Encouraging the transmittal of data between providers, such as offering provider directories mapped to Direct addresses and standard identifiers.
- Enabling patients to contribute information to their medical records that is related to their care.
- Creating an interface to claims/administrative data using common identifiers such as plan member ID to permit the construction of longitudinal measures.

Related to capture of this important information, we suggest adding measures to the MSSP measure set that capture some core individual meaningful uses of health IT in addition to demonstrating overall satisfaction of Meaningful Use requirements. These structural measures document capabilities and processes that are most relevant to the goals of ACO participants, including care coordination and patient engagement. We envision that initially, CMS would require that providers report on these measures without holding them to specific benchmarks for achievement. Over time, however, we encourage CMS to add these measures as conditions of participation in MSSP, and recommend that an ACO demonstrate success on these measures for a minimum percentage of their attributed patient population as part of the ACO's application to MSSP. These measures include the extent to which:

- an ACO participant electronically sends Summaries of Care to providers to whom patients have been referred;
- an ACO participant helps its patients actually view, download, or transmit their health information (for instance, through a patient portal or an Application Programming Interface);
- an ACO participant helps its patients actually electronically exchange secure messages with their provider (for instance, through a patient portal or an Application Programming Interface); and
- an ACO participant incorporates into their EHR personally-generated health data from the patient.

Such structural measures are especially relevant because ACOs should be leaders in coordinating care and must lead the way in fostering health information exchange. Likewise, giving patients the tools to access and manage their own health information electronically is foundational to patient engagement and high quality care. A comprehensive national survey from the National Partnership for Women & Families finds that patients who have utilized online access to their health information report that it has positively impacted their knowledge of their health, ability to communicate with their doctor, and desire to do something about their health.⁷ As these measures of health IT use evolve, we encourage CMS to incorporate criteria that are as or more robust than those of the Meaningful Use program, as well as equivalent thresholds.

⁷ National Partnership for Women & Families, *Engaging Patients and Families*, p. 29.

VALUE-BASED PAYMENT MODIFIER AND PHYSICIAN FEEDBACK PROGRAM

We applaud CMS for its commitment to ensuring that all physicians and other EPs, regardless of group size, are included in the value-based payment modifier (VM) program by 2017, and we support many of the proposals to improve the program. However, most changes are fairly minor adjustments to the VM program. We would like to see more significant changes to the program, such as higher-value measures and performance scores that reflect the variation we know is present in care delivery, to create a stronger foundation before the transition to the Merit-Based Incentive Payment System (MIPS).

- We support applying the VM to non-physician eligible professionals who are Physician Assistants, Nurse Practitioners, Certified Nurse Midwives, and Certified Registered Nurse Anesthetists.
- We support continuing the two-category approach for CY 2018 VM based participation.
- We support applying the quality-tiering methodology to all groups and solo practitioners in Category 1 for the CY 2018 payment adjustment period.
- We support applying the VM to groups and solo practitioners who participate in the MSSP regardless of whether any eligible professionals in the group or the solo practitioner also participated in an Innovation Center model.
- We strongly support the proposal to apply an additional upward +1.0x to MSSP participants classified as high quality if their attributed patient population has an average beneficiary risk score in the top 25% nationwide.
- We strongly support the proposed inclusion of the CAHPS survey in the VM for MSSP ACOs.

ADDITIONAL PROGRAMS, REQUESTS FOR INFORMATION, AND COMMENTS

Impact of MACRA: Payment for Global Surgical Packages

Section 523 of MACRA addresses payment for global surgical packages. When collecting data on a recurring basis from practices and other facilities, CMS should ensure it is from a cohort of efficient practices and facilities. CMS should not be paying physicians at rates that include wasteful and inefficient care.

MACRA: Low-Volume Threshold for the Merit-Based Incentive Payment System

CMS seeks input on the best approach to establishing a low-volume threshold below which an EP would be excluded or exempt from participating in the Merit-Based Incentive Payment System (MIPS). The goal of setting a low-volume threshold should be to include the largest number of providers who care for Medicare beneficiaries while still providing a large enough sample to enable reliable reporting of performance information. We find the initial suggestion of excluding EPs that do

not have at least 10% of their patient volume derived from Medicare Part B encounters to be reasonable. Nonetheless, we encourage CMS to phase down this percentage over time if initial data indicate that a lower patient volume would still result in reliable performance information.

MACRA: Clinical Practice Improvement Activities

MACRA provides six categories that must be included under clinical practice improvement activities. We encourage CMS to expand and enhance the categories in the following ways:

(1) Expanded practice access, such as same day appointments for urgent needs and after-hours access to clinician advice.

In addition to same-day appointments and after-hours access, expanded practice access should also include availability by phone, email, or in-person during evenings and weekends and other off-hours. Moreover, “access” should be defined to include beneficiaries’ ability to access their clinical information online, wherever and whenever needed, and to view, download, and share this information with family caregivers and other care team members as appropriate. Expanded access must also accommodate the needs of patients with limited physical mobility, English proficiency, cultural differences or other issues that could impede access to care or act as a barrier to successful patient self-management. Finally, expanded practice access should facilitate ready and appropriate access to a full scope of services and providers, including mental health providers, social supports, and community-based resources.

(3) Care coordination, such as timely communication of test results, timely exchange of clinical information to patients and other providers, and use of remote monitoring or telehealth.

Truly coordinated care has processes in place to effectively monitor and manage all tests, referrals, and procedures; shares such information with patients as well as with providers, and ensures that patients receive appropriate follow-up care and help in understanding results and treatment recommendations. Further, care coordination ensures smooth transitions by assisting patients and families as the patient moves from one care setting to another, such as from hospital to home. Care coordination should also help patients choose specialists and obtain medical tests when necessary. Care teams should inform specialists of any necessary accommodations for the patient’s needs.

Much of care coordination is accomplished through robust utilization of health IT and health information exchange infrastructure. For example, the Meaningful Use program’s proposed requirements for Stage 3 illustrate how health IT can and should help support these critical components of care coordination:

- Providers receiving Summaries of Care from referring providers incorporate the Summaries into their EHRs. This measure effectively closes the referral loop and realizes coordination of care, going beyond the routine practice activity of *sending* Summaries of Care.
- Providers give patients the ability to send secure messages and respond to these messages in a timely manner. Secure messaging allows patients and their authorized representatives to receive and send information and questions that support person-centered communications. We do not propose requiring a specific timeliness standard, only the measurement and reporting of timeliness rates, as is current practice for industry leaders such as Kaiser Permanente.
- Providers incorporate data from non-clinical settings. Collecting and utilizing data from community settings and non-clinical providers are valuable actions that contribute to person-centered care by encompassing providers across the care continuum.

(4) Beneficiary engagement, such as the establishment of care plans for individuals with complex care needs, beneficiary self-management assessment and training, and using shared care planning and shared decision-making mechanisms.

Meaningfully engaging beneficiaries and families at all levels of care delivery is critical to transformation. Patients and families should be primary allies in clinical improvement initiatives. CMS defines beneficiary engagement at the point of care, which is critical to practice improvement. Health information technology can contribute significantly to beneficiary engagement at point of care, facilitating not only enhanced care coordination but also sustained partnerships between providers and their patients. In addition, we believe that transformative beneficiary engagement means supporting patient and family participation as equal partners in not only their own health and health care decisions, but also at the care redesign, governance, and community levels. Examples of robust partnership with patients and families in the primary care setting include:

- Practices work in partnership with patient/family advisors throughout the process of choosing, implementing, and evaluating a patient portal. Patients and families can help practices ensure a portal is easy to use and includes functions that are important to patients, and can also help practices understand how to communicate with patients about portals most effectively.
- Practices work in partnership with patient/family advisors to enhance the support the practice provides to patients and families as the patient transitions home and back to the practice following an acute and/or post-acute care stay.

- Practices partner with patient/family advisors in identifying helpful community-based supports and resources and building better connections between the practice and those organizations/systems.

In addition to these refinements, we encourage CMS to expand and enhance these categories to include continuous quality improvement within a practice via the use of patient-reported outcome (PRO) tools and corresponding collection and reporting of PRO data in a systematic way. Such data collection could significantly improve the future development of PROMs, which is frequently hindered by too few providers using a given tool in practice or by barriers to data access. We would also support other approaches to encourage the collection and use of patient-generated data in quality improvement and to facilitate beneficiary engagement, such as through:

- Incorporation of patient-generated health data into their EHRs. The information patients can provide about their abilities and support needs for self-management complements clinical information generated by care teams to provide a comprehensive, person-centered view of an individual's health. This type of clinical improvement also builds the foundation for better measurement of patient-report outcomes and patient experience. As practices incorporate patient-generated data into the EHR, practices should be rewarded for using that data to measure and improve the quality of care and patient experience.
- Care planning that prioritizes patients' identification of their individual health goals and the reconciliation of these goals with clinical goals.