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ALLIANCE
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November 17, 2015

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

RE: CMS-3321-NC: Request for Information Regarding Implementation of the Merit-based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative 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 Request for Information (CMS-3321-NC). C-P Alliance is a collaboration of leading consumer, labor, and employer organizations committed to improving the quality and affordability of health care through the use of performance information to guide consumer choice, payment, and quality improvement.

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 payment models should result in better health outcomes, improved care coordination and patient experience of care, and decreased costs.[1] To that end, we urge CMS to design both the Merit-based Incentive Payment System (MIPS) and the Alternative Payment Model (APM) requirements to transform the health care delivery system to meet the National Quality Strategy aims.

[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."

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Principles for the Merit-based Incentive Payment System

As the new default payment program for clinicians participating in Medicare Part B, it is critical that the MIPS design rewards high performance and improvement rather than supporting the status quo. MIPS provides the opportunity to address the limitations in existing physician evaluation programs such as the Physician Quality Reporting System (PQRS) and to implement more rigorous physician-level performance metrics. In addition, the MIPS program can be used to capitalize on investments in the infrastructure for better performance measurement, such as health information technology used in clinical settings or for health information exchange, and any new measures and measure systems funded through the new measure development appropriation established in MACRA. CMS is charged with using quality measures that focus on health outcomes and patient-reported outcomes, a charge that closely aligns with consumer and purchaser priorities for measurement. We will only accelerate the development of better measures in these areas with a concerted effort to improve the infrastructure for performance measurement. The Clinical Practice Improvement Activities segment of the MIPS score should be utilized as a vehicle for improving performance measurement, including improving the measures themselves, and to support providers' transition to APMs.

In the Appendix, we recommend that CMS give greater weight to specific measures, issues, and activities that are top priorities for consumers and purchasers. Further, we recommend that CMS give greatest weight a handful of high-value cross-cutting measures to catalyze improvement on those priority areas, and to update the top-weighted measures over time. We recognize that even a large relative difference in weight between any two activities or measures in any one of the performance categories is unlikely to have a major impact on the overall MIPS score and thus, on a clinician's overall Medicare Part B payment. Nonetheless, assigning greater weight to select activities or measures clearly signals that they are a priority, particularly when aligned with private sector initiatives, and encourages faster improvement in those areas. In the same vein, we recommend that CMS establish minimum program requirements for MIPS that would result in a composite MIPS score below 100 for a clinician who meets only the minimum requirements, and specify a few opportunities to earn a higher score by exceeding those minimum requirements in priority areas (e.g., using patient-reported outcomes in continuous quality improvement, robust use of health IT and patient-generated data). This scoring arrangement would not penalize providers meeting the minimum requirements when they are compared to the pre-established benchmark, but would allow CMS to identify and reward high performers in key areas.

Principles for Alternative Payment Model Criteria

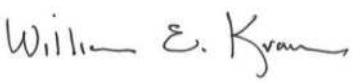
Although a strong MIPS program is an important lever contributing to lower health system costs overall, we do not anticipate it being sufficient to achieve the Triple Aim. The resource use component of the MIPS score offers some incentives for

efficiency and prudence by physicians, but the measures of resource use available today are not comprehensive enough to drive this change as far as is needed. We need to move further away from the fee-for-service design that rewards volume over value; we need to test and spread more innovative alternative payment models that support and reward rapid progress toward the National Quality Strategy aims. CMS should encourage providers to participate in APMs while maintaining rigorous standards that ensure these models will meaningfully increase the value of health care. Within the framework laid out by CMS in 2014, we support the use of Category 4 models as well as Category 3 models with two-sided risk that could include a range of different payment strategies.[2] Models with two-sided risk or capitation-like arrangements incentivize providers to adopt practices that have been shown to increase value to a range of stakeholders including consumers and purchasers, not just models that slightly alter payment arrangements.

MACRA requires that a clinician assumes "more than nominal" risk to be a qualifying APM participant. 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. The design of risk in an APM should come with an emphasis on outcomes: health outcomes, patient experience and patient-reported outcomes, and comprehensive views of resource use. At the same time, the APM design must offer significant flexibility for innovation in how a clinician or practice achieves those outcomes.

In the Appendix, we provide responses to the specific questions and issues raised in the Request for Information. If you have any questions or would like to discuss our recommendations further, please contact Stephanie Glier, Senior Manager for the Consumer-Purchaser Alliance, at sglier@pbgh.org or (415) 615-6341.

Sincerely,



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[2] Rajkumar R, Conway PH, Tavenner M. CMS--engaging multiple payers in payment reform. JAMA. 2014 May 21;311(19):1967-8. Accessed November 2015 from http://jama.jamanetwork.com/article.aspx?articleid=1864086.

APPENDIX

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

A.1. MIPS Eligible Professional (EP) Identifiers and Exclusions

We urge CMS to use identifiers that facilitate performance measurement at the most granular level: at the level of the individual clinician. As performance measurement becomes more integral to clinician participation in Medicare Part B, it is important that program-level identifiers support the needs of performance measurement as well. As we noted in our comments on the proposed Medicare Physician Fee Schedule for CY 2016, consumers need information about individual doctors and other health care professionals to inform their health care decisions—measures at the practice, group, or other organization level simply do not provide enough granularity for meaningful consumer choice.[3] Rather than creating a distinct MIPS provider identifier that might not be utilized by the private sector, we recommend using existing identifiers, specifically the NPI type 1. The NPI type 1 is consistent across payers and would allow for clinician-level performance measurement that consumers and purchasers would like to see incorporated into all CMS programs. MACRA and MIPS provide a timely opportunity to strengthen NPIs as a clinician-level identifier. We are not opposed to using TINs in combination with NPIs, however TINs do not offer the most logical unit of performance measurement since they reflect groups of providers who bill together, instead of the providers rendering care.

A.3. Quality Performance Category

Consumers and purchasers have long viewed PQRS as a missed opportunity for CMS to incentivize more substantial advances in better care. We have previously expressed concern that PQRS continues to require too little of individual eligible providers, who need only report on a small handful of measures of their choice to meet program requirements. This is a fundamental flaw in the PQRS program for multiple reasons: the existing measure set includes many low-bar documentation and process measures that offer little value to consumers or purchasers; any small handful of measures is unlikely to reflect the spectrum of patients and conditions treated by the EP; and providers are given a choice of which measures to report, effectively permitting "cherry-picking" and potentially giving an inaccurate picture of his/her practice.

MACRA presents an opportunity for MIPS to improve upon the PQRS reporting criteria and evolve into a more meaningful program, one that is founded on more

[3] Consumer-Purchaser Alliance comments to CMS on CY 2016 Proposed Medicare Physician Fee Schedule, submitted September 8, 2015. Available from: http://consumerpurchaser.org/files/CPAlliance_CY2016_PFS_final.pdf.

robust requirements and measures. We support the requirement that selected PQRS measures must cover at least three of the six National Quality Strategy domains to ensure breadth of measurement. However, we would also like to see MIPS measures move away from process measures and we strongly urge CMS to design the Quality Performance category such that a majority of the quality measures are outcomes-based, including patient-reported outcome measures (PROMs), patient experience of care, process measures closely linked to outcomes, and cross-cutting measures. As consumers and purchasers have advocated for in the past, measures of process of care should be de-emphasized or entirely excluded from the MIPS measure set, particularly those that are only documentation or standard-of-care measures. These low-bar measures may be useful in an audit function or to demonstrate that a provider meets conditions of program participation, but they offer little information of value to consumers and purchasers. Overall, we strongly urge CMS to identify a small number of high-value measures to weight most heavily among all measures in the Quality Performance category.

Priority Measures

We strongly urge CMS to give greater weight to PROMs and measures of patient experience of care. These high-impact measures are meaningful to consumers, purchasers, and providers, and can drive both quality improvement and increased value. In addition, many cross-cutting measures reflect issues that are important to consumers and purchasers, while having the added benefit of applying to providers across specialties. As new measures are developed and added to the MIPS set, all new measures should go through a multi-stakeholder review process to ensure they are evidence-based and meet the needs of all stakeholders, including consumers and purchasers.

Measuring patient experience and satisfaction is often the only way to evaluate elements of care that patients and caregivers identify as most important to improving their health outcomes and their care experience. As the current primary source of patient experience information, CAHPS is a valuable instrument. We recommend that CAHPS reporting be included as a mandatory part of the quality performance category. As we have noted in previous comments, consumers and purchasers would like to see CMS require all group practices, and ideally all EPs, to report on patient experience regardless of reporting mechanism. As the core communication CAHPS measures apply to almost all of a clinician's patients, reporting these measures at the individual clinician level should be achievable in the very short term, particularly for primary care providers. We support the use of an electronic short form patient experience survey to lessen survey expense and reduce respondent burden, thereby enabling patient experience measurement at the individual physician level. For example, a recent pilot program by the Pacific Business Group on Health and Massachusetts Health Quality Partners tested an

electronic short form survey with promising results, indicating it may be a cost-effective alternative to the longer, paper survey format.[4]

Additionally, we would support CMS in the exploration or integration of additional information or modules for patient experience reporting. We have previously recommended the use of the Surgical CAHPS survey to expand the provider types to whom CAHPS surveys apply. We would support CMS consideration of patient experience questions beyond the CAHPS core set – including supplemental item set questions – that reflect areas of significant importance to patients and families. For example, the Cultural Competence supplemental item set includes questions assessing:

- Whether a provider spoke too fast or used words a patient didn't understand;
- Whether the patient felt they were treated unfairly because of their race, ethnicity, or how well they spoke English; and
- If necessary, whether an interpreter was provided, and how they would rate the interpreter.

The HIT supplemental item set includes questions such as:

- Whether patients are able to email their provider with questions, and get responses back in a timely fashion; and
- Whether the provider's office puts laboratory or other test results on a website for the patient to see, and how easy it is to find those results.

As CMS considers the best approach to including patient experience in the Quality Performance category, we urge you to take into account the need for rapid and actionable feedback of this information to clinicians and practices to support quality improvement. We also urge you to develop strategies for collection of patient experience info as part of clinical workflow in order to minimize cost and burden for both providers and patients. Finally, we urge the inclusion of patient and consumer advocates in the development of these measures. Improving the CAHPS tool or another patient experience tool will increase the meaningful information available to consumers, purchasers, and providers.

As the development of the MIPS program proceeds and draws on existing aspects of PQRS for quality performance reporting, we would like to emphasize that existing measures do not meet all of the needs of consumers and purchasers. Addressing measure gaps should remain an ongoing priority so that enhanced measures can drive improvement in clinical outcomes, patient-reported outcomes, patient and family experience of care, patient safety, and care coordination.

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[4] Public results are forthcoming as of mid-November, 2015. For more information, please contact Stephanie Glier, Senior Manager for the Consumer-Purchaser Alliance, at sglier@pbgh.org.

Reporting Mechanisms

We support all of the existing PQRS reporting mechanisms for MIPS because the mode of reporting is less critical than the content of the reporting criteria. However, if CMS chooses to maintain group reporting options we strongly urge the measures to be reported at the most granular level even if subsequent aggregation takes place; in particular, we want individual clinician-level information available through public reporting whenever appropriate for a given measure.

Data Stratification

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 identifying intervention points and strategies. Measure stratification has great potential to detect disparities among different patient populations, and could help to identify physician practice patterns that are impacting care, for example, with respect to ordering tests and procedures or safety practices. Such data will help practices direct resources efficiently toward quality improvement initiatives and allow providers to address gaps in health equity.

We encourage CMS to make stratified quality data publicly available at both individual and practice levels. Doing so will report trends in health equity that aid consumers in making informed choices, and will help providers identify and ultimately reduce health disparities. Because of the potentially confusing nature of reporting stratified data, we strongly urge CMS to do consumer testing on the language that would accompany public reporting on stratified data and health disparities.

Additionally, we support including improvements in health equity and reductions in health disparities as part of the definition of improvement with respect to measures and activities for the MIPS performance categories.

A.4. Resource Use Performance Category

Resource use measures are an integral part of understanding and evaluating the efficiency and value of care delivery. Beyond the resource use measures now in place via the Hospital Value-Based Purchasing program and the Physician Value-Based Payment Modifier, information about provider resource use has recently become more widespread and in greater demand, as demonstrated by initiatives such as the Network for Regional Health Improvement (NRHI) multi-region total cost of care pilots, system-wide websites like California Healthcare Compare, and public and private sector applications using information CMS has made publicly

available.[5,6,7] C-P Alliance applauds CMS for making this information available and we encourage you to continue evolving the measures and performance expectations for this MIPS category beyond the Physician Value-Based Payment Modifier policies now in place.

We strongly support the concept of a total cost of care measure, particularly one that can apply consistent methodologies across multiple populations (i.e., we would like a measure that applies to the Medicare Part B population as well as commercial populations). We also support the continued use of the Per Capita Costs for All Attributed Beneficiaries measure. In addition, we encourage CMS to include measures of appropriate resource use in this category. We would like to see this category include measures of unnecessary care (e.g., Choosing Wisely measures), particularly measures that target unnecessary utilization of high cost services and treatments (e.g., radiology for particular conditions, and surgical treatments without a strong evidence base including certain stents, angioplasty, and spinal fusion) and utilization measures that indicate a patient's care is not well-managed (e.g., emergency department visits and other measures of ambulatory care sensitive conditions and utilization). Similarly, to the extent these measures are feasible for use in Medicare Part B, we encourage CMS to consider resource use measures utilized in private sector programs like the Integrated Healthcare Association pay-for-performance program; this program includes 13 resource use measures such as all-cause readmissions, percent of outpatient procedures done in a preferred facility, and generic prescribing for certain types of drugs.[8]

Regarding peer groups for assessing performance, patients expect the same high level of care regardless of the type of provider they're seeing. If a measure can evaluate performance on resource use at the individual clinician level, there is no reason to stratify by provider type.

A.5. Clinical Practice Improvement Activities Performance Category

We were glad to see MACRA include the Clinical Practice Improvement Activities (CPIA) category in the MIPS program design and strongly support many of the subcategories outlined in the statute, such as expanded practice access, care coordination, beneficiary engagement, and patient safety and practice assessment. We commend CMS for the inclusion of these subcategories as critical steps towards the true transformation of practices. **CPIAs should function as a vehicle for improving provider performance—including improving performance**

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[5] Network for Regional Health Improvement, Regional Total Cost of Care Project, information available from http://www.nrhi.org/work/multi-region-innovation-pilots/tcoc/.
[6] Consumer Reports and California Department of Insurance, California Healthcare Compare, http://www.cahealthcarecompare.org/cost_select.jsp.
[7] See, e.g., CMS Open Payments Data tool at https://openpaymentsdata.cms.gov/, ProPublica Open Payments Explorer at http://projects.propublica.org/open-payments/.
[8] Integrated Healthcare Association, Recommended Measurement Set for Measurement Year 2016, updated September 2015, available from http://www.iha.org/pdfs_documents/p4p_california/MY2016-Measure-Set.pdf.

measurement itself—and supporting providers in the move from fee-for-service payment arrangements to APMs.

Consumers and purchasers have several recommendations on both subcategories and types of activities that should be considered as clinical practice improvement for EPs. As this category is new to CMS quality performance programs, we look forward to offering additional input on the proposed structure of this MIPS component and the methodology by which providers will receive credit.

We recommend that the following should be considered CPIAs:

- We encourage CMS to add a subcategory of activities that support continuous quality improvement within a practice via the use of **patient-reported outcome (PRO) tools and the corresponding collection of PRO data in a systematic way**. CMS should provide guidance on acceptable PROs and require data reporting back to CMS that supports measure development efforts. Such data collection could significantly improve the use of PROs in clinical practice and future development of PROMs which is frequently hindered by too few providers using a given PRO tool or by limited data access for measure development and testing. In particular, we encourage CMS to incentivize the collection of global health PROs in the public domain (e.g., PQH-2/PHQ-9 and the PROMIS instruments) and the use of PROs for clinical conditions that have validated PRO tools available but no PROMs developed or in widespread use (e.g., Seattle Angina Questionnaire, pain management for cancer patients via the MD Anderson Symptom Inventory, functional health status via SF-12/VR-12).[9]

- We would like to see CMS include CPIAs that **standardize measurement and transparency for continuous quality improvement**. For example, Howard Beckman's Rochester Individual Practice Association (RIPA) may serve as a model for incorporating rapid feedback on resource use measures that focus on appropriate utilization and eliminating overuse. Specifically, RIPA supports continuous quality improvement in the IPA as well as lower resource use for diabetic patients seen by these practices.[10]

- This category should include provider participation in **Innovation Center models that drive delivery system transformation but do not meet the criteria for APMs**. For example, provider participation in one of the recently formed 29 Practice Transformation Networks should qualify as a CPIA.

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[9] For additional recommendations about PROs that could be included in a CPIA, please see: Hopkins D, Huff JE. "Action Brief: Patient Reported Outcomes," Consumer-Purchaser Alliance, July 2015, available from http://consumerpurchaser.org/files/CPA_Patient-ReportedOutcomesBrief_05.pdf.

[10] Greene RA, H Beckman, T Mahoney. "Beyond the Efficiency Index: Finding a Better way to Reduce Overuse and Increase Efficiency in Physician Care," Health Affairs, June 2008, available from http://content.healthaffairs.org/content/27/4/w250.abstract.

- We strongly support activities that promote **increased patient and family engagement and patient- and family-centered care**. Meaningfully engaging beneficiaries and families at all levels of care delivery is critical to transformation. The MACRA RFI focuses primarily on beneficiary engagement at the point of care; together with the National Partnership for Women & Families, we urge CMS to go further and prioritize beneficiary engagement at all levels of care, including in care redesign, governance, and in the community. Patients and families should be primary partners in clinical improvement initiatives across all CPIA subcategories as all of the CPIAs will have an impact on care delivery and patient experience. Based on consumer and purchaser experience, we have some specific recommendations for these types of CPIAs:

    - Use standardized care processes for continuous quality improvement. The Intensive Outpatient Care Program (IOCP) funded by CMS and operated by the Pacific Business Group on Health uses certain care guardrails across its 23 participating physician groups in order to promote increased patient and family engagement for high-risk Medicare patients. For example, all practices participating in IOCP use the Patient Activation Measure (PAM) as part of the initial patient assessment, which enables the care coordinator to focus the interaction so it is appropriate to the patient, and to modify the interaction as the engagement level changes over time. This approach helped providers achieve improved health outcomes and prevent avoidable hospital use. The standardized use of the PAM and the development of shared action plans, supported by motivational interviewing, individualized the patient-care coordinator relationship. It also shaped other provider-led communication strategies that facilitated patient-centered care and shared decision-making.

    - Support new evidence-based approaches to person-centered care. For example, CMS should also carefully monitor the Hartford Foundation-Scan Foundation-funded person-centered planning project operated by the National Committee on Quality Assurance. The project has developed recommendations for demonstrating person-centered planning for those with complex health needs.[11]

- We encourage CMS to focus on practice improvement activities that **leverage patients' electronic access to and use of their health information**. These activities are particularly relevant for the beneficiary engagement and care coordination subcategories. For example, CPIAs that build on patient online access to their health information could include health information reconciliation, shared care planning, and the capture of social determinants

[11] National Committee on Quality Assurance. "Policy Approaches to Advancing Person-Centered Outcome Measurement," September 2015, available from http://bit.ly/1Hrqv4T.

of health with links to community resources. A critical component of these activities is the use of patient-generated data in care, and the incorporation of patient-generated data into a provider's EHR or other health IT system.

Although our recommendations include specific APM-like activities, we are concerned about the CPIA subcategory of "participation in an APM" which, alone, does not mean that a practice is changing and improving how they deliver care. Practices participating in APMs must demonstrate that they are actually moving towards meaningful transformation. We encourage CMS to require more than attestation for CPIAs wherever feasible to tie successful practice transformation to the MIPS financial incentives—this performance category requires a balance between innovative activities and validation that those activities are truly contributing to practice improvement and delivery system transformation.

At the same time, differing reporting requirements for the various types of CPIAs may push providers to engage in those activities with less rigorous or less burdensome reporting or performance requirements. We urge CMS to support those providers willing to engage in priority CPIAs by giving these activities greater weight within the MIPS category. For example, the CPIA score could be capped at 10% of the maximum 15% unless the provider successfully completed a CPIA from a menu of "priority/challenge" activities. We recommend that any such "priority/challenge" activity set include those activities that prepare providers to take on more financial risk for their patients, show real practice transformation toward the more holistic approach to patient care required by APMs, and support improved physician performance measurement overall.

A.6. Meaningful Use Performance Category

Robust health information exchange is fundamental to improving performance in the other three categories of MIPS – quality, resource use, and clinical practice improvement activities. The "Meaningful Use" Electronic Health Record (EHR) Incentive Program requirements, and the technical standards deployed through the parallel ONC Certification program, are accelerating the development of necessary standards and services to make care coordination across health systems easier and more efficient for both providers and patients.

The Meaningful Use category should encourage and accelerate the robust use of health information technology. The foundational goals of MIPS to incentivize high-quality, efficient practices would be undermined if providers were allowed to fail any Meaningful Use measure and associated threshold and still receive credit—even partial credit—in the Meaningful Use category.

Meaningful Use thresholds were carefully set such that all eligible providers had a chance to succeed. Accordingly, experience so far shows that, on average, providers

are greatly exceeding thresholds. We encourage CMS not to undermine requirements by allowing providers to meet only selected thresholds.

Additionally, we are concerned that allowing providers to be selective about the measures on which they report will delay progress on more recent patient and family engagement measures (for example, the ability for patients to view, download, and transmit their health information to a third party or send a secure message to their provider). These patient-facing measures often require providers to improve policies at the practice level, and also involve larger cultural shifts to view patients as active partners in care (versus passive recipients) – both of which take time, and both of which we cannot afford to delay further.

We understand the desire to provide flexibility for providers in this new performance model. However, the reasonable thresholds, reporting flexibility, and exemptions currently employed in the Meaningful Use program already provide significant flexibility. Given the fundamental role that the meaningful use of Certified EHR Technology (CEHRT) plays in promoting the ability to share and use data to enhance care delivery and improve health outcomes, CMS should continue to require providers to meet all measures and associated thresholds to receive credit in the Meaningful Use performance category.

Tiered Methodology

CMS should not adopt a tiered methodology for scoring the meaningful use of CEHRT performance category that awards partial credit for performance below established thresholds. We suggest an alternate methodology that still requires providers to meet the required minimum thresholds, but also rewards high performance on certain performance measures of the meaningful use of EHRs. In this scenario, we envision that providers would be awarded 20% of the available 25% of the MIPS score allocated for the Meaningful Use category for attesting to all meaningful use measures, or conversely receive a score of zero percent if they fail to meet all measures and associated thresholds.

Providers would be awarded the remaining five percent for excelling in the use of health IT in measures for two objectives finalized for Stage 3 of the Meaningful Use incentive program: *Objective 6—Coordination of Care through Patient Engagement*, and *Objective 7—Health Information Exchange*. In the Meaningful Use program, providers would fulfill these objectives by meeting the required thresholds for two of the three measures. Our proposed methodology would reward providers for meeting all three measures included in these categories. Accordingly, providers would receive 2.5% above their 20% score for meeting all three measures for each objective, respectively.

We have selected these measures as indicators of high achievement because they document uses of health IT that have great potential to facilitate patient and family engagement, promote care coordination, and ultimately improve health outcomes.

In this methodology, in order to gain the additional 5%, providers must meet or exceed the thresholds for each of the following measures:

Objective 6: Coordination of Care through Patient Engagement (2.5%)—Must Meet 3/3

- 10 percent of patients or their authorized caregivers use their ability to view online, download, and transmit to a third party their health information.
- For 25 percent of patients, providers send a secure message to the patient or in response to a patient message.
- For five percent of patients, providers incorporate patient-generated health data into their EHR, either from patients themselves or non-clinical settings.

Objective 7: Health Information Exchange (2.5%)—Must Meet 3/3

- For 50 percent of transitions of care or referrals, providers send Summary of Care records electronically to physicians to whom they transfer or refer patients.
- For 40 percent of transitions of care or referrals, providers incorporate electronic Summary of Care records into their EHRs from referring physicians.
- For more than 80 percent of transitions of care or referrals, providers perform a clinical information reconciliation of medications, medication allergies, and problem list.

We believe this tiered methodology is both a reasonable continuation of the Meaningful Use program and a way to encourage increasingly robust use of certified EHR technology.

A.7. Other Measures

In considering measures that are currently used for payment systems other than the Physician Fee Schedule, we strongly urge CMS to use only the best possible core set of high impact, high value measures that will drive improvements in quality, provide meaningful information for consumer decision-making, and provide useful information for value-based payment and purchasing by CMS and other purchasers. In particular, we encourage CMS to prioritize outcome measures, particularly PROMs, and measures of patient experience. Over time, we hope to see evolution toward better measures and measurement systems, including:

- better outcome measures and measures based on patient-reported data,
- measures suitable for assessing new delivery and payment models without detracting from clinician-level information,
- measures that can be collected efficiently in the course of clinician-patient workflow, particularly those that utilize electronic data capture, and

- measures that provide real-time, actionable data for various stakeholders.

There are a number of "emerging" PROMs in use in other programs or accountability programs that CMS should consider for MIPS. As noted in our comments above regarding collection of PROs for the CPIA category, we believe these PROMs can provide valuable information for providers for continuous quality improvement as well as for accountability purposes. Condition-specific measures that are gaining traction in accountability programs include: depression remission at 6 and 12 months, optimal asthma control, functional improvement following hip or knee surgery, and functional health improvement following back surgery. For general health surveys, the VR-12 or VR-36 are widely used. We also support the use of the Patient-Reported Outcomes Measurement Information System (PROMIS). PROMIS measures patient-reported functional status. PROMIS promotes parsimony because it is cross-cutting. It provides a stable of "general" surveys that can be used to measure patient functioning in various clinical areas. We recognize PROMIS may not be ready for "prime time" use but encourage CMS to lay groundwork for its use.

Similarly, as we noted earlier, we would support use of the Patient Activation Measure (PAM) as a reporting requirement, though not as a performance measure. When patients are informed and effective managers of their health, this can lead to improved patient satisfaction as well as improved clinical outcomes and lower health care costs. Engagement and "activation" become particularly important for patients with chronic conditions because patients can play an important role in their ongoing care and functioning. The PAM, developed by Dr. Judith Hibbard, helps categorize how activated a patient is in their care by assessing skills, knowledge, beliefs, and behaviors. By knowing a patient's stage of activation, providers can tailor care plans that better meet their patient's needs. Research indicates that the use of PAM leads to better outcomes. The PAM has undergone significant testing and is considered to be a valid and reliable instrument. To facilitate better, more appropriate engagement tailored to individual patients and caregivers, we encourage CMS to consider developing a public domain performance measure of clinician use of the PAM survey as a reporting requirement. We do not suggest using the PAM for performance scores because of the risk such a score may pose to truly patient-centered care and patient-provider relationships.

For additional measures, we encourage CMS to look at advanced measure dashboards being used in the private sector for both physicians and for APMs, as well as for hospital measures that could apply to physicians (e.g., surgical procedures). CMS should consider the top priority measure gaps identified by the National Quality Forum and the Measure Applications Partnership as these gaps reflect the input of many health system stakeholders. We encourage CMS not to use documentation measures; we strongly prefer measures that report a score or outcome over documentation that a score was obtained. Further, we urge CMS to use more comprehensive measures as much as possible, such as composite measures rather than individual component measures.

A.8. Development of Performance Standards

In the development of performance standards for MIPS, we recommend that CMS develop principles and features for a glide path toward an ideal future state of clinician accountability. Such a future state would use increasing larger patient samples and eventually eliminate sampling from reporting requirements to better support groups in internal benchmarking for quality improvement while enabling measurement at all levels of the system and identification of disparities among patient populations.

We support benchmarks that accurately reflect the variations in performance; benchmarks are set too low if all providers can achieve them. MIPS standards should reward attainment of a benchmark as well as continued improvement. It is possible that benchmarks could decrease over time and reward performance that does not reflect improvement. Thus, we support the proposal to reward EPs who improve scores on individual measures from year to year, as that is a more effective mechanism for rewarding improvement. C-P Alliance continues to support the ABC methodology for benchmarks that roll into a 5-star summary rating, as this methodology sets the bar at an achievable level that still requires improvement from most providers.

A.9. Flexibility in Weighting Performance Categories

In the Request for Information, CMS asks if there are situations in which certain EPs could not be assessed at all for purposes of a particular performance category. We encourage CMS to design MIPS such that every EP is scored in each of the four performance categories at a minimum, even if the score for a particular category is zero. Though we encourage CMS to use higher value measures in all four performance categories whenever possible, measures should be selected that are applicable to as many EPs as possible, and that all clinicians should be held accountable for – that is, outcome measures, resource use, and improvement in the meaningful use of health IT.

A.11. Public Reporting

Publicly available performance information is central to understanding value-based performance and drives quality improvement, accountability, and consumer choice. As we noted in comments above, consumers find individual-level provider quality information extremely valuable when selecting a physician, therefore we strongly advocate not only for individual clinician-level measurement but also public reporting of individual clinician-level measures when that information is valid, reliable, and meaningful. We also encourage CMS to require public reporting of quality measurement at higher levels of aggregation in order to be as transparent as

possible. For quality data to be relevant and useful for all consumers, we support stratifying quality data by demographic characteristics, including race, ethnicity and gender as feasible and appropriate.

A.12. Feedback Reports

Quality and Resource Use Reports are essential in gauging progress and identifying challenges as clinicians strive to improve. It is vital that CMS do everything possible to provide such reports as frequently as possible and to minimize the lag between the conclusion of the time period measured and the delivery of the report. At a minimum, we urge CMS to ensure they can provide such reports on a quarterly basis. Rapid or real-time feedback reports on practice performance enable practices to deploy quality improvement strategies as needed, particularly in high-impact areas like patient experience of care. We believe that feedback reports will be most effective if they reflect individual provider performance. To the extent possible, providing data at an even more granular patient level is most useful in identifying where gaps, variation, or duplication may exist, and provides the most actionable information to target improvement efforts.

Where possible, we urge CMS to consider alignment with feedback reports provided by other payers to streamline the information provided to providers and allow for better understanding of gaps and areas for improvement.

ALTERNATIVE PAYMENT MODELS (APMs)

APM Risk

As we note in our principles for APMs, we support payment arrangements that move away from fee-for-service and toward value, and we are open to a range of strategies to achieve this transformation. In defining APMs for the purposes of clinician payment, CMS should give preference to population-based payment and other two-sided risk structures that move providers away from fee-for-service. APMs should have a fixed payment component, span multiple services and providers, focus on payments to provider organizations rather than to individual clinicians, and provide a meaningful shift from fee-for-service to two-sided risk.

We also recognize that two-sided risk in a fee-for-service environment can help move toward the triple aim. Within that framework, the amount at risk should be meaningful enough to encourage and reward providers for making meaningful changes to the way they deliver care. The statutory requirement that APMs bear more than "nominal" risk should be interpreted to be enough financial incentive to encourage reduced spending and better quality, with more flexibility to innovate on how to do so than is available in fee-for-service arrangements that tie incentives to granular processes and individual component outcome measures. Given this

interpretation, we urge CMS to consider results being achieved in addition to level of risk. Ideally, the CMS approach for provider payment should frame risk as an opportunity, rather than a liability, to practice medicine in a way that makes the most sense to providers.

Eligible Alternative Payment Entity (EAPM Entity) Requirements

Quality Measures

Regardless of the type of EAPM entity, individual clinician-level quality measures should be used in addition to metrics at the APM level so that consumers can use equivalent information to compare providers. Measures do not have to mimic MIPS but should use the same categories of criteria, and we urge CMS to emphasize outcomes, particularly PROMs, and measures of patient experience. Similarly, measures should address the key features new models are trying to address: e.g., better coordination, patient-centeredness, and efficient use of resources. In parallel with our recommendations for the approach to MIPS measures, all new measures should go through a multi-stakeholder review process to ensure they are evidence-based and meet the needs of all stakeholders, including consumers and purchasers. We support preferential treatment or additional payments for APM participants using more advanced performance measures that capture important outcomes and patient experience; for example, APMs should be rewarded for reporting on depression remission.

Use of Certified EHR Technology

APMs must excel in the use of health IT to improve the quality and efficiency of care in the clinical setting, as well as to engage beneficiaries in their own health and care.

- *APMs should accelerate the effective use of health information technology.* Health IT including EHRs can help providers facilitate care coordination, analyze trends in their patient populations, and offer care that is better tailored to patients' unique needs. Providers' ability to track patients' health status in real time using health information technology can improve provider-patient communication, help patients manage their care, and improve health outcomes.

  To improve both care quality and health outcomes, it is critical that health information technology facilitate the safe and secure sharing of information, not just between providers but among patients, families and other designated care team members (including social services and supports). Giving consumers the tools to access and manage their own health information electronically is foundational to patient engagement and ensuring that patients receive high quality care.

- *APMs should partner with patients to facilitate electronic access, understanding, and use of their own health information.* Patients cannot effectively manage their health and health care, or support interoperability, without accessible and convenient information about their health status, diagnoses and treatment received, etc. At the same time, providers cannot succeed under new models of care without activated and engaged patients. The National Partnership for Women & Families' comprehensive national survey 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.[12]

- *APMs should incorporate and require meaningful use of the following specific functions:*
    - APM participants should provide patients the ability to view, download, and transmit their health data (within 24 hours, accelerating the current timeline) via a patient portal, Application Programming Interface (API), or some other mechanism. The data available to patients should include data currently available in View, Download, and Transmit requirements of the Meaningful Use program, as well as clinician notes.
    - Providers participating in APMs should be able to send summary of care records to providers to whom patients have been referred; it is equally important that providers incorporate summaries of care into their own systems and act upon this information. These summaries of care should include the documentation of patient goals, health status evaluations and concerns, and care team members (including caregivers).
    - APMs should enable patients to send and receive secure messages with their provider (for instance, through a patient portal or an Application Programming Interface). APM providers should do more than merely turn on this functionality, and should engage their patient populations to assist them in making use of this feature.
    - APMs should incorporate into their EHRs patient-generated health data. This information can include data generated or submitted by patients themselves or data from non-clinical settings, such as nutritionists, physical and occupational therapists, psychologists, and home health workers.

- *APMs should utilize health IT to further connect patients, their providers, and other resources throughout the continuum of care.* Therefore, in addition to performing health IT functions envisioned for the meaningful use category of MIPS, we encourage that APMs be required to perform additional uses of CEHRT (2015 edition):

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[12] National Partnership for Women & Families. *Engaging Patients and Families: How Consumers Value and Use Health IT*, December 2014, available from http://www.nationalpartnership.org/research-library/health-care/HIT/engaging-patients-and-families.pdf.

- APM participants should capture patient health information on care preferences, which includes advance directives.
- APM participants should provide patients electronic education materials specific to their needs, particularly in patients' preferred languages—as the technology permits. Indeed, APM participants should provide patients with access to all of their health information in the top 15 languages nationally, and Spanish at the very least.[13]
- APM participants should document social, psychological and behavioral data. These data include fields like financial resource strain, education, social connectedness and isolation, and physical activity.

[13] In its recent notice of proposed rulemaking regarding Section 1557 of the Affordable Care Act, the Department of Health and Human Services proposed using "the top 15 languages spoken by individuals with limited English proficiency nationally" in order to prevent discrimination based on language and national origin. Department of Health and Human Services, "Nondiscrimination in Health Programs and Activities NPRM," 80 Federal Register 54172, 54179 (Sept. 8, 2015). The NPRM raised the question, however, whether the top 15 languages should be assessed for each state or regionally rather than nationally. Id., p. 54180.