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

August 21, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: CMS–5522–P: Medicare Program; CY 2018 Updates to the Quality Payment Program

Dear Administrator Verma:

The 17 undersigned organizations represent a collaboration of leading consumer, employer, and purchaser organizations committed to improving the quality and affordability of healthcare. A high-value health care system requires value-driven payment arrangements and we are encouraged by the opportunities available through the Quality Payment Program (QPP) to spread these arrangements to more providers. Such value-based payments should result in better health outcomes, improved care coordination and patient experience of care, and decreased costs.[1] We appreciate the opportunity to provide comments on the proposed changes to the QPP for CY 2018.

We commend CMS's leadership in continuing implementation of the Advanced APM track. We strongly support the original intent of the QPP to encourage clinicians to move towards alternative payment models (APMs) that reward high-value care and support care delivery innovations. We further support CMS's intent to recognize clinicians on the path to adopting APMs and to support clinicians as they move away from traditional fee-for-service payment arrangements that do not meet the needs of consumers and purchasers.

Accountability for cost, quality, and patient experience are key drivers of a high-value health care system. To that end, it's critical that CMS encourage and prepare clinicians to take on accountability for these aspects of care, including financial risk, as this is an important lever in transforming care. The QPP should be designed and implemented in ways to improve patient care and outcomes, while also addressing cost.

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

Furthermore, we believe that advancing the current state of performance measurement and increasing the availability of performance information for consumers and other stakeholders should be a top priority in QPP implementation, as a way to understand if the program is delivering on the promise of high-quality patient-centered care. Patient-reported outcome (PRO) tools, patient-reported outcomes measures (PRO measures or PROMs), and measures of patient experience are essential components of a patient-centered health care system.[2] PROMs enable value-based payment based on a co-definition of 'value' between the clinician and the patient by providing both a systematic channel for soliciting patient feedback and reliable data on the impact of care from the perspective of patients. In the current landscape, PROMs are not widely available for many important areas of care quality. We urge CMS to invest resources and support the further development of PROMs by promoting adoption of PRO tools and meaningfully incorporating these tools into all aspects of care transformation and performance assessment throughout the QPP.[3]

In our view, the proposed rule moves the QPP in the wrong direction. The expanded low-volume exemption effectively widens the gap between clinicians participating in the Merit-based Incentive Payment System (MIPS) track and those in Advanced Alternative Payment Models (AAPMs). We have concerns that, by proposing to fully exempt from the program a majority of Part B participating clinicians, CMS is sending the message that these excluded clinicians are not expected to deliver quality, high-value care. These changes would undermine those clinicians who have already begun investing in the transition to value-driven payment and care delivery, not to mention slowing or even preventing achievement of the full potential of the QPP.

Below, we offer feedback and recommendations on the specific proposals in the proposed rule as well as additional recommendations to improve the QPP. With these changes, CMS can foster a robust and timely transition to value-driven payment and care delivery, supporting the maximum number of clinicians while meeting the needs of consumers and other stakeholders.

Exempting Clinicians Due to Low Volume

We strongly urge CMS to retain the low-volume threshold from the first program year to support the original goals of the program: to drive quality improvement and value in the health care system by spreading value-based payment arrangements to the maximum number of clinicians. The QPP cannot fulfill its promise if a majority of clinicians are excluded from the program.

The proposed low-volume threshold would change the original intent of MIPS to assess and reward clinicians based on their performance relative to their peers (i.e. the average Medicare clinician). By concentrating the MIPS penalties and rewards on a much smaller group of Medicare clinicians (approximately 134,000 fewer clinicians), the proposed additional exemption could result in unfair penalties for some clinicians who perform above the median/mean of all Medicare clinicians and who would otherwise have earned a positive payment adjustment.

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[2] We use terms rooted in the medical model, however choice of terminology is particularly important when the worlds of independent living and health care provider intersect often. The disability field refers to patient-reported outcomes and patient experience surveys/measures as consumer-beneficiary-participant-patient reported outcomes and patient-consumer-beneficiary-participant experiences of care surveys/measures.

[3] Use of PRO tools is a necessary intermediate step toward developing more PRO measures. Data obtained from PRO tools are used in the measure development process to ensure the PRO measure is valid, reliable and responsive. This data is also used to determine important aspects of PRO measures, such as the scoring algorithm used to translate a raw PRO measure score into its corresponding degree of 'change in health status'.

For clinicians between the 2017 low-volume threshold and the proposed threshold for 2018, this proposed change would be confusing and disruptive and would undermine any efforts taken in preparation for participation in the QPP. Exempting practices sends the message that these clinicians are not essential to transforming the health care system nor should they be held to the same high quality standards.

We encourage CMS to explore other ways to support the participation of small practices as they transition to quality and cost accountability other than exempting low-volume clinicians altogether from MIPS.

Supporting Small Practices

The QPP presents an important opportunity for CMS to set expectations for high-quality, patient-centered, efficient care for all clinicians by creating some new mechanisms to reward high performance as well as progress toward this vision. While we believe that it is appropriate for consumers, purchasers, and other stakeholders to have high performance expectations of all care providers, we acknowledge that not all clinicians are prepared for the system transformation and payment approaches needed to achieve these goals. Small practices, as well as providers who care for vulnerable and underserved populations, face barriers to effectively participating in the QPP. We appreciate CMS's intent in the proposed rule to offer additional bonus points and flexible options for small practices to compensate for some of these barriers, however, emphasize that this approach is not a long-term solution.

We encourage CMS to offer a meaningful path to participation and to consider providing resources, such as direct financial support or technical assistance, to help small practices undertake practice transformation and participate in the QPP. For example, CMS could consider pursuing an upside-only MIPS program for clinicians who would be excluded from the program under the current proposal, with the expectation that these clinicians would be transitioned into the full MIPS program as the QPP matures. This upside only program should include as a core goal, supporting the unique care delivery and financial needs of those clinicians who predominantly serve economically disadvantaged and underserved patients. We emphasize that any upside-only MIPS program should serve as a transition for low-volume clinicians and, therefore, should be phased out in a few years. CMS could, for example, reduce the flexibilities for small practices annually and then move all upside-only MIPS clinicians into the full MIPS program.

We do not believe that providing bonus points and other flexibilities for small practices in MIPS will adequately prepare them for a future in which continuous quality improvement, meaningful HIT use, and financially accountability for cost and quality are expected of them. An alternative approach such as this would provide a meaningful incentive for small practices to familiarize themselves with the MIPS participation requirements and the use of data to drive quality improvement and appropriate spending, while also protecting them from untimely financial risk. Further, this approach would potentially increase the availability of performance information for additional clinicians (i.e., those who choose to participate and report) that would benefit consumers, purchasers, and other stakeholders.

Establishing a Meaningful Pathway to Full QPP Implementation

We support CMS's efforts to encourage early participation in the QPP by allowing clinicians to become familiar with the program over time. However, we are concerned that clinicians are facing a cliff for the 3rd program year – asking clinicians to focus all-at-once on reporting requirements, managing resource use, and overall performance as measured against peers may have negative consequences for both patients and clinicians.

By statute, in the QPP's third program year, the cost performance category must be weighted at 30% and the MIPS performance benchmark must be set at either the mean or the median score of all MIPS participants. The proposed design of the second transition year will not adequately prepare clinicians for these requirements and other aspects of a fully mature QPP, including the quality data completeness requirements and learning to use certified health IT in ways that improve patient care.

We strongly recommend CMS weight the cost performance category at 10%, as was finalized in CY 2017 rulemaking. Assigning weight to the cost performance category will encourage clinicians to gain valuable experience in managing resource use.

We strongly recommend CMS set the performance threshold closer to the cumulative number of points a clinician would earn for minimum participation (i.e., reporting) across all MIPS performance categories, and require that eligible clinicians participate in the quality performance category to avoid a negative payment adjustment. A performance threshold set at 42.5 points would incentivize clinicians to make the necessary practice changes and investments for full MIPS participation, and rewards those clinicians who have already done so.[4] Additionally, by requiring clinicians to submit some quality measures that meet the necessary data completeness requirement, clinicians are encouraged to prepare for accountability for quality of care delivered and to become familiar with reporting quality measures and using quality data to support practice improvement.

Taken together, our recommendations will encourage clinicians to gain experience in each performance category and familiarize themselves with the program's reporting requirements so that they can better focus on performance in future program years.

Limitations of the Quality Measure Menu Approach

We remain very concerned about the limitations of the MIPS menu approach to selecting quality measures. A menu approach may lead providers to report only those measures for which they are high performers, obscuring results of poor care. A menu approach also prevents an "apples to apples" comparison among providers, leaving consumers and purchasers to make choices without critical information about provider performance.

Already, the pick-your-measures approach has created problems in MIPS program implementation, hindering CMS's ability to both identify topped out measures that should be removed from the pay-for-performance segment of the program and evaluate meaningful quality improvement by clinicians. We support CMS's intent to reward clinicians who make meaningful improvements in the quality of care delivered. However, without year-over-year reporting on the same quality measures, CMS cannot know whether or by how much quality has improved. The menu approach also undermines virtually

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[4] Clinicians who submit all required quality measures with the necessary data completeness (18 points), successfully submit the Advancing Care Information base scores measure (12.5 points), and fully participate in the CPIA category (15 points) can earn 42.5 points.

any methodology used for identifying topped-out measure benchmarks. Calculating a measure's benchmark using data only from those clinicians who choose to report on the measure provides an incomplete picture of performance on that measure.

CMS should move as quickly as possible to establish core sets of high-value measures by specialty or subspecialty. A core set approach using high-value measures would enable direct comparison among similar clinicians, with assurance that they are being assessed against a consistent and standardized set of important quality indicators that are closely linked to their clinical practice. Meaningful and actionable performance information is critical for consumers to make informed health care decisions, enabling them to take control of their health and health care.

In the near term, CMS should consider awarding bonus points to those clinicians who report on a complete Core Quality Measures Collaborative (CQMC) core measure set to promote alignment within the program as well as with other payers. The measures that compose the CQMC core measure sets have already been adopted into MIPS, and clinicians who report on a full set should be rewarded for their additional effort.

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

Sincerely,

AARP
The Alliance
American Association on Health and Disability
Consumers' Checkbook/Center for the Study of Services
Dallas-Fort Worth Business Group on Health
The Empowered Patient Coalition
The Leapfrog Group
Maine Health Management Coalition
Mothers Against Medical Error
National Alliance of Healthcare Purchaser Coalitions
National Coalition for Cancer Survivorship
National Partnership for Women & Families
Northeast Business Group on Health
Pacific Business Group on Health
St. Louis Area Business Health Coalition
Texas Business Group on Health
Wyoming Business Coalition on Health

APPENDIX A: ADVANCED ALTERNATIVE PAYMENT MODELS (AAPMs)

We continue to strongly support CMS's move toward a value-based health care system, and we are pleased to see the continued implementation of the Advanced Alternative Payment Model (AAPM) track within the QPP. AAPMs have great potential to drive and reward high-quality comprehensive, coordinated, patient- and family-centered care while driving down costs.

We encourage CMS to continue adding models that qualify as AAPMs to offer clinicians more opportunity to participate in value-based payment and care delivery. As APMs are adopted more widely, it is more likely that a single patient will receive care through multiple APMs. We encourage CMS to establish reasonable policies to address attribution issues in these cases and further encourage CMS to stage or tier models such that financial benefits accrued for successful participation in an APM are commensurate with the level of responsibility for a patient's care, health outcomes, and experience of care.

For existing AAPMs, we encourage CMS to maintain a rapid pace of innovation to continue driving transformation. CMS should provide clinicians with the opportunity to be rewarded for measurement innovation as a key feature of APMs. For example, in programs like Next Generation Accountable Care Organizations (Next Gen ACOs), measure sets should include aspirational and "test" measures (e.g., PROMs, cross-cutting measures) for which clinicians can earn incentives for participating in their development and deployment.

Need for Multi-Stakeholder Input into Design & Implementation of AAPMs

We encourage CMS to increase transparency and public input in the development and implementation of models categorized as AAPMs and to specifically involve consumers and patients at every stage of development and implementation. Consumers and patients should be integral partners in developing all new models of care and payment; we strongly recommend that multi-stakeholder input on AAPM quality measures and other design elements be a standard part of the process of developing AAPM models. Providing stakeholders the opportunity to participate in developing and implementing new models of care and payment better positions these models to meet the needs of all stakeholders, especially patients and their families.

Additional Criteria for AAPMs and Other Payer AAPMs

As CMS prepares to roll out the All-Payer APM option in 2019, we urge the agency to establish clear criteria requiring AAPMs and Other Payer AAPMs to demonstrate to CMS that they promote and support effective, equitable, patient- and family-centered care delivery. Specifically, we urge CMS to adopt an additional criterion for both AAPM attestation and Other Payer AAPM attestation that requires a model to demonstrate how payment reinforces the delivery of coordinated, patient- and family-centered care with a strong grounding in primary care.

APPENDIX B: INTERMEDIATE APMs (MIPS APMs and Other MIPS APMs)

We support the use of the Intermediate APM (or "MIPS APM") option for clinicians participating in care and payment models that do not meet the financial risk or other Advanced APM (AAPM) requirements. We agree with CMS that it is important to recognize providers on the path to AAPMs through streamlined reporting requirements.

We strongly support the proposal to measure and assign a quality score to MIPS APMs and Other MIPS APMs. Quality and cost accountability are key drivers of a high-value health care system and it is imperative that clinicians on the path toward AAPMs take on meaningful accountability for these outcomes of care. We encourage CMS to assign a weight to the cost performance category for participants in MIPS APMs and Other MIPS APMs to ensure that they are being assessed on cost performance, receiving performance feedback on MIPS cost measures, and to promote efficient and appropriate care delivery.

APPENDIX C: Merit-Based Incentive Payment System (MIPS)

Transition Year Policies

We are supportive of the intent of transition year policies to acknowledge and support those clinicians who are not yet ready for full participation in the Merit-Based Incentive Payment System (MIPS) by providing a slow acceleration of program requirements. We are concerned that the proposed transitional policies, however, are not a meaningful step and will not adequately prepare clinicians to participate successfully in a fully mature Quality Payment Program (QPP). To better prepare clinicians for success in future program years in which payment is dependent on performance across all four categories relative to peer clinicians, we urge CMS to adopt the following recommendations:

- We urge CMS to maintain the intent of the transition years by not delaying the previously finalized increase in the data completeness threshold to 60%. In future years as clinicians gain experience reporting quality measures, the data completeness criteria should be strengthened. Patients and caregivers who rely on this information to make health care decisions need a reliable assessment of a clinician's care quality – capturing 50% of available data is insufficient for the needs of consumers, purchasers, and other stakeholders. A larger patient sample provides a more reliable and valid representation of true performance and will better support clinician groups in internal benchmarking for quality improvement.
    - Accordingly, we support the use of all-payer data for quality measures to provide an even fuller picture of a clinician's performance.
- We urge CMS to assign a 10% weight to the cost performance category, in advance of the QPP's third year statutory requirements, to ensure that clinicians gain experience with managing resource use using the MIPS cost measures. This is an opportunity for CMS to insulate clinicians from the shock of both a 30% increase in the weighting of the cost performance category and the increase in the MIPS performance threshold to either the mean or the median.
- We refer readers to the body of this letter for our specific comments on increasing the MIPS performance threshold to the number of points equivalent to full participation in MIPS.

The Fundamental Need for Valid, Reliable, & Actionable Performance Information

A foundation of valid and reliable performance information is essential to meaningfully assess clinicians' performance. Consumers also need meaningful, accurate and reliable performance information to make informed health care decisions. We are concerned that some of the proposed policies to reduce clinician reporting burden will compromise the program's ability to both reliably assess performance and capture the true distribution of performance among Medicare providers. We urge caution not to overemphasize clinician flexibility at the cost of performance information for consumers, clinicians, and other stakeholders; specific proposals that make this tradeoff are highlighted below.

Multiple Submission Mechanisms

We support the proposal to allow the use of multiple submission mechanisms across the 3 performance categories, but strongly oppose the additional flexibility to allow a single quality measure to be reported via more than one submission mechanism. Given that there are no validated methods to re-aggregate measure data across multiple submission mechanisms, only a portion of data collected on such measures would be used to assess performance. In other words, the same amount of data collected by clinicians would provide a less reliable and less accurate assessment of performance, making it more difficult to differentiate performance among clinicians on that aspect of care or to evaluate year-over-year improvement on that measure.[5]

Already, small sample sizes create concerns about measure reliability in clinician reporting programs – this additional flexibility would further exacerbate the problem. Ideally, CMS should move towards common data elements across submission mechanisms to enable data aggregation and to facilitate the development of a single quality benchmark for each quality measure.[6] The current proposal takes us in the opposite direction.

Accounting for Quality Improvement

We strongly support rewarding clinicians for meaningful improvements in quality of care. MIPS can support clinicians in improving quality through the use of appropriate incentives, high-value performance measures, and rapid-cycle performance feedback. However, we have significant concerns about the proposed approach to assess quality improvement at the performance category level. Assessment at the performance category level will make it impossible to distinguish whether quality of care has truly improved for patients or whether the reporting entity has chosen different measures on which they perform better.

The proposed approach may discourage clinicians from choosing to report a more difficult-to-achieve measure (e.g., clinical outcome, patient safety, or patient-reported outcome measures) for consecutive years as it would be easier to simply switch to reporting another measure on which they know they will perform better, resulting in flawed conclusions about quality improvement. These conclusions, in turn, would lead to an inappropriate use of funds that would otherwise go toward rewarding high-performing clinicians.

We strongly urge CMS to calculate improvement only at the measure level and to assign an improvement score only to clinicians who report and demonstrate improvement on the same measure(s) from the previous year. CMS could consider allowing clinicians to report the same measure for a second year solely for the purposes of demonstrating improvement, while also reporting separate measures for the performance score (i.e., reporting more than the minimum 6 measures). Under this recommendation, clinicians who switch from facility-based scoring to MIPS scoring would not receive an improvement score in their first year after the switch is made.

Small Practices

Small practices face unique challenges in transitioning to value-based care. We see the value of policies that allow small practices to familiarize themselves with MIPS participation requirements at a slower pace. It is crucial, however, that these special policies be phased out over time. Consumers who choose small practices have a reasonable expectation of high-quality, high-value care and good health outcomes.

To lower the bar indefinitely for small practices sends the message that these practices should not be held to the same high quality standards, nor should they undertake robust use of health IT or practice

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[5] Tang, P., Ralston, M., Arrigotti, M., Qureshi, L. and Graham, J. (2007). Comparison of Methodologies for Calculating Quality Measures Based on Administrative Data versus Clinical Data from an Electronic Health Record System: Implications for Performance Measures. *Journal of the American Medical Informatics Association*, 14(1), pp.10-15.

[6] Conway, P., Mostashari, F. and Clancy, C. (2013). The Future of Quality Measurement for Improvement and Accountability. *JAMA*, 309(21), p.2215.

improvement activities. Additionally, these policies increase the program's complexity which may make it more difficult for clinicians to work toward the ultimate goal of moving to APMs. Such increased complexity could contribute to a higher total cost of care if clinicians are forced to hire external support to help navigate the program successfully. CMS should evaluate transition policies annually for appropriateness and consider phasing out many of the small practice policies as the QPP matures.

Quality Data Completeness Requirements

We strongly support CMS's proposal to lower the number of points available to practices that do not meet the data completeness criteria from 3 points to 1 point. This policy will encourage clinicians to report more complete performance data, in turn supporting the robust high-measurement underlying the QPP's overall assessments, bonuses, and penalties.

In future years, as clinicians gain experience with the program's reporting standards, we encourage CMS to adopt the same strong incentive for small practices to collect quality measure data effectively; it is important to be able to assess the quality of care delivered by these practices as well as larger practices. CMS should adjust the points assigned to small practices in future years for not meeting the data completeness criteria to align with the policies that apply to larger groups.

Virtual Groups

We support virtual groups as a pathway to move small practices toward shared accountability. Virtual groups can help small practices take on financial risk, pool resources for meaningful health IT use, and come together to collaborate on quality improvement.

We recommend that CMS require a majority of clinicians in a virtual group to participate in activities attested to in the CPIA and ACI categories in order for that virtual group to receive credit for those activities. Additionally, CMS should ask virtual groups to report a plan, prior to the start of the performance year, on how group members (i.e. all participating TINs) plan to share performance data internally. For example, the virtual group participants should identify the measures that the virtual group will report to CMS and then share NPI-level performance data on those measures with each other during the performance year to facilitate performance improvement.

We encourage CMS to explore ways to allow third-party entities to organize small practices and report on behalf of the virtual group for MIPS. Independent Practice Associations (IPAs) have potential to support clinicians in moving toward shared accountability by leveraging existing organized administrative systems to improve a virtual group's efficiency and accuracy in performance reporting. For example, an IPA could act as a virtual group convener to arrange clinicians into reporting groups by specialty. This would ensure that clinicians are reporting measures that are directly relevant to their practice and that each clinician's performance has a meaningful contribution to the final quality score.

In the future, we encourage CMS to build in requirements regarding the composition of virtual groups (e.g., geographically or by specialty) to further facilitate the use of virtual groups to enhance health outcomes and goals. Participation in practice improvement activities, use of EHR, and data sharing workflows are critical to include in agreements between members of a virtual group. In addition, CMS should provide guidance on specific efficiencies and practice improvement goals that a virtual group would best support and encourage virtual groups to create a plan for achieving those goals as a virtual group.

Complex Patient Bonus

We support the complex patient bonus proposal. Providers who serve the most vulnerable and underserved populations often have few discretionary resources, limited infrastructure, and significant time pressure. We strongly believe performance measures should not be adjusted for social risk factors; instead, CMS should use payment adjustments to fully support the practice patterns needed to provide effective and comprehensive care to patients. We encourage CMS to continue exploring ways to provide fair and reasonable incentives and financial support for clinicians caring for complex and vulnerable patients to improve care delivery and meet performance standards laid out in MIPS.

Quality Measurement

As stated earlier, the MIPS program must be built on a foundation of valid and reliable performance information in order meaningfully assess clinicians' performance and drive toward high-value care. In addition to the concerns we expressed about the program's menu approach to quality measurement, we offer the following comments and recommendations to strengthen the quality performance category to better assess and distinguish quality of care delivery by clinicians.

MIPS Quality Measures

Over time, we encourage CMS to reduce the total number of quality measures in MIPS by removing low-value measures and retaining high-value measures of clinical and patient-reported outcomes, patient experience, care coordination, patient safety, and other priority issues. By narrowing the MIPS measures to include only high-value measures, CMS can maintain a low reporting burden for clinicians while prioritizing the most important areas of measurement that both enhance quality improvement and give consumers the necessary information to choose among clinicians for elective procedures. CMS should continue to add high-value measures to the program as they become available.

Addressing Topped Out Measures

We do not support the proposed approach to remove measure benchmarks identified as topped out from the MIPS quality measure list. We have significant concerns about the validity of virtually any methodology used to identify topped out measures in a program that uses the menu approach for quality measurement. When clinicians can choose to report a small handful of measures from a large menu, it becomes impossible to know if a measure is truly topped out – that is, if clinicians are uniformly performing well on the measure, even among those not reporting the measure – or if a measure only appears topped out because it is reported by clinicians who will score well on the measure.

To address this issue, we recommend that CMS identify topped out measures at the reporting entity level. For example, CMS could institute a scoring cap in which a clinician or group that scores at a consistently high level on a particular measure would, after two years of high performance, no longer be eligible to receive points towards their quality achievement score for reporting that measure.

Some types of quality measures should never be removed, even if they are topped out, because these aspects of care quality are essential for high-quality patient care and/or have consequences if done poorly (e.g. patient safety, patient experience). These aspects of care quality require continuous monitoring – many of the CAHPS for MIPS SSMs fall into these categories, including "How Well Providers Communicate", "Health Promotion and Education", and "Shared Decision Making".

Reporting period

We support CMS's proposal to return to a full year of reporting for the quality and cost performance categories. We encourage CMS to increase the reporting periods for the ACI and CPIA categories as well to achieve alignment across performance categories.

Patient Experience Measures

Patient experience measures are critical for quality improvement, consumer choice, and value-based purchasing.[7] The MIPS program presents an opportunity for CMS to reinforce the message to providers that patient experience is a key tenet of a person-centered health care system. We urge CMS to require a standardized patient experience measure for all MIPS clinician groups of 2 or more and to allow multiple standardized CAHPS tools to fulfill the patient experience reporting requirement. C-P Alliance has previously recommended the use of specialty-specific CAHPS tools where available, such as the Surgical Care CAHPS instrument. CMS should not delay consumers' access to this information or delay requiring the robust collection and reporting of patient experience data using currently available tools.

CAHPS for MIPS

We are concerned by CMS's proposal to reduce the reporting period (i.e., survey fielding period) for CAHPS for MIPS from 16 weeks to 8 weeks. We recommend that CMS maintain a 10-14 week reporting period to align with the CAHPS guidelines.[8] A sufficient reporting period allows survey vendors to capture patient experience information from a representative sample of patients – some of whom may not respond during a curtailed reporting period.

We do not support CMS's proposal to collect, but not score, the "Health Status and Functional Status" summary survey measure (SSM). We disagree with CMS's assessment that this SSM reflects only underlying patient characteristics and does not speak to the patient's experience of care with the group. The functional status SSM provides valuable insight into whether patients (especially complex patients) are receiving appropriate care specific to their individual needs. Additionally, functional status connects to health outcomes in a more meaningful way than some other SSMs. For these reasons, we recommend that CMS continue scoring the Functional and Health Status SSM for clinicians who report CAHPS for MIPS.

Further, we encourage CMS to make rapid strides toward widespread collection and use of patient-generated information about their health status beyond the CAHPS instruments to inform and improve care, particularly through the use of patient-reported outcome tools and patient-reported outcome measures.

CAHPS Patient Narrative Elicitation Protocol

Open-ended questions allow patients to share nuanced and rich information that can make patient experience surveys more meaningful for quality improvement. Patient feedback can help clinicians interpret their CAHPS scores in a way that provides insight into activities likely to improve quality and

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[7] LaVela, Sherri L. PhD, MPH, MBA and Gallan, Andrew S. PhD (2014) "Evaluation and measurement of patient experience," *Patient Experience Journal*: Vol. 1 : Iss. 1 , Article 5.
Available at: http://pxjournal.org/journal/vol1/iss1/5

[8] Agency for Healthcare Research and Quality. 2015. Fielding the CAHPS Clinician & Group Survey: Sampling Guidelines and Protocols. Retrieved from:
https://www.cahpsdatabase.ahrq.gov/files/CGGuidance/Fielding_the_Survey_CG30_2033.pdf

patient experience. For example, when a patient indicates that her clinician is not communicating with her in ways that she understands, she could also describe why – for example, perhaps the provider is using a great deal of technical jargon or the practice fails to provide for an interpreter when needed. Narrative feedback can help clinicians understand how to effectively improve the more obscure aspects of care quality, such as communication, and can also help other consumers contextualize quality ratings by offering clues as to why a clinician may have lower measures on certain ratings and higher ratings on others.

We strongly support collecting patient narratives in a systematic and structured way, and support CMS's intention to add open-ended questions to the CAHPS for MIPS survey in future rulemaking. Already, patients' comments about their doctors and other clinicians are proliferating on the internet, demonstrating the need for patients to have information about their providers. However, internet-based narratives are not necessarily representative of the clinician's patient panel or valid given that comments are volunteered anonymously with no way of ascertaining if the commenter received care from the provider in question. The existing narrative questions under development would be a significant step towards capturing information from patients about what matters most to them. We encourage CMS to incorporate these questions as soon as possible in subsequent rulemaking.

CAHPS for ACOs

We are very supportive of CMS's proposal to introduce CAHPS for ACOs into the quality scoring assessment for Medicare Shared Savings Program and Next Generation ACO participants that submit quality measures through the CMS Web Interface.

Cross-Cutting Measures

We are disappointed with the proposal to remove cross-cutting measures from the majority of specialty and sub-specialty measure lists. This proposal is a significant step backwards from the previous PQRS requirement that all clinicians who see patients in face-to-face encounters be required to report on a cross-cutting measure. We urge CMS to retain all the cross-cutting measures currently available to clinicians. Many cross-cutting measures reflect issues that are important to consumers and purchasers and have the potential to support clinician collaboration across specialties to improve patient experience and patient care.[9] Cross-cutting measures are also important for comparing performance across clinician specialties and provider settings. For clinicians to embrace and accept quality measurement, however, we recognize that the measures themselves need to be more meaningful. We encourage CMS to dedicate resources to developing better cross-cutting measures.

Advancing Care Information Performance Category

A high-value health care system requires infrastructure that supports robust health information exchange and use of health IT to achieve coordinated care and improved health outcomes. Health IT can help patients and their caregivers generate and share important health information, be more connected to their care teams, and better manage their own health through enhanced access to their own personal health information. Providers also benefit from the functionalities provided by robust health IT use; for example, delivery system reforms depend upon health IT and information exchange to support care transitions and transform the way care is coordinated across health settings. To achieve

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[9] Valuck, T., Blaisdell, D., Dugan, D., Westrich, K., Dubois, R., Miller, R. and McClellan, M. (2017). Improving Oncology Quality Measurement in Accountable Care: Filling Gaps with Cross-Cutting Measures. *Journal of Managed Care & Specialty Pharmacy*, 23(2), pp.174-181.

these benefits, we need more clinicians to become comfortable using CEHRT in ways that improve patient health outcomes and care coordination.

Eligibility Changes

We are concerned by the proposals to reweight the ACI category to 0% for:

- Non-patient facing clinicians;
- Hospital-based clinicians;
- Ambulatory surgical center-based clinicians;
- Nurse practitioners (NPs), physician assistants (PAs), Certified Registered Nurse Anesthetists (CRNAs) or Clinical Nurse Specialists (CNSs);
- Clinicians facing a significant hardship;
- Clinicians using decertified EHR; and
- Small practices (15 or fewer clinicians and solo practitioners).

We understand the need to construct a realistic transition period for clinicians, however, CMS should consider alternatives to support such a large portion of MIPS clinicians as they become comfortable using CEHRT. Consumers deserve the promise of health IT and health information exchange to achieve a high quality, patient centered health care system. Delaying the inevitable transition will only further disadvantage these clinicians in the long run.

Certification Requirements

We support the 2015 Edition certification requirements, which include new and important patient-facing functionalities as well as implementation specifications designed to improve interoperability. The proposed delay in requiring 2015 Edition CEHRT postpones our shared vision for a more connected, interoperable health care system.

We support the proposed bonus for clinicians that report ACI objectives and measures using only 2015 edition CEHRT as a way to encourage clinicians to upgrade their systems and use priority functions of health IT.

Definition of a Meaningful User

We are concerned with proposal to base CMS's estimation of meaningful EHR users on data from the performance period that occurs four years before the MIPS payment year. The four-year look back period is unreasonably long given the rapid pace of technology, and especially given continued delays in adopting 2015 Edition technology. We encourage CMS to shorten this look-back period, as prematurely reducing the ACI category's weight could impair progress towards robust, person-centered uses of health IT.

Hardship Exceptions

We are concerned by the proposal to not apply the five-year limit to significant hardship exceptions (e.g., clinicians who lack internet connectivity). Although it is important to acknowledge circumstances outside of a clinician's control, it does not seem necessary to grant these hardship exceptions in perpetuity

Scoring

We are very supportive of the continued use of base and performance score categories and urge CMS to maintain this structure, which simultaneously encourages adoption and use of health IT by new clinicians while rewarding performance on measures that have the greatest impact on patient and family engagement, care coordination and interoperability.

We encourage CMS to strengthen and refine the ACI measures to emphasize these innovative, person-centered uses of health IT that support health system transformation. We urge CMS to consider the following for future performance years:

- Increasing the weight of the performance score relative to the base score;
- Establishing thresholds for performance measures; and
- Over time, adding additional patient-facing measures to the base score.

We support the proposed bonus points to encourage important clinician behaviors, such as adopting 2015 Edition technology, reporting to registries, and leveraging health IT in improvement activities. However, we urge CMS to be judicious with this approach to avoid distracting clinicians from continuing to make progress on the higher-value performance category measures.

Reporting Period

We are disappointed that CMS has proposed another 90-day reporting period for 2018 and, as we noted earlier, urge CMS to move to full calendar year reporting as soon as possible. Patients and families should be able to experience the benefits of health IT – getting questions answered through secure email, or having summary of care records incorporated into new providers' health records – any day of the year, rather than a particular three-month period. Furthermore, requiring full year reporting is more likely to prompt changes to provider workflows that would allow clinicians to be rewarded for sustained progress on ACI measures and would better support CMS's goals of alignment across MIPS performance categories.

Improvement Activities

Improvement Activities (CPIAs) have the potential to improve health outcomes and patient experience by guiding clinicians to undertake quality improvement in a stepwise and strategic manner. CMS should encourage clinicians to select CPIAs based on data-driven practice improvement goals by offering guidance and technical support to clinicians on how to choose activities that effectively target specific areas of care delivery. For example, CMS could identify quality measures that assess the intended goals of each CPIA (including PROMs and patient experience measures) to support clinicians in making data-driven decisions about whether or not switching to a new quality improvement goal, and corresponding set of CPIAs, would advance their clinical transformation.

We agree that the QPP should evolve to score clinicians based on performance and improvement on selected activities, rather than on attestation. To enable this kind of evaluation, we suggest identifying existing metrics that assess the expected impact of each improvement activity on patient outcomes and patient experience. We encourage CMS to explore ways to leverage patient-reported outcome (PRO) and patient experience metrics for these purposes, including developing new PRO and patient experience measures to fill gap areas. To get a score for improvement, clinicians should be required to report on these metrics for at least two years (even if they select different/new activities in the second year).

Advancing Care Information Bonus

We strongly support the new activities eligible for ACI bonus points, and appreciate that CMS intends to continue incentivizing the use of health IT and telehealth to connect patients with the care and community-based services they need. We support CMS's intent to include additional activities in future rulemaking that leverage emerging certified health IT capabilities.

New Clinical Practice Improvement Activities

We support the expanded inventory of activities, particularly the following new activities that advance health and health care priorities for patients and families:

- Provide Clinical-Community Linkages
- Primary Care Physician and Behavioral Health Bilateral Electronic Exchange of Information for Shared Patients
- Advance Care Planning
- CDC Training on CDC's Guideline for Prescribing Opioids for Chronic Pain
- Consulting AUC Using Clinical Decision Support when Ordering Advanced Diagnostic Imaging

Our additional comments about two of these activities follow.

Clinical-Community Linkages (A_PM_XX)

Community services and supports can have a significant impact on a patient's care and outcomes, and are critical to creating a culture of health. We encourage CMS to further specify details for qualifying activities, in particular what it means for community health workers to "provide" a comprehensive link to community resources. Qualifying activities should also proactively include patients and families. For example:

- Partnering with patient/family advisors in identifying helpful community-based supports and resources and building better connections between the practice and those organizations/systems;
- Ongoing efforts to ensure these links remain valid and relevant; and
- Educating clinicians about the availability of these resources and how best to recommend them to patients and families.

Advance Care Planning (IA_PM_XX)

Advanced care planning requires clinicians to work closely with patients and their families. We encourage CMS to add qualifying activities that emphasize support and intervention for patients and families at the appropriate time, in an appropriate setting, delivered by the appropriate team of qualified individuals. For example:

- Documenting clinician training on how to effectively provide palliative and end-of-life care in a team setting;
- Documenting the patient's preferences for goals of care, treatment options, and setting of care (in addition to the Advance Care Plan) within the medical record;
- Converting the patient treatment goals into medical orders;
- Documenting patient verification of an advance care plan that is consistent with their values and preferences; and updates to the advance care plan as appropriate; and
- Conducting retrospective comparisons of how closely care received aligns with the advance care plan, using patient-reported data when possible.

Clinical Practice Improvement Activities with Changes

Leveraging a QCDR to Promote Use of PRO Tools (IA_AHE_3)
We strongly support the proposed changes to this activity and commend CMS for further promoting the collection and use of patient-generated data through this CPIA. Employing patient-reported outcome (PRO) tools and collecting PRO data are key elements of patient-centered care, shared decision-making and care planning. We support CMS's proposal to increase the weight of this activity from medium to high, and to change the activity's eligibility for the ACI bonus score (for clinicians who collect PRO data via their electronic health record). We further support the change in activity title, to Promote Use of Patient-Reported Outcome Tools, as it better communicates the goals of this activity.

Participation in MOC Part IV (IA_PSPA_2) and Participate in IHI Training/Forum Event; National Academy of Medicine, AHRQ Team STEPPS® or Other Similar Activity (IA_PSPA_3)
We also support the proposed changes to the Maintenance of Certification-related activities in the Patient Safety & Practice Assessment subcategory to clarify additional activities and MOC programs that that would quality for this improvement activity. We believe this supports a dual goal of promoting practice improvement while expanding clinician's options for pursuing MOC requirements.

Implementation of formal quality improvement methods, practice changes, or other practice improvement processes (IA_PSPA_19)
We continue to urge CMS to ensure that patient safety and quality improvement activities reflect the role of patients and families in driving safer, high-quality care. We appreciate efforts to promote greater transparency by sharing practice-level quality, patient experience, and utilization data with patients and families (as well as staff) and believe practices should move beyond simply sharing this information. We strongly encourage CMS to include additional activities in which clinicians act upon patient experience data. For example, an activity could be "data-driven care planning" in which clinicians would engage patient and family advisors in analyzing the patient experience data, co-develop an improvement plan, and then participate in its execution and evaluation.