COALITION FOR
Better Care

June 27, 2016

The Honorable Sylvia Matthews Burwell
Secretary, U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Mr. Andy Slavitt
Acting Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

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

Dear Secretary Burwell and Acting Administrator Slavitt:

The Coalition for Better Care (CBC) appreciates the opportunity to offer comments in response to the proposed rule: Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models (CMS-5517-P). The CBC is a broad-based coalition of consumer organizations with a direct stake in improving the health and quality of life of patients and their family caregivers. We are committed to ensuring that new models of care delivery and payment provide the comprehensive, coordinated, patient- and family-centered care patients want and need while helping to drive down costs.[1]

We applaud CMS for its continued commitment to shifting to value-based payment and moving away from payment models that reward volume rather than quality and value. The implementation of the Medicare Access and CHIP Reauthorization Act (MACRA) is a critical opportunity to strengthen the delivery of care for Medicare beneficiaries, and we welcome the opportunity to offer comments on this new regulatory framework. The proposed rule represents a

[1] For brevity, we refer throughout 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."

1875 Connecticut Avenue, NW, Suite 650
Washington, DC 20009
P 202.986.2600
F 202.986.2539

bold first step towards transforming our health care system in this direction. We believe that consumer engagement, enhanced delivery of care, consumer safeguards, and meaningful quality measurement are all critical to the success of these new payment policies and their ability to achieve our shared goals of improved health outcomes, improved patient experience and lowered cost of care. We offer the following comments and recommendations to strengthen the proposed rule.

1. **We urge CMS to ensure consumers and patients are involved in the development of the underlying models that are categorized as Advanced Alternative Payment Models (APMs).**

The Coalition for Better Care strongly supports movement towards new payment models that reward value rather than volume and are extremely pleased to see CMS accelerate the transition to APMs. If designed and implemented correctly, APMs have the potential to provide comprehensive, coordinated, patient- and family-centered care while driving down costs. Ultimately, APMs can only achieve all three tenets of the Triple Aim – better health outcomes, better experience of care and lower costs – if they meet the needs of the patients they serve and improve how care is delivered.

However, Advanced APMs under MACRA will only be as strong as the underlying models that meet the requirements. Therefore, we urge CMS to consider how to increase transparency and public input into the development of these models. Consumers and patients must be viewed as co-creators in our health care system and integral partners in developing all new models of care and payment. We believe it is critically important that multiple, diverse stakeholders have the opportunity to weigh in during development and implementation of new payment models. For example, CMS could appoint an advisory committee or Technical Expert Panel (TEPs) consisting of patient and consumer advocates, as well as other stakeholders, when CMS is developing new models.

We also raise concerns about consumer involvement in future years when participation in non-Medicare alternative payment models will contribute to a provider's eligibility for the Advanced APM bonus. In the context of commercial models, which may be less known to advocates, we believe it is especially important to include patients, consumers, and advocates in determining which models should be included for the purpose of determining Advanced APM eligibility.

2. **We urge CMS to require that all Advanced APMs use a clinical care model that results in improved delivery of care and reinforces a strong foundation of primary care (i.e., greater care coordination and communication; use of shared care planning and partnership with patients at all levels of care; timely access to care; and demonstration of improved patient care experience).**

We are concerned that, for the Advanced APM program (with the exception of models considered Medical Home Models), there are no requirements concerning the clinical care delivered by the underlying APM. Cost savings and the transition of health care spend to value-based payment models cannot be the sole focus of our transition away from fee-for-service. Meaningful transformation to value based payment requires that the transition to APMs also results in improved delivery of care (i.e., greater care coordination; use of shared care planning and partnership with patients at all levels of care; and demonstration of improved patient care experience).

We strongly recommend that as entities take on financial accountability for quality performance and value, assume financial risk, and move towards capitation-like payment models, these entities must likewise be able to demonstrate that they promote and support sustainable, effective, evidence-based, accessible, patient- and family-centered care delivery. We therefore recommend that CMS add an additional criterion for Advanced APMs that requires them to demonstrate that their payment approach will reinforce the delivery of coordinated patient- and family-centered care, and a strong primary care foundation.

We strongly encourage CMS to consider requiring all models qualifying as Advanced APMs meet care delivery requirements similar to those for Advanced APM Medical Home Models.

We note also that robust quality measures will be essential to assessing whether Advanced APMs are delivering better coordinated patient- and family-centered care. Advanced APMs should incorporate quality measures that assess how well models are improving care, increasing coordination, and engaging patients.

3. We urge CMS to require Medical Home Models seeking to qualify as an Advanced APM to meet all seven requirements laid out in the rule's definition of a Medical Home Model.

Primary care plays an important role in improving the quality of health care overall, reigning in high medical costs, and improving the patient's experience of care. As a general matter, payment models should foster coordination, particularly between primary and specialty care, in order to promote: optimal coordination, communication and continuity of care; trusted relationships between clinicians and patients/families; concordance with patient goals, values and preferences; integration of non-clinical factors and community supports; and coordination with services delivered through non-traditional settings and modalities that meet patient needs.

The special consideration given to Medical Home Models as Advanced APMs acknowledges the critically important role of primary care. We strongly support the separate financial standards for Medical Home Models and appreciate CMS's attention to placing a high-value on the provision of primary care.

However, with regards to the requirements around Medical Home Models, we urge CMS to go further and require Medical Home Models seeking to qualify as Advanced APM to meet all seven of the domains listed in the proposed rule's definition of a Medical Home Model: (1) planned coordination of chronic and preventive care; (2) patient access and continuity of care; (3) risk-stratified care management; (4) coordination of care across the medical neighborhood; (5) patient and caregiver engagement; (6) shared decision making; and (7) payment arrangements in addition to, or substituting for, fee-for-service. All seven domains are key elements of a true Medical Home Model. Particularly with respect to first six criteria, we can identify no criterion that could acceptably be missing from a high-quality medical home.

The requirements for Medical Home Models also need much greater definition and specificity, particularly with respect to patient and caregiver engagement and to shared decision-making.

4. We urge CMS to ensure consumer safeguards are keeping pace as more providers move into risk-based alternative payment models.

We support the financial incentives in place to encourage uptake of alternative payment models and to incentivize clinicians to practice medicine and deliver care in innovative ways as they work to improve patient experience, quality, and efficiency. However, as CMS continues to develop new models of care and payment and providers take on increased risk, reward, and responsibility, it is important that CMS ensure that the evolution and application of consumer protections are keeping pace. We therefore urge CMS to clarify how consumer protections will be enhanced as more providers move into Advanced APMs.

CMS should prioritize improvement of a broad array of consumer protections, including more complete notice requirements concerning empanelment or participation in an Advanced APM, greater emphasis on consumer outreach and education, and adequate protections concerning alignment, attribution, and data sharing. CMS must monitor and ensure that patients get the care they need and that ongoing care is not interrupted.

Payment models should collect data that allows for assessment of differential impacts and the identification and redress of disparities in health, health outcomes, care experience, access, and affordability. New models should have protections against stinting, cherry-picking, and discrimination, especially for vulnerable, high-risk and high-need populations.

Further, care and information should be linguistically and culturally appropriate and tailored to the health literacy level of patients and families. To ensure educational materials and notices are well-designed, materials should be collaboratively developed and vetted by patients, families and consumer representatives.

5. We urge CMS to improve the structure and reporting around Clinical Practice Improvement Activities.

Clinical practice improvement activities should drive and support sustained, comprehensive clinical practice transformation. Transformed clinical practices view patients and families as partners in their care and incorporate patients and families into transformation efforts and governance systems. They are responsive to patient and family caregiver needs and are oriented towards achieving the goals of higher quality care, better patient and family experience of care, and reduced costs. We appreciate that the activities under this category were created to drive health system transformation, and strongly support the inclusion of new categories on health equity and behavioral/mental health integration.

Clinical practice improvement activities must be meaningfully implemented such that they have a demonstrable beneficial impact on patient experience and health outcomes. We recommend more specific descriptions and definitions of the activities themselves to ensure CPIAs are not simply low-impact "check the box" activities but rather are, as intended, investments in continuous quality improvement and better care delivery.

In future years, we also recommend aligning established quality measures with improvement activities to help understand activities' impact on health outcomes and patient experience. Requiring providers to simply attest to clinical practice improvement activities is not enough and we urge CMS to go further to ensure that providers are making progress towards meaningful transformation.

6. We urge CMS to retire the "one patient" threshold in the Advancing Care Information (ACI) performance category base score – in name as well as in concept.

We appreciate that the two-tiered scoring system of the ACI category (base and performance scores) simultaneously encourages adoption and use by new clinicians while rewarding performance on measures that have the greatest impact on patient and family engagement, care coordination and interoperability. However, future changes to the scoring methodology and more stringent measures of health IT use will be important to realize the promise of health IT that enhances the overall health of patients.

Keeping the "One Patient" threshold from the Meaningful Use Incentive Program – and broadening its application to all measures in the base score (not just the patient engagement measures) – undermines CMS's commitment to make patients and family caregivers true and equal partners in improving health through shared information and shared decision-making. It sends the wrong signal – to the nation's patients and families, and to clinicians. Such a low threshold essentially creates check-the-box process measures for health IT, rather than encouraging substantial uses. Measuring performance for a single patient or encounter is hardly a sufficient proxy for determining whether providers are robustly using health IT to improve patient care and outcomes.

We strongly recommend increasing the performance threshold for the base score to five percent starting in reporting year 2019.

7. We urge CMS to develop a path forward for development and implementation of better quality measures that reflect what consumers value – such as patient reported outcome measures and patient experience measures.

We appreciate the emphasis placed on outcomes measures in the quality performance category of MIPS. However, we urge CMS to rapidly develop a path forward for development and implementation of high value measures that reflect both patient-reported and clinical outcomes as well as patient experience, care coordination, shared decision-making, participant-directed services, safety, access and resource use. We believe strongly that both measure development and measure selection for MIPs and APMs should be guided by a multi-stakeholder process that includes patients, consumers, and advocates.

Further, we believe that measures are needed not just for performance measurement, but also to provide real-time feedback on practice performance so that clinicians can deploy quality improvement strategies as needed, particularly in high-impact areas like patient experience of care. We urge CMS to invest resources in evolving Consumer Assessment of Healthcare Providers and Systems (CAHPS) instruments – or potentially new tools – to be more meaningful to consumers, more efficient to administer and collect, and better able to supply providers with real-time, actionable feedback for practice improvement. We also encourage CMS to utilize qualified clinical data registries as a tool for collection of patient-reported data that reflects outcomes and patient experiences.

Information about individual clinicians' performance is important for quality improvement, value-driven payment and insurance design, and informed consumer decision-making. Quality measures,

particularly patient experience, should use individual clinician-level information whenever possible.

Thank you for the opportunity to respond to the proposed rule for the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models (CMS-5517-P). We reiterate our appreciation for the work that CMS is undertaking to move us toward high-quality, patient-centered care. If you have any questions about our comments and recommendations, please contact Stephanie Glover, Health Policy Analyst at the National Partnership for Women & Families, at sglover@nationalpartnership.org or (202) 986-2600.

Sincerely,

AMDA – The Society for Post-Acute and Long-Term Care Medicine
American Association on Health and Disability
Asian & Pacific Islander American Health Forum
Association of Asian Pacific Community Health Organizations (AAPCHO)
Center for Medicare Advocacy
Community Catalyst
Consumers' Checkbook/Center for the Study of Services
Families USA
Healthwise
Informed Medical Decision Making Foundation
Institute for Patient- and Family-Centered Care
Lakeshore Foundation
LeadingAge
Medicare Rights Center
National Committee to Preserve Social Security and Medicare
National Consumers League
National Health Law Program
National Partnership for Women & Families