national partnership for women & families
Because actions speak louder than words.

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 National Partnership for Women & Families 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 National Partnership represents women across the country who are the health care decision-makers for themselves and their families and who want to ensure that health care services are both affordable and of the highest quality. We are deeply invested in improving the quality and value of health care and committed to ensuring that all models of care delivery and payment provide women and families access to comprehensive, high-quality, and well-coordinated patient- and family-centered care.

We applaud the Centers for Medicare & Medicaid Services (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 bold first step towards transforming our health care system in this direction.

We believe that high-value quality measures, robust use of health information technology, continuous practice improvement, and meaningful patient and family engagement 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.

1875 connecticut avenue, nw ~ suite 650 ~ washington, dc 20009 ~ phone: 202.986.2600 ~ fax: 202.986.2539
email: info@nationalpartnership.org ~ web: www.nationalpartnership.org

Specifically, we offer recommendations to improve the Quality Payment Program by rapidly developing and implementing quality measures that are meaningful to patients and consumers; strengthening the structure of Clinical Practice Improvement Activities; increasing the threshold for the base score of Advancing Care Information beyond "one patient;" requiring clinical care models with a foundation in primary care for all Advanced Alternative Payment Models (APMs); and engaging patients, consumers, and advocates in the development of new Advanced APMs.

If you have any questions about our comments and recommendations, please contact Stephanie Glover, Health Policy Analyst, at sglover@nationalpartnership.org or (202) 986-2600.

Sincerely,

Debra L. Ness, President

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

The National Partnership for Women & Families strongly supports the Merit-Based Incentive Payment System (MIPS) as a glide path to move Medicare providers towards a payment framework that rewards value rather than volume. As the new default payment program for most clinicians participating in Medicare Part B, it is critical that the MIPS framework reward high quality performance and improvement and that it not simply support the status quo.

We are concerned about the proposed MIPS framework for payment bonuses and penalties, which creates a forced curve of winners and losers. We believe that measure targets should be set in absolute (not relative) terms and should include a range of scores on each measure to enable the incentive system to reward both performance and improvement. Relative scoring diminishes incentives for improvement, for both low and high performers, and can decrease the likelihood of collaboration between providers and/or between integrated systems. We recognize that CMS may be limited by statutory constraints under MACRA, but nonetheless express our concerns on the overarching framework for bonuses and penalties.

Quality Performance Category

The Quality performance category of MIPS is an opportunity to improve upon the Physician Quality Reporting System (PQRS) reporting criteria and evolve into a more meaningful program with more robust requirements and measures. We applaud CMS for identifying and emphasizing the types of measures that offer the most value to consumers: measures of outcomes, appropriate use, patient safety, efficiency, patient experience and care coordination. However, we believe it is necessary to specifically call out and prioritize patient-reported outcomes (PROs) and PRO-based measures (PROMs). While outcomes are proposed as priority measures, this category typically refers to clinical outcomes rather than PROMs. PROMs and other measures using patient-generated data assess issues that are important to patients and are a key element of patient-centered care, enabling shared decision-making and care planning.

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

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

Regarding the Data Completeness provision for this category, we recommend the use of larger patient samples over time and the eventual elimination of sampling from reporting requirements. This approach will better support groups in internal benchmarking for quality improvement while also enabling measurement at all levels. We support the

proposal to use all-payer data for quality measures, recognizing that this data will create a more comprehensive picture of a clinician's performance.[1] We also support all-payer data for patient experience surveys.

To truly support high-value care and value-based payment, performance measurement must be meaningful to all stakeholders and useful not only for quality improvement but also for equipping consumers to distinguish between providers who deliver excellent, average, or poor care. Although we support the direction of the proposed rule relative to the existing quality programs, we encourage CMS to move rapidly to a core set of measures by specialty or subspecialty. A core set approach using high-value measures would enable direct comparison between similar clinicians, and would provide assurance that the comparison is based on a consistent and sufficiently comprehensive set of quality indicators. As noted above, we support measures of highest value to consumers and patients: measures of outcomes, appropriate use, patient safety, efficiency, patient experience, and care coordination. Future core measure sets should incorporate these critical measurement domains.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

We applaud CMS for emphasizing the importance of patient experience measures by including this category in the list of priority measures. Patient experience of care is a key tenet of a person-centered health care system and patient experience measures are critical for quality improvement and consumer choice. However, we are disappointed that CMS is not requiring the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS and, therefore, strongly encourage CMS to require a CAHPS measure for all MIPS eligible clinicians in groups of two or more.

Measuring patient experience and satisfaction with their care is often the only way to evaluate elements of care that patients and family caregivers identify as most important to improving their health outcomes and their care experience. Given the exceptionally high value of patient experience measures, we also strongly encourage CMS to invest resources in evolving CAHPS instruments – or creating new tools – to be more meaningful to consumers, more efficient and less costly to administer and collect, and better able to supply providers with real-time feedback for practice improvement. Enabling individual-clinician-level collection and reporting of patient experience measures in a manner that is useful to both consumers and providers should be of high priority.

If CMS decides to add CAHPS as a requirement for the MIPS performance category, then we urge CMS to go beyond the "core" CAHPS survey and also consider including questions – and 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 did not understand;

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

- Whether the patient felt she was treated unfairly because of her race, ethnicity, or how well she spoke English; and
- If necessary, whether an interpreter was provided, and how the patient would rate the interpreter.

These aspects of the care experience are critical to quality and safety outcomes. A patient is not going to be able to follow a provider's recommendations if they do not understand what they are being asked to do.

Additionally, the Health Information Technology 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 was to find those results.

Giving patients the tools to access and manage their own health information electronically is foundational to patient engagement and high quality care. Understanding patients' experiences engaging with their providers through the use of health information technology (health IT) will inform efforts to engage them in activities that are essential to better care and improved health outcomes.[2]

We also support continuing research and implementation efforts to combine patient experience survey scores with narrative questions. Integrating more open-ended questions will allow beneficiaries and patients to share nuanced and rich information that will make patient experience surveys more meaningful for quality improvement. For example, when a patient indicates that her provider is not communicating with her in ways 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 an interpreter when needed.

Data stratification

We strongly support reporting quality measures and data stratified by demographic characteristics as an important tool for uncovering disparities and quality gaps as well as identifying intervention points and strategies. Collection and reporting of stratified data will help create a long-term agenda for improving healthcare quality for vulnerable and traditionally underserved populations. Measure stratification also has great potential to identify physician practice patterns that are impacting care, such as ordering tests and procedures or safety practices. Stratified data should help practices direct resources efficiently toward quality improvement initiatives and allow providers to address gaps in health equity.

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[2] National Partnership for Women & Families, *Engaging Patients and Families: How Consumers Value and Use Health IT*, pp. 19-20, 32 (Dec. 2014), available at http://www.nationalpartnership.org/research-library/health-care/HIT/engaging-patients-and-families.pdf.

Specifically, we recommend stratifying measures by variables including race, ethnicity, gender, disability status, primary language, gender identity, sexual orientation and other demographic characteristics. We encourage CMS to make stratified quality data publicly available at both individual and practice levels.

Resource Use Performance Category

Resource use measures are an integral part of understanding and evaluating the efficiency and value of care delivery. We strongly support the continued use of the two total cost measures: Total Per Capita Cost and Medicare Spending Per Beneficiary (MSPB). We also support replacing the four condition measures with a set of measures that are more specific to services or procedures for a particular condition or diagnosis. To identify and prevent unintended consequences of these measures, we recommend that appropriate use measures accompany them whenever possible. We also recommend assessment at the individual clinician level. All clinicians should be assessed at the individual level in addition to the group level, as individual clinicians have significant control over resource use. Measurement at the individual level will provide needed information on within-practice variations to individual clinicians, physician groups, CMS, and other stakeholders.

We also strongly encourage CMS to move rapidly to including Part D drug costs as well. Prescription drug costs are too significant to be excluded from the shift to value-based payment.

As these measures are implemented, it will also be important to ensure providers understand the relationship between resource use and quality of care. Many may assume "resource use" information can be found solely in their financial data, and do not see the link between their clinical practice patterns (e.g., inappropriate use of imaging studies, duplication of lab tests, etc.) and the impact on resource use. We encourage CMS to provide support and feedback to providers to ensure they understand what is included in the measures, and how they can make appropriate changes to their practice to improve them.

Clinical Practice Improvement Activities Performance Category

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

We appreciate that these proposed activities aim to drive health system transformation, and support the inclusion of new categories on health equity and behavioral/mental health integration. We strongly support improvement activities aimed at identifying and reducing disparities. Engaging a diverse population of patients and family caregivers, including those from underserved communities, in practice transformation and improvement activities can help practices to better understand gaps in care and improvements that may help to reduce those gaps.

We have long advocated for transformation that aims to help primary care providers deliver high quality, coordinated, and patient- and family-centered care. We are pleased to see

many activities that are generally aligned with our priorities for transformed delivery of care and meaningful engagement of patients and families (please see Appendix A for the National Partnership's vision for patient centered medical homes). For example we particularly support the following activities under CPIA:

- Care coordination and communication among health team members, including patients and families
- Managing transitions of care in partnership with community-based entities and services
- Developing and updating individual care plans with patients
- Fostering linkages with neighborhood/community-based resources to support patient health goals
- Use of evidence-based decision aids to support shared decision-making[3]
- Support for patient self-management using techniques such as teach back, action planning or motivational interviewing
- Expanded access to care

Patients and families bring unique experiences, insights and perspectives to their own health care and to broader discussions focused on care process redesign and improvements at system levels. Meaningful engagement of patients and families in these activities requires viewing patients not as "objects" of care but as partners; meaningful collaboration goes beyond engagement at the point of care to include patients as partners in redesigning care and developing solutions to improve quality.

We also support activities that leverage person-centered uses of health information technology, such as providing patients "access to an enhanced patient portal that provides up to date information…and includes interactive features allowing patients to enter health information and/or enables bidirectional communication." CMS could also consider adding activities to the CPIA inventory that leverage health IT in innovative ways. These activities could allow clinicians to explore emerging functionalities that warrant inclusion in the definition of CEHRT, as well as newly introduced certified capabilities that are not yet required of all eligible clinicians (e.g., a CPIA that leverages the optional 2015 CEHRT criterion related to integrating and using social, psychological and behavioral data).

We are also pleased to see the inclusion of patient-reported outcome (PRO) tools in the list of activities. Such data collection could significantly improve the use of PROs in clinical practice and future development of PRO measures, which is frequently hindered by too few providers using a given PRO tool or by limited data for measure development and testing. CMS should provide guidance on preferred PROs and require data reporting back to CMS to augment measure development efforts.

Overall, we view the CPIA category of MIPS as a strong first step towards transforming clinical care and encouraging ongoing practice improvement. However, the category lacks

[3] Please see our comments on the Medical Home Model under Alternative Payment Models for a detailed explanation of how shared decision making can be better defined.

sufficient requirements to ensure that the clinical improvement activities are resulting in continuous quality improvement and better care delivery. For instance, the currently proposed 90-day reporting period does not provide sufficient time to document sustained practice engagement in these activities; accordingly, we strongly recommend a full-year reporting period for CPIAs.

In future years, we recommend that the CPIA category be strengthened to ensure that clinical practice improvement activities are being meaningfully implemented and impacting patient experience and health outcomes. We envision that this strengthening could occur in three ways: (1) by providing more specificity around the descriptions and definitions of clinical practice improvement activities, (2) by consolidating certain activities, and (3) by aligning quality measures with clinical practice improvement activities to promote data-driven quality improvement. Additional detail regarding these three recommendations follows.

Provide more specificity in defining clinical improvement activities.

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. For example, we encourage CMS to extend the same level of robust specificity to the definitions of beneficiary engagement activities that is currently attributed to chronic disease management activities.[4] Below, we offer recommendations for strengthening definitions of beneficiary engagement and care coordination activities. Additionally, for future iterations of clinical practice improvement activities, we urge CMS to include additional activities aimed at better leveraging collaboration and partnerships between providers and patients and families at all levels of care.

Patient and Family Advisory Councils (PFAC)

We applaud the inclusion of a beneficiary engagement activity that encourages practices to "Regularly assess the patient experience of care through surveys, advisory councils, and/or other mechanism." We note, however, that practices must go beyond working with PFACs to identify problems or solicit feedback (as one would with a focus group); practices also should work with patient and family advisors to develop solutions and plans for improving quality. In our experience, effective Patient and Family Advisory Councils meet regularly (at least eight times a year), report directly to ambulatory/system leadership, are meaningfully involved in improvement projects from conception to completion and document and evaluate goals, projects and accomplishments.

Patient experience of care

[4] For instance, one proposed CPIA for the Population Management subcategory entails "participation in a systematic anticoagulation program (coagulation clinic, patient self-reporting program, patient self-management program) for 60 percent of practice patients in year 1 and 75 percent of practice patients in year 2 who receive anti-coagulation medications (warfarin or other coagulation cascade inhibitors)."

The National Partnership supports activities focused on collecting patient experience data and using it to improve quality. To ensure its effectiveness, however, we recommend expanding the definition and description of the activity to include encouraging practices to engage patient and family advisors in analyzing the data, developing an improvement plan, and participation in its execution and evaluation.

Shared care plans

The proposed rule outlines multiple activities, of varying levels of strength, which are aimed at improving care planning. The National Partnership strongly believes that all care planning should be approached as shared care planning. Shared care planning should be done in collaboration with a patient and (as appropriate) a designated family caregiver. Please see our recommendations below for the Medical Home Model, included in our comments on Advanced Alternative Payment Models, for a detailed explanation of how shared care planning concepts can be better defined and implemented.

Culture change for patient safety

The National Partnership supports activities that advance a practice culture in which all staff actively participate in patient safety improvement activities. However, engaging patients and families as partners in improving safety is also an important component of culture change. We urge CMS to ensure that activities regarding culture change reflect the role of patients and families in driving safer care. While 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), practices should move beyond simply *sharing* this information. Practices should engage with patients and families as partners to identify key safety issues, and to prioritize, shape and evaluate practice changes to improve care. For example, the activity could include collaborating with patient and family advisors to assess and modify policies related to care transitions and communication between the practice and acute or post-acute care organizations.

Linkages with community organizations

We strongly supports the activity encouraging practices to develop pathways to neighborhood and community-based resources that can support patients and their families and help them meet health goals. These pathways should be bidirectional – it is not enough to simply give patients the names of community-based resources. Rather, it is important to help patients make the connection with such organizations, and to confirm with the service organization that they are supporting the patient. We recommend adding that patient and family advisors can play an important role in helping practices identify and connect to community resources that are most useful to its patient populations.

Consolidate repetitive clinical improvement activities.

Within the specific activities included under CPIA, we noted that many are similar in definition or objective. We recommend that CMS consider consolidating some of these activities into one or more activities that add a more comprehensive set of practice improvement objectives. Such consolidation not only will provide greater simplicity, but also will allow practices to focus on high-impact activities. This approach also could prevent

practices from being able to receive full credit for three activities that are essentially the same and advance improvement in a narrow way.

For example, as noted above, there are currently many proposed activities for engaging patients in the creation of care plans. To enhance the CPIA category, we suggest a single shared care planning activity that engages patients and their family caregivers in the development and adjustment of a shared care plan that (1) captures all relevant information and (2) documents this information in the patient's electronic health record. Such a consolidated, strengthened activity would encompass the following:

> "Engage patients and authorized family caregivers in developing individualized plans of care that prioritizes patients' goals for action. These plans of care should be appropriate to age and health status and may include health risk appraisal; gender, age and condition-specific preventive care services; plan of care for chronic conditions; and advance care planning. These plans of care should be documented in the certified EHR technology, and clinicians should provide patients annually (at a minimum) with an opportunity for development and/or adjustment of their plan of care."[5]

Further, the activity could include specific information documented in CEHRT including some or all of the following:

- Caregiver name/role/status;
- Assessment and plan of treatment (including referrals to community-based services and supports);
- Health concerns;
- Goals (both patient and provider); and
- Advance directive content.

This example is informed by our consumer principles for health and care planning.[6] Consumers envision moving beyond the concept of a care plan as a document fixed in time, to a multidimensional, person-centered health and care planning process built on a dynamic, electronic platform. This next generation of care plans connects individuals, their family and other personal caregivers, and health care and social service providers, as appropriate, and provides actionable information to identify and achieve individuals' health and wellness goals. We subsequently developed use cases to illustrate how this kind of robust, electronically-enabled health and care planning could look for individuals of different ages, health conditions and socioeconomic backgrounds.

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[5] This example incorporates elements from multiple proposed CPIAs related to care planning, including: Population Management – "Proactively manage chronic and preventative care…"; Population Management – "Provide longitudinal care management…"; Care Coordination – "Implementation of practices/processes to develop regularly updated individual care plans…"; Care Coordination – "Develop pathways to neighborhood/community-based resources; and Beneficiary Engagement – "Engage patients, family and caregivers in developing a plan of care…".

[6] Care Plans 2.0: Consumer Principles for Health and Care Planning in an Electronic Environment (Nov. 2013), available at http://www.nationalpartnership.org/research-library/health-care/HIT/consumer-principles-for-1.pdf.

Align quality measures with clinical practice improvement activities to promote data-driven decision-making.

As noted, Clinical Practice Improvement Activities should function as a vehicle for improving quality, health outcomes and patient experience, as well as for supporting transition to APMs. To ensure that provider implementation of clinical practice improvement activities indeed demonstrates delivery of higher-quality, more patient- and family-centered care, we recommend CMS support practices in making data-driven decisions about how and where to target improvement activities. For example, one way to approach this could be to align quality measures – such as patient experience and PROMs – with improvement activities.

While attestation alone may indeed confirm that a provider is duly implementing a clinical practice improvement activity, aligning quality measure with improvement activities will better help providers assess progress and impact.

In determining which quality measures might be appropriate for helping providers to assess how/whether a practice is meeting patient-centeredness and care-delivery transformation benchmarks, we encourage CMS to consider not only clinical outcomes measures, but also patient reported outcomes measures and patient experience measures. Patient experience measures would yield particularly important information concerning Care Coordination and Beneficiary Engagement CPIAs.

Furthermore, taking a more holistic, comprehensive approach could strengthen overall efforts to achieve high-quality, well-coordinated, patient- and family-centered care. Moving forward, providers should be encouraged to select quality measures, Clinical Practice Improvement Activities and relevant Advancing Care Information (ACI) measures that complement one another. For example, a provider focused on managing chronic conditions within her patient population would choose care plan-related CPIAs, quality measures that focus on patient experience and/or improved outcomes, and ACI measures that leverage patient-centered communication (soliciting goals for patient-generated health data, encouraging patients to access lab results via a patient portal, etc.).

Certified Patient Centered Medical Homes (PCMH)

Finally, we recognize and support the value of aligning full credit of Clinical Practice Improvement Activities with existing PCMH recognition programs. We believe such recognition can be an important way to assess whether a practice is delivering care in a way that is consistent with the patient-centered medical home model.

As recognition programs and the clinical practice improvement activities evolve, we will continue to urge a stronger focus on the areas that matter most to patients and families, most specifically:

- Collecting and reporting patient experience of care;
- Meaningful engagement of patients and families. (For a framework for meaningful patient engagement, please see our recommendations for strengthening the

definition for Medical Home Models, included below in our comments on Advanced Alternative Payment Models.)

These areas should be required or "must pass" priorities for any practice certified as a patient-centered medical home.

We also support moving toward inclusion of performance thresholds in recognition programs. Currently, many recognition programs focus on infrastructure changes and quality improvement activities, without requirements to track how well practices are performing in each domain to achieve improved patient experience and outcomes.

Advancing Care Information Performance Category

The robust use of health IT and health information exchange is fundamental to achieving the foundational goals of incentivizing high-quality, efficient practices, coordinated care and improved health outcomes.

For consumers, health IT can be used to engage individuals as equal members of their health care team by equipping them with the tools to work in partnership with professional care team members, better understand and manage their own health, and care for loved ones.[7] Specifically, health IT can help patients and their caregivers make more informed decisions; be better connected to their care team; generate and share important health information; and set, track and achieve personal health and wellness goals. MACRA must advance patient and family caregivers' ability to access, contribute to, and use their own health information if we want to achieve high-value care and healthier people.

With this in mind, the overall arc of the Quality Payment Program is directionally positive in driving advanced, person-centered uses of health IT. The Advancing Care Information category of MIPS – particularly through the measures prioritized in the performance score promotes the objectives of interoperability, care coordination, and patient and family engagement. Furthermore, several activities in the CPIA category leverage the use of certified electronic health record technology (CEHRT) to manage chronic and preventive care, create linkages to community-based resources and support progress on patient-identified health goals.

However, proposed requirements for health IT adoption and use for both MIPS and Advanced APMs as currently proposed are not sufficient to provide substantial, patient-centered uses of health IT that would lead to health system transformation. Changes to the scoring methodology and more advanced measures of health IT use will be important to truly transform care and enhance the overall health of patients.

Eligibility and Measures

We appreciate that, through their eligibility for MIPS, more types of clinicians will be using health IT (than were previously eligible for the Meaningful Use EHR Incentive Program). Widespread adoption facilitates greater health information exchange and interoperability

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

across the care continuum, and supports care coordination. We encourage CMS to invest resources to support clinicians new to using health IT in fulfilling the ACI performance category. Additionally, CMS should conduct oversight and provide timely feedback on how all clinicians are fulfilling measures of health IT use. Providers serving vulnerable populations would especially benefit from additional support and technical assistance to address barriers to equal access to health IT, as well as to implement patient-facing communication platforms and educational materials that are tailored to patients' language preferences, literacy levels, and accessibility needs. As adoption and use of health IT increases among MIPS eligible clinicians, ACI measures will need to evolve to make continued progress on patient engagement, care coordination, and interoperability objectives.

Structural requirements

We strongly support the CMS proposal to align measures in the ACI category with measures finalized for Meaningful Use, as a way to ease transition from participation in the Meaningful Use program to MIPS.

We also support full calendar year reporting for the ACI category to achieve alignment across MIPS categories (e.g. the Quality performance category). Requiring full-year reporting is more likely to prompt changes to provider workflows that are essential to realizing the full potential of health IT. Full-year reporting allows for sustained progress on prioritized ACI measures, particularly those that maybe be most challenging such as Care Coordination through Patient Engagement objective. Limiting reporting on measures to 90 days also hinders progress on interoperability and health information exchange. 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 – <u>any</u> day of the year, rather than a particular three-month period.

Additionally, we appreciate that there are clear interrelationships among MIPS program categories that leverage and use health IT, especially between the ACI and CPIA categories. These intersections help to further integrate health IT use and corresponding workflow and culture changes. For instance, CPIAs that leverage CEHRT to engage patients and their family caregivers in the creation of care plans, documentation of patient goals, or sharing of information through advanced portals would presumably facilitate clinician performance in the ACI category as well (secure messaging, patient generated health data, educational materials, etc.) – and vice versa.

Scoring

We understand that the two-tiered scoring system of the ACI category (base and performance scores) simultaneously encourages adoption and use of health IT by new clinicians while also increasing incentives to improve performance on patient and family engagement, care coordination and interoperability.

<u>Base score</u>

While we appreciate the intent of the base score (to create a proxy for basic health IT use that provides a foundation for all eligible clinicians (including new adopters of health IT)), we are dismayed that CMS again proposed the "one patient" threshold, this time for all measures in the base score.

Keeping the "one patient" threshold – and broadening its application to all measures (not just View/Download/Transmit and Secure Messaging) – undermines CMS's commitment to make patients and family caregivers true and equal partners in improving health through shared information and shared decision-making. It sends the wrong signal – to the nation's patients and families, and to clinicians.

Additionally, such a low threshold essentially creates check-the-box process measures for health IT rather than encouraging effective use of health IT.

We strongly urge CMS to increase the threshold for the base score measures to five percent starting in reporting year 2019. A minimum standard of five percent is well below or equal to all Meaningful Use thresholds for 2017, and signals a genuine expectation by CMS that organizations and providers make the process changes necessary to support electronically-enabled care. Additionally, CMS could consider increasing the weight of the performance score relative to the base score, to further emphasize performance on high-value and person-centered uses of health IT.

With respect to CMS's proposals for the base score, we prefer the primary proposal in which providers would report on 11 measures (as opposed to the alternate proposal that would require additional submission on Clinical Decision Support (CDS) and Computerized Provider Order Entry (CPOE)). Removing CDS and CPOE from the measure set will enable providers to direct their attention to measures that have the greatest potential for improvement and impact on care delivery, which often require more robust changes to workflow and corresponding organizational culture.

We also support CMS's proposed requirement to fulfill the objective to protect patient health information (perform a security risk analysis and implement security updates as necessary) in order to receive any base score, and ultimately any score in the ACI category. We appreciate the continued attention paid to protecting the privacy and security of consumers' electronic health information.

Performance score

With respect to the performance score, we strongly support the prioritization of measures that promote interoperability, care coordination and patient and family engagement. These measures have great potential to improve the quality, efficiency and experience of care.

Consumers need a comprehensive and accurate view of their health and health care, and they should be able to direct their health information based on personal preferences. We enthusiastically support the inclusion of measures that assess individuals' use of online access to their health information and secure email exchange with care team members.

Additionally, we support the following ACI performance score measure requirements:

- Family caregivers: Allowing authorized family caregivers the ability to access the health information of their loved ones and send secure messages on their behalf reinforces caregivers' role as essential members of the care team.
- Application Programming Interfaces (APIs): By requiring providers to offer patients the ability to view, download and transmit their health information through both portals and APIs, CMS pursues the transition to APIs prudently.
- Patient-generated health data & data from non-clinical settings: Effective care planning and coordination require a comprehensive approach to health that is not exclusively focused on interactions with the health care system. Incorporation and use of both non-clinical and patient-generated health data are an effective approach for engaging patients and their families, ensuring that care results in better outcomes, and decreasing costs associated with unnecessary readmissions and difficulties with adherence.
- Health information exchange: Meaningful and effective coordination of care requires electronic sharing of information across all providers, as well as with patients and families. We support supplementing medication reconciliation for transitions of care with reconciliation of medication allergies and problems, as part of the health information exchange objective. These criteria will enhance safety as well as coordination.

In response to CMS's request for comment on how to increase the impact of ACI measures in future years, we suggest that CMS reward clinicians for improvement through bonus points. Specifically, we recommend that clinicians who increase their ACI performance score by five percentage points or more would receive two bonus points to be added to their total ACI performance score. This would give providers the flexibility to experiment with health IT functionalities (and specific measures) in the ways that are most relevant to their practices and patient populations.

Definition of meaningful user

The definition of Meaningful User will have an important effect on health IT adoption and robust use. We are concerned that prematurely reducing the ACI category weight could have a chilling effect on progress towards robust, person-centered use of health IT.

Therefore, we prefer the primary proposal to use a 75-point threshold (rather than the alternate proposal of 50 points) to determine Meaningful Users, but urge CMS to consider a higher threshold in future years. We oppose the alternate proposal to lower the threshold to 50 points because it would mean that providers who fulfill the base score (in which providers have to complete measures for only one patient/encounter) would be considered a meaningful EHR user. This is hardly a sufficient proxy for determining whether providers are robustly using health IT to improve patient care.

Information blocking

We strongly support CMS's inclusion of timely access by patients to their electronic health information in the required attestation regarding information blocking. Hindering individuals in accessing and using their health records is a prime example of information

blocking.

Public Reporting of MIPS Scores

We strongly support the proposal to publicly report data on MIPS clinicians' performance. Publicly available quality information is essential for value-based decision making and drives quality improvement and accountability. Individual-level provider quality information is extremely valuable to consumers when selecting a physician, therefore we strongly advocate not only for individual clinician-level measurement but also for public reporting of individual clinician-level measures when that information is valid, reliable, and meaningful.

Additionally, research has shown that much of the variation in quality and cost occurs at the individual provider level, not the practice site, group, or health system level. Providing transparent information on quality performance at the individual provider level will enable consumers to make more informed decisions about providers and care settings.

We encourage CMS to consider publicly reporting not only the cumulative MIPS scores for individual providers, but also the specific measures on which clinicians are reporting. Providing more granular information will help patients to understand the basis on which providers are being scored. Further, if physicians report on different measures from year to year (for example, a surgeon reports on joint replacement outcomes in Year 1 but not Year 2), consumers should be able to access that information.

We strongly support consumer engagement and consumer testing in developing the language explaining quality measures to ensure that the information is meaningful and understandable for patients and families. Only through partnering with patients and consumers can CMS be sure that the quality measures reflect what matters to patients and families, and that the information is presented in an understandable format.

We also encourage CMS to require public reporting of quality data stratified by patient demographic characteristics at both individual and practice levels. Doing so will reflect trends in health equity that aid consumers in making informed choices, in addition to aiding providers in identifying and ultimately reducing health disparities.

ADVANCED ALTERNATIVE PAYMENT MODELS

The National Partnership strongly supports movement towards new payment models that reward value rather than volume. We are extremely pleased to see CMS accelerate the movement towards 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 should enable us achieve all three tenets of the Triple Aim – better health outcomes, better experience of care, and lower costs – but they can do so only if they engage and meet the needs of the patients they serve and improve how care is delivered. Indeed, reduced spending, excellence in quality, and genuine improvement in care delivery are inextricably linked. (Please see Appendix B for the National Partnership's crosscutting criteria for alternative payment models.)

Advanced APMs under MACRA will only be as successful as the models of care delivery they produce and support. 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, with a strong primary care foundation. We also urge CMS to consider how to increase transparency and public input into how it determines which APMs will qualify as Advanced APMs. Finally, we also offer recommendations on how to strengthen CEHRT requirements for Advanced APMs, the quality measurement guidelines, the financial risk standards, and the Advanced APM Medical Home Model.

Care Delivery Requirements for Advanced APMs

We are concerned that there are no requirements for use of clinical care models by the Advanced APMs (other than the models considered Medical Home Models). Cost savings and transition to value-based payment approaches are not the sole goals of health care transformation. Meaningful transformation requires that the transition to APMs also results in improved delivery of care including greater care coordination and continuity; use of shared care planning and partnership with patients; and demonstration of improved patient care experience.

We strongly recommend that as entities take on financial accountability for quality and value, assume financial risk, and move towards capitation-like payment, they also demonstrate that they promote and support effective, equitable, 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 reinforces the delivery of coordinated, patient- and family-centered care, with a strong grounding in primary care.

Primary care should play a foundational role in all new payment models. Therefore, at minimum, all models qualifying as Advanced APMs should have similar care delivery requirements as Advanced APM Medical Home Models. We have previously raised specific concerns about the models of care in two of the approved Advanced APMs (Next Generation ACO and Medicare Shared Savings Program), including the need for greater requirements around patient engagement and consumer/beneficiary participation in governance and care design as well as better communication with beneficiaries.

Multi-Stakeholder Input into Determining Qualification for Advanced APM Designation

CMS must ensure consumers and patients are involved in the development of the underlying models that are categorized as Advanced APMs. As noted above, delivery of high-quality, patient-centered care is a key element of health system transformation that in addition to reduced health care spend.

Therefore, we urge CMS to consider how to increase transparency and public input into the development of alternative payment models. Consumers and patients must be 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 all 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 developing new

payment models. This is critical to ensuring that Advanced APMs are meeting the needs and priorities of all stakeholders, especially patients and their families.

Use of Certified Electronic Health Records Technology

The National Partnership believes there must be strong incentives in place to encourage the use of health IT to exchange health information across the care continuum, including with patients and families, in order to meet the goals of transformed care. Since qualifying Advanced APMs receive a substantial lump sum bonus of five percent, it is reasonable to expect a strong commitment by these APMs wide adoption of health IT.

We support the use of CEHRT because it leverages existing technological functionality to facilitate high-value care and supports movement towards patient-centered care through capture of critical information about individuals' health and care outside the clinical setting. With respect to the threshold for CEHRT use, while we appreciate that some clinicians included in potential Advanced APMs have not previously used CEHRT (as they were not eligible under the Meaningful Use program), we feel the proposed 50 percent threshold to qualify as an Advanced APM should be increased in future years of the program. Therefore, we support CMS in its proposal to increase the threshold for CEHRT use to 75 percent of clinicians in the second performance period.

Furthermore, additional requirements may be necessary to ensure that Advanced APMs leverage health IT in innovative ways to improve patient care, experience, and outcomes. It will be important to monitor the health IT- related requirements that are incorporated into Advanced APMs to ensure continued progress in the use of health IT. For example, in order to successfully engage in activities that lead to health care system transformation, providers would benefit from functionalities available in but not yet required by the 2015 Edition of CEHRT. Some features currently deemed "optional" are critical for the level performance expected in new models of care under Advanced APMs, as well as for certain ACI and CPIA activities, should include, for example, Social, Psychological, and Behavioral Data; Care Plans; Clinical Quality Measures – Filter; and Accessibility-Centered Design. These functionalities are instrumental to engaging patients, and coordinating and evaluating care including many specified CPIAs in the Beneficiary Engagement and Coordinating Behavioral and Mental Health sub-categories. Moving forward, these features should be included as required components of the MACRA regulations' definition of certified EHR technology.

Payment Based on Quality Measures

The Advanced APMs quality measures will only be as strong as the underlying models' requirements. There is no consistency in how these models obtain feedback from consumers and purchasers on the quality measure sets or other program features. We strongly recommend that multi-stakeholder input on APM quality measures (as well as other model design elements) be a standard part of the design and designation process. One way to operationalize this is to obtain the feedback through the Measure Applications Partnership.

The proposed rule does not address measure development or innovation for Advanced APMs. It is recognized by all stakeholders that the current state of measurement falls short of providing meaningful and robust information to providers and to consumers. We strongly encourage measurement innovation to be a key feature or option in all Advanced APMs.

Measures must be developed to address key features that innovative alternative payment models are intended to address, such as improved care coordination, communication, information sharing, continuity, patient-centeredness, and efficient use of resources.

Partnering with patients and families throughout the measure development process is important to these efforts. As CMS noted in its draft Measure Development Plan, "the development of patient-centric measures is dependent on having the voices of patients, families and/or caregivers incorporated during the measure development process." We encourage CMS to partner with patients, families and consumer advocates in meaningful ways and as early as possible in the measure development process. For example, including patients and families in the prioritization and re-evaluation of measures will ensure that their unique insights and perspectives add value to the process and lead to the creation of measures that reflect what is important to patients and families and to the system as a whole.

Meaningful collaboration with patients and families relies upon thoughtful outreach and recruitment as well as tailored preparation and support for both patients/families and meeting facilitators (and additionally other stakeholders). Indeed, these best practices are crucial to supporting effective patient and family engagement and overcoming any challenges. We urge CMS to reach out to organizations that have expertise in this area for continued guidance.

Finally, we note that regardless of the type of APM, physician-level quality measures must be used in addition to metrics at the APM level, so that consumers can use information to compare providers and make informed choices about their care.

Financial Risk

We support the proposal to require two-sided risk for Advanced Alternative Payment Models. Financial risk is a key driver of coordination and shared accountability for outcomes. Encouraging payment models to bear risk can be an effective strategy to incentivize clinicians to practice medicine and deliver care in innovative, resource-effective ways as they simultaneously 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 safeguards are keeping pace. We therefore urge CMS to clarify how consumer protections will be enhanced as more providers move into Advanced APMs. APMs should be built upon a strong foundation of robust consumer protections that ensure consumer needs are met and that safeguard consumer rights and access to care. New payment models must emphasize provider accountability for patient health outcomes and care experience across all patient populations, while also protecting patient choice and agency.

CMS should prioritize improvement and adoption of a broad array of consumer safeguards, including more complete notice requirements, greater emphasis on consumer outreach and education, and adequate protections concerning alignment, attribution, and data sharing. CMS must monitor and ensure that patients are able to access the care they need and that ongoing care is not interrupted. Furthermore, CMS will need to conduct ongoing

assessment of APMs to ensure that the models are indeed achieving the goals of better outcomes, experience of care, and equity.

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.

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 of 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. We also encourage CMS to go further and consider improvements to the Relative Value Unit system that underlies most APMs, particularly those changes that would enable a more equitable distribution of resources to primary care.

However, with regards to the requirements around medical home models, we strongly urge CMS to go further and require Medical Home Models seeking to qualify as Advanced APM to meet <u>all seven</u> 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 the 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. (For more information about our vision for patient centered medical homes, please see Appendix A.)

Patient and caregiver engagement

Patient and family caregiver partnership is critical to the success of a Medical Home Model. We strongly urge CMS to craft a strong definition for this category to ensure that it is meaningfully implemented. We believe patient and family engagement should be defined as follows: "The practice meaningfully partners with patient and family caregivers at all levels of care, including at the point of care, in care redesign and in governance. At point of care, providers emphasize shared care planning, joint goal-setting, collaborative care and treatment planning. The practice also encourages and supports patient and family integration in governance boards, quality improvement initiatives, and Patient and Family Advisory Councils."

As we shared in previous comments on the MACRA RFI, examples of robust partnership with patients and families in the primary care setting include:[8]

- Practices work in partnership with patient/family advisors throughout the process of implementing and evaluating a patient portal. Patients and families can help practices ensure a portal is easy to use and includes functions that are important to patients, and can also help practices understand how to communicate with patients about portals most effectively.
- Practices work in partnership with patient/family advisors to enhance the support the practice provides to patients and families as the patient transitions to other settings and providers following an acute and/or post-acute care stay.
- Practices partner with patient/family advisors in identifying helpful community-based supports and resources and building better connections between the practice and those organizations/systems

Shared decision-making

We applaud the inclusion of shared decision-making in the requirements of the Medical Home Model. However, we have long advocated that shared decision-making be re-framed as an integral part of "shared care planning." Unlike shared decision-making, which may be tied to a singular episode of care, shared care-planning occurs across a patient's lifespan. Individualized shared care plans are a core element of effective care coordination and positive patient experience. Proactively and explicitly engaging a patient and patient-designated caregivers in the development of a care plan helps to ensure that the individual's abilities, culture, preferences and values are respected and care instructions are more likely to be understood and followed.

We also encourage CMS to offer a more specific definition of "shared decision-making" (or, alternatively, of "shared care-planning"). There are two key elements to shared decision-making process that must be captured in such a definition. First, patients faced with a treatment decision must be informed about all the reasonable options, including doing nothing, and told what is known about the potential risks, benefits and alternatives to those options. Second, patients must be meaningfully involved in the decision making process, which includes the opportunity to discuss the options, ask questions, and express

[8] You can find our full comments in response to the MACRA Request for Information here: http://www.nationalpartnership.org/research-library/health-care/comments-on-macra-request-for-information-november-2015.pdf.

their preferences about which path to follow. Meaningful shared decision-making should facilitate bidirectional communication between providers and patients in which risks, benefits and alternatives of proposed treatment are discussed and together the provider and patient share in the process of deciding what is best for the patient based on her individual goals, preferences, and values.

For shared decision-making to be effective and meaningful, providers must also be specifically trained to facilitate shared decision-making. We encourage CMS to establish clear standards for practices to ensure that providers have the skills and training to furnish these services at a high level of quality. Likewise, we recommend that CMS require providers to demonstrate that they have undergone training on how to effectively use shared decision making tools, and that CMS certify that such training has taken place. We believe that this specialized training should be integrated into the education and credentialing of a diverse array of health care professionals across fields.

Finally, we encourage CMS to move towards measuring whether meaningful shared decision-making has occurred, specifically through patient reported measures.

Intermediate APM Options

The National Partnership supports the Intermediate APM option to serve as a glide path from MIPS to Advanced APMs. Moreover, we support streamlining requirements for MIPS APMs to create consistency with goals of Advanced APMs and reduce barriers to becoming an Advanced APM. Ultimately, we would like to see MIPS APMs seek to become Advanced APMs rather than long-term MIPS participants.

However, we are concerned that non-ACO MIPS APMS will not be subject to a quality score in the first year. These models require payment based on quality, and those quality measures should be included in the composite score beginning in the first year. We are also concerned that 75% of the non-ACO MIPS APMs composite performance score is based on the ACI score. The recommended addition of the quality score will help better balance the composite score components.

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

CONCLUSION

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.

APPENDIX A

Fact Sheet: Cross Cutting Consumer Criteria for Patient-Centered Medical Homes

Cross Cutting Consumer Criteria for Patient-Centered Medical Homes

APRIL 2016

A truly patient-centered medical home (PCMH) is grounded in comprehensive and well-coordinated primary care that treats the whole person and is consistent with each patient's unique needs and preferences. Patient-centered medical homes provide care that takes into consideration the patient's life situation, including his or her family and caregiver circumstances, as well as the patient's values and preferences, age and home environment when making health care and treatment recommendations.

A truly patient-centered medical home (PCMH) is grounded in comprehensive and well-coordinated primary care that treats the whole person and is consistent with each patient's unique needs and preferences.

Exemplar PCMHs utilize an interdisciplinary care team, provide ready access to care, partner with patients and their families at all levels of care and coordinate their care over time and across various settings and providers. The medical home also leverages the capacity of electronic health information exchange and strives to assure the highest possible quality of care and continuous quality improvement. It places a high priority on preventive care, care coordination and care management, including support for self-management, to help patients become and stay healthy.

PCMHs Provide Ready Access to Care

In a patient-centered medical home, patients and family caregivers have ready access to care. The practice:

- Ensures 24/7 provider availability by phone, email, video or in the office. In-office appointments and tele-consultations are scheduled promptly. The PCMH offers same-day appointments and accommodates walk-ins. Care team providers can rapidly access their patients' electronic medical records outside of conventional office hours.
- Accommodates the needs of patients with limited physical mobility, English proficiency, cultural differences or other issues that could impede access to needed examination and treatment, and/or impact patients' self-management ability.
- Facilitates patients' ready and appropriate access to services and providers outside of the practice.
- Has systems in place to help patients with health insurance eligibility, coverage and appeals, and to refer patients to helpful sources.

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- Assesses whether cost is a barrier to patients' getting needed care/services and helps to meet those needs and/or connect patients and family caregivers to appropriate support.

PCMHs Effectively Coordinate Patient Care across Settings and Providers

The patient-centered medical home takes responsibility for coordinating its patients' health care across care settings and services over time, in consultation and collaboration with patients and family caregivers. The practice:

- Enables providers to practice within the full scope of their expertise, appropriately delivering minor procedures and other treatments that other primary care providers might refer out but that can be safely completed within the practice.
- Helps patients choose specialists and obtain medical tests when necessary. The patient's care team informs specialists of any necessary accommodations for the patient's needs.
- Helps the patient access other needed providers or health services (including providers or health services not readily available in the patient's community, e.g., in a medically underserved area).
- Has processes in place to effectively monitor and manage all tests, referrals, procedures and appropriate follow-up care.
- Ensures smooth transitions by assisting patients and families as the patient moves from one care setting to another, such as from hospital to home.
- Ensures that medications are actively managed and reconciled to avoid adverse interactions. Patients and their caregivers are valuable sources of information and are included in reconciliation processes. This helps ensure the accuracy and reliability of data stored in medical records while simultaneously empowering patients and their caregivers to be active partners in their health and health care.

In a patient-centered medical home, an interdisciplinary team guides care in a continuous, accessible, comprehensive and coordinated manner.

- The patient is both the center of the care team and a member of the care team. Patients are asked whom they want involved in their care and define who is considered a family caregiver. Practices respect patient choices and actively encourage family caregiver involvement.
- The care team demonstrates strong linkages with community resources, including those that provide non-medical services and support to vulnerable populations.
- The care team provides initial and routine assessments of patients' health status and places a high priority on preventive care, care coordination and chronic care management to help patients get and stay healthy and maintain maximum function.
- The care team is led by a qualified provider, and different types of health professionals, including non-physician providers, may serve as team leader.

The care team works together in a manner that facilitates continuous communication among both clinical and non-clinical staff. In a patient-centered medical home, patients and family caregivers are supported in managing the patient's health. The practice:

- Works with the patient and/or their caregiver to set goals for the patient's health and care and helps the patient meet these goals and manage health conditions.
- Integrates culturally appropriate community-based support resources – such as social services, transportation, peer support groups and exercise programs – into care plans.
- Assesses patients who are unable to effectively manage their own care because of cognitive or physical challenges and accommodates these patients by working with family caregivers, legal surrogates or other sources of support.

PCMHs Treat Patients as Partners at All Levels of Care Delivery

In a patient-centered medical home, patients, family caregivers and providers are partners in making key decisions. The practice:

- Meaningfully partners with patient and family caregivers at all levels of care, including at the point of care, in care redesign and in governance. At point of care, providers emphasize shared care planning, inclusive of shared decision making, joint goal-setting, collaborative care and treatment planning. The practice also encourages and supports patient and family participation in governance boards, quality improvement initiatives and Patient and Family Advisory Councils.
- Ensures that patients and family caregivers are provided useful, consumer-friendly educational information, including electronically, that helps them understand their conditions and the results of any medical tests or consultations (with both primary care providers and with specialists).
- Provides unbiased, evidence-based information on all treatment options, including possible side effects, costs and the benefits and risks of different options (including alternative therapies), so that patients can make an informed choice that reflects their personal preferences.
- Provides patients and family caregivers with timely access to the results of laboratory and other diagnostic tests through telephone, email, fax, personal health records and/or patient portals.

In a patient-centered medical home, open communication between patients and the care team is encouraged and supported. The practice:

- Knows about and overcomes any language, cultural, literacy or other barriers to ensure effective communication with patients, family members and other caregivers.
- Communicates information to patients and caregivers in plain language (rather than medical jargon), in patients' preferred languages, with links to explanatory, contextual information as needed and in a manner that is accessible to those with visual, hearing, cognitive and communication impairments.

The patient-centered medical home fosters an environment of trust, transparency and respect. The practice:

- Treats patients and family caregivers with dignity and respect.
- Respects patients' choice of treatment and provider.
- Works with patients and families to help them understand why and how patient health information will be stored, exchanged, used and protected; conveys the opportunity to opt-out of data-sharing; and clarifies other consumer rights and protections. The practice ensures that no treatment decisions are made without the patient's consent and understanding.
- Ensures that examinations and discussions with or about patients take place in a setting that affords appropriate privacy from other patients or staff.

PCMHs Commit to Delivery of High-Quality Care and Continued Quality Improvement

The patient-centered medical home provides care that is safe, timely, effective, equitable and patient- and family-centered. To accomplish this, the practice:

- Seeks out and encourages patient-reported data on health outcomes and patient feedback on their experience of care, and uses that information to improve the quality of care provided.
- Collaborates with patients and family caregivers in quality improvement strategies and practice redesign.
- Collects data on race, ethnicity, sex, gender identity, sexual orientation, primary language and language services for each patient and records that information in a manner that can be reported and used to plan and respond to the health and language needs of patients.
- Regularly evaluates and improves the quality, safety and efficiency of its care using scientifically sound measures. Quality performance information is reported to an entity and made publicly available in a manner that patients and caregivers can understand and access.
- Creates systems for medication reconciliation and shared medical records to help prevent errors when multiple clinicians, hospitals or other providers are caring for the same patient.
- Routinely undertakes efforts to identify and reduce any disparities in the quality of care provided to patients.
- Ensures all of its patients have equal access to high-quality care, regardless of source of payment.

PCMHs Commit to Patient- and Family-Centered Use of Health Information Technology

The patient-centered medical home robustly utilizes health information technology (HIT) and electronic health information exchange. HIT is a foundational element of improving a practice's ability to share information and communicate both amongst providers and with patients and families. The practice:

- Has ready access to the patient's complete, up-to-date medical history, including the patient's electronic health record, and shares summaries of care and other critical information with outside providers as appropriate.
- Ensures that patients and authorized family caregivers also have electronic access to the patient's electronic health record and are able to view, download and transmit the patient's health information. Online access to patients' health information is a critical tool for improving patients' knowledge about their health, empowering their ability to communicate with providers and increasing their desire to take proactive action to manage their health.
- Enables two-way communication with patients in and outside of in-person encounters, for example through secure email messaging and/or patient portals.
- Offers patients and family caregivers the ability to contribute information (i.e., patient generated health data) to their medical record that is relevant to their care. The information patients and their family caregivers provide about their abilities and need for self-management support complements clinical information to provide a comprehensive, person-centered view of the patient's health and health care needs.
- Ensures all patient-facing information and communication platforms are displayed in plain language, in patients' preferred languages, with links to explanatory, contextual information as needed, through accessible technology platforms (including mobile devices), and at no charge.

APPENDIX B

Fact Sheet: Cross Cutting Consumer Criteria for Alternative Payment Models

Cross Cutting Consumer Criteria for Alternative Payment Models

DECEMBER 2015

If designed and implemented correctly, Alternative Payment Models (APMs) have the potential to provide comprehensive, coordinated, patient- and family-centered care while driving down costs. APMs move away from the traditional fee-for-service method of paying for health care, which rewards providers for the volume of care they provide, and toward value-based arrangements that tie payment for health care services to quality performance, health outcomes and value. Ultimately, APMs' successful achievement of all three tenets of the Triple Aim – better health outcomes, better experience of care, and lower costs – rests on their ability to meet the needs of the patients they serve and to improve how care is delivered. APMs must be able to demonstrate not only cost savings and high performance on quality metrics, but also sustained implementation of transformed, patient- and family-centered care. Indeed, reduced spending, excellence in quality performance and transformation of how care is delivered are inextricably linked.

Realizing the promise of APMs also requires meaningful partnership and collaboration with patients and families at all levels of care – including at the point of care, in care redesign, in governance and policy and in the community. Only through meaningful partnership with consumers and family caregivers – the end users of APMs – will we successfully engage patients and achieve all three tenets of the Triple Aim.

Realizing the promise of APMs requires meaningful partnership and collaboration with patients and families at all levels of care.

Additionally, APMs should be built upon a strong foundation of robust consumer protections that ensure consumer needs are met and safeguard consumer rights and access to care. New payment models must emphasize provider accountability for patient health outcomes and care experience across all patient populations, while also protecting patient choice and agency. Thus, all APMs must both robust quality measures and meaningful consumer protections.

On the following pages, we lay out key cross-cutting consumer criteria that should be required of all APMs.

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To achieve better health outcomes, APMs must ensure delivery of safe, timely and high quality care.

1. **APMs should be founded upon and support evidence-based clinical care models that effectively coordinate care and incorporate patients as full members of an interdisciplinary care team.** APM clinical care models should promote the use of multi-disciplinary care teams that coordinate care across providers and care settings. Patients and families should be treated as integral parts of the care team and partners in the co-creation of their health and care. Clinical care models should demonstrate effective use of electronic health information sharing, shared care planning, shared decision making and self-management tools to increase patient engagement and agency.

2. **APMs should ensure that beneficiaries have ready access to care.** Patients assigned to APMs should have timely access to care, including access to providers outside of regular business hours. APMs must ensure provider availability by phone, email or in person during evenings and weekends, and ensure that providers schedule in-office appointments promptly. APMs should facilitate patients' ready and appropriate access to services and providers across the care spectrum, including mental health and community health providers.

3. **To evaluate quality performance and ensure delivery of high-quality care to patients, APMs should be required to do ongoing assessment of quality outcomes and care experience, public reporting of quality performance data and implementation of continuous quality improvement programs.** Quality data should be measured, tracked and inclusive of patient-reported data, including patient-report outcomes and care experience for patients and family caregivers.

   In particular, measurement of and reporting on patient experience of care and patient-reported outcomes should provide actionable data that helps providers improve care delivery and supports informed consumer decision making with respect to choosing health plans, providers and care settings.

   APMs should facilitate reporting quality performance data not only at the APM or delivery-system level, but also at the individual clinician/provider level.

4. **APMs should accelerate the effective use of health information technology**. Electronic health records (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 caregivers. 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.

5. **To improve health outcomes meaningfully, APMs should address social determinants of health and non-clinical factors that contribute to health and wellbeing (e.g.,**

housing, public safety, access to education and job opportunities, language services, availability of places to exercise, healthy food choices and other environmental factors). Information sharing and automated connections between providers and community-based agencies are vital in order to connect patients to appropriate community supports and services. APMs should encourage investment in a health care workforce that can support the physical, behavioral, social and economic wellbeing of patients.

6. **To improve health across all populations, APMs should address disparities in access to care and health outcomes.** The impact and appropriateness of care for different patient populations should be monitored. Data on race, ethnicity, sex, preferred language, disability and sexual orientation/gender identity should be collected to address any disparities that are identified. This data should be expanded over time to include geography and disability.

   Quality measure reporting should be stratified by demographic data, as this facilitates identifying disparities and quality gaps, and intervention points and strategies. APMs should use the new consensus metrics developed by the National Quality Forum (NQF) to assess cultural competency and language services. Implementing these measures is critical to address biases and barriers to care, poor patient-provider communication and poor health literacy.

To achieve a better care experience, APMs must view patients and caregivers as valuable partners and focus on providing patient- and family-centered care.

7. **APMs should ensure partnership with patients and families at every level of care delivery.** A better care experience and active patient engagement requires supporting patient and family participation as equal partners not only in their own health and health care decisions, but also at the care design/redesign, governance and community levels. APMs should demonstrate strong commitment to delivering patient- and family-centered care by promoting partnership with patients at every level of care. Patient-and family-centered care criteria should be incorporated into the clinical care delivery process, as well as into APM and governance structures and public accountability.

8. **APMs should partner with patients and families to make health information electronically available and useful.** Online access to patients' own health information is a critical tool for improving knowledge of health, ability to communicate with providers and desire actively manage one's health. APMs should ensure that patients and designated family caregivers can access and use their complete health information, including provider notes. Comprehensive health data should be available to all patients using diverse and accessible technology platforms, including mobile technologies, in the patient's preferred language and free of charge.

9. **At point of care, APMs should demonstrate a commitment to shared care planning and shared decision making.** Proactively and explicitly engaging patient and family caregivers in the development of a care plan and treatment decisions helps to ensure that the individual's abilities, preferences and values are respected, and care instructions and recommendations are more likely to be understood and followed. APMs should also enable patients' ability to contribute and correct health information (such as family health history, goals, chosen support individuals and networks and advance directive content) to help manage their care and wellbeing.

10. **APMs should promote and support engagement of patients and families in designing care delivery that improves care coordination and patient care experience.** Participation in quality improvement initiatives, establishment of Patient and Family Advisory Councils (PFACs) and electronic portal implementation and education are key ways to improve patient care experience and care coordination.

11. **Consumers should be part of APM governance structures.** Consumer engagement should integrate patients' values, experience and perspective into governance, oversight and policy-making. Consumers and patients should participate in relevant governance boards, leadership committees and oversight committees.

    - Consumers should have proportionate representation. Proportionate representation requires having more than one patient, family caregiver or consumer representative on a governance board. APMs should ensure that consumer representation on the governance board reflects the diverse patient population it serves.
    - Consumer representatives should be "true" consumers and/or consumer and patient advocates. "True" consumers interact with but do not directly benefit financially from the health care system. A consumer advocate or patient advocate is an individual representing an organization that has a stated mission to serve as an advocate or fiduciary for a population of consumers. Consumer and patient representatives should be able to contribute both direct experiences as care recipients and the skills associated with advocating for broader groups of patients in policy and governance settings.
    - Consumer representatives should be meaningfully involved in decision making. All representatives on the governance entities (including consumer/patient representatives) should have an equal seat at the table and an opportunity to share their perspectives as decisions are made.
    - Consumer representatives should receive orientation and onboarding support to facilitate their successful participation. Successful orientation and onboarding strategies help ensure that consumer advocate and patient representatives are effective in their governance roles and ultimately help APMs and delivery system models meet their quality, patient experience and affordability goals.

To achieve lower costs, APMs should offer appropriate financial incentives to providers that balance cost-saving interests with quality performance and health outcomes.

12. **In an APM, financial incentives should be contingent upon performance on quality measures.** Providers participating in APMs must be required to meet minimum standards of care, as indicated through quality measures, to be eligible to benefit from financial rewards or incentives or to participate in gains sharing. Requiring eligible providers to meet robust quality metrics ensures accountability for improving and maintaining high quality care and patient experience, as well as accountability for delivery of high-value care. Financial rewards (including gains sharing and other payment adjustments) based on cost-savings alone can lead to stinting on care, but robust quality measures can help ensure patients are getting appropriate, high quality, well-coordinated, patient- and family-centered care.

13. **APMs' reimbursement structures should reflect the complexity of their aligned patient population.** APMs should include risk-adjusted payment mechanisms, based on patient complexity. Payment should be adequate and flexible enough to support care coordination, transition management and medication management, and to enable providers to address non-clinical determinants of health when essential to care and outcomes. There also must be adequate payment for language services for individuals with limited English proficiency.

As APMs work to achieve the Triple Aim of better health outcomes, better experience of care, and lower costs, models must maintain strong consumer rights and protections.

14. **APMs should include strong consumer protections.** Strong quality measures can help ensure that providers do not stint on care, but as financial risk increases for providers, so does the incentive to stint on care. As new models of payment are developed that encourage providers to take on increased risk, reward and responsibility, it is critical that the evolution and application of consumer protections keep pace.

15. **Consumer protections should include choice in enrollment, provider selection, transparency regarding provider incentives and a fair appeals process.** Consumers should be notified of providers' and facilities' participation in any new payment model, including disclosure of any provider or facility financial incentives or shared savings opportunities. Consumers also should be clearly informed of the opportunity to opt out of new payment models. An external appeals process should be available to consumers whose providers or care facilities are participating in a new payment model that offers providers/facilities the opportunity to profit from savings generated through the program. Additional consumer protections should include complete and consumer friendly notice requirements; greater emphasis on consumer outreach and education; and adequate protections concerning alignment, attribution and data sharing.

16. **Consumers should be protected against discrimination.** APMs cannot discriminate against individuals eligible to enroll, participate or align in any alternative payment models on the basis of race, color, national origin, sex, sexual orientation, gender identity, health status or disability, and must assure that they will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation, gender identity, health status or disability.

17. **APMs should notify consumers about any data sharing that is part of the APM and provide information on the ability to opt out of data sharing.** Consumers should be notified as to why and how their health information will be stored, exchanged, used and protected; the opportunity to opt out; and other consumer rights. Any data sharing that is part of an APM must be compliant with federal and state law.