



November 17, 2015

VIA ELECTRONIC SUBMISSION

Acting Administrator Andy Slavitt
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3321-NC
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models (CMS-3321-NC)

The Medicare Rights Center (Medicare Rights) is pleased to submit comments on the Request for Information (RFI) Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models (CMS-3321-NC). Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Medicare Rights provides services and resources to over two million Medicare beneficiaries, family caregivers, and professionals annually.

We applaud the Centers for Medicare & Medicaid Services (CMS) for its continued commitment to value-based payment and the continual adoption of payment models that reward high quality care. The implementation of the Medicare Access and CHIP Reauthorization Act (MACRA) represents an important opportunity to improve care for people with Medicare. Overall, we urge improved quality measurement, express our support for clinical practices oriented towards the Triple Aim (improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care), and applaud robust use of electronic health information exchange.

As new payment models are implemented, we especially urge CMS to adopt beneficiary protections and mechanisms for oversight to ensure that people with Medicare retain appropriate access to care as healthcare providers increasingly take on shared risk. In addition, it is critical for CMS to make sure all Medicare providers are given ample opportunity to build an infrastructure and receive technical assistance that allows them to participate in the payment system best suited to their and their patient's needs. The following comments are informed by our experience working with Medicare beneficiaries and their families. For additional information, please contact Casey Schwarz, Senior Counsel for Education and Federal Policy, at CSchwarz@medicarerights.org or 212-204-6271 and Stacy Sanders, Federal Policy Director at SSanders@medicarerights.org or 202-637-0961.

A. THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) AND ALTERNATE PAYMENT MODEL (APM)

The RFI asks about the relationship between MIPS and APMs, requirements for APMs, and criteria for physician-focused payment models (PFPMs). We believe MIPS and APMs should support comparisons within and among each Medicare payment option. Encouraging clinicians to improve, through such comparisons, is an important goal. The law supports movement away from MIPS with the automatic 5% APM bonus. We also support the following statutory measures:

- Virtual Groups: The virtual groups that clinicians are permitted to create for MIPS measurement have the potential to encourage clinicians to work together to address quality and strengthen care coordination both within and outside the group. To facilitate this, we recommend that CMS provide guidance on how to form virtual groups, how to use the groups to improve integration and quality, and how to build on the groups.
- Meaningful PCMH & PCSP Standards: PCMHs and PCSPs will receive automatic credit for MIPS Clinical Performance Improvement Activities (CPIAs). We urge CMS to require that these practices meet National Committee for Quality Assurance (NCQA) PCMH and PCSP program standards or similar standards that are at least as rigorous.

We suggest that CMS advance additional incentives, including:

- Care Coordination: We suggest that MIPS include coordination measures to assess continuity among clinicians and across settings. We expect the inclusion of these measures will be particularly important for specialties that treat chronic conditions for which bundled payments are more challenging and coordination is essential.
- Regional Aggregation for MIPS Comparison: We suggest that MIPS scores be reported for all clinicians in specific areas, as the Medicare Payment Advisory Commission (MedPAC) suggested for comparing FFS to managed care.¹ This could help both beneficiaries and healthcare providers see how FFS compares to APMs, ACOs, and MA plans.
- Patient Panels: CMS should help MIPS clinicians identify their panel of patients, for example by having patients themselves identify their preferred primary care provider or via attribution as is done for ACOs.

B. MEASURE CRITERIA

For APM criteria, a first priority should be high-value performance measures to assess and improve the quality of care. High-value measures are: clinically important, evidence-based, transparent, feasible, valid and reliable, actionable, and rigorously audited to ensure accuracy. We urge CMS to require APM measures to meet these criteria, as lesser measures will not provide the support healthcare providers need to improve.

¹ Medicare Payment Advisory Commission (MedPAC), Report to Congress: Medicare and the Health Care Delivery System, Chapter 3, Measuring Quality of Care in Medicare, June 2014

In addition, CMS should require APMs to demonstrate a proven ability to manage populations and coordinate care with other clinicians and across all settings. APMs built on the solid foundation in PCMH and PCSP standards have already documented this ability for success. CMS should further require APMs to demonstrate how they can potentially align with ACOs and MA plans as well as other public and private managed care plans.

C. PERFORMANCE MEASURES AND REPORTING

Reporting Options. CMS asks whether to maintain all seven current performance reporting options. We suggest gradually phasing out non-automated reporting methods, which require manual input that creates potential for errors, selection bias, and even outright gaming. As these are gradually phased out, we encourage CMS to move to reporting of data drawn directly from and validated through electronic health record (EHR) entries that occur in the natural workflow of providing care. This will minimize the potential for errors, bias, and gaming and reduce administrative effort.

Number & Types of Measures. Rather than the total number overall, we recommend that CMS assess each measure's value in helping healthcare providers improve and helping beneficiaries and other stakeholders make meaningful comparisons. Measures meeting the high-value criteria described above are more likely to promote these goals, without placing an undue burden on practices. The desire to reduce burden should focus on selecting high-value, high-impact measures and efficient data collection, not on arbitrarily limiting the number of measures.

We recommend including measures covering all the important domains identified in the National Quality Strategy. These domains were developed through a consensus-based, multi-stakeholder process. We expect this will promote harmonization in performance-based payment and other quality improvement efforts among all public and private payers who look to the National Quality Strategy for guidance.

For types of measures, we encourage CMS to ensure that, over time, a majority of measures in the MIPS quality measure set are outcomes-based, including patient-reported outcomes measures (PROMs), patient experience measures, process measures that are linked to outcomes, and cross-cutting measures. Measures of process of care should be de-emphasized, particularly those that are only documentation or standard of care measures. Many cross-cutting measures reflect issues that are important to consumers and purchasers, while having the added benefit of applying to providers across specialties.

We recognize, however, that the existing pool of outcomes measures is limited and likely to grow significantly only after more widespread use of EHRs and re-specification of existing measures for electronic reporting. Even with more outcome measures that meet high-value criteria, application of them by individual clinicians under MIPS is problematic, given the likelihood of numbers too small for statistical significance. This introduces the possibility of holding clinicians accountable for outcomes over which they have only limited influence.

To mitigate this, CMS should include only outcome measures for which individual clinicians have statistically sufficient numbers. Until adequate outcome measures are developed and tested, CMS will need to utilize structure and process measures that are reliable and are directly linked with outcomes, such as on high-value preventive care services, which point clinicians to needed improvements. To effectuate the development of more useful outcome measures, CMS should encourage collection of data on patient-reported outcomes and accountability at a larger, regional level.

We encourage CMS to assign greater weight to PROMs and patient experience measures in the quality performance category. These high-impact quality measures are meaningful to both beneficiaries and providers. Clinical outcome measures alone, for example, provide an incomplete picture of quality, since they do not capture the patient's perspective, personal goals, and priorities. PROMs help patients understand and evaluate their treatment and provider options. Patient Reported Outcomes (PROs) capture information about a provider's ability to, for example, successfully restore function to someone with knee pain, difficulty breathing, or back pain.

Using CAHPS to evaluate quality performance. 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. As CAHPS is currently the tool we have to assess experience of care, we believe CAHPS measures should be included in the quality performance category for MIPS, as well as in, or strongly linked to, the clinical practice improvement activities category. Clinical practice improvement activities will play a critical role in a patient's experience of care.

We encourage CMS to explore ways to improve the current mechanism for gaining patient feedback, however. The CAHPS tools have sound psychometrics and address important topics, but the current methods of administration are costly and the survey tools are lengthy, contributing to low response rates. We suggest that CMS look into more efficient ways to generate patient experience feedback that give healthcare providers this data as close to real time as possible, such as through a mobile app, to supplement traditional survey techniques.

Data Stratification and Health Disparities. We support requiring data submissions that can be stratified by demographic characteristics and we strongly encourage CMS to make this information publicly available. Stratifying measures by demographic data is an important tool for uncovering healthcare disparities and quality gaps as well as identifying intervention points and strategies. Measure stratification has the potential to identify disparities among different patient populations and could help identify physician practice patterns that are affecting access to care. In turn, this data could help practices direct resources efficiently toward quality improvement initiatives and allow providers to close health equity gaps.

The use of Certified EHR technology (CEHRT), for example, gives providers the ability to stratify quality measures: the final 2015 Edition Certification Criteria would include the technological capacity to filter and stratify electronic clinical quality measures by multiple variables—such as sex, race, and ethnicity—that can help identify disparities in care. We recommend that data also be reported based on sexual orientation and gender identity and functional and cognitive status.

We encourage CMS to require public reporting of stratified quality data at both individual and practice levels. We expect that doing so will help consumers make informed choices and aid providers in identifying and ultimately reducing health disparities. Because of the potentially confusing nature of reporting stratified data, we strongly urge CMS to carry out consumer testing on the language that would accompany any such public reporting.

Clinical Practice Improvement Activities (CPIAs). The request asks what criteria to apply to CPIAs and whether it should include additional activities to those described in statute. We support the criteria established in the statute, and encourage CMS to ensure that CPIA criteria closely parallel those for PCMHs and PCSPs and other programs. We commend CMS for the inclusion of subcategories including expanded practice access, care coordination, beneficiary engagement, and patient safety and practice assessment.

For all CPIA subcategories, we recommend that clinical practice improvement activities include only those activities central to helping hospitals and provider practices provide more patient and family-centered care. We appreciate CMS' thoughtful consideration of what data should be submitted to demonstrate clinical practice improvement and how CMS should assess performance on clinical practice improvement activities. We support a staged approach to CPIA assessment that increases the threshold or quantity required, over time, to support continued improvement for providers at all levels.

Beneficiary Engagement Subcategory. Meaningfully engaging beneficiaries and families at all levels of care delivery is critically important, and we strongly support the inclusion of this sub-category. While the RFI focuses primarily on beneficiary engagement at the point of care, we urge CMS to prioritize beneficiary engagement at all levels of care, including in care redesign, governance, and in the community. Patients and families should be primary partners in clinical improvement initiatives across all six CPIA subcategories, as all of these categories will have an impact on how care is delivered and how patients experience care.

In response to the RFI question about whether performance in this category should be based on demonstrated availability of specific functions and capabilities, we note that the following examples and capabilities can help to reflect whether practices are undertaking meaningful engagement, including:

- Use of accessible, shared care-planning platforms that support joint development, maintenance, and updating by patients and family caregivers as well as members of the care team;
- Incorporation of patient-generated health data into the practice's EHRs;
- Processes for orienting and on boarding beneficiary representatives in governing boards, quality improvement task forces, or other boards and bodies; and
- Systems/processes in place to connect patients with community-based services and supports.

Additionally, we recommend that providers pursuing improvements in the beneficiary engagement subcategory begin with a self-assessment of such practices in order to identify gaps and inform improvement goals. Such an assessment should cover not only activities at the clinical care level, such as participation in shared care planning processes, but also assess beneficiary engagement activities at the following levels:

- Care redesign/improvement. For example, are beneficiaries/patients involved in analyzing and recommending solutions to information about patients' experience of care? Are consumers involved in quality improvement and patient safety work groups or task forces?
- Governance. For example, does the provider have a Patient and Family Advisory Council (PFAC), or include a proportionate number (at least two) of beneficiary/family caregivers on key governance or decision-making bodies?
- Community. For example, does the provider leverage partnerships and relationships with community-based and consumer organizations to facilitate smooth care transitions, or to better understand patient needs?

If beneficiaries are engaged in the above ways, it is also valuable to seek their perspectives on how well they are being engaged, for example, by asking whether they help to set the agenda and identify priorities in meetings, whether they have the information and support they need to participate effectively, and whether they feel they are having an impact on the way care is delivered. While practices may believe they are effectively engaging patients, asking questions of beneficiaries can help to more realistically illustrate gaps and areas for improvement.

Partnering with beneficiaries through Patient and Family Advisory Councils (PFACs) or in other meaningful ways can also support the development of mutually beneficial solutions that improve care in the ways that work best for beneficiaries and achieve practice goals. For example, if a practice's CAHPS scores indicate that patients are finding it difficult to schedule an urgent appointment when needed, Patient and Family Advisors can help the practice to understand where the problem lies and offer solutions to make it better.

Reducing Disparities in Care. For the key subcategory of ensuring equity and reducing disparities in care, we encourage CMS to align with the Office of Minority Health's standards for Culturally and Linguistically Appropriate Services. These standards address the need to understand and meet the cultural and linguistic needs of clinicians' patients/families by:

- Assessing their patient population's diversity;
- Assessing their patients' language needs;
- Providing interpretation or bilingual services to meet their patients' language needs;
- Providing printed materials in their patients' languages;
- Using electronic systems to record patient information as structured data on race, ethnicity, and preferred language; and
- Collecting and regularly updating health assessments, including assessment of health literacy.

Other Sub-Categories. We strongly support the suggested additional sub-category of Promoting Health Equity and Continuity and we urge CMS to adopt it. We also support the proposed subcategories of Social and Community Involvement, Achieving Health Equity, and Integration of Primary Care and Behavioral Health.

Other Measures for MIPS. CMS asks what types of measures used in other payment systems to include, what to use for specialties lacking high-value measures, and how to link clinicians to facilities and data sources. We encourage CMS to ensure that MIPS measures align with APMs, ACOs, and MA plan measures so clinicians, beneficiaries, and other stakeholders can make meaningful comparisons within and across each of these different payment and coverage options.

In particular, population-based measures, like preventable hospital admissions and readmissions, are critical for apples-to-apples comparisons of MIPS clinicians in aggregate at regional or national levels to APMs, ACOs, and MA plans. We suggest that CMS consider the MedPAC recommendation to aggregate clinicians in a community or geographic region for measures with limited meaning for individual clinicians. Local aggregation could allow comparisons of population-based measures among clinicians in a region under MIPS versus those in APMs, ACOs, and MA plans. It is important to note, however, that some outcome measures may not be appropriate for individual clinicians who have little ability to influence the outcomes.

Performance Standard Development. CMS asks what historical standards and benchmarks to use and how to define, measure, and incorporate improvement opportunities—and improvement itself—into MIPS. We encourage CMS to use prior year results as benchmarks and to do so independently of group size. Results should be stratified by socioeconomic status for analysis to identify and track progress on reducing disparities.

To define and measure improvement, we suggest weighting methods. Importantly, the evaluation should take improvement potential into account. For example, clinicians with a score of 60 on a given measure have 40 potential points of improvement, while clinicians scoring 90 have only 10 potential points for improvement. CMS will need to periodically update improvement definitions and baselines to promote continual improvement.

Weighting Flexibility. CMS asks how to weight results when providers cannot be assessed in some categories, and how to determine when that is the case. To weight results for providers who cannot be assessed in some categories, we suggest increasing weights for other measures.

Composite Scores and Public Reporting. We strongly recommend using an approach similar to the Medicare Advantage (MA) Star Ratings methodology. The Star Ratings program combines individual measure scores into composite scores that are more understandable, while retaining the ability to ‘drill down’ to the component measures. Most importantly, this methodology will best facilitate comparison of quality between MIPS clinicians, MA plans, and other payment options.

D. INFORMATION TECHNOLOGY

Data Integrity. The request includes several questions on protecting the accuracy of data reported for value-based payment. It is critical to require rigorous auditing, oversight, or retrospective accuracy checks for all reported data to ensure reliable, valid results. We believe a concurrent audit is the best process. Rigorous auditing will allow CMS to promptly identify and address poor data practices and will be essential for protecting the integrity of MIPS and APM data now that significant dollars are attached to quality scores.

We suggest a high threshold for data integrity, given the impact on beneficiary health, taxpayer dollars, and fairness among clinicians. Intermediate consequences should include conversations, learning opportunities, corrective action opportunities, and financial sanctions. Disqualification from participation in Medicare and other federal programs should serve as a final consequence, for both clinicians and vendors who fail to meet integrity standards. Strong data integrity provisions are necessary to protect beneficiaries, taxpayers, and clinicians.

E. MEANINGFUL USE

Meaningful Use criteria. Robust health information exchange is fundamental to improving performance in the other three categories of MIPS—quality, resource use, and clinical practice improvement activities. The “Meaningful Use” Electronic Health Record (EHR) Incentive Program requirements, and the technical standards deployed through the parallel ONC Certification program, are accelerating the development of necessary standards and services to make care coordination across health systems easier and more efficient for both healthcare providers and patients. Meaningful Use thresholds were carefully set such that *all* eligible providers have a chance to succeed. Accordingly, experience so far shows that, on average, providers are greatly exceeding thresholds. As such, we ask CMS not to undermine requirements (by allowing providers to meet only selected thresholds), and to implement the final, stage 3 Meaningful Use rule released previously.

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

F. RESOURCE USE MEASURES

Types of Measures. The RFI asks what resource use measures to use, how to align with other Medicare resource measures, and whether to include Part D. As described below, we support the use of HEDIS Relative Resource Use (RRU) and *Choosing Wisely* measures, in addition to Total Per Capita Costs for All Attributed Beneficiaries and Medicare Spending per Beneficiary measures.

Relative Resource Use Measures: RRUs track all resource use for people with five common chronic conditions that account for over 50% of health spending—asthma, cardiac disease, chronic obstructive pulmonary disease (COPD), diabetes, and hypertension. RRUs are broader than the Total Per Capita Costs for Beneficiaries with Specific Conditions (diabetes, coronary artery disease, COPD, and heart failure) measure. Thus, they are better suited for harmonization with other programs—a key goal for MIPS and measurement overall. Results are derived from claims and based on Medicare prices and risk adjustment.

RRUs, when plotted against HEDIS and other clinical quality measure results, clearly document how little correlation there is between resource use and quality. Some plans and provider groups achieve very high quality with very low resource use, while others provide low quality with high resource use. Incorporating RRUs into MIPS should allow stakeholders to readily distinguish clinicians providing efficient, high-quality care.

Use of prescription drugs is an important exception to the weak correlation between resource use and quality. Appropriate prescription drug use can reduce higher-cost services like hospitalization and chronic disease complications. As such, it is critical to include Part D prescription drug utilization in MIPS resource use measurement. To further align resource and quality measures, it will be important to distinguish good resource use, such as high-value preventive services and prescription drugs, from overuse and inappropriate use, such as imaging for uncomplicated low back pain. HEDIS includes some overuse measures, for example on imaging for low back pain, but more are needed.

Choosing Wisely measures would track additional services that physicians themselves agree are wasteful. Despite this broad consensus, there has been little progress on reducing their use.² In general, we support methods like these to provide feedback, information, and financial incentive to providers—rather than beneficiaries—to reduce the utilization of low-value care. Both in our experience, and as supported by empirical research, patients defer to their physician’s recommendations concerning services and treatments. We believe adding *Choosing Wisely* measures into MIPS could provide financial incentives to reduce the waste and harm to patients from these dubious services. However, these measures would need to be developed for MIPS and would require clinical data that largely resides in EHRs rather than claims.

CMS could use all of these recommended measures to align MIPS with other Medicare resource use measures. Total cost and RRU measures, for example, can apply to all types of clinicians, including specialists, who are part of comprehensive care teams.

G. ALTERNATIVE PAYMENT MODELS (APMs)

Patient Centered Medical Homes (PCMH). CMS asks how to determine which state PCMH initiatives are comparable to Center for Medicare & Medicaid Innovation (CMMI) initiatives, how to determine whether APMs have measures comparable to MIPS and non-Medicare payers, and what Meaningful Use criteria to require.

² Rosenberg et al., “*Early Trends among Seven Recommendations from the Choosing Wisely Campaign*,” JAMA Internal Medicine, October 12, 2015.

Under MACRA, APMs that are patient-centered medical homes under § 1115A(c) of the Social Security Act would be exempt from bearing financial risk. Given this, we strongly recommend that CMS establish comprehensive guidelines for PCMHs and the process by which CMS will determine whether providers have met PCMH certification requirements. We note that these guidelines should also apply to patient-centered medical homes reimbursed under MIPS. Under MIPS, any eligible professional in a practice certified as a PCMH (or comparable specialty practices as determined by the Secretary) will receive the highest potential score for the category of clinical practice improvement activities.

Whether receiving payment through MIPS or an APM, it is critical that clear guidelines are in place to ensure patient-centered medical homes are, in fact, providing comprehensive, well-coordinated, patient-centered care. Providers should have to meet certification requirements that are at least as robust as the requirements developed by the National Committee for Quality Assurance (NCQA). Further, CMS should have in place ongoing oversight and enforcement procedures to ensure that practices are continuing to follow PCMH guidelines. Principles that should guide the recognition of groups as PCMH include:

- Provides Personalized, Whole-Person Care. The PCMH provides care that is “whole person” oriented and consistent with a patient’s unique needs and preferences. The PCMH has ready access to the patient’s complete, up-to-date medical history; offers to involve patients and family caregivers in the development of medical records; has systems in place to help patients with health insurance eligibility, coverage, and appeals; assesses whether cost is a barrier to receiving needed care and helps to meet those needs; and communicates with patients in culturally and linguistically appropriate ways.
- Ensures Ready Access to Care. The PCMH ensures 24/7 provider availability by phone, email, video, or in-person during evenings and weekends. In addition, the PCMH offers same-day appointments, accommodates walk-ins, and schedules all visits promptly. Importantly, the PCMH 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.
- Coordinates Patient Care. The PCMH takes responsibility for coordinating its patients’ health care across care settings and services over time, in collaboration with patients and family caregivers. The PCMH helps the patient access other needed providers or health services; has processes in place to effectively monitor and manage all tests, referrals, procedures, and appropriate follow-up care; facilitates smooth care transitions across settings; ensures that medications are actively managed and reconciled to avoid adverse interactions; and uses health information technology (HIT) and electronic health information exchange.
- Guides Care through an Interdisciplinary Team. The PCMH care team has the patient at its center and is led by a qualified provider of the patient’s choice. A PCMH care team has strong linkages with community resources, including those that provide non-medical services and supports to vulnerable populations. Additionally, 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.
- Supports Patients and Family Caregivers in Managing the Patient’s Health. The PCMH works with the patient or their caregiver to set goals for their health and care and develop a shared electronic care plan; ensures that patients and authorized family caregivers have electronic access to the patient’s electronic health record; and assesses and accommodates patients who are unable to effectively manage their own care because of cognitive or physical challenges.

- Treats Patients as Partners at All Levels of Care Delivery. The PCMH 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 information that helps them understand their conditions and the results of any medical tests or consultations; provides unbiased, evidence-based information on all treatment options; and provides patients and family caregivers with timely access to the results of laboratory and other diagnostic tests.
- Commits to Continued Quality Improvement. The PCMH seeks out patient-reported data on health outcomes and patient feedback on their experience of care; collaborates with patients and family caregivers in quality improvement strategies and practice redesign; collects and uses data on race, ethnicity, sex, gender identity, sexual orientation, primary language, and language services for each patient; regularly evaluates and improves the quality, safety, and efficiency of its care using scientifically sound measures; routinely undertakes efforts to identify and reduce any disparities in the quality of care provided to patients; and ensures all of their patients have equal access to high-quality care, regardless of source of payment.

Comparing APM, MIPS, and PCMH measures. To determine whether APM, MIPS, and non-Medicare measures are comparable, we suggest using a core measure set that applies across populations and specialties. A core set would allow comparison across MIPS, APMs, ACOs, MA plans, and other payers with appropriate specifications for each unit of accountability. The core set measures should address a common set of domains, identified with multi-stakeholder input, such as those identified by the National Quality Strategy.³ Many existing measures address possible core domains, such as preventive and evidence-based care, and could facilitate cross-program comparison.

The core set can then support nesting of measures needed for other purposes. For example, groups of measures can be used as building blocks that are aggregated for each core quality domain. Domain scores meet the needs of consumers who prefer higher-level quality data, and other stakeholders seeking to focus on a reduced measure set. There is also a need for measures outside the core set for certain sub-sets of populations and clinician types. These include measures that specifically address the unique needs of vulnerable populations, including patients with functional and cognitive limitations and serious mental illness. They also include measures for specific medical specialties providing unique services not addressed in the core set.

For Meaningful Use, APM requirements should be the same as for MIPS. Core functions, including population management, care coordination, and patient engagement, are all critical. To define EHR use, reporting to all payers via EHRs, whether required or not, is ideal.

Physician-Focused Payment Model (PFPM) Technical Advisory Committee. CMS asks what to require in proposals for APMs and what criteria to use in assessing proposals. We encourage CMS to require that APMs use only those measures that meet the high-value measurement criteria outlined above. In addition, CMS should require the ongoing assessment of clinical quality, public reporting of quality performance data, and implementation of continuous quality improvement programs. Quality data needs to be measured, tracked, and reported. It should also be inclusive of patient-reported data, including patient-reported outcomes and patient/family caregiver experience.

In particular, measurement of and reporting on patient experience of care and patient-reported outcomes can help providers improve care delivery and support informed consumers decision-making with respect to choosing health plans, providers, and care settings. Patient reported outcomes measures should robustly capture the patient's views

³ Department of Health and Human Services, "National Quality Strategy" available at: <http://www.ahrq.gov/workingforquality>

regarding the care they received. These high impact quality measures, which are meaningful to both consumers and providers, can help APMs drive quality improvement and value.

CMS also should require any proposal to demonstrate an ability to coordinate with other clinicians and across settings, as well as to align with ACOs, MA plans, and other payer initiatives. Proposals for any new models should state why they are a priority and how they differ from current approaches. Proposals that include previously tested models should be required to include background and an independent assessment of their results. We agree that CMS should consider proposals incomplete if they lack the list suggested in the RFI on pages 39-41.

Essential Beneficiary Protections. APMs must be built upon a strong foundation of robust consumer protections that ensure beneficiary needs are met and access to care is maintained. New payment models must emphasize provider accountability for improved patient health and experience of care across all patient populations and safeguard respect for beneficiary choice and agency. This requires the incorporation of robust quality measures and meaningful consumer protections in all APMs.

Below, we identify criteria that should be required of all care models seeking APM payments. These criteria should be consistent across all MACRA-eligible APMs, as well APMs in which MIPS-eligible providers are participating. APMS must:

- Be Founded on Evidence-Based Clinical Care Models that Effectively Coordinate Care. 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. 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.
- Ensure 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 guarantee prompt scheduling of in-office appointments. Additionally, APMs should facilitate patients' ready and appropriate access to services and providers across the care spectrum, including mental health and community health providers.
- Address Social Determinants of Health and Non-Clinical Factors that Contribute to Health. These factors include housing, public safety, language services, availability of places to exercise, healthy food choices, and other environmental factors. Facilitating information sharing and automated connections between providers and community-based agencies is vital in order to connect patients to appropriate community supports and services. APMs should encourage investment in a health care workforce that can meet the physical, behavioral, social, and economics needs of patients.
- Seek to Reduce Disparities in Access to Care and in Health Outcomes. The impact and appropriateness of care for different patient populations must be monitored and addressed. APMs should collect data on race, ethnicity, sex, preferred language, disability, and sexual orientation/gender identity in order to address disparities in payment models. This data should also be expanded over time to include geography and disability in order to gain more comprehensive information on health disparities.

Towards this end, quality measure reporting by APMs should be stratified by demographic data. Stratifying measures by demographic characteristics is an important tool for identifying disparities and quality gaps as well

as identifying 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.

- Make Health Information Electronically Available and Useful. APMs should ensure that patients (and caregivers, as appropriate) 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.
- Include Beneficiaries and Family Caregivers in Governance Structures. Consumer engagement should integrate patients' values, experiences, and perspectives into governance and oversight and in policy-making. Patients assigned to an APM should have the opportunity to participate in related governance boards, leadership committees, and oversight committees as well as participate in overall policy priority setting and policy making.

Finally, we suggest that shared savings be contingent upon performance on quality measures in addition to cost-savings. We recommend that providers participating in APMs must meet minimum standards of care, as indicated through quality measures, to be eligible to participate in shared savings.

Strong Beneficiary Rights and Protections. As new models of payment are developed that encourage clinicians to take on increased risk, reward, and responsibility, it is important to ensure that the evolution and application of consumer protections keep pace. We suggest that beneficiary protections be enhanced as the level of risk increases. The following beneficiary protections should be required of any APM and their application regularly monitored:

- Promote Beneficiary Choice and Transparency. 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 should be clearly informed of the opportunity to opt-out of new payment models. Notices explaining provider and facility involvement in an APM should be focus group tested and developed with input from beneficiaries, consumer advocates, and health literacy experts.
- Provide Access to Second Opinions Outside of the APM and an Appeals Process. In addition to the continued freedom to see any Medicare provider, beneficiaries in APMs should have access to a formalized internal appeals process and an external appeals process.
- Conduct Outreach to Beneficiaries, Family Caregivers, and the Community. In areas where an APM is established, in addition to the notices described above, CMS should educate and engage both the beneficiary community as well as trusted community organizations, including State Health Insurance Assistance Programs (SHIPs), to ensure that beneficiaries who reach out with questions about APMs have access to unbiased, accurate information.
- Protect Against Discrimination. Make clear and explicit that 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. APMs 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. CMS should establish protocols to evaluate for potentially discriminatory practices by APMs.

- Notify Consumers about Data Sharing. Beneficiaries should be notified as to why and how their health information will be stored, exchanged, used, and protected. Importantly, consumers must also be notified about the opportunity to opt-out of such data sharing and any other beneficiary rights. Any data sharing that is part of an APM must be compliant with federal and state law.

Complaint Tracking and Monitoring. In addition to the above outlined standards for APM participation, we strongly encourage CMS to create a centralized resource for collecting, resolving, and tracking complaints regarding APMs. Beneficiaries encountering these provider models for the first time may have questions, complaints, and problems ranging from trouble understanding the model's impact on their care and how to find a provider in an APM to serious access issues, discrimination, or privacy violations.

It is essential that Medicare beneficiaries are able to reach trained assistors who can provide accurate, unbiased information. Furthermore, by analyzing the most frequent and most serious types of calls and complaints, CMS can help healthcare providers in APMs avoid patient confusion, identify and remove bad actors from the program, and ensure that these reforms do not disrupt the basic promise of the Medicare program—to provide access to medically necessary care for older adults and people with disabilities.

Along these same lines, we encourage CMS to leverage the SHIP program and to ensure that its trained professionals and counselors are fully engaged as APMs are developed and implemented. We also encourage CMS to make certain the Medicare Ombudsman has the capacity to respond to casework inquiries related to APMs. As appropriate, we encourage CMS to consider the creation of an ombudsman whose primary role is to monitor and track beneficiary questions, complaints, and problems associated with care delivered through APMs. Given the newness of these models and a relatively swift timeline for their establishment, it is critical that CMS identify a centralized resource armed to appropriately respond to beneficiary needs and unexpected or unintended issues that arise through the establishment and expansion of APMs.