March 1, 2016

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: Eric Gilbertson, CMS MACRA Team
Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 240
Phoenix, AZ 85016-4545

Re: Public Comment on the Draft CMS Quality Measure Development Plan implementing the Medicare Access and CHIP Reauthorization Act

Dear Acting Administrator Slavitt:

On behalf of the Healthcare Quality Coalition (HQC), we write to provide comments on the Draft Centers for Medicare and Medicaid (CMS) Quality Measure Development Plan under the implementation of the Medicare Access and CHIP Reauthorization Act (MACRA). Overall, the HQC strongly supports the development of robust value-based payment initiatives. Our members believe properly structured incentives to provide high value care (i.e., high quality, low cost care) will result in better care for patients at a lower cost for payers.

The HQC is comprised of hospitals, physicians, health systems, and associations committed to value-based healthcare. Combined, our members have more than 19,000 licensed hospital beds, employ more than 21,000 physicians, and have more than 225,000 employees across the country. Organized in 2009, the HQC supports efforts to create a sustainable Medicare system through incentivizing high-value care.

We believe value-based payment policies can drive better quality, lower cost of care, and reduce overall costs for the Medicare program. The HQC strongly supports continued implementation of payment systems that reward value and are pleased to provide comments on the CMS Quality Measure Development on implementation of the MACRA regarding the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs).

CMS General and Technical Principles
Quality Domains and Priorities

The draft measure development plan proposes a number of general and technical principles to guide the development and implementation of quality measures under new pay for performance initiatives in the Medicare Access and CHIP Reauthorization Act (MACRA). In providing guidance, the HQC offers the following comments on the Measure Development Plan (MDP).

Quality Measures

Comment: To drive value-based care, we recommend quality measures be appropriately risk-adjusted, valid, reliable, relevant to providers, and focused on patient outcomes. We are pleased that the development plan reinforces the focus on quality outcomes. We also recommend syncing measures were inconsistencies exist. In addition, we also suggest measures that no longer have value to providers and patient care or are overlapping or closely related have a process to be removed from the program. We also suggest measures include appropriateness of care and patient-reported outcomes as part of the MDP. Finally, we suggest the MDP be updated annually with at least a year for providers to implement and reflect flexibility in selecting measures and reporting options for the quality performance category so long as the focus is on quality outcomes.

Overall, the HQC supports utilizing existing infrastructure as the foundation for drawing quality measures in the MIPS and APMs. We also support the overall goals of the National Quality Strategy and CMS in transitioning towards measures emphasizing patient outcomes. Outcomes provide more meaning and value for patients, and are critical for delivering high quality care. In recognizing the development of relevant quality measures, specialty societies, and associations have been diligently developing quality measures that are applicable to their practice. The measure plan should recognize and ensure providers and health systems have options available, such as those through Qualified Clinical Data Registries and Regional Health Improvement Collaboratives (RHICs). In addition, we ask that the measure development plan include a process to not only add new and better measures of quality, but also to remove measures no longer applicable or relevant for improved patient care outcomes. We suggest this principle be added to the MDP.

Measures of Resource Use/Efficiency

Comment: The HQC has long advocated for the inclusion of robust measures of cost, efficiency, and resource use in value-based programs. We continue to advocate for value-based care as a reflection of cost and quality, equally weighted. As part of measure development strategy, we ask that CMS place a priority on exploring, developing, and proposing efficiency measures that that align with quality measures as a better representation of value-based care for MIPS. In addition, to improve transparency for efficiency efforts, we urge CMS to improve the availability of Medicare prices to providers.

We appreciate the continued use of cost and efficiency measures in the physician value modifier as a platform for the MIPS resource use category. The strength lies in a set of cost measures that carry a

counter balance with measures of quality. We request the MDP to reflect the need to continue exploring measures of cost/resource use that align with physician quality measures as a better representation of value-based care. This approach helps provide a foundation for a robust, MIPS program where performance categories have quality and counter-balancing cost/efficiency measures. In addition, so providers understand pricing of services, we request improved Medicare pricing transparency for providers to ensure networks and referrals for patients are understood to leverage better use of services and decision-making.

Clinical Practice Improvement Activities

Comment: The HQC offers suggestions on meeting the requirements for clinical practice improvement activities as part of MIPS, such as membership in RHICs and/or the CMS Partnership for Patients Hospital Engagement Network. Overall, we recommend flexibility in meeting clinical practice improvement activities and urge inclusion of existing programs as part of the MIPS domain. In addition, we ask CMS to clearly articulate in the forthcoming proposed rule what activities will be available for providers to satisfactorily meet the MIPS category and produce a plan for measuring clinical practice improvement. Finally, we urge the measure development plan to minimize overlap with measures in the quality domain and in other programs.

In the forthcoming proposed rule, we ask CMS to clearly articulate what clinical practice improvement activities will be made available, and how providers and groups are to satisfactorily meet the parameters of the domain. As a general matter, we recommend the identified activities be attainable, but also that they require sufficient engagement and effort to ensure that providers are being rewarded for their effort toward improving clinical practice. In addition, we request CMS to recognize current quality improvement programs and opportunities as the foundation for meeting the parameters of Clinical Practice Improvement Activities domain in the MIPS.

As such, we ask CMS to consider the following programs for inclusion as options for providers and health systems as part of the Clinical Practice Improvement criteria:

- Membership in a RHIC.
- Successful completion of a formal quality improvement initiative sponsored by a RHIC.
- Attendance at one or more "learning events" sponsored by a RHIC.
- Membership and participation in a CMS Partnership for Patients Hospital Engagement Network

Many state and regional-based collaboratives were created as a means of convening and facilitating quality improvement initiatives with multi-stakeholders. Organizations and groups such as RHIC's and several others exist to facilitate new models and quality improvement initiatives. Included in MACRA is funding for technical assistance for RHIC's for providers in rural and medically underserved areas. Allowing for RHIC involvement in clinical practice improvement activities and

other initiatives will provide an important link between funding and goals of MACRA and the new payment system (MIPS).

Measure integration to support MIPS and APMs

Comment: The integration of existing programs and measures for use in MIPS and APMs is a critical strategic and policymaking element for the ultimate success of the programs. Currently, the MIPS infrastructure is a combination of existing separate programs (Physician Value Modifier, Electronic Health Record Meaningful Use, and Physician Quality Reporting System). Although we agree existing measures should serve as the starting point, integrating the separate programs into MIPS should be an opportunity to assess, revise, align, and improve the baseline reporting programs. We ask CMS take this opportunity to consult with organizations, health systems, and associations that represent eligible professionals (EP's) and implement changes that will enhance the practicality and utility of all three programs.

Regarding the approach to the development of APMs, we ask CMS to establish a clear path and efficient process for providers to enter APM arrangements. Next, we request the MDP reflect a priority of incentivizing organizational structures that focuses on care coordination, and provide tools for providers to control over when, where and how the beneficiaries they are aligned with health care services. The MDP should reflect a strategy of coordination across federal agencies that will be critical to effectively implementing new payment models. Finally, we support and appreciate consideration as a guiding principle for measure integration to recognize the unique circumstances faced by rural and low-volume providers in MIPS and those that desire to participate in APMs.

The MIPS combines existing, separate programs into a single payment adjustment mechanism. The HQC shares the goals of the law in driving towards a robust value-based payment system. In transitioning from the current reporting and value-based payment programs, we urge CMS to carefully assess the integration of existing programs. It is imperative that a seamless, coherent transition occurs into the MIPS. As such, we ask CMS to integrate the programs through improvement that will eliminate obstacles, streamline reporting, enable interoperability and minimize administrative burden to providers.

The HQC believes physician-focused APM's will be instrumental in driving delivery system reform, coupled with a new robust value-based fee-for-service payment system (MIPS). We ask that the MDP make a priority in developing and implementing quality measures to establish a clear path and efficient process for becoming an APM. In addition, it should be encouraged that existing infrastructure be utilized to the extent feasible. To minimize administrative burden, quality reporting, for example, should build on existing initiatives and reporting infrastructure.

Also, the MDP should align with the approach of developing Physician-focused APMs towards an organizational structure that encourages care coordination. Patients will be better served with a

team of providers collaborating on their care, as opposed to individual providers operating in silos with limited or no connections to other providers caring for those patients. Integration among providers is a key element to cost and quality improvement. Providers would also know upfront their patient population and could engage with them to influence how they receive care, and such, need proper tools to improve quality and reduce cost. Providers will be willing to take on more payment risk if they are given more control over when, where, and how the beneficiaries they are aligned with seek health care services.

The HQC appreciates the law's inclusion of technical assistance to small, rural practices and those serving shortage areas. Resources available for rural providers in underserved areas also ensure tools are in place to ensure continuity for vulnerable populations. We recognize and appreciate the MDP's consideration for the unique circumstances for rural and low volume providers in MIPS and APMs.

Reducing Provider Burden of Data Collection for Measure Reporting

Comment: We cannot reinforce enough the importance of minimizing provider burden in reporting of quality measures. To minimize administrative burden, quality reporting, for example, should build on existing initiatives and reporting infrastructure to the extent feasible. We appreciate this strategic priority.

Existing program structures can serve as a foundation for quality reporting and data collection. However, we urge the MDP to allow for opportunities to improve the existing reporting infrastructure, and to allow providers to utilize the availability of various quality reporting tools to meet the requirements of MIPS and APMs.

Shortening the Time Frame for Measure Development

Comment: The HQC appreciates the strategic approach of shortening the time line for developing quality measures, using lean principles to improve efficiency. However, it is imperative sufficient outreach, stakeholder input, and feedback are allotted to ensure quality measures are meaningful, transparent, focus on outcomes, and minimize provider burden. We also seek guidance on the use of current data in the physician value modifier and how it will be used in the MIPS.

Overall, we are encouraged by the approach of efficient measure development strategies. Using best practices, such as lean principles, help guide processes. However, MACRA clearly articulates the importance of stakeholder input in the measure development and implementation process throughout MIPS and APMs. We urge caution in balancing the efficient development and implementation of quality measures while providing ample opportunity for stakeholder input. We appreciate opportunities to provide public comment and this should be allotted sufficient time in the public domain.

We also seek additional guidance around the timeline for when data submission begins for particular dates of service and particularly when the physician value modifier ends for PQRS and begins for

MIPS would be helpful information to have and would allow us to prepare for MIPS. There is currently a 2 year lag in incentive/payment adjustments under this model and we would like clarification on how this timeline will be affected by MIPS, if at all.

Identifying and Developing Meaningful Outcome Measures

Comment: The HQC appreciates the continued focus on patient outcome measures in the MDP. We believe there is an opportunity to improve patient attribution and we suggest this be reflected as a strategic priority. We would like clarification regarding the use of PQRS, Electronic Health Record Meaningful Use attribution, or a new method. Also, we offer our support for exploring sociodemographic factors in risk-adjustment models as acknowledged in the MDP.

As noted and reinforced throughout this comment letter, we continue to support on quality measures focused on patient outcomes. In implementing this guiding principle, there is an opportunity to improve patient attribution to providers. In transitioning to a new value-based payment system, the HQC also believes providers should be recognized for keeping patients healthy and out of the hospital, while also not being dis-incentivized from caring for patients with multiple chronic conditions. Improved patient attribution with robust risk adjustment methodology better reflects value-based care and population health. This would provide an important balance between caring and managing high-risk patients, while continuing to be recognized for maintaining and improving quality outcomes. We ask the MDP reflect this approach to patient outcomes and keeping patients healthy.

Risk-adjustment is a critical part of any quality and pay-for-performance program. Providers should be assessed based on their performance, and their grades should not be influenced by the types of patients they treat. Risk-adjustment helps ensure accurate and fair comparison of patient case mix, taking into consideration severity of illness. In 2006, the National Quality Forum (NQF) established a policy against using sociodemographic factors in risk adjustment methodology for measuring quality of care, including race, ethnicity, and native language. However, the NQF policy has been recently revised in 2014 to reflect changing trends in medical care, and is moving through the referenced trial period and pilot project where sociodemographic adjustment will be applied to measures, subject to review and endorsement.

Given the many input elements to consider in sociodemographics, we believe CMS should consider steps to stratify and incorporate sociodemographic factors in risk adjustment methodology. This process needs to be through provider input and consensus on how to define, collect, and report these factors and ensure sufficient population size within the measure. We support the approach towards potentially incorporating sociodemographic factors into risk adjustment and appreciate the incorporation into the MDP.

Conclusion

With the opportunity to transform the healthcare system towards value-based care, the HQC appreciates the opportunity to comment on the CMS MDP. Representing hospitals, providers and associations, including integrated healthcare systems, we urge CMS to work together with hospitals and physician groups to ensure value-based payment programs are working in tandem to achieve the goals of better quality and lower cost. We look forward to continuing to provide feedback on the implementation of the new payment programs in MACRA.

Sincerely,

The Healthcare Quality Coalition

The Healthcare Quality Coalition represents healthcare providers throughout the nation dedicated to the concept of value-based care. In short, we believe healthcare entities should be held accountable for the quality and value provided to the patients and communities we serve. The HQC is committed to developing value-based payment initiatives in a way that encourages fair payment to providers delivering high value care to the patients they serve. www.qualitycoalition.net