



August 21, 2017

The Honorable Tom Price, M.D.  
Secretary, U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, D.C. 20201

Ms. Seema Verma  
Administrator, Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, D.C. 20201

**Re: Medicare Program; CY 2018 Updates to the Quality Payment Program [CMS-5522-P]**

Dear Secretary Price and Administrator Verma,

The National Partnership for Women & Families appreciates the opportunity to comment in response to the proposed rule on updating the Quality Payment Program (QPP) for calendar year 2018. 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 well-coordinated patient- and family-centered care.

We applaud the Centers for Medicare & Medicaid Services (CMS) for its continued commitment to shift toward payment models that reward quality and value over volume. We support the intent of the QPP to encourage clinicians to move to alternative payment models (APMs) that reward clinicians based on better health outcomes, improved care coordination and patient experience of care, and decreased costs, and to recognize clinicians on the path to Advanced APMs.

We are concerned, however, that the proposed requirements for the second year of the QPP will have a chilling effect on the transition to a value-based system. Several of the changes proposed for 2018 would remove or delay measures and functionalities that are a priority for patients and families in order to allow clinicians to defer, or entirely avoid, making a full transition to the QPP. In the following comments, we highlight our most significant concerns and offer suggestions for continued progress in areas of importance to patients and families.

If you have any questions about our comments and recommendations, please contact Katie Martin, vice president for health policy and programs at [kmartin@nationalpartnership.org](mailto:kmartin@nationalpartnership.org) or (202) 986-2600.

Sincerely,

A handwritten signature in black ink, appearing to read "D. Ness", with a long horizontal flourish extending to the right.

Debra L. Ness

## I. MERIT BASED INCENTIVE PAYMENT SYSTEM:

The National Partnership for Women & Families strongly supports the Merit-Based Incentive Payment System (MIPS) as a glide path to move Medicare providers toward a payment framework that rewards value rather than volume. As the new default payment system for clinicians participating in Medicare Part B, it is critical that the MIPS framework reward high-quality performance and improvement, rather than perpetuate the status quo.

We acknowledge that small practices, as well as clinicians who care for vulnerable and underserved populations, face significant barriers to effectively participating in the QPP. We encourage CMS to offer a meaningful path to participation for those currently exempted and/or offered bonus points. For example, CMS could consider providing additional resources – such as direct financial support or technical assistance – to ensure that *all* clinicians have the resources required to undertake practice transformation and fully participate in the QPP.

We are concerned, however, that the proposals for the second year will not adequately prepare clinicians for a fully mature QPP or a transformed health care system, particularly:

- Changes to eligibility criteria that result in significantly fewer clinicians participating overall;
- Extended transition year policies that delay the full transition to a value-based system;
- Exemptions from the advancing care information (ACI) performance category;
- More bonus points and other options to help clinicians maximize their performance score without enough meaningful improvement on measures that matter to patients and families;
- Ninety-day reporting periods for the quality and advancing care information performance categories; and
- Delayed implementation of 2015 Edition certified technology, which includes new functionalities to support patient engagement and improve interoperability.

These proposals appear to signal a different intent for the QPP program; one that is no longer focused on driving quality improvement and transitioning to value. Furthermore, the increased flexibility by itself will not effectively prepare clinicians to take on financial risk in future years, which is at the heart of transitioning from fee-for-service into a value-driven model.

We appreciate attempts to reduce unnecessary burden on clinicians, and share the goal of engineering a health care system in which providers find joy and purpose in their work and are able to interact meaningfully with their patients. We encourage CMS, however, to balance attempts to alleviate administrative burden with the effort that is required to make

progress in areas that hold the most promise for improving the quality of care and health outcomes for patients.

#### MIPS Scoring – Measure Stratification

We reiterate our support of stratification by demographic characteristics to the degree that such stratification is feasible and appropriate. Stratifying measures by variables including race, ethnicity, gender, disability status, primary language, gender identity, sexual orientation and other demographic characteristics is an important tool for uncovering disparities and quality gaps as well as identifying intervention points and strategies. We encourage CMS to make stratified quality data publicly available at both individual and practice levels.

#### MIPS Scoring – Complex Patient Bonus

We support CMS' proposal to give bonus points to providers who serve complex patients. Payment policies should offer providers and practices adequate resources to provide high-quality care for their patient population. We appreciate that CMS' approach to defining patient complexity takes into account multiple factors affecting patient health outcomes, including the health status and medical conditions of patients and social risk factors. As CMS states, we believe this proposal will help address discrepancies in the resources needed to treat high-need patients, without masking provider performance.

#### **A. Cost Performance Category**

Resource use measures are an integral part of evaluating the efficiency of care delivery and making the best possible use of our health care resources. While reducing cost is not the only goal, measuring clinicians' performance on resource use measures helps them better understand how the care they provide contributes to value.

We support CMS's intent to encourage participation in the QPP by providing a ramp for clinicians to become familiar with the program. However, the proposal to reweight the cost category to zero percent for 2018 will not provide the time or experience necessary for providers to succeed when the threshold increases to 30 percent in 2019, as is required by statute. We strongly encourage CMS to return to its original proposal of weighting the cost performance category at 10 percent for the 2018 performance year. Given the complexity of the QPP program as a whole, assigning weight to the cost performance category in year two will help clinicians gain valuable experience in reporting and understanding their resource use, and will smooth the transition to the required 30 percent threshold in 2019.

#### **B. Quality Performance Category**

The National Partnership appreciates CMS's continued emphasis on driving high-quality care through MIPS, but continues to believe the program would benefit from a better approach to offering patients and families a meaningful way to compare clinician performance. Specifically, we encourage quality and performance information be reported across clinicians in a way that distinguishes between high and low performers and more accurately reflects quality of care across the Medicare population.

Payment and delivery reform efforts should endeavor to meet the needs of consumers and their families, and should account for the many factors that impact a person's health, including the social determinants of health, and drive reductions in health care disparities. Quality measurement is a key tool to understanding disparities and driving toward improvements in care. We encourage CMS to identify health equity measures for future development and inclusion in MIPS, drawing upon resources such as the National Quality Forum's draft report, "A Roadmap to Reduce Health and Healthcare Disparities through Measurement."

#### Menu Approach

We are concerned that the menu approach to measure selection in the quality performance category may lead providers to report only those measures for which they are high performers, obscuring the results of poor care. A menu approach also prevents an "apples to apples" comparison among providers, leading consumers to make choices without critical, comparable information about provider performance. Furthermore, this approach impairs CMS' and other stakeholders' ability to calculate improvement over time, as well as to identify measures that are truly "topped out." Any plan to identify and remove seemingly topped out measures should make sure that measures are not retired prematurely and that clinicians continue to provide high-quality care.

Flexibility for providers should not come at the cost of meaningful and actionable information that helps consumers make choices about their medical decisions. We encourage CMS to move rapidly to a core set of high-value measures by specialty or subspecialty. A core set approach using high-value measures would enable direct comparison between similar clinicians, with assurance that all clinicians are being assessed against a consistent and standardized set of important quality indicators. Core measure sets can be designed in a way that preserves a clinician's ability to select measures that are meaningful to their practice and patient population.

We support measures of highest value to consumers and patients: measures of outcomes – especially patient-reported outcomes, appropriate use, patient safety, efficiency, patient experience, and care coordination. Future core measure sets should incorporate these critical measurement domains.

#### Crosscutting measures:

We are disappointed with the proposal to remove crosscutting measures from the majority of specialty and subspecialty measure lists. This proposal is a significant step backwards from the Physician Quality Reporting System (PQRS) requirement that all clinicians who see patients in face-to-face encounters be required to report on a crosscutting measure. We urge CMS to retain all of the crosscutting measures currently available to clinicians, as many of these measures reflect issues that are important to consumers. Moreover, they have the potential to support clinician collaboration across specialties to improve patient experience and patient care. Crosscutting measures also are important for comparing performance across clinician specialty or setting. For clinicians to embrace and accept quality measurement, however, we recognize that the measures themselves need to be more meaningful. We encourage CMS to dedicate resources to developing better crosscutting measures.

### Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey

We continue to urge CMS to require a standardized patient experience measure for all MIPS clinician groups of two or more. Consumers can benefit greatly from information from other patients when making medical decisions. Requiring such measures signals that patient experience is a key tenet of a person-centered health care system. CMS should not delay requiring robust collection and reporting of patient experience data using currently available tools.

*Narrative Questions:* We strongly support CMS' intention to incorporate open-ended questions to CAHPS for MIPS survey in future rulemaking. Collecting and reporting open-ended responses with greater scientific rigor will help validate patient narratives. Open-ended questions allow beneficiaries/patients to share nuanced and rich information that can make patient experience surveys more meaningful for quality improvement. For example, narrative comments can help other consumers contextualize quality ratings – offering clues as to why a clinician may have lower ratings on certain measures and higher ratings on others. Patient feedback can also help clinicians gain insight into activities that are likely to improve quality and patient experience.<sup>1</sup> The existing narrative questions under development would be a significant first step toward capturing what matters most to patients.

*Reduced Reporting Period:* We are concerned with the proposal to reduce the minimum fielding period for CAHPS for MIPS from four months to two months in the 2018 performance year. Two months of data is woefully inadequate for a meaningful assessment of patient experience. We encourage CMS to field the CAHPS for MIPS survey for at least 12 weeks; this would improve the patient response rate and avoid unintentionally excluding patients who have a more difficult time responding within the shortened response period. Additionally, a 12-week period would align with existing CAHPS guidelines.

*Summary Survey Measures:* We are similarly concerned with the proposal to stop scoring the “Functional and Health Status” summary survey measure (SSM) as part of the CAHPS for MIPS survey. We disagree with CMS' assessment that this SSM reflects only underlying patient characteristics and does not speak to the patient's experience of care with the group. The functional status SSM provides valuable insight into whether patients (especially complex patients) are receiving appropriate care specific to their individual needs. Additionally, functional status connects to health outcomes in a more meaningful way than some other SSMs.

### **C. Advancing Care Information (ACI) Performance Category**

The robust use of health IT and health information exchange is fundamental to achieving the foundational goal of MIPS: incentivizing highquality, efficient practices, coordinated care and improved health outcomes. For consumers, health IT enables access to the information and tools necessary to play a more active role in managing their own health and caring for loved ones. Specifically, health IT can help patients and their caregivers make more informed decisions; be better connected to their care team; generate and share

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<sup>1</sup> Schlesinger, M., Grob, R., Shaller, D., Martino, S.C., Parker, A.M., Finucane, M.L., Cerully, J.L., & Rybowski, L. (2015). Taking Patients' Narratives about Clinicians from Anecdote to Science. *New England Journal of Medicine*, 373, 675-679.

important health information; and set, track and achieve personal health and wellness goals.<sup>2</sup>

### Eligibility Changes

We are concerned, therefore, with the number of clinicians who will be essentially exempt from the requirements of the ACI performance category under the current proposal to reweight the category to zero for:

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

We understand the need to construct a realistic on-ramp for clinicians, but to achieve our shared goals of a high-quality, patient-centered health care system, we need *more* clinicians using certified health IT in ways that improve patient care, not fewer. Delaying the inevitable transition to health IT will only further disadvantage these clinicians in the end. Similarly, we are concerned by the proposal to exempt clinicians facing a significant hardship from the five-year limit. While it is important to acknowledge circumstances outside of the provider's control, it does not seem necessary to grant these hardship exceptions in perpetuity.

### Certification

We are similarly disappointed in the delayed transition to the 2015 Edition certification requirements. Consumers need digital health technologies that advance their ability to access, contribute and share health information. The 2015 Edition includes new and significant patient-facing functionalities as well as certification standards and implementation specifications designed to improve interoperability, including:

- Accessing health information via Application Programming Interfaces (APIs)
- Patient-generated health data
- Non-clinical data (i.e., social determinants of health)
- Incorporate/accept summary of care record

The proposed delay further postpones our shared vision for a more connected, interoperable health care system. We support the proposed bonus for clinicians who report ACI objectives and measures using only 2015 Edition technology. We believe this will encourage clinicians

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

to upgrade their systems and begin to use these more innovative and functions, but prefer that the transition to the 2015 Edition certification requirements proceed as previously planned.

### Scoring

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

We continue to believe that ACI measures should evolve in future performance years to emphasize these innovative, person-centered uses of health IT that support health system transformation and the nation's health imperatives. We encourage CMS to consider the following for future performance years:

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

We support the proposed bonus points to encourage important clinician behaviors, such as adopting 2015 Edition technology, reporting to registries, and leveraging health IT in improvement activities. However, CMS should use this approach cautiously so that clinicians continue to make progress on more innovative performance category measures and do not rely on the availability of bonus points to improve their overall ACI performance score.

### Reporting Periods

We are disappointed that CMS has proposed another 90-day reporting period for 2018. 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 may be more challenging such as the *Care Coordination through Patient Engagement* objectives.

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 – any day of the year, rather than during a particular three-month period. Full calendar year reporting for the ACI category would better support CMS' goals of alignment across MIPS performance categories (e.g., the Quality performance category).

### Definition of Meaningful User

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



#### **D. Improvement Activities Performance Category**

Improvement Activities should function as a vehicle for improving quality of care, health outcomes and patient experience, as well as for supporting clinicians' transition to APMs. We continue to recommend that CMS encourage providers to select a suite of activities that further a particular improvement goal (for example, care planning) rather than choosing several discrete activities which together may not move the practice toward transformation. We also support a full-year reporting period for Improvement Activities, rather than 90 days, as a way to create alignment across performance categories.

To ensure that provider completion of clinical practice improvement activities indeed demonstrates delivery of higher-quality, more patient- and family-centered care, we also recommend CMS support practices in making decisions about how and where to target improvement activities based on the specific needs of their patient population. This is critical to rewarding clinicians based on their performance.

We agree that the QPP should evolve to score clinicians based on performance and improvement on selected activities, rather than simple attestation. To enable this kind of evaluation, we suggest identifying existing metrics of impact (especially patient-reported outcomes and patient experience measures) that align with each improvement activity. To get a score for improvement, clinicians should be required to report on these metrics for at least two years (even if they select different/new activities in the second year).

We appreciate the finalization of the "Achieving Health Equity" subcategory as an Improvement Activity and further encourage CMS to integrate health equity across all MIPS measures. We encourage CMS to develop new activities for the Achieving Health Equity subcategory, and consider assigning a high weight to all activities in this subcategory. In addition, limited English proficient persons should be identified as a specific underserved group and CMS should give a high weight to providing language services for non-English speakers.

#### Advancing Care Information (ACI) Bonus

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

#### New Activities

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

- Provide Clinical-Community Linkages
- Primary Care Physician and Behavioral Health Bilateral Electronic Exchange of Information for Shared Patients
- Advance Care Planning

- Centers for Disease Control and Prevention (CDC) Training on CDC’s Guideline for Prescribing Opioids for Chronic Pain
- Consulting Appropriate Use Criteria (AUC) Using Clinical Decision Support when Ordering Advanced Diagnostic Imaging

*Clinical-Community Linkages (A\_PM\_XX)*

As mentioned above, we support the new clinical-community linkages activity. Community services and supports can significantly affect a patient’s care and outcomes and are critical to creating a culture of health. Community health workers are also a powerful tool for reducing health care disparities, and we would support this activity’s inclusion in the “Achieving Health Equity” subcategory rather than the “Population Management” subcategory.

We suggest that the term “community health worker” be clarified to include, but not be limited to, case managers, patient/community education specialists, outreach workers, transportation staff, eligibility assistance workers and interpreters. Additionally, we encourage CMS to add more specificity regarding qualifying activities, particularly what it means for community health workers to “provide” a comprehensive link to community resources. Qualifying activities should also proactively include patients and families. For example:

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

*Advance Care Planning (IA\_PM\_XX)*

Working closely with patients and their families is necessary for effective advance care planning. We encourage CMS to add qualifying activities that emphasize giving beneficiaries and their families the support they need at the appropriate time, in an appropriate setting, delivered by the appropriate team of qualified individuals. For example:

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

### Activities with Changes

#### *Leveraging a QCDR to Promote Use of PRO Tools (IA\_AHE\_3)*

We strongly support the proposed changes to this activity. Employing patient-reported outcome (PRO) tools and collecting PRO data are key to patient-centered care, shared decision-making and care planning. We support CMS' proposal to increase the weight of this activity from medium to high and to change the activity's eligibility for the ACI bonus score (for clinicians who collect PRO data via their electronic health record). Changing the activity title to *Promote Use of Patient-Reported Outcome Tools* better communicates the goals of this activity.

#### *Participation in Maintenance of Certification (MOC) Part IV (IA\_PSPA\_2) and Participate in IHI Training/Forum Event; National Academy of Medicine, AHRQ Team STEPPS® or Other Similar Activity (IA\_PSPA\_3)*

We also support the proposed changes to the Maintenance of Certification-related activities in the Patient Safety & Practice Assessment subcategory that will add additional qualifying activities and MOC programs . We believe this supports the mutual goals of promoting practice improvement and expanding clinicians' options for pursuing MOC requirements.

#### *Implementation of formal quality improvement methods, practice changes, or other practice improvement processes (IA\_PSPA\_19)*

We continue to urge CMS to ensure that patient safety and quality improvement activities reflect the role of patients and families in driving safer, high-quality care. 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. We strongly encourage CMS to include additional examples of how to act upon patient experience data as qualifying activities. For example, engaging patient and family advisors in analyzing the data, co-designing an improvement plan and participating in its execution and evaluation.

## **II. ADVANCED ALTERNATIVE PAYMENT MODELS**

We continue to support the administration's move toward a value-based health care system, and are pleased to see the continued implementation of Advanced Alternative Payment Models (APMs). If designed and implemented correctly, APMs have the potential to provide comprehensive, coordinated, patient- and family-centered care while driving down costs. However, CMS could strengthen implementation of Advanced APMs to meet our shared goals of improved health outcomes, better patient engagement, improved patient experience and lower costs. To ensure the models meet the needs of patients and families, we offer the following recommendations, consistent with our past letters on the QPP:

### *1. Advanced APMs should promote coordinated, patient- and family-centered care*

All Advanced APMs should have requirements ensuring the delivery of high-quality, patient-centered care. 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, integration of shared care planning and shared decision-making, 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 the payment approach reinforces the delivery of coordinated, patient- and family-centered care, with a strong grounding in primary care.

*2. CMS should increase transparency and public input into the development of APMs*

We reiterate the need for 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 and reduced spending.

Therefore, we urge CMS to consider how to increase transparency and public input into the development of APMs. Consumers and patients should be co-creators in our health care system and integral partners in developing all new models of care and payment. 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 essential to ensuring that Advanced APMs are meeting the needs and priorities of all stakeholders, especially patients and their families.

As CMS moves toward consideration of other payer models, including commercial models, there is an even greater need for transparency. In the context of commercial models, which may be less known to advocates, we believe it is especially important to include patients, consumers and advocates in determining which models should be included for the purpose of determining Advanced APM eligibility.

Thank you for the opportunity to comment on the CY 2018 Updates to the Quality Payment Program. If you have any questions about our comments and recommendations, please contact Katie Martin, vice president for health policy and programs at [kmartin@nationalpartnership.org](mailto:kmartin@nationalpartnership.org) or (202) 986-2600.