

Consumer-Purchaser ALLIANCE

Better information. Better decisions. Better health care.



September 10, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: CMS-1693-P: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program

Dear Administrator Verma:

The 12 undersigned organizations represent a collaboration of leading consumer, employer, and purchaser organizations committed to improving the quality and affordability of healthcare. A high-value health care system requires value-driven payment arrangements and we are encouraged by the opportunities available through the Quality Payment Program (QPP) to spread these arrangements to more providers. Such value-based payments should result in better health outcomes, improved care coordination and patient experience of care, and decreased costs.¹ We appreciate the opportunity to provide comments on the proposed changes to the QPP for CY 2019.

We continue to support the intent of the QPP to encourage clinicians to move towards alternative payment models (APMs) that reward high-value care and support care delivery innovations. We further support CMS's efforts to recognize clinicians on the path to adopting APMs and to support clinicians as they move away from traditional fee-for-service payment arrangements that do not meet the needs of consumers and purchasers. We strongly support CMS's intention to:

- Adopt four new patient-reported outcome measures, which are vital to ensuring that patient perspectives play a role in how 'value' is defined in the health care system;

¹ For brevity, we refer in various places in our comments to "patient" and "care," given that the Quality Payment Program is rooted in the medical model. People with disabilities frequently refer to themselves as "consumers" or "persons." Choice of terminology is particularly important for purposes of care planning and care coordination, when the worlds of independent living and health care provider often intersect.

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- Continue to require reporting of quality measures for a full-year (rather than just 90 days);
- Increase the weight of the cost performance category to 15 percent of the final score in 2019;
- Require the use of 2015 Certified Electronic Health Record Technology (CEHRT) starting in the 2019 performance year; and
- Strengthen the Advanced APM CEHRT threshold to require that at least 75 percent of eligible clinicians in each APM entity use Certified EHR Technology (CEHRT).

However, the proposals for Year 3 do not go far enough to prepare clinicians for a fully mature QPP or a transformed health care system. We are particularly concerned by the following proposals:

- Extend the delay in public reporting of quality measures (from one year) to the first two years a measure is in use in the quality performance category;
- Low-volume thresholds, which exempt large numbers of clinicians from required participation in the program²;
- Continuation of the menu approach to measure selection in the quality performance category; and
- Elimination of patient engagement measures that encourage patients and family caregivers to use online health information and communicate electronically with providers in the promoting interoperability performance category.

The QPP should evolve in a way that drives continuous performance improvement among all clinicians. Indeed, the Bipartisan Budget Act of 2018 requires CMS to continue to increase the MIPS performance threshold year-over-year. We must raise the bar to meet this legislative imperative, and build a system that meets the needs of consumers and purchasers.

In the appendices, we provide more specific comments and feedback on the proposed rule. If you have any questions or would like to discuss our recommendations further, please contact Bill Kramer (wkramer@pbgh.org) or Debra Ness (dln@nationalpartnership.org), co-Chairs of the Consumer-Purchaser Alliance.

Sincerely,

(in alphabetical order)

American Association on Health and Disability
Caregiver Action Network
Consumers' Checkbook/Center for the Study of Services
Empowered Patient Coalition
Health Policy Corporation of Iowa
Medicare Rights Center
Minnesota Health Action Group
National Coalition for Cancer Survivorship

² Page 1075 of the QPP CY 2019 Proposed Rule: <https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-14985.pdf>

National Partnership for Women & Families
Pacific Business Group on Health
St. Louis Area Business Health Coalitions
Wyoming Business Coalition on Health

APPENDIX A: Merit-Based Incentive Payment System (MIPS)

Low-Volume Threshold

We support CMS's proposals to provide opportunities for more clinicians to join MIPS. This includes adding new categories of clinicians, such as physical and occupational therapists, social workers, and clinical psychologists, as well as allowing low-volume clinicians to opt-in to MIPS if they surpass any one of the low-volume thresholds. We are also very encouraged by CMS's proposal to set the third criterion threshold at 200 or fewer covered professional services to allow a significant number of clinicians to opt-in to MIPS and to avoid excluding additional clinicians from the program.

We remain very concerned, however, that the majority of clinicians are excluded from the program and question the ability of the QPP to drive quality improvement and value in the health care system without greater numbers of participating clinicians. We acknowledge the legislative imperative created by the Bipartisan Budget Act of 2018 to modify the definition of the low-volume threshold, to apply the \$90,000 minimum amount to allowed charges for covered professional services rather than to total allowed charges. However, we believe the transition to value will be better served by having more clinicians in the program. We strongly urge CMS to lower the thresholds for the low-volume criteria over time.

The current low-volume threshold undermines the original intent of MIPS: to assess and reward clinicians based on their performance relative to their peers (i.e., the average Medicare clinician). By concentrating the MIPS penalties and rewards on a much smaller group of Medicare clinicians, the current low-volume threshold may result in unfair penalties for some clinicians who perform above the median/mean of all Medicare clinicians and who would otherwise have earned a positive payment adjustment. Further, exempting practices sends the message that these clinicians are not essential to transforming the health care system nor should they be held to the same high quality standards.

We encourage CMS to explore other ways to support the participation of small practices as they transition to quality and cost accountability other than exempting low-volume clinicians altogether from MIPS.

MIPS Performance Threshold

We support CMS's efforts to encourage early participation in the QPP by allowing clinicians to become familiar with the program over time, and support CMS's intention to incrementally increase the performance threshold through Year 5. We support CMS's proposal to increase the MIPS performance threshold to 30 points for Year 3.

We strongly recommend that CMS adopt an additional requirement for clinicians to avoid a negative payment adjustment: participation in the quality performance category. By requiring clinicians to submit some quality measures that meet the necessary data completeness requirement, clinicians are encouraged to prepare for accountability for quality of care delivered (e.g., become familiar with reporting quality measures and use quality data to support practice improvement).

Cost Performance Category

We strongly support the proposal to increase the cost performance category to 15 percent. We were pleased that CMS finalized the 10 percent threshold for 2018 and believe another increase for Year 3 will facilitate a smoother transition to the statutorily required 30 percent threshold. To continue providing clinicians with valuable experience in managing resource use, we encourage CMS to incrementally increase the cost category weighting through Year Five.

Resource use measures are an integral part of understanding and evaluating the efficiency and value of care delivered, and we strongly support the proposals to adopt the following eight episode-based cost measures:

- *Elective Outpatient Percutaneous Coronary Intervention (PCI);*
- *Knee Arthroplasty;*
- *Revascularization for Lower Extremity Chronic Critical Limb Ischemia;*
- *Routine Cataract Removal with Intraocular Lens (IOL) Implantation;*
- *Screening/Surveillance Colonoscopy;*
- *Intracranial Hemorrhage or Cerebral Infarction;*
- *Simple Pneumonia with Hospitalization;* and
- *ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI).*

To identify and prevent unintended consequences of these measures, we recommend that appropriate use and quality (outcome) measures accompany them whenever possible.

We encourage CMS to continue its efforts to develop additional episode-based cost measures, so that a greater number of clinician specialties can have access to this important information.

Quality Performance Category

Importance of Patient-Reported Outcomes

In response to CMS's request for input on which patient-reported outcomes (PROs) produce better outcomes, we emphasize the importance of PROs in their own right. Outcomes typically refer to clinical outcomes, however, PROs are also meaningful outcomes of treatment/care – improved functioning, reduced pain, and improved quality of life. In this way, patient-reported outcome measures (PROMs) offer additional valuable information for consumers and providers, beyond what is provided by traditional clinical outcomes measures. PROs collection can also be used to initiate and/or support shared care planning and to track progress on a patient's individual goals, which very often go beyond achieving positive clinical indicators of health.

Public Reporting

We strongly oppose the proposal to extend the delay in public reporting of quality measures to the first 2 years a measure is in use in the quality performance category. We urge CMS to account for the public's right to quality and cost transparency and consumers' reliance on publicly available information to make important healthcare decisions; and, to maintain the current 1-year delay in public reporting for measure which is a more appropriate balance of stakeholder needs.

The Path to Meaningful Quality Reporting

To drive towards a higher-value health care system that meets the individual needs of each patient, ‘quality of care’ must be evaluated from the patient’s perspective, assessing both the experience of and results achieved by care provided. There can be no surrogates for such information. We strongly agree that quality measures have differing levels of value; most existing quality measures do not actually provide information on the effectiveness or experience of care. We applaud CMS for classifying measures most important to consumers and purchasers as high-priority: outcome measures including patient-reported outcomes, patient safety, appropriate use, efficiency, patient experience and care coordination. When such high-value quality measures are available, clinicians should be required to collect and report data on a harmonized set.

We urge CMS to move as quickly as possible to establish and require core sets of high-value measures for each specialty or subspecialty for the quality performance category. A core set approach using high-value measures would enable direct comparisons among similar clinicians, with assurance that they are being assessed against a consistent and standardized set of important quality indicators that are closely linked to their clinical practice. Moreover, public reporting of such information is critical for consumers to make informed health care decisions, enabling them to take control of their health and health care.

As we have noted previously, we remain very concerned about the limitations of the MIPS menu approach to selecting quality measures. A menu approach may lead providers to report only those measures for which they are high performers, obscuring results of poor care and leaving consumers and purchasers to make choices without critical information about provider performance. A menu approach also prevents an “apples to apples” comparison among providers, and we have significant concerns that the reporting of clinicians’ final quality category scores on Physician Compare is misleading when used to compare physicians on overall quality.

Further, the pick-your-measures approach hinders CMS’s ability to both evaluate meaningful quality improvement by clinicians and to identify topped out measures that should be removed from the pay-for-performance segment of the program. We support CMS’s intent to reward clinicians who make meaningful improvements in the quality of care delivered. However, without year-over-year reporting on the same quality measures, CMS cannot know whether or by how much quality has improved. The menu approach also undermines virtually any methodology used for identifying topped-out measure benchmarks. Calculating a measure’s benchmark using data only from those clinicians who choose to report on the measure provides an incomplete picture of system-wide performance on that measure.

As a transitional approach while CMS undertakes the development of core quality measure sets, we support the concept of tiering quality measures. We expect that any approach to tiering quality measures would replace the use of bonus points for high-priority measures. We further support an approach to tiering quality measures that would require the same number of quality measures be submitted and adjusts the potential number of achievement points based on the value classification of each measure reported. This would create a strong incentive for clinicians to choose high-priority measures, and better serves the program’s

overall goals to reward clinicians based on quality and outcomes of care. The alternative option to set a pre-determined denominator for the quality category would inappropriately weight the reporting of multiple process measures at the same level as reporting of a single outcome measure.

To meet the needs of consumers and purchasers, it is imperative for CMS to move away from bonus points and tiered quality measures in a voluntary reporting system to require core sets of high-priority quality measures by specialty or subspecialty.

Topped Out Measures

We have significant concerns about the validity of virtually any methodology used to identify topped out measures in a program that uses the menu approach for quality measurement. When clinicians can choose to report a small handful of measures from a large menu, it becomes impossible to know if a measure is truly topped out – that is, if clinicians are uniformly performing well on the measure, even among those not reporting the measure – or if a measure only appears topped out because it is reported by clinicians who will score well on the measure. For this reason, do not recommend the removal of measures which have been classified as “topped out” for fewer than three consecutive years regardless of how topped out a measure appears in any given year.

Some types of quality measures should never be removed, even if they are topped out, because these aspects of care quality are essential for high-quality patient care and/or have consequences if done poorly (e.g. patient safety, patient experience). These aspects of care quality require continuous monitoring – for example, many of the CAHPS for MIPS SSMS fall into these categories, including “How Well Providers Communicate”, “Health Promotion and Education”, and “Shared Decision Making”.

Quality Measure Inventory

We appreciate CMS’s intent to drive toward outcome measures and other high-value measures by incrementally removing process measures and other low-value measures. By narrowing MIPS measures to include only high-value measures, CMS can encourage clinicians to focus on the most important areas of measurement that both enhance quality improvement efforts and give consumers the necessary information to choose among clinicians. We recommend the following principles to guide CMS’s initiative to remove low-value measures:

- Maintain an adequate number of measures available to each specialty or sub-specialty; measures should not be removed when the removal would impact a specialty or sub-specialty’s ability to meet the reporting requirements of the quality performance category.
- Remove process measures when there is an outcome, intermediate outcome, or other process measure more closely linked to patient outcomes available for that same aspect of quality – to encourage reporting of the higher-value measure.
- Do not remove measures that assess areas of quality which requires continuous monitoring – for example, measures of patient safety, patient experience, and

appropriate use –unless there is another higher-value substitute measure immediately available.

Below, we offer recommendations on CMS’s proposals to adopt or remove specific quality measures.

We applaud CMS for proposing to adopt four patient-reported outcome measures. Patient-reported outcomes reflect issues that are important to patients and provide a valuable perspective on care that cannot be obtained from other data sources (e.g., severity of pain, physical functioning). We strongly support the proposals to adopt the following measures:

- ***Average change in functional status following lumbar spine fusion surgery (A.2.)***
- ***Average change in functional status following total knee replacement surgery (A.3.)***
- ***Average change in functional status following lumbar discectomy laminotomy surgery (A.4.)***
- ***Average change in leg pain following lumbar spine fusion surgery (A.6.)***

We do not support the proposed adoption of the process measure: ***Zoster (Shingles) Vaccination (A.8.)***. This measure needs to be updated to reflect the most recent clinical guidelines. Given the parallel proposal to negate performance on measures for which clinical guidelines were updated during the same performance year (i.e., physicians who choose to report such a measure would not have their performance calculated and would have their quality category denominator reduced by 10), it is inappropriate to adopt a measure with a known gap in clinical guidelines.

We do not support the proposed adoption of the process measure: ***HIV Screening (A.9.)***. There is no demonstrated performance gap (measure testing results showed very high performance overall) and the measure still needs to be tested at the clinician-level. We encourage HHS to monitor HIV screening at the population level through other programs and vehicles (e.g., through community-based services).

We strongly support the proposed removal of the measure: ***Ischemic Vascular Disease: Use of Aspirin or Another Anti-Platelet (#204)***; and, we strongly oppose the proposed adoption of the measure intended to replace it: ***Ischemic Vascular Disease Use of Aspirin or Anti-platelet Medication (A.7.)***. This is a useful measure concept, however, it is already captured in the ***Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control) (#441)***. Given the ‘pick-your-own measures’ design of the quality category, we strongly recommend not including such a measure in the program where it could displace reporting of the higher-value composite measure. Composite measures have a greater potential to drive improvements in care and better outcomes, and we would expect a clinician or group that chooses to report a composite measure to review their own performance on component measures to identify room for improvement.

We do not support the proposed removal of the measure: ***Adult Sinusitis: More than One Computerized Tomography (CT) Scan within 90 Days for Chronic Sinusitis (#334)***. Despite the 2018 MIPS quality benchmarking data which indicates that the measure’s

performance is extremely high and unvarying, it is impossible to know whether the measure is truly topped out – that is, if all clinicians are uniformly performing well on the measure – based on benchmarking data from a single performance year. The topped out status of the measure could be an artefact of the ‘pick-your-own measures’ design of the quality performance category, as clinicians who are more likely to score well on a measure are more likely to choose to report it. Furthermore, this is the first year the measure has been identified as topped out.³ We strongly urge CMS to follow the previously finalized 4-year process for removing topped out measures for all measures proposed for removal due to topped-out status, as this multi-year process provides a much greater level of certainty that the measure is truly topped-out prior to removal.

Data Completeness

We commend CMS for its focus on promoting data completeness in quality reporting and support CMS’s policy to continue assigning 1 point to practices that do not meet the data completeness criteria, as well as the proposal to lower this to zero points starting in performance year 2020. We strongly encourage CMS to lower the number of points assigned to small practices to 2 points for failing to meet the data completeness requirement. The current scoring rules do not distinguish small practices based on their data completeness, as 3 points are assigned to small practices regardless of whether the data completeness criteria was met. All practices should be incentivized and rewarded for their efforts to report complete quality data.

In future years, as clinicians gain experience reporting quality measures, we strongly encourage CMS to strengthen the data completeness criteria. Patients and caregivers who rely on this information to make health care decisions need reliable assessments of a clinician’s care quality – capturing 60% of available data is insufficient for the needs of consumers, purchasers, and other stakeholders. A larger patient sample provides a more reliable and valid representation of true performance and will better support clinician groups in internal benchmarking for quality improvement. Accordingly, we support the use of all-payer data for quality measures to provide an even fuller picture of a clinician’s performance.

Quality Measure Submission Mechanisms

As we have noted previously, we strongly oppose the flexibility to allow the same measure to be submitted via multiple collection types. This flexibility undermines the goals of the data completeness criteria, as only a portion of data collected on a single measure would be used to calculate performance. In other words, the same amount of data collected by clinicians would provide a less reliable and less accurate assessment of quality, making it more difficult to differentiate true performance among clinicians on that aspect of care quality or to evaluate year-over-year improvement on that measure. Already, small sample sizes create concerns about measure reliability – this flexibility further exacerbates the problem.

³ The measure was not identified as topped in the 2017 benchmarks. When the measure was reported through PQRS, benchmarking data for performance year 2016 showed an average performance of 7.66% with a standard deviation of 18.4%.

Further, we strongly oppose the corresponding policy to take the highest available score across collection types to determine a clinician or group's performance on that quality measure. At a minimum, the assigned score – for a quality measure submitted through multiple collection types – should be the taken from the collection type for which the submitted sample size was largest.

Ideally, CMS would move towards common data elements to enable data aggregation across collection types and to facilitate the development of a single quality benchmark for each quality measure.

Bonus Points

We support the proposal to remove high-priority measure bonus points assigned to CMS Web Interface measures, as clinicians who report through the CMS Web Interface do not have the ability to choose their measures. This proposal strengthens the use of high-priority measure bonus points as an incentive and meaningful reward for providers who actively elect to report high-priority measures.

Promoting Interoperability Performance Category (formerly Advancing Care Information)

Certified Electronic Health Record Technology

We strongly support the requirement to transition to the 2015 Edition of Certified Electronic Health Record Technology (CEHRT), which enables critical functionalities that are foundational to a patient- and family-centered health care system, including application programming interfaces (APIs) for consumer access, more robust demographic data collection, and information on social determinants of health.

Scoring

Overall, we support performance-based scoring and applaud the focus on interoperability and patient access in the proposed changes to the Promoting Interoperability Performance Category. We believe widespread electronic exchange of health information is a prerequisite for reimbursing value-based care and improving health outcomes and support the proposal to weight heavily measures of information exchange and patient access.

Patient Access and Engagement Measures

We appreciate CMS's commitment to providing patients access to their electronic health information. We strongly support the proposal to allocate the most weight to the Provide Patients Electronic Access measure (forty out of a possible one-hundred points for performance year 2019) and encourage CMS to finalize this scoring structure and maintain this emphasis on patient access in future performance years. However, we are concerned that the removal of the complementary patient engagement measures will limit the effectiveness of the program in driving meaningful improvements in interoperability. We do not support the proposals to eliminate measures that help patients and family caregivers to use their online health information (View/Download/Transmit), communicate electronically with providers (Secure Messaging) and contribute information to their medical record that is specific and material to their care (Patient Generated Health Data). Patient generated health data (PGHD) is essential for encouraging collection and use of patient-reported outcomes, which is a high

priority for consumers and purchasers. We strongly encourage CMS to preserve the PGHD measure to encourage providers to establish workflows to collect and integrate these critical data into their medical records, thereby promoting interoperability and patient-centered care.

Reporting Period

We are disappointed that CMS has proposed another 90-day reporting period for 2019 and we urge CMS to move to full calendar year reporting as soon as possible. Patients and families should be able to experience the benefits of health IT – getting questions answered through secure e-mail, or having a summary of care records incorporated into new providers' health records – any day of the year, rather than a particular three-month period. Furthermore, requiring full-year reporting is more likely to prompt changes to provider workflows that would allow clinicians to be rewarded for sustained progress on ACI measures.

Clinical Practice Improvement Activities Performance Category

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

- Provide financial counseling to patients or their caregiver about costs of care and an exploration of different payment options (Financial Navigation Program).
- Completion of a collaborative care management training program that provides comprehensive training in the integration of behavioral health into the primary care practice.
- Participate in training on relationship-centered communication, including listening with empathy, eliciting patient stories and perspectives, and developing a shared care plan.
- Provide written and verbal education regarding the risks of concurrent opioid and benzodiazepine use (Patient Medication Risk Assessment).

APPENDIX B: ADVANCED ALTERNATIVE PAYMENT MODELS

We continue to strongly support CMS's move toward a value-based health care system, and we are pleased to see the continued implementation of the Advanced Alternative Payment Model (AAPM) track within the QPP. AAPMs have great potential to drive and reward high-quality comprehensive, coordinated, patient- and family-centered care while driving down costs. We encourage CMS to continue adding models that qualify as AAPMs to offer clinicians more opportunity to participate in value-based payment and care delivery.

Intermediate APMs (MIPS APMs and Other MIPS APMs)

We support the use of the Intermediate APM (or "MIPS APM") option for clinicians participating in care and payment models that do not meet the financial risk or other Advanced APM (AAPM) requirements. We agree with CMS that it is important to recognize providers on the path to AAPMs through streamlined reporting requirements.

Advanced APM Criteria: CEHRT Use

We strongly support CMS's proposal to increase the CEHRT Use criteria for Advanced APMs to require at least 75% of eligible clinicians in each APM entity to use CEHRT.

APPENDIX C: CMS Requests for Information

Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange Through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals and other Medicare and Medicaid Participating Providers and Suppliers

We support the goal of achieving widespread electronic exchange of health information across the health care spectrum. We believe data is a shared resource, rather than a competitive asset, and information that supports/enables optimal care (i.e., tailored to the patient's individual needs and priorities) must be available to those who care for the patient – including the patient themselves. Moreover, interoperability is critically needed to improve health care system efficiency and to reduce hospital overhead costs. We appreciate that this Administration is committed to bold action to advance interoperability and to support efforts that increasingly enable patients and their providers to seamlessly access and share their digital health information.

Request for Information on Price Transparency: Improving Beneficiary Access to Provider and Supplier Charge Information

We are encouraged by CMS's proposal to improve consumers' access to price information by requiring hospitals to post standard charges online. However, given that these charges are not reflective of what consumers ultimately pay, patients and families also deserve individualized estimates of out-of-pocket costs in advance of services, including information on deductibles, co-insurance and copayments. Cost information should always be supplemented with data on provider quality and health outcomes to prevent their conflation, as consumers may be led to believe that higher prices are indicative of better quality care.